Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue: Boardroom, Sandwell General Hospital

Date: 2 June 2016; 0930h – 1245h

Members attending:

Mr R Samuda	(RSM)	Chairman
Ms O Dutton	(OD)	Vice Chair
Mr M Hoare	(MH)	Non-Executive Director
Mr H Kang	(HK)	Non-Executive Director
Mr R Russell	(RR)	Non-Executive Director
Dr P Gill	(PG)	Non-Executive Director
Cllr W Zaffar	(WZ)	Non-Executive Director
Mr T Lewis	(TL)	Chief Executive
Mr T Waite	(TW)	Director of Finance
Dr R Stedman	(RST)	Medical Director
Mr C Ovington	(CO)	Chief Nurse
Ms R Barlow	(RB)	Chief Operating Officer
Miss K Dhami	(KD)	Director of Governance
Mrs R Goodby	(RG)	Director of Organisation Development

In attendance:

Mrs C Rickards	(CR)	Trust Convenor

Board Support

Mr D Whitehouse	(DW)	Head of Corporate Governance

Time	Item	Title	Reference Number	Lead
09:30h	**1.**	**Apologies**	Verbal	**DW**
	2.	**Declaration of interests** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting.*	Verbal	**Chair**
09:35h	**3.**	**Patient story**	Presentation	**CO**
09:55h	**4.**	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 5 May 2016 as a true and accurate records of discussions*	SWBTB (06/16) 041	**Chair**
	5.	**Update on actions arising from previous meetings**	SWBTB (06/16) 042	**DW**
10:00h	**5.1**	**Local food suppliers (Halal)**	SWBTB (06/16) 043	**CO**
	5.2	**Cancelled Operations – Update on Pre-Assessment Process**	SWBTB (06/16) 044	**RB**
	5.3	**Paediatric community caseloads**	SWBTB (06/16) 045	**RB**
	5.4	**Junior doctor placements 2016-17**	SWBTB (06/16) 046	**RG**
	5.5	**Primary Care Interface Prescribing**	SWBTB (06/16) 047	**RST**
10:25h	**6.**	**Questions from members of the public**	Verbal	**Chair**

Time	Item	Title	Reference Number	Lead
10:40h	**7.**	**Chair's opening comments**	Verbal	**Chair**
		UPDATES FROM THE BOARD COMMITTEES		
10:45h	**8.**	Update from the **Finance and Investment Committee** meeting held on 27 May 2016	To follow	**RSM/ TW**
	9.	To consider the update from the **Quality & Safety Committee** meeting held on 27 May 2016 and to note the minutes of the meeting held on the 22 April 2016	To follow SWBTB (06/16) xxx	**OD/ CO**
	10.	To note the minutes of the **Charitable Funds Committee** meeting held on the 19 May 2016	To follow	**WZ/ RW**
	11.	To consider the update from the **Audit and Risk Committee** meeting held on the 1 June 2016	To follow	**RR/ KD**
		MATTERS FOR APPROVAL OR DISCUSSION		
11:00h	**12.**	**Chief Executive's report**	SWBTB (06/16) 048	**TL**
11:10h	**13.**	**Trust Risk Register**	SWBTB (06/16) 049	**KD**
11:20h	**14.**	**Preparation for Summer Consultation**	SWBTB (06/16) 050	**RG**
	14.1	**16-18 Workforce Changes Phase 1 (Easter 2016) Progress Report**	SWBTB (06/16) 051	**RG**
11:35h	**15.**	**Financial Plan 2016-17**	To follow	**TW**
11:50h	**16.**	**Initial feedback from in house inspections – May 2016**	Verbal	**KD**
12:05h	**17.**	**Integrated Performance Report**	SWBTB (06/16) 052	**TW**
12:20h	**18.**	**Security Update**	SWBTB (06/16) 053	**CO**
12:30h	**19.**	**Draft Annual Report and Quality Account: to adopt**	SWBTB (06/16) 054	**RW**
12:40h	**20.**	**Annual Accounts 2015-16: to adopt**	SWBTB (06/16) 055	**TW**
		MATTERS FOR INFORMATION		
12:55h	**21.**	**Financial performance – P01 April 2016**	SWBTB (06/16) 056	**TW**
	22.	**Any other business**	Verbal	**All**
	23.	**Details of next meeting** The next public Trust Board will be held on 7 July 2016 starting at 09:30am at the West Bromwich African Caribbean Centre, West Bromwich.		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD PUBLIC

Venue Anne Gibson Board Room, City Hospital **Date** 5 May 2016 09:30h – 13:00h

Members Present

Mr Richard Samuda	Chair
Ms Olwen Dutton	Vice Chair
Mr Mike Hoare	Non-Executive Director
Mr Toby Lewis	Chief Executive
Ms Rachel Barlow	Chief Operating Officer
Miss Kam Dhami	Director of Governance
Mrs Raffaela Goodby	Director of Organisation Development
Mr Colin Ovington	Chief Nurse
Dr Roger Stedman	Medical Director
Mr Tony Waite	Director of Finance & Performance Management

Also in attendance:

Ms R Wilkin	Director of Communications
Mrs C Rickards	Trust Convenor
Board support:	
Mr Duncan Whitehouse	Head of Corporate Governance

Minutes	**Paper Reference**
1 Apologies	
Apologies were received from Mr Robin Russell and Mr Harjinder Kang.	
2 Declarations of interest	SWBTB (05/16) 020
Mr Gill declared an interest in agenda item 19 (approval and execution of lease of the Old Chapel, Sandwell Hospital) as a Trustee of Healthy Hearts.	
2.1 Register of Interests	SWBTB (05/16) 021
The Register of Interests was approved as a correct record of interests held as of the 1 May 2016 with the addition of Cllr Waseem Zaffar being a member of the Britain Stronger in Europe campaign. It was clarified that there was not a requirement to formally declare affiliations to a political party.	
3 Patient Story	
Ms Talbot introduced the item and video that focussed on the implementation of Ten out of Ten and the progress that was being made from a patient and staff perspective. Learning from the focussed care rapid improvement programme had been used to develop a 100 day implementation programme in the Assessment Units for the	

consistent delivery of Ten out of Ten. The fast pace of implementation was being received well by nurses. There was clear evidence of motivation amongst staff with a noticeable change in culture. The patients interviewed highlighted that they understood the reasons for being tested for MRSA, that they were allowed to manage when they took their own medication and confidence in hygiene on the wards with staff visibly washing their hands. In terms of staff then they were clear about the value of assessing patients against the ten criteria within 8 hours and the checklist provided ensured patients were kept informed. The checklist was now being seen as a vital part of effective patient care. Dr Gill queried when the Ten out of Ten processes concluded. In response the Board were informed that assessment continued throughout the patient's stay until discharge. Ms Dutton welcomed the assurances provided to the Board in terms of implementation and the feedback of the value of the checklist in improving patient care. The feedback provided opportunity to reflect on the communication of Ten out of Ten previously and gain important learning for the role out of future programmes. Mr Lewis thanked the teams for the progress being made in implementing what was an important Board priority. He queried the focus on pain management. Assurances were given that pain management was addressed quickly with an active approach in engaging patients to ensure they were comfortable. In response to a query from Miss Dhami about the ongoing focus in terms of Ten out of Ten then the lifestyle standard was identified as one of the key areas that needed further attention and support.	
4 Minutes of previous meeting – 7 April 2016	SWBTB (05/16) 022
Resolved: the minutes of the previous meeting were agreed as an accurate record.	
5 Update on actions arising from previous meetings	SWBTB (05/16) 022a
Cllr Zaffar again highlighted the need for the Board to reflect on catering services and the provision of Halal food across the Trust. Mr Lewis agreed that an update be provided to the June Board meeting. The further investigations that the Quality and Safety Committee were undertaking in respect of wider safe staffing was welcomed with agreement that the findings would be presented to the June Quality and Safety Committee and July Board meeting. **Actions:** **1. that an overview of the provision of Halal food be presented to the June Trust Board meeting.** **2. that the wider safe staffing report be scheduled to come back to the Board in July 2016.**	
5.1 Cancelled operations on the day of surgery and multiple cancellations	SWBTB (05/16) 023

Ms Barlow introduced the paper which updated the Board following previous discussions prompted by the Integrated Performance Report. From the period April 2015 to March 2016 there was 2,538 cancelled surgical procedures with 316 patients experiencing more than one cancellation. There had been some progress in year with improvement focus having evidenced a reduction in avoidable cancellations.

In terms of on the day cancellations the improvement focus is around ensuring theatre lists started on time, sufficient planning to ensure specialist equipment is identified and addressing results and consent issues in respect of missing patient information.

A third of multiple cancellations were due to procedures being brought forward. This should be addressed through improved scheduling. There were also actions being taken to address issues in respect of pre-assessments and missing patient information.

Mr Samuda queried the performance position of the Trust in comparison with other Trusts. Ms Barlow responded that the Trust compared well in terms of on the day cancellations. Mr Kang challenged the extent to which issues behind the levels of multiple cancellations were being drawn out and addressed. Ms Barlow responded by stating that currently there was not the granularity of detail in the data in multiple cancellations to do this. The data did however highlight that a third of cancellations had been brought forward due to scheduling factors rather than clinical necessity.

Ms Dutton challenged the timescale for the issue being addressed. Ms Barlow stated that there was a clear trajectory through to the end of the year. Mr Lewis gave a reassurance that urgent patients were not being cancelled and that the Trust was well within national norms. That being said that Board and all staff should be intolerant of patients being subject to a second cancellation.

Ms Dutton also queried the level of clinical buy in to the importance of this issue and the risk that the public perceive that it is almost inevitable that their NHS operation may be cancelled whether carried out in the Trust or elsewhere. Ms Barlow responded by stating that a lot of work was ongoing with Groups to engage the support of clinicians. Oral surgery was one example of where there was active work underway with clinicians.

Dr Gill queried the process through which patients were informed of cancellations stating that text messaging and new technology was important but should not totally replace a simple phone call where this would more appropriately meet a patient's needs. Ms Barlow stated that the Trust was reviewing its communication channels. Mr Lewis stated that upcoming upgrades to the IT systems would make it easier from July to understand individual patient communication preferences and tailor communication more effectively. Ms Barlow also gave an assurance to Mr Kang that the supply chain was able to keep pace with the forward planning of schedules.

Action: that a paper be brought to the next Board in respect of pre-assessment and the actions being taken to improve performance.

5.2 Reducing unplanned admissions | SWBTB (05/16) 024

Ms Barlow introduced the item stating that there had been sustained improvement in unplanned admissions since March last year. The pilots had seen a 6% improvement with the use of the LACE scorecard and wrap around support. Further work was needed however to embed LACE and work was ongoing to scope the contribution the third sector and Trust volunteers could make to ongoing improvements. Mr Hoare welcomed the report stating that it highlighted the impact that concentrated focus on an issue can have. Cllr Zaffar also highlighted the effective work that was taking place in the community by the third sector and that he would be willing to facilitate dialogue to draw closer links. Mr Samuda queried the effectiveness of the support infrastructure that was wrapped around individual patients to reduce unplanned admissions. Ms Barlow responded stating that every patient was risk assessed in respect of factors such as whether they lived on their own which increased the risk of readmission. Work was ongoing to develop the existing workforce to develop wider geriatric wraparound support. Mr Lewis drew the Board's attention to the negotiations with the CCG about funding and the need for the CCG to target effective resources at a model of care that the Trust has proven works. **Action: future Board visits to be programmed that enables the Board to see the impact of community services.**	
5.3 PMO capacity and development	SWBTB (05/16) 025
Ms Barlow introduced the item which set out the revitalising of the Change Team and the PMO function to support the Trust in delivering its ambitions. There were four main areas of focus with these being planned care and contract income, a workforce that could meet the challenges that lay ahead, addressing unfunded beds and wider non-pay matters. There was intentionally a strong alignment between the PMO function and the Executive Team. Procurement would also be an accelerated work stream. Mr Lewis stated that the reinvigorated Change Team would support the Executive in terms of the grip on money and delivery against the Quality and Safety Plans. They would also be integral to the embedding of the operating model. Mr Kang challenged the extent to which new faces would ensure results. Mr Lewis responded by stating that it was not just about what the Trust was asking the team to do but also to ensure effective leadership and accountability around the pace of change. Ms Dutton felt the changes were positive but challenged where the accountability to the Board sat to ensure effective traction. She asked for real time data to be assured that these changes were having an impact and that there was genuine traction. Ms Barlow responded by stating that this piece on its own would not provide the assurances needed. Twenty other change leaders had been identified across the organisation and the effective use of Quality Improvement Half Day time. There would be an accelerated programme over the coming months.	

Mr Lewis made explicit that the PMO capacity would supplement the leadership focus. The Board needed access to effective data and progress to be able to challenge any disconnect between the stated ambitions of the Board and the frontline. There needed to be a clear trajectory around what we will do differently to ensure sustained change can be embedded. Mr Lewis stated that he would be the conduit through which the work of the team would feed through to the Board. Mr Lewis drew attention to the Leadership Conference that was taking place in a couple of weeks. This provided the opportunity to share a very clear narrative with the leadership of the organisation about the direction of travel and the integration and alignment needed across programmes. There were challenges ahead but the Trust need to face these head on in an environment of hope not fear and with a clear narrative around patients being at the heart of our journey to improve care and remove waste.	
6 Questions from members of the public	
Mr Hodgetts queried the position in terms of oncology services and raised concerns that oncologists were speaking openly to patients about the continuity of service and generating unnecessary worry. Mr Lewis highlighted the update that was provided within his Chief Executive's report and that dialogue was ongoing with commissioners. He reiterated that the service was safe and providing quality care to those receiving the service. The Trust would continue to deliver against the contract it had. The fact that patients would continue to receive a service was what should be being communicated to patients and clinicians have been informed of the current position and hence there is no need to cause worry to patients.	
7 Chair's opening comments	
Mr Samuda drew the Board's attention to a common theme that ran through the agenda for today's Board which was the importance of having a clear grasp on delivering against the Board's agreed priorities at pace. It was important for everybody across the Trust to have a firm grip on income and delivery against volumes of work.	
8 Revised terms of reference for the Audit and Risk Committee	SWBTB (05/16) 026
Miss Dhami introduced the paper highlighting the legislative requirement to establish an Auditors Panel. Guidance stated that in most circumstances Trust's would adopt the approach of assigning the role to its Audit Committee. The Board was asked to approve the revised terms of reference for the Audit and Risk Committee with it becoming the Auditor Panel as set out in the Local Audit and Accountability Act 2014. **Approved: that the revised terms of reference for the Audit and Risk Committee be approved extending its remit to become the Trust's Auditor's Panel.**	
9 Minutes from the MPA Committee meeting held on the 30 March 2016	SWBTB (05/16) 027
The minutes were noted. Mr Samuda highlighted that Mr Russell had kindly agreed to be observer on the SPV Board for the Midland Metropolitan Hospital project.	

10 Minutes from the Finance and Investment Committee meeting held on the 26 February 2016 and the update from the meeting held on the 1 April 2016	SWBTB (05/16) 028
The minutes were noted. Mr Samuda stated that the committee had received assurances that the procurement exercise for the Electronic Patient Record (EPR) had been carried out thoroughly and endorsed the preferred bidder in light of the value for money analysis.	
11 Minutes from the Quality and Safety Committee meeting held on the 22 April 2016	SWBTB (05/16) 029
Ms Dutton drew the Board's attention to the investigation the committee were undertaking into wider safe staffing and that they had considered the draft Quality Account which appeared later in the Board agenda. There would be a renewed focus for the agendas based around the Safety and Quality Plans and Healthwatch were to be invited to attend future meetings. NHS Improvement had also attended the meeting to observe and provide feedback.	
12 Update from the Workforce and OD Committee meeting held on the 30 March 2016	SWBTB (05/16) 030
The minutes of the meeting held on the 30 March 2016 were noted.	
13 Update from the Audit and Risk Committee meeting held on the 28 April 2016	SWBTB (05/16) 031
Miss Dhami highlighted that the committee had considered the Internal Audit Plan and Clinical Audit Plan. The Clinical Audit Plan had been completed reviewed in term of its focus and scope. Ms Dutton welcomed the review of the Clinical Audit Plan and its need to drive continued improvements.	
14 Chief Executive's report	SWBTB (05/16) 032
Mr Lewis introduced his report thanking all staff who had had offered additional support during the junior doctors industrial action. Planned care had been cancelled to free staff capacity to support emergency and inpatient areas. The cost of the last period of strike action was £800k. The risk of 24 hour industrial action would have a far greater impact in terms of deploying sufficient staff to ensure safe care. In terms of Trust finances there was a planned deficit of £5, which was over £9m adrift from the Trust's long term financial plan. The largest factor contributing to that gap was the delayed phasing of cost improvement plans. The Cost Improvement Plan (CIP) would remain challenging going forward with the need for £30m in savings taking into account the full year effect. Mr Lewis also highlighted that the organisation was preparing itself for a workforce consultation. Mrs Goodby highlighted that a consultation in terms of the closure of the day nurseries was underway and would shortly conclude. Some staff would be redeployed to the Sandwell site and staff had been supported in developing options around an alternative business model which was being explored. The majority of parents had accepted alternative provision. Mr Ovington provided an update on safe nurse staffing as outlined in the appendix to the Chief Executive's report. Early warning assessment had been the subject of review	

over recent weeks. A new measure in terms of care hours per patient per day would come into effect from May 2016.

In response to a challenge from Ms Dutton in regard to the high fill rates for maternity Mr Ovington suggested that there must be an issue in term of how the data had been captured and recorded in the context of community midwifery.

Ms Dutton also questioned how the new care hours per patient would be calculated and whether families caring for patients were taken account of in the indicator. Mr Ovington stated that it would not be included and rather than recording 1:1 care there would be a figure for the care of a cohort of patients where family members were present to provide support.

Dr Gill queried the impact on medical staffing from the 1 August in terms of new contracts. Mr Lewis stated that the impact would relate to FY1's in the first instance. What was needed was clarity in terms of vacancies versus changes to contracts. It was agreed that a report would be brought to the June meeting to provide a basis for discussion.

Action: that a paper be brought to the June Board in respect of junior doctor allocations.

15 Contribution of volunteers to SWBH | SWBTB (05/16) 033

Mr Ovington introduced the paper highlighting ongoing conversations that were taking place with Carers Sandwell. In terms of next steps these included actions to address the gap in volunteers in community settings and to encourage staff to undertake voluntary work.

Mr Kang challenged whether the Trust had up until now had a passive relationship with the third sector. Ms Wilkin stated that the Trust was devoting time to building a more pro-active approach and in getting community members involved. Mr Ovington in response to a query from Ms Dutton also sighted the work underway with local colleges to attract students on a voluntary basis.

Cllr Zaffar was critical of the speed with which the Trust was quick to respond to following up leads with the voluntary and community sector highlighting examples of where links could be followed up such as with Aspire and Succeed Lizella. Mr Ovington also highlighted the difficulties he experienced in accessing the Trust's website and signing up to be a volunteer which was a matter that was being addressed.

Mr Lewis stated that there was a lot of work going on but there was a need to focus on the ten objectives set out in the report and RAG rate these with a clear trajectory and progress to date. This would give clarity over the areas that still needed attention. It was essential to not get to the end of the year to see if we had achieved our targets or not. He also reiterated the importance of reflecting on the totality of volunteering. Mrs Goodby highlighted the work ongoing with colleges around patient experience and hair and beauty treatments for example. Mr Lewis also stressed the need to address demand as well as supply ensuring enough appropriate opportunities for the Trust to utilise the value of volunteers across the breadth of what the Trust did.

16 Better back to work – with a focus on long term sickness	SWBTB (05/16) 034
Mrs Goodby introduced the paper which set out a summary position of sickness absence levels for 2015-16 and the proposed focus for 2016/ 17. Work was underway to review the relationship with Occupational Health and differential absence targets were included in the report for each Group. Accelerated action was being taken to address issues in terms of long term sickness with managers being held to account for how long term sickness cases were being managed. There was also a centrally based HR lead that had oversight of vacancy opportunities to support staff back into work and facilitate those conversations. Mr Kang welcomed the level of granularity that was now being presented in terms of the data but challenged the pace of actions being taken to address issues flagged up by the data. Mrs Goodby stated that managers needed to be explicit in the questions they wanted Occupational Health to answer. The greater the level of detail in terms of the person and the job, the more accurate the final report would be and the more effective that report would be in providing support to the individual involved. There was a strong commitment to the use of data to drill down into areas of high sickness and address root causes. Mr Ovington highlighted that 30% related to matters of stress and anxiety. He queried what additional support was needed to improve the figures. Mrs Rickards added that there were a lot of issues in relation to dignity at work and the importance of addressing issues as they arose amongst staff or between staff and their line manager. It was important to think innovatively about return to work options. Mrs Goodby stated that a central HR lead would assist in supporting people back to work in a different environment. It was essential for managers to retain an effective dialogue with those off sick and to support people back into work otherwise the longer somebody was off then potentially the more difficult it would be for them to return.	
17 Trust Risk Register	SWBTB (05/16) 035
Miss Dhami introduced the report stating that no new risks had been escalated to the Board from the Clinical Leadership Executive. In terms of risk 121 (unpredictable birth activity and the impact of cross charging from other providers) Mr Waite asked that this remain on the Risk Register as the SLA had yet to be signed. In respect of risk 1643 (unfunded beds) the risk commentary would be revised follow the work underway to address the issue. As regards risk 329 (sonographer capacity) the training programme would commence from Q2.	
18 Integrated Performance Report (IPR)	SWBTB (05/16) 036
Mr Waite introduced the IPR which set out the end of year report and performance against key standards. Areas of improvement included VTE and cancer targets with a focus on tumour site level performance. In terms of areas requiring ongoing focus these included 4 hour wait times and RTT. Ms Dutton challenged progress in respect of Delayed Transfers of Care. Ms Barlow responded stating that bed days would increase from April. There had been significant bed pressures at Sandwell and exceptional figures of 97 patients awaiting transfers of	

care at one point following the council changing providers and issues arising from the transfer of the service. Mr Samuda challenged the fall in stroke performance. Ms Barlow responded by stating that the fall in performance was a consequence of a group of particularly ill patients and a combination of delayed transfers and patient choice. Ms Dutton queried performance in respect of the friends and family test response rates. Mr Ovington stated that other places did perform better. There was real value in face to face dialogue regarding people's feelings on the quality of treatment received. Options were being considered in terms of improving response rates.	
19 Approval and execution of a lease of the Old Chapel, Sandwell Hospital to HHI Limited trading as Healthy Hearts	SWBTB (05/16) 037
The paper set out the proposal to renew the granting of the lease of the Old Chapel building at Sandwell Hospital to HHI Limited, trading as Healthy Hearts. **Approved: that the Trust execute the seal to renew the lease of the Old Chapel building, Sandwell Hospital to HHI Limited, trading as Healthy Hearts.**	
20 Financial performance – P12 March 2016	SWBTB (05/16) 038
Mr Waite introduced the report stating that the Trust had met its key financial targets and duties for 2015-16. A headline surplus for the year of £3.8m had been achieved but with reliance on contingencies. Mr Lewis, on behalf of the Board, thanked the finance team for the work and effort put in to concluding the year end and in ensuring the meeting of key targets.	
21 Complaints and PALs report: 2015/ 16 quarter 4	SWBTB (05/16) 039
Miss Dhami introduced the report highlighting the progress that had been made in responding to complaints in a timely manner. Mr Lewis sought assurances around the data and what it presented in regard to the level of complaints from ethnic groups and whether a picture could be drawn as to groups that made up a greater percentage of the total number of complaints. Miss Dhami stated that there was a trend in a greater number of complaints from black communities. This needed to be understood in greater detail in regard to effective communication with patients and their families and carers. **Action: that a report be brought back to the July/ August Board outlining the actions that will be taken to address the issue of the higher percentage of complainants that were from black communities.**	
22 Any other business There were no other items of business.	

24 Details of the next meeting:	
The next public Trust Board will be held on 2 June 2016, starting at 09:30 in the Boardroom, Sandwell General Hospital.	

Signed ……..

Print ……..

Date ……..

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board Action Tracker

1-Jun-16

	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
SWBTCACT.510	Smoking Cessation	SBBTB (11/15) 181	05-Nov-15	Updates to be provided to the Board as the policy is progressed	TL	07/07/2016	Updates to be provided as appropriate on progress.	Open
SWBTBACT.521	Learning Disabilities: People's Parliament	SWBTB (01/16) 210	07-Jan-16	1 page scorecard to be developed providing assurances around objectives and in particular objectives 1, 4 and 5	CO	07/07/2016	Changing Our Lives are being commissioned to udertake an audit of the Trust. Once the audit has been completed the outcome of the audit and relevant scorecard will be brought back to the Board	Open
SWBTACT.523	Financial performance	SWBTB (01/16) 211	07-Jan-16	Report to June meeting on list of generic drugs agreed between Trust and GPs	RSt	02/06/2016	Report included on the agenda for the June meeting	Closed
SWBTACT.524	Wider safe staffing	SWBTB (01/16) 213	07-Jan-16	Report back on table top review of ward rotas determining accurate ratios of wider staff time on wards.	RG	07/07/2016	A report was presented to Quality and Safety Committee on the 22 April 2016. At that meeting it was agreed that further work was needed to build an accurate picture of the implications of wider safe staffing and that this be brought back to the Quality and Safety Committee before being presented to the Board.	Open
SWBTACT.526	Trust Risk Register	SWBTB (03/16)	03-Mar-16	Report to be brought back to the May meeting regarding multiple cancellations	RB	05/05/2016	A report was considered by the Board at its May meeting	Closed
SWBTACT.530	Community caseloads	SWBTB (04/16) 004	07-Apr-16	That a report be brought back to the June meeting with a focus on midwifery	RB	02/06/2016	A report is included on the agenda for the June Board meeting	Closed
SWBTACT.531	Questions from the public		07-Apr-16	A car parking strategy be developed	CO	05/01/2017	Car parking startegy to be developed linked to financial planning for 2017/ 18	Open
SWBTACT.532	Cancer Services	SWBTB (04-16) 012	07-Apr-16	A report to be brought back to the Board in July	RB	07/07/2016	Report to be scheduled for the July meeting.	Open

SWBTACT.533	Actions from previous meetings	SWBTB (05/16) 022a	05-May-16	Report to be provided to the Board on Halal food across the Trust	CO	02/06/2016	Report included on the agenda for the June meeting	Closed
SWBTACT.534	Actions from previous meetings	SWBTB (05/16) 022a	05-May-16	Wider safe staffing report to be brought back to the July meeting following further consideration by Quality and Safety Committee	RG	02/06/2016	Report to be presented to the July Board meeting	Open
SWBTACT.535	Cancelled operations	SWBTB (05/16) 023	05-May-16	Report on pre-assessment to be brought to the June Board meeting	RB	02/06/2016	Report included on the agenda for the June meeting	Closed
SWBTACT.536	Chief Executive's Report	SWBTB (05/16) 032	05-May-16	Report to be presented to the June Board meeting on junior doctor allocations	RG	02/06/2016	Report included on the agenda for the June meeting	Closed
SWBTACT.537	Complaints and PALs report	SWBTB (05/16) 032	05-May-16	Report to be brought back to the August meeting outlining actions to address higher number of complaints from some community groups	KD	04/08/2016	Report to be presented to a future meeting.	Open

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Local Food Suppliers (Halal)
SPONSOR (EXECUTIVE DIRECTOR):	Colin Ovington – Chief Nurse
AUTHOR:	Steve Clarke – Deputy Director - Facilities
DATE OF MEETING:	Thursday 2nd June 2016

EXECUTIVE SUMMARY:

Board members are aware that we have been trying to source supplies including food locally which helps as achieve a number of objectives including reducing the environmental burden one of our public health objectives, and also to support local economy. The purpose of this paper is to inform the Trust Board of the current position regarding sourcing local food suppliers, especially in relation to Halal meals. To note that there has been some progress in finding out the capability of local providers of Halal food, I expect during the next month to have come to some conclusions about the best way forward for the Trust and ask the board to receive a further update in August.

REPORT RECOMMENDATION:

To receive an update at the August 2016 Board Meeting.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		**X**

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial		Environmental	**X**	Communications & Media	
Business and market share	**X**	Legal & Policy		Patient Experience	**X**
Clinical		Equality and Diversity	**X**	Workforce	

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

PREVIOUS CONSIDERATION:

LOCALISED FOOD SUPPLIERS (HALAL)

REPORT TO THE TRUST BOARD ON THURSDAY 2ND JUNE 2016

Localised Suppliers

The Trust is currently undertaking a review of all local food suppliers to assess if there are local companies who can meet the required food hygiene controls and regulations and offer a value for money service.

Procurement are also running mini-competitions/quotations for meat, bread, chilled foods, ethnic and dysphasic frozen ready meals where the focus is on buying sustainably-trying to source more locally, asking for red tractor/free range/farm assured/freedom foods where suitable, combined with better quality-lower salt/sugar/fat content and hopefully reducing or at least not increasing costs.

Approved Suppliers

The Food Safety Regulations for the procurement of food suppliers for the NHS states that all food suppliers have to demonstrate their due diligence with regards to their food purchases, premises, equipment, production etc., this will ensure there is an evidence based audit trail. There are a number of approved companies who undertake the due diligence on our behalf and credit the companies with a certificate of approval.

Local Trusts

The majority of local Trusts purchase their halal meals from the same supplier as used by SWBH NHS Trust, the company is based in Sheffield. In terms of the Black Country Alliance (BCA) Walsall Manor purchase their meals from a company in London and Dudley has an external patient meal provision supplied from a commercial patient food manufacturing company.

A local company in Birmingham that produce halal meals has recently achieved approval from SALSA (Safe and Local Supplier Approval). The Trust is seeking advice from our EHO (Environmental Health Officer) prior to arranging an official visit to ascertain if the company meets the required food hygiene standards.

As part of the review we are also checking out all other local options. There is a neighbouring Trust that produces halal meals in their cook-chill facility, however there is a need to review quality, quantity and costs and also identify if they source their halal meat locally.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Cancelled Operations – Update on Pre-Assessment Process**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow - Chief Operating Officer**
AUTHOR:	**Michelle Harris - Director of Operations**
DATE OF MEETING:	**2nd June 2016**

EXECUTIVE SUMMARY:

At the Trust Board in May 2016 the presentation of the Multiple Cancellations paper identified that in March 2016, 55 patients had their procedure on more than 1 occasion. Of those 55 patients, 49 had been cancelled on 2 occasions and 6 on 3 occasions. 45% of those cancellations were due to inadequacies in the pre-assessment process including post discharge planning.

The Board requested a more detailed view of our pre-assessment pathway at the June meeting.

This paper will outline the background issues, the progress to date including the next steps in securing a service that is fit for purpose.

The Trust Board is asked to discuss this updated paper, recognise the improvements that have been made so far and agree the timescale for full implementation of improvements.

REPORT RECOMMENDATION:

The Trust Board is asked to discuss the themes and improvement focus and goals with regard to theatre cancellations.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
x		x

KEY AREAS OF IMPACT *(Indicate with 'x' all those that apply):*

Financial	x	Environmental		Communications & Media	x
Business and market share		Legal & Policy	x	Patient Experience	x
Clinical	x	Equality and Diversity		Workforce	

Comments: Failure to escalate any potential avoidable on day cancellation and achieve a reduction overall cancellations will impact on in-list theatre utilisation, activity targets and income as well as providing a suboptimal experience for our patients.

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Cancelled Operations – Performance metrics

PREVIOUS CONSIDERATION:

Background Issues

- All patients whose procedures were to be undertaken by local anaesthetic or ASA 1 patients having elective day case surgery were seen in pre-assessment clinic and booked into 30-45 minute slots. Very little pre-assessment is actually required so wasting the resource.

- Incorrect booking in to Pre-Assessment appointments by booking teams and secretaries.

- Issues with access and demand for pre-assessment was communicated though the Theatre Scheduling meeting, this was directly related to short notice, high volume requests for pre-assessment due to poor scheduling

- Inadequate staffing made cross-site pre assessment problematic and delayed appointments being available.

- Misalignment of resource i.e. only one day case clinic each site, led to booking day case patients into appointments meant for patients undergoing more complex surgeries. This caused delays in access to pre-assessment, which in turn caused operations to be cancelled.

- Staff vacancies and long term sickness.

Progress to date

1. The Pre-assessment Team now has strong leadership presence and all vacancies have been recruited into.

2. Senior Sister Samantha Beck creates weekly utilization reports to highlight capacity through pre-assessment.

3. A capacity and demand review has been undertaken to identify wastage and incorrect booking of slots. 18% of main spine pre assessments were incorrectly booked.

4. Patients undergoing their procedure with local anesthesia are no longer seen in pre-assessment. In order to ensure these patients receive their MRSA screening, they are invited to attend one of our cross-site 'walk in' clinics

5. The Pre-op Health and Social Care questionnaire has been revised to include RAG rating to assist in triaging patients. These questionnaires are now completed when the patients attend their outpatient appointment.

6. All social issues surrounding pre assessment are now communicated via email by pre-assessment to the admitting ward.

7. The pre-assessment team now triages the questionnaires completed in outpatients and either sees the patient as a walk in or allocates the most appropriate appointment for patients before the patient leaves the hospital.

8. The pre-assessment team is working with Gynaecology and Trauma and Orthopaedics in creating a pool of pre-assessed patients, who will be available at short notice should any unforeseen cancellations occur.

9. A telephone pre-assessment service has been tested and some issues have been identified in respect of giving information to patients over the phone, language barriers, age constraints and the increased

resource required to contact patients at convenient times.

10. The newly developed 'walk-in' service went live on 3rd May 2016. This supports the telephone pre-assessment by providing access to the patient's medical records, interpreter availability and the ability to visually assess patients and undertake observations by the team leads to a reduced risk of cancellations.

11. Our pre-assessment clinics are in the process of being changed to offer more day case/walk in slots to meet demand of 70 slots per day and to also increase the time allocated to complex patients to 1 hour to allow a comprehensive assessment and discharge planning process at pre-assessment.

12. An email account has been set up by anaesthetics to allow the appropriate escalation of patients that pre assessment wish to get reviewed.

13. Training sessions have been given to staff to update their knowledge and skills for example around diabetic management.

14. Site specific surgery is being checked against eDTA form and issues escalated.

15. Validation phone calls are being offered to reconfirm fitness for surgery 72 hours before TCI.

Next Steps

- As part of the ongoing development of the service and to ensure and secure a service that is fit for purpose, Pre-assessment is one of 5 service improvement projects agreed by Theatre Management Board. The Project leads for this are Miss Gabby Downey, Group Director for WHU and Samantha Beck, Senior Sister.

- A workshop is being held on Thursday 2nd June to evaluate the pathway redesign work recently put in place and also to review and challenge the current theatre scheduling process.

- Pre assessment are currently reviewing NICE guidance on Pre-operative Investigations to provide the team's with clear guidance on investigations and to prevent wastage regarding over testing.

- The timescale for completion of the project and the implementation of all changes is 3 months.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Community Caseloads
SPONSOR (EXECUTIVE DIRECTOR):	Rachel Barlow, Chief Operating Officer
AUTHOR:	Elaine Newell, Director of Midwifery
DATE OF MEETING:	2nd June 2016

EXECUTIVE SUMMARY:

This paper is an update on how we are tackling community caseloads in the Women's and Children's Clinical Group. The teams involved are committed to maximising their interface with patients, improving patient experience and minimising wasted time. The staff groups involved are Community Children's Nurses (CCN), Health Visiting (HV) Children's Therapy Service (CTS) and Community Midwifery. These diverse teams have very distinct and specialised functions with caseload management having national benchmarks for some but not all. Where possible care is provided in clinic situations, but for some patients there is no option but to provide care in the home. All services have a single point of access and a spectrum of administration, support staff and registered practitioners involved in care delivery.

The paper details an action plan for the next year to progress the objective of managing and making the most effective use of the community teams.

REPORT RECOMMENDATION:

The board are requested to receive the update.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	x
Clinical	**X**	Equality and Diversity		Workforce	x

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Key objective - Safe High Quality Care

PREVIOUS CONSIDERATION:

Annual priority update: Tackling Community caseloads

Priority for 2015-16	How were we performing at the start of 2015/16?	Where do we need to get to?
Tackling caseload management in community teams	• **Successful implementation of new IT tools to make caseload management more visible and part of our management of performance**	• **All nursing caseloads (at team level) reduced to median in Black Country** • **Patient contact time increased by 10% among district nurses, health visitors and midwives**

1. Introduction

Within the domain of Safe High Quality Care is an annual objective to tackle the management of community caseloads.

For the purpose of this report the community teams included are from Women & Child Health Clinical Group, namely;

- **Community Midwifery** caseloads are driven by the number of pregnant women in Sandwell and West Birmingham (average 10,500 per annum in totality) and the contact with women is prescribed and delivered in line with NICE guidance and college standards. Care is delivered at home, GP practices, and Children's Centres. The funded caseload for a community midwife is 104 (national recommendations suggest 1:95), but actual caseloads due to vacancies are on average 146.
- **Health Visiting (HV)** caseloads are driven by the number of 0-5s in the Sandwell borough with 5 key visits mandated in GP practices, at home, nurseries and Children's Centres. Health visiting caseloads are on average 400 children per HV (recommended average is 250).
- **Children's Therapy Service (CTS)** caseloads are dictated by demand in schools, clinics and at home. The wte number of CTS staff is 35.56 wte (19.92 wte Speech and Language Therapist [SLT], 7.56 wte Occupational Therapist [OT] and 8.27 Physiotherapist [PT]). The current collective caseloads for the services are 4,295 children.
- **Community Children's Nurses (CCN)** have 4 teams delivering care at home, clinics, schools and Children's Centres. Specifically, these include acute/chronic post discharge, palliative care, complex, continuing healthcare needs and special education (special and mainstream).

Staff group	wte	Caseload overview
CCN - acute	5.24	Acute and chronic children (district nurse role)
CCN – special schools / focused care	7.42	523 – delivered at Orchard and Meadows school plus focused care in mainstream
Complex and palliative care	15.1	Packages of care funded discretely by CCG on an individual child basis

2. Progress to date

All services have:

- Single point of access for each service
- All services with the exception of community midwifery have a triage process. It is not appropriate to triage women in pregnancy and all women are seen in accordance with pathways determined by national standards to optimise safety.
- Multiple practitioner delivery of care – all teams contain admin, non-registered and registered staff of varying grades and skills. Visits / contacts are triaged and delegated to match the practitioner skills to the needs of the client. For example – developmental assessments are carried out by nursery nurses in clinics held in children's centres, unqualified support staff provide overnight care for complex children and therapy assistants provide support to children who have physical disabilities.
- Centralising delivery of care – clinics , children's centres, schools, attendance at acute clinics
- Electronic patient records (EPR) – all services have EPR (BadgerNet for maternity, System 1 for all other services), but some services do not have access to appropriate mobile technology. For example, HVs do not have access to mobile technology; midwives have iPads – but are unable to connect to Trust systems e.g. IPM, CDA etc.
- All services utilise community clinics as the main mode of care delivery. Clinics are held in schools, children's centres, GP practices and health centres. Home visits are only undertaken when clinical need prevails.
- Centralised scheduling systems in each of the services, however this is not real time and is often dependent on admin staff or other agencies (e.g. GP receptionist)

3. Next steps

- Securing appropriate portable IT kit - All community staff require access to mobile, lightweight devices to facilitate EPR at the point of clinical delivery. All services are highly engaged in this work and are currently trialling laptops and tablets to evaluate the best option. This will reduce the amount of un-necessary travel for mobile workers – providing clinicians with real time access to their calendars will help prevent them attending cancelled appointments and give them more time for direct patient contact. This will also improve patient care at point of delivery in the community by providing live access to patient records, resulting in better informed decisions and allow improved communication between clinicians.
- Further delegation of tasks / visits / duties in low risk post natal women will be undertaken by an appropriately skilled non registered practitioner. University programmes are now in place and local competency packages agreed. 1 member of staff has recently been appointed with a further out to advert.
- Rationalisation of midwifery venues and co-location of midwifery, health visiting and lifestyle services in large community hubs.
- Scheduling is still largely done at base and not in real time due to lack of connectivity of mobile devices currently in use, if available. Standardising real time scheduling is an imperative for all community services to maximise time for clinical care, reducing administration, patient DNAs and travel times.
- Community Children's Nursing and Therapies have received demonstrations of the Gel tool and are considering its benefits in comparison with the Balance Solution tool from whom they have also had a demonstration. The Balance tool is currently in use in Dudley so in line with the Black Country Alliance it may prove to be of greater operational value. A response to this will be made by the end of Q1. To note GEL are currently unable to work with the Trust due to other commitments.
- Agree strategy to improve the recruitment and retention of Midwives and Health Visitors in order to improve the quality of services provided to women and families
- A deep dive in to the caseloads and activity of every acute CCN over a 3 month period in Q1 with analysis and reporting at the end of Q2 to review:
    - Average daily contacts by band
    - Variance in number of contacts by band
    - Appropriate delegation of tasks
    - Adherence to established / best practice pathways

4. Key actions

Timeframe	Proposed Productivity Gain Method	Action	By Whom
Q1-3	Optimise use of technology – to maximise direct patient contact time	- Secure appropriate mobile devices for use in the community - Explore the use of Skype technology	Group Director of Midwifery / Group Director of Operations
Q1- 2	Optimise direct patient contact time	Deep dive and analysis of CCN caseloads: - Average daily contacts by band - Variance in number of contacts by band - Appropriate delegation of tasks - Adherence to established / best practice pathways	Group Director of Midwifery / Head of Paediatric services
Q1- 4	Optimise direct patient contact time	Community Midwifery review with CCG: - Rationalisation of midwifery venues and co-location of midwifery, health visiting and lifestyle services in large community hubs	Group Director of Midwifery
Q2-3	Optimise direct patient contact time	Review of scheduling solutions to: - maximise time for clinical care - reducing administration - reduce patient DNAs - reduce travel times	Group Director of Midwifery / Head of Paediatric services
Q1-3	Prioritising the skills of community midwifery	- Roll out of low risk post natal women care by an appropriately skilled non registered practitioner	Group Director of Midwifery
Q1 -2	Optimise direct patient contact time	- Review of the use of Balance tool	Head of Paediatric Services
Q1 - 2	Optimise direct patient contact time	- Agree strategy to improve the recruitment and retention of Community Midwives and Health Visitors	Group Director of Midwifery

5. Summary

Women and Child Health Community services are committed to maximising their interface with patients, improving patient experience and minimising wasted time by implementing all of the above during this year.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Junior Doctor Placements 2016/17**
SPONSOR (EXECUTIVE DIRECTOR):	**Raffaela Goodby – Director of Organisation Development**
AUTHOR:	**Philip Andrew – Head of Medical Staffing**
DATE OF MEETING:	**2nd June 2016**

EXECUTIVE SUMMARY:

Each year the Trust has a number of educational placements offered to junior doctors, the allocation of these is made at the end of May.

As at the time of writing there are **23 gaps** in the junior doctor allocation, these are detailed in the attached report across FY1 / ST higher and lower posts. This is an increase of 1 from the same point in 2015. By August 2015 there were 16 vacancies remaining.

There will be another round of activity to attempt to fill these vacancies. Consideration is being given to the national picture, where HEWM advise that junior doctors are choosing Scotland and Wales for their placements in response to the predicted introduction of the revised Junior Doctor Contract. This doesn't seem to have affected SWBH to date, but worth bearing in mind.

SWBH is a well respected educational institution that rates highly nationally (top ten) for junior doctor placements. Independent feedback and commentary is included in the attached report.

REPORT RECOMMENDATION:

Note the contents of the report and discuss.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		X

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	
Clinical		Equality and Diversity		Workforce	X
Comments:					

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

PREVIOUS CONSIDERATION:

Unfilled placements 16/17 as at 18th May 2016.

Specialist Training Registrar (Lower)	Acute Medicine	City Hospital
Specialist Training Registrar (Lower)	Anaesthetics	City Hospital
GP Specialty Training Registrar	Anaesthetics	City Hospital
Specialist Training Registrar (Lower)	Cardiology	City Hospital
Specialist Training Registrar (Higher)	Emergency medicine	City Hospital
Specialist Training Registrar (Higher)	Emergency medicine	City Hospital
Specialist Training Registrar (Higher)	Emergency medicine	Sandwell General Hospital
Specialist Training Registrar (Higher)	Emergency medicine	Sandwell General Hospital
Specialist Training Registrar (Higher)	Emergency medicine	Sandwell General Hospital
Specialist Training Registrar (Lower)	Endocrinology and diabetes mellitus	City Hospital
Specialist Training Registrar (Higher)	Gastro-enterology	City Hospital
Specialist Training Registrar (Higher)	Gastro-enterology	City Hospital
Specialist Training Registrar (Lower)	Gastro-enterology	City Hospital
Foundation Year 1	General surgery	Sandwell General Hospital
Specialist Training Registrar (Higher)	Geriatric medicine	Sandwell General Hospital
Specialist Training Registrar (Higher)	Intensive care medicine	City Hospital
Specialist Training Registrar (Higher)	Nuclear medicine	City Hospital
GP Specialty Training Registrar	Obstetrics and gynaecology	Sandwell General Hospital
Specialist Training Registrar (Higher)	Ophthalmology	Birmingham Midland Eye Centre (Bmec) City Hospital
Specialist Training Registrar (Higher)	Plastic surgery	Sandwell General Hospital
Specialist Training Registrar (Lower)	Respiratory medicine	City Hospital
Specialist Training Registrar (Lower)	Rheumatology	Sandwell And West Birmingham Hospitals NHS Trust
Specialist Training Registrar (Higher)	Trauma and orthopaedic surgery	Sandwell General Hospital

Education programme planning and quality – feedback from QA visit.

It was clear to the panel that the Trust was committed to education and training and offered a programme that included: high quality teaching from enthusiastic Consultants, an active Junior Doctors Forum (JDF), a clear GMC accreditation plan for supervising Consultants, and excellent PACES teaching with pre/post MCQ. This was seen as good practice.

Core Medical Training (CMT) and General Internal Medicine (GIM) Trainees praised the level and quality of consultant supervision from enthusiastic and accessible Consultants. All Trainees reported that multidisciplinary team members such as Advanced Care Practitioners and other specialist nurses were very experienced, helpful and supportive.

Foundation review extract:

There is a good educational environment within the Trust with a strong educational presence at Board level. The consultant body are highly committed to education and training. Both students and trainees feel well supported and appreciate the learning and teaching opportunities that consultants provide.

February 2016 Undergraduate visit:

1. In common with previous visits, the Panel were again particularly impressed with the Academy team who are very ably led by the Head of Academy (HoA), Dr Carruthers. Dr Carruthers again demonstrated that he has developed an educational culture and that education is valued at SWBH.

2. The Panel noted that every student spoken to during the visit endorsed their Senior Academic Tutor (SATu). All reported regular, useful meetings. This is the only Trust where this has been the case.

3. The Undergraduate Admin Team received positive comments throughout the day, particularly from the students who were grateful for the organisation of the placement. No student was concerned about the cross-site teaching, which is an endorsement of the organisation of this placement.

4. The Panel noted that the Academy staff were always quick to respond to feedback from students. The Panel saw some examples of this in practice and were encouraged that this is part of the everyday business of the Academy.

5. All students would recommend the placement to their peers, in addition around five students noted they would like to take up a foundation post at the Trust

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Primary Care Interface Prescribing
SPONSOR (EXECUTIVE DIRECTOR):	Dr Roger Stedman, Medical Director
AUTHOR:	Dr Roger Stedman, Medical Director
DATE OF MEETING:	2nd June 2016

EXECUTIVE SUMMARY:

The aim of this paper is to inform the Board of the processes that are in place for the governance of prescriptions issued from the Trust. There are 2 main areas for discussion and they are the prescribing of TTO's (take home medication from an inpatient stay) and prescriptions generated following and an outpatient or A/E visit on an FP10.

The objective for the Pharmacy department at Sandwell and West Birmingham Hospitals NHS Trust is to provide for the safe and secure use of medicines by giving overarching guidance on the prescribing, requisitioning, storage and administration of all medications.

REPORT RECOMMENDATION:

The Board to reflect and comment on the governance arrangements in place for prescriptions issued by the Trust.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		X

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial		Environmental	x	Communications & Media	
Business and market share		Legal & Policy		Patient Experience	x
Clinical	**x**	Equality and Diversity		Workforce	

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

PREVIOUS CONSIDERATION:

Prescribing at the Secondary / Primary Care Interface

The aim of this paper is to inform the Board of the processes that are in place for the governance of prescriptions issued from the Trust. There are 2 main areas for discussion and they are:

- the prescribing of TTO's (take home medication from an inpatient stay)
- prescriptions generated following and an outpatient or A/E visit on an FP10.

The objective for the Pharmacy department at Sandwell and West Birmingham Hospitals NHS Trust is to provide for the safe and secure use of medicines by giving overarching guidance on the prescribing, requisitioning, storage and administration of all medications

There is a Trust policy (Pt Care/05) that outlines the roles and responsibilities of staff when prescribing and dispensing medicines and for the monitoring of the prescriptions.

Our formulary is shared with the CCG and in turn with the GP's. There is representation from both Sandwell and West Birmingham and Cross City CCG's on the Drugs and Therapeutics Committee and Professor Ferner attends the Area Prescribing Committee (APC) on the Trust's behalf.

For prescriptions that are dispensed by the hospital pharmacy generic medicines are substituted as a matter of course; except where continuing the same formulation is necessary (a few classes of drugs for example anti-epileptics). The use of FP10's for prescribing pose more of a problem as community pharmacies are unable to do the same. Electronic TTOs are able to be policed, but FP10s are not obvious until the (Prescription Pricing Authority (PPA) report is issued. Where there are high rates of non-Formulary prescribing this is followed up although there is a delay of one – two months before the receipt of the report. Often the prescribers have been junior doctors who have since left the Trust and these are then difficult to follow up. There have been problems identified with expensive specials prescribed on FP10's and as they are dispensed by community pharmacies it is difficult to police in a timely manner.

Medicines 'To Take Out' (TTOs)

When the patients are admitted to hospital the pharmacy dispenses original packs of medication wherever possible. The pharmacy will supply enough original packs (normally 28 tablets in each) to cover treatment for 28 days and the supply to the ward is ready labelled for discharge, so that as and when the patient is ready to go home the supply can be used as part of their TTO. Generally if the patient has used less than half the supply i.e. has at least 14 days of the supply remaining, then that will be all that is supplied on discharge. If the patient has used more than half the original supply an additional original pack is dispensed to ensure that the patient goes home with at least 14 days' supply of medication. With this process the patient may go home with as little as 14 days' supply or as much as a 42 day supply (the average is 28 days' supply). Whilst this would appear a little random, for pharmacy it is less labour intensive and far more practical than counting the number of days' supply the patient has on the ward at the point of discharge and then dispensing

enough additional tablets to give them a total of 14 days' supply. Pharmacy will document on the discharge letter accompanying the TTO the quantity of medication supplied so the GP will be aware of when further supplies will be required.

FP10's

The majority of outpatient prescriptions are now written on FP10 prescriptions for dispensing by community pharmacists and generally a minimum of 14 days' supply is prescribed. However often this will be an original pack which will last 28 days. This is supported by the CCG to prevent patients requesting urgent appointments with GPs to have prescriptions written following their hospital appointments. GPs are informed how much medication was prescribed for their patient when they receive the clinical letter following the outpatient appointment. Pharmacy receives a report (via the NHS business services authority) usually 6 to 8 weeks after the hospital appointment detailing what was supplied on the prescription by the community pharmacist. There are several reasons identified for the delay including the patient not taking their prescriptions to the pharmacy immediately after their appointment, or the community pharmacist not submitting the prescription to the business services authority for payment until several weeks after it was dispensed.

Conclusion

The Trust provides leadership both locally and more widely in the governance of prescribing and the strict adherence to 'generic first' prescribing practice.

Patients will never leave hospital with less than 14 days supply of medication or a 14 day prescription and this will always be as a generic unless specifically indicated.

Outpatient prescribing practice of established medical staff is subject to the discipline of the local formulary. However doctors in training that rotate from other trusts will bring their prescribing habits with them which may fall outside the guidance of the DTC. The feedback mechanism for deviations from formulary are slow and cumbersome due to the involvement of local pharmacies and the PPA - however the DTC retains oversight of this.

GPs will always be informed of stopped, changed or new prescriptions via the discharge letter or outpatient clinic letter.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality and Safety Committee

Venue Anne Gibson Committee Room, City Hospital **Date** 22 April 2016; 1030h – 1230h

Members attending:		**In attendance:**	
Ms O Dutton Samuda	Chair	Ms Allison Binns	Assistant Director of Governance
		Mrs Gayna Deakin	Deputy Director of Workforce
		Ms Yasmina Gainer	Head of Performance
Dr R Stedman	Medical Director	Giles Tinsley	NHS Improvement
Ms R Barlow	Chief Operating Officer	Martina Morris	NHS Improvement
Mr C Ovington	Chief Nurse	**Committee support:**	
Miss K Dhami	Director of Governance	Mr D Whitehouse	Head of Corporate Governance

Minutes	**Paper Reference**
1. Apologies for absence:	**Verbal**
Apologies were received from Mr Samuda, Ms Parker and Mr Waite.	
2. Minutes of the previous meeting	**SWBQS (04/16) 002**
The minutes of the previous meetings were agreed as a true and accurate record.	
3. Matters and actions arising from previous meetings	**SWBQS (04/16) 003**
The action tracker for the committee was noted.	
3.1 Patient Story to the Board	
In respect of the patient story that was presented to the last meeting of the Board it was being used with staff to promote learning from what was a very powerful and emotional story. Ms Dutton stated that there were clear examples of unacceptable care highlighted in the story and that it was important that the Board heard such stories in a public setting but that there was also a public discussion as to what would be done to prevent such incidents happening again. Mr Ovington stated that the person in the DVD had worked closely with the matron for that	

area to ensure the Trust learnt the lessons from that experience. The upcoming Board patient experience would have a focus on Ten out of Ten with representatives from clinical teams also in attendance to share their experiences.	
4. Quality & Safety Committee Forward Plan 2016-17	**SWBQS (04/16) 004**
Mr Ovington introduced the paper highlighting the intention to have a stronger focus for the agenda to ensure the committee could effectively fulfil its assurance role. The key part of the forward plan would be around gaining assurance around progress against the Quality and Safety Plans with staff in attendance to speak about the reality of implementation on the frontline. Meetings would be themed against the priorities of each of the plans. Rising Stars would also be invited to attend as they found the experience of attending the committee valuable, as did the committee. It was also requested that an invitation be sent to Healthwatch to nominate a representative on the committee. **Approved:** • **That the work programme for the committee be agreed.** • **That an invitation be sent requesting a representative of Healthwatch to sit on the committee.**	
5. Readmissions	**SWBQS (04/16) 005**
Ms Barlow introduced the report highlighting the innovative work that Fiona Shorney and Nigel Page had been working on which was showing impact over the past 6 months. A pilot was being undertaken in AMU A at Sandwell which had reduced readmissions by 6%. All patients had received medicine reconciliations, a phone call at home or a phone medicine reconciliation and follow up. Work was now ongoing to develop a larger piece of work which was a priority to fund. Work was also ongoing to support frail patients coming onto the unit and to support nursing homes through additional wrap around care. A paper would be presented to the Board which would highlight the evaluation of the AMU pilot. There would be a wider review of readmissions across the Trust and from that set a new and ambitious trajectory going forwards. Dr Stedman highlighted that the biggest impact would be around AMU. Those that went on to wards would inevitably have more complex discharge needs which increased the risk of later readmission. It was important to embed good practice with high standards being delivered but not always consistently. He stated that there was a KPI in respect of reducing readmissions. Ms Barlow stated that a proportion of discharges would always be high risk in terms of likely readmission but the focus should be on those 2-3 discharges that can consistently be managed effectively. Funding from the system remained an issue with the need for a broader understanding of the initiatives that were delivering impact to patients most consistently. Ms Barlow stated that a refreshed paper would go to the Board which would build on the sustainability of delivering against the ambitions. Consideration also needed to be given to maximising the relationship with the third sector to better support the lower end of high risk patients.	
6 Draft Quality Account	**SWBQS (04/16) 006**
Dr. Stedman introduced the draft Quality Account which still had some data still to be included.	

He stated that the intention was to write it in as patient friendly language so as to be accessible to the general public. In terms of peer review comparators the Trust did use a mix of foundation and non-foundation comparators but these would be kept under review to ensure we remained aspirational in our targets. Ms. Dutton stated it would be useful to see how the Trust compared to its neighbours with Mr Ovington stating that local communities would probably prefer local comparators that they were familiar with. In response to a query as to who the audience was Ms Wilkin stated that the Quality Account would form part of the Annual Report and would be sent to stakeholders and be available to the public. The Quality Account, once finalised and approved would be uploaded to NHS Choices by the 30 June 2016. **Resolved: that the committee endorse the draft Quality Account.**	
7. IRMER [Ionising Radiation (Medical Exposure) Regulations] Report	**SWBQS (04/16) 007**
Dr Stedman introduced the paper which highlighted ongoing reductions in the number of near misses and reportable/ non-reportable incidents. Ms Dutton queried what appeared to be a high number of wrongly attributed patients. Dr Stedman responded by stating that there was a flaw in the electronic system which made it easy to select the incorrect patient but that this would be resolved with the introduction of EPR and would be addressed before treatment started through the comprehensive ID checks. The incorrect anatomy figures were more of an issue given the risks of irradiating the wrong limb. The majority were non-reportable incidents but there was no room for complacency. Dr Stedman stated that unlike surgery the patient was not required to fill in a consent form for an x-ray. One of the key mechanisms was to ask the patient as part of the standard checklists that were in place. Given the thousands of x-rays that were carried out the error rate remained very small and these cases were the subject of extensive discussion at the Patient Safety Committee. Ms Dutton queried whether operators challenged the request that were made. Dr Stedman stated that operators followed the instructions on the referral card as notes did not accompany the patient to an x-ray. Where a patient speaks to the radiologist then they would query the request. Miss Dhami stated that the issue of training had previously been the subject of an improvement notice hence the strong performance around training was a positive step.	
8. Wider safe staffing – desk top exercise	**SWBQS (04/16) 008**
Mrs Deakin introduced the report which provided an update on the wider safe staffing work that was being undertaken. The work earlier in the year had focussed on a specific ward. Since then a desktop exercise had been undertaken to bring in a wider scope of safe staffing across the Trust. She had received positive engagement from groups in carrying out this work. It was early stages in terms of building up the model including developing a wider profile that would enable analysis of quality trends. Mr Ovington sought clarification in terms of the definition of clinician in the document and Dr Stedman highlighted the value in breaking down data in terms	

of doctors in training and consultants. Ms Dutton questioned what uses there would be for the data once collated. Mrs Deakin stated that the data would be used for a range of purposes including focusing on the correlation between quality and wider safe staffing levels, to inform future workforce modelling and to also inform the debate regarding 7 day working. Mr Ovington stated that the KPI around hours per patient per day was a key indicator with the work now developing. There would be useful intelligence drawn out from this if it was mapped across such things as falls and pressure sores. The committee welcomed the work that had gone into producing the report but requested that the data be further refined based on the discussion at the meeting. **Action: that the wider safe staffing report be updated based on the comments at the meeting and reported back to the Quality and Safety Committee before being presented to the Board.**	
9. Integrated Performance Report	**SWBQS (04/16) 009**
Ms Gainer introduced the report highlighting end of year progress in respect of c diff and MRSA and the positive performance around sepsis screening. Performance in respect of falls and pressure sores was also positive. VTE performance had also achieved national targets. In terms of theatre cancellations performance was mixed and improvements were still need in theatre utilisation. Fractured Neck of Femur had seen significant process improvements which had impacted through improved performance. There had also been significant improvement in the indictor relating to Rapid Access Chest Pain. Ms Barlow drew the committee's attention to Delayed Transfers of Care with a sharp increase over the past week. There were 97 patients in the past week which was the highest rate for some time. The sharp increase was a consequence of the Borough Council having changed domiciliary care providers and problems that had occurred during the transition to the new provider. Contingency plans had been put in place which would hopefully have an impact over the coming days. The bed pressures were quite extreme given the upcoming industrial action by junior doctors and the bank holiday. Ms Dutton sought assurances that the Trust were sighted on the areas for improvement with Ms Barlow stating that there was a clear understanding of the areas of focus.	
10. Serious Incident report	**SWBQS (04/16) 010**
The report was noted.	
11. Clinical audit forward plan: monitoring report	**SWBQS (04/16) 011**
The report was noted.	
12. **Matters of topical or national media interest**	
There were no matters raised under this item	
13. **Meeting effectiveness**	
The committee welcomed the focussing of the work programme and highlighted that with	

focussed presentations on the impact of the work around the Quality and Safety Plans would lead to stronger assurance that could be provided to the Board.	
14. **Matters to raise to the Board and Audit & Risk Management Committee**	
There were no matters raised under this item	
15. **Any other business**	
There were no other matters of business.	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

REPORT TO THE TRUST BOARD HELD IN PUBLIC

Chief Executive's Report –June 2016

The agenda for the board contains, on the one hand, our formal reports for 2015-16, which reflect learning and improvement, but also relatively exceptional financial results (4th best in the provider sector nationally). And, on the other hand, the major challenge to retain that success in 2016-17 and 2017-18. We do not yet have a balanced, let alone a surplus plan, and our extant plan demands considerable cost improvement (£18m). The Board is aware of changes in our PMO structure, and the creation of additional support resource internally to both implement existing ideas and create new opportunities. Within our private Board papers there is an update on the wider STP programme across West Birmingham and the Black Country. Plans are due to be submitted at the end of June and, at the very least, it will be important to make a strong case to retain local NHS funds locally.

We must ensure, and I believe we are, that planning for the coming 60 months does not see us lose focus on next month, or tomorrow. The basics of good care and grip on NHS Constitution standards are important: We are delivering the RTT standard and cancer wait time standards. Emergency care performance outperforms others but it not yet good enough.

1. **Our patients**

The last week has seen an active programme of *in-house inspections* of standards across our organisation, supported by external invited input from staff from regulatory organisations, as well as the NHS retirement fellowship and Health-watch. This repeats and extends what we did in November, and plan to do in the autumn. We are looking for good practice, for improvement, and for weaknesses. We also want to provide a chance for staff and patients to talk about their experiences. The Board will hear oral feedback on the visits. At a time when nationally, the CQC are altering their inspection method, and perhaps less regular site visiting is envisaged, we are stepping in to make sure that there is a rigour to a 'fresh pair of eyes' looking at local teams. Of course, the Board's own, newly expanded visiting programme is part of that, as well as specific work, such as the intended re-look by Health-watch at issues raised from their August 2015 report.

Nationally wait times in *emergency care* continue to deteriorate. At the Trust we fall short of either the 95% standard, or our contractual 92.5% goal. However, there is improvement in April and May as against winter months. In particular, we are seeing encouraging delivery most days of the week at City Hospital, as well as continued short waits in our eye hospital. The improvement at City reflects team-working changes both within the department, and in

addressing how the 'whole hospital' makes a difference. There remain pinch points but we can build on the changes. At Sandwell, we know that performance has fallen sharply since November 2015, and is directly bed flow related. I am leading personally a review through June of our bed base to Midland Met, which I will report to the Board at the start of July. Initial analysis suggests scope to improve delayed transfers of care, re-admissions, and time of discharge. Taken together the bed base is sufficient. We need however both to consistently deliver on those improvements, and to better manage variation in admitted numbers and variation in AMU discharge patterns. As we reduce our bed base, our susceptibility to variation is, of course, altered.

At our May Board meeting we heard directly from staff involved in the *100-day challenge* to deliver our Ten Out Of ten safety checklist in our AMUs. This period of rapid improvement concludes at the start of July. There are many ways to judge delivery, including the engagement of staff which we tested with our own visits to site. But the simplest will be to present next time June's VTE and MRSA screening results for the ward clinical teams involved. These are good measures not merely because they are key safety indicators, but because they require multi-professional working.

As we did in 2015-16 the Trust remains distinctive in our consistent delivery of *planned care* waiting times – for diagnostic services, cancer care, and elective care. At a specialty level we expect to achieve the so-called RTT incomplete standard by July in all disciplines bar dermatology. For non-RTT patients, the Board is aware of the open referrals issues faced by the Trust, and project work to sustainably resolve these issues once again continues. I am asking the audit and risk management committee to take a view at mid-year on the sufficiency of our response. The expansion in demand for cardiac imaging and cardiac testing generally at the Trust is an underlying pressure which we need to, and are, working to meet. Last year we created our new cardiac MRI service, and as we look forward now with the imaging MES in place – thus providing a rapid route to new high quality equipment – we need to ensure that we remain at the forefront of care in support of our clinical team of the year from 2015.

The integrated performance report shows a series of indicators of *low rates of harm*. The upswing in pressure sores merits investigation in the weeks ahead, and we will return to the Board in July to reflect after analysis on the rebasing of mortality data nationally – our SHMI remains better than anticipated. Implementation plans for our 2016-2019 Safety Plan are developing and in August we will confirm the 'rollout' plan for that programme.

2. **Our workforce**

I am pleased to be able to report both on a sharp fall in *sickness absence* in April, and on the conclusion of our work to ensure 100% appraisal coverage among staff. The effort involved from HR professionals in Organisation Development, and our 572 line managers, cannot be overstated. We are firm in our view that appraisal is both a right of employment and an

obligation among employees. After a year's pause, in autumn 2016 we will deploy revised appraisal and performance systems, which should produce a simpler, and more consistent, view of the potential and delivery of everyone working within SWBH. That attention to detail will be important to tackling our retention issues, which we agreed in March were focused in specific parts of our Trust, and which need to be addressed if we are to deliver care through consistent team-working.

On June 3rd, nominations are due to close for our *annual awards ceremony* – our SWBH Stars 2016. Combined with our new monthly award for compassionate care, we continue to work create a culture which celebrates improvement and excellence. Recent weeks has seen national success in awards, with Kelly Stackhouse, our foecal continence nurse lead, winning the prestigious patient choice award from the Royal College of Nursing. And our outpatient triage service reached the final few in the HSJ Value Awards. Recognising the excellence in our midst has to be an important part of raising standards, and again this year we will operate our Beacon Awards, this time with a focus on Research and Development – in keeping with our R&D Plan and drive to increase the scale and quality of innovation in our Trust.

In coming weeks, we are both concluding our corporate restructure consultation from April, and preparing for the *major reorganisation of some teams and services*, affecting around 450 roles (of which many are not substantively filled), which is due to begin statutory consultation in early July. Both sets of changes prepare us for future care models, retaining valued employees, but seeking to place people into roles which we will have in future years. Overall we have been open for many years about our future pay expenditure plans, and the need to reduce that spend safely. In 2014 and 2015 we have been outstandingly successful at achieving redeployment for staff internally and on occasion externally, and the same endeavour will be in place this summer to sustain local employment. We know that, as we change what we do, and how we do it, there is scope to alter staffing models. However, as in 2014 and 2015, the consultation exercise will seek to identify alternative proposals and highlight risks to be mitigated. There is, patently, no do-nothing option, anywhere in the NHS, still less at our Trust, but we need to ensure, by listening and adapting, that we take forward the right proposals from the start of October.

In May we held *our annual leadership conference*. Over 150 clinical and non-clinical leaders attended. The focus of the event was on how we make sure that our workforce changes, our investments in technology, our alterations to estate and service configuration, and our overall finances are congruent and reinforcing. In particular, we have to make sure that 'change' is experienced inside our organisation as a joined up set of ideas and plans, and not a series of silos. I was greatly encouraged by the honesty, skill and commitment evident throughout the conference from leaders in service and corporate functions. Our investment in leaders, and in coaching, at all levels of the Trust, will be important in making sure that that talent is able to flourish. Over coming weeks we need however to match that with

improvements in data quality, visibility and impact. That improvement will help leaders to scale their efforts and red-flag adverse impacts. As we made clear previously as a Board, our established prospective Quality Improvement Assessment of change schemes, must be matched by August by tracking arrangements for projects as they go live.

3. **Our partners**

The Trust has led the way locally with our work on apprenticeships. We have previously agrees to take further *our Live Work project*, and expand it to provide next-step accommodation for lower paid employees moving into their first roles in the Trust. I will update the Board on that plan, in partnership with St Basils, when we meet. If we proceed that would then conclude the retained estate re-development of the east end of the Sandwell site – and we will move forward at pace with a proposal for land disposal on both the far side of Hallam Street and with the disposal of the part-occupied Hallam building. This is consistent with our approved estate strategy. The specific case for change will be overseen via the FIC. At City the planning application for development of the to-be disposed estate will be submitted later in July.

The decision of the Board to *award preferred bidder status to Cerner* for our 2017 Electronic Patient Record has been widely reported. This has helped us to begin to develop the infrastructure for implementation, in advance of contract close, which must be preceded by NHSI approval (although funding is entirely internally sourced). As with Carillion, we view this as a partnership relationship for the long term. We will consider via the MPA what measure of Board-to-Board interaction we will put in place above the usual formal contract structure to ensure that we maximise the benefits of this relationship. Cerner's bid was distinctive in part because of its emphasis on quality improvement and evidence of that method employed elsewhere. We are exploring how we ensure we capture and deploy that learning inside our organisation.

We continue to move forward in varied ways with *GP collaborations*. Recruitment is commencing for some innovative roles which are part-time GPs and part-time hospital senior clinicians. This forms part of an emerging collaboration with Your Health Partnership, who provide GP care in West Bromwich and in Rowley Regis. At the same time, work with GP colleagues in north-west Birmingham has seen both cardiac and physio services expand. The Trust remains actively involved with the Modality group in its evolution, and we very much hope that mutual interests can help us to innovate and learn in ways which are consistent with, among other considerations, the Midland Met activity model and commercial case.

NHS England has now announced plans associated with the development of *nursing associates*. The Trust is exploring with BCA partners, and with universities, in particular in Wolverhampton, how best to respond rapidly to the call for early adopter sites. JCNC has been active in recent months in working to resolve issues in the role and banding of health

care assistants in the Trust, and there appears to be an exciting opportunity to create in our organisation a true escalator from band 2 onwards in providing nursing and related care. That we could do this across community and hospital settings, and potentially in collaboration with others such as care homes, would be a distinctive feature of our submission.

4. **Our regulators**

The 4th Never Event of 2015-16 triggered the involvement of the then Trust Development Authority in assessing the sufficiency of our assurance and improvement responses to those four unacceptable errors. I am able to report that that evaluation has concluded that we have extremely robust and appropriate arrangements in place in respect of *Never Event management*. Implementation of the action plan from the final event continues, and I would suggest that during Q2 2016-17, our quality and safety committee examines how many actions from the four events remain incomplete, if any.

The Trust has been visited as part of the *cancer peer review* process in respect of Cancer of Unknown Primary (CUP). The review, as expected, gave rise to concerns, and we have submitted the action plan outlining how provision will change from July with the creation of a specific MDT sub-set of our GI MDT. The executive Cancer Board, chaired by Rachel Barlow, will oversee implementation of these alterations.

5. **Q1 oncology services – requested update from prior Board meeting**

At our last public board meeting a patient raised concerns about their care following a conversation with their oncologist. The matter also features on our risk register. Board members are aware that in autumn 2015, UHB indicated that they would no longer be able to provide on-site oncology clinics. Since this notification we have worked to develop a replacement service that would provide patients with more responsive cancer care. We have worked closely with partners at UHCW and RWT and have constructed a service which is larger than the prior offering, therefore shortening waiting times and being available across the full year with cross cover. We have involved patients in these developments through a series of public and patients meetings since October 2015. The new service model also facilitated improved access for residents to both the QE and Wolverhampton, which was something our own patient groups and Healthwatch advocated strongly for. UHB agreed to participate in that service and have remained with us. This has been operating since April with the support of our multi-disciplinary tumour group leaders. For patients this has meant that many have continued to receive care from their existing oncologists. Some patients including new referrals have been seen by new oncologists. The full range of cancer services that is provided for patients at Sandwell and City Hospitals has continued (and will continue).

Unfortunately - in my view - specialised commissioning colleagues have instructed us to change this model, because they are not fully assured about it, though their instituted weekly oversight has confirmed no safety concerns to date. The overall assurance analysis (sometimes considered to be external reports) was not something that the Trust was given the opportunity to respond to or comment upon, which is unusual, and it appears to contain important errors and misunderstandings. Commissioners intend that a solid-tumour oncology service will be led by UHB: A decision not subject to a tender process, nor our input in design terms, nor ostensibly a written submission in advance. We continue to discuss with commissioning colleagues and with provider partners how best to create an integrated cancer service with oncology clinicians embedded within it. It would appear a retrograde step, not to mention at variance with national cancer policy, to create distinct surgical and non-surgical cancer services, as many patients move between treatment modalities, particularly surgery and chemotherapy. The fixed point must be high quality MDT working.

The different views between parties, and time taken to resolve the matter without a clear decision process, has created ongoing uncertainty for staff, and indeed for long term patients, which is deeply regrettable. We have aimed to keep patients and staff fully informed through regular meetings. All organisations are now working to resolve that uncertainty. Critically in the short term there is no expectation of a change in service. The Trust's Board will wish, through our executive cancer board, to monitor closely wait times and other metrics to ensure that any commissioned changes to the services result in improvement and not a deterioration. We are discussing with NHS Improvement how partnership working can be improved now they have oversight across both NHS Trusts and Foundation Trusts. All involved are agreed that these matters could and should have been addressed more rapidly and differently and accordingly there is something to learn – for us as well as others.

6. **Other matters**

As pledged, attached to this report, is an update on diversity pledges. Together with data on recruitment against the trajectory approved at the start of the year. *Next month* the Board will see the first of our quarterly reports on our five strategic plans (R&D, safety, quality, education and public health), as well as an overall update on the 20 priorities set out in our 16-17 annual plan.

Toby Lewis, Chief Executive

May 26th 2016

FOR INFORMATION

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SAFE NURSE STAFFING UPDATE

Report to Trust Board on 2nd June 2016

1 EXECUTIVE SUMMARY

1.1 This report is an update on nurse staffing data collected for April 2016.

2 APRIL DATA UPDATE

The demand for additional staff on areas where there additional beds are in operation continues to be the case during April. We have continued to ensure additional wards have some of our permanent staff on duty to provide shift leadership and continuity. The average fill rates across the trust for registered nurses which includes permanent, bank and agency staff for day shifts is 94% and for night shifts is 95.4% which are very similar to the previous month. For support staff the day time fill rate is 97.3% and the night time fill rate is 99.5%. Our leaders who manage the community wards are making a concerted effort to draw patients who require focused care off the acute wards to help unblock acute capacity for new admissions. The impact is however an increasing trend of focused care which will require monitoring over a period of time to assess the acuity and dependency of these wards and whether there is any resource shift required. It should also be noted that the community wards are still finding it difficult to fill vacant positions although it seems likely that some staff will join the team from the forthcoming qualifying students.

New reporting arrangements began on the 1st May to record care hours per patient day, the first data will be in next months report

Table 1. – Three Month Average Fill Rate Percentages For Each Hospital

	Site Code	Site Name	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Feb-16	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	420	420	210	195	518	518	148	148	100.0%	92.9%	100.0%	100.0%
	RXK02	CITY HOSPITAL	27047	25992	11249	10768	25705	24916	8501	8412	96.1%	95.7%	96.9%	99.0%
	RXK10	ROWLEY REGIS HOSPITAL	3906	3279	3664	3960	2604	2557	2779	3098	83.9%	108.1%	98.2%	111.5%
	RXK01	SANDWELL GENERAL HOSPITAL	25483	23052	12166	12244	21532	19958	9856	9788	90.5%	100.6%	92.7%	99.3%
			56856	52743	27289	27167	50359	47949	21284	21446	92.8%	99.6%	95.2%	100.8%
Mar-16	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	555	465	277	221	462	573	157	194	83.8%	79.8%	124.0%	123.6%
	RXK02	CITY HOSPITAL	24357	27553	10043	11106	22770	26280	7890	8653	113.1%	110.6%	115.4%	109.7%
	RXK10	ROWLEY REGIS HOSPITAL	3936	3194	4367	4836	2625	2530	3224	3693	81.1%	110.7%	96.4%	114.5%
	RXK01	SANDWELL GENERAL HOSPITAL	28158	25581	13813	13543	23643	21025	10958	10617	90.8%	98.0%	88.9%	96.9%
			57006	56793	28500	29706	49500	50408	22229	23157	99.6%	104.2%	101.8%	104.2%
Apr-16	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	450	457	225	206	555	555	148	175	101.6%	91.6%	100.0%	118.2%
	RXK02	CITY HOSPITAL	28863	27928	11830	10759	27267	25879	9244	8557	96.8%	90.9%	94.9%	92.6%
	RXK10	ROWLEY REGIS HOSPITAL	4185	3631	4702	5260	2790	2754	3417	3881	86.8%	111.9%	98.7%	113.6%
	RXK01	SANDWELL GENERAL HOSPITAL	27066	24907	13360	13080	21663	20686	10532	10611	92.0%	97.9%	95.5%	100.8%
			60564	56923	30117	29305	52275	49874	23341	23224	94.0%	97.3%	95.4%	99.5%
3-month Avges	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	475	447	237	207	512	549	151	172	94.2%	87.4%	107.2%	114.1%
	RXK02	CITY HOSPITAL	26756	27158	11041	10878	25247	25692	8545	8541	101.5%	98.5%	101.8%	99.9%
	RXK10	ROWLEY REGIS HOSPITAL	4009	3368	4244	4685	2673	2614	3140	3557	84.0%	110.4%	97.8%	113.3%
	RXK01	SANDWELL GENERAL HOSPITAL	26902	24513	13113	12956	22279	20556	10449	10339	91.1%	98.8%	92.3%	98.9%
	Total	*Latest 3 month average====>*	58142	55486	28635	28726	50711	49410	22285	22609	95.4%	100.3%	97.4%	101.5%

3 RECOMMENDATION

The Board are requested to receive this update and agree to publish the data on our public website.

Colin Ovington,

Chief Nurse

23rd May 2016

Appendix 1 – April 2016 ward nurse staffing data

	Ward	site	No. Beds	Morning shift RN's expected	Afternoon /Evening shift RN's expected	Night shift RN's expected	Percentage day time fill rate during April 2016	Percentage night time fill rate during April 2016	Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during April 2016	Percentage night time fill rate during April 2016
Medicine & Emergency care	D5	City	13	5	5	5	98.3%	100.0%	1	1	0	86.7%	N/A
	D7	City	19	3	3	3	98.0%	99.3%	1	1	0	73.3%	N/A
	D11	City	21	3	3	3	100.0%	100.0%	2	2	1	95.8%	100.0%
	D12	City	10	2	2	2	100.0%	100.0%	1	1	1	89.9%	96.5%
	D15	City	24	3.5	3.5	3	112.1%	138.3%	2	2	1	98.3%	96.7%
	D16	City	21	3	3	3	91.3%	107.2%	2	2	1	100.0%	89.2%
	D26	City	21	3	3	3	100.5%	100.0%	2	2	1	101.6%	113.3%
	AMU 1	City	41	10	10	10	97.1%	100.8%	4	4	4	88.3%	70.8%
	AMU 2	City	19	5	5	5	98.3%	80.6%	1	1	1	118.3%	96.5%
	PR4	Sandwell	25	7	7	7	95.6%	82.8%	3	3	3	84.9%	88.9%
	PR5	Sandwell	34	5	5	4	91.7%	96.7%	3	3	2	108.3%	100.0%
	NT4	Sandwell	28	4	4	4	97.4%	100.0%	3	3	3	90.8%	98.9%
	LY 4	Sandwell	34	5	5	4	88.6%	89.1%	3	3	2	87.0%	116.7%
	temporary ward LY2	Sandwell	29	4	4	4			4	4	2		
	N5	Sandwell	15	5	5	2	100.0%	100.0%	1	1	1	100.0%	100.0%
	AMU A	Sandwell	32	11	11	11	94.6%	100.0%	4	4	3	100.0%	106.7%
	AMU B	Sandwell	20	3.5	3.5	3	97.9%	100.0%	3	3	3	98.3%	100.0%

	Ward	site	No. Beds	Morning shift RN's expected	Afternoon /Evening shift RN's expected	Night shift RN's expected	Percentage day time fill rate during April 2016	Percentage night time fill rate during April 2016	Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during April 2016	Percentage night time fill rate during April 2016
Surgery A	D21	City	23	4	4	2	96.5%	101.6%	2	2	2	93.3%	98.3%
	D17	City	19	4	4	2	94.6%	96.6%	2	2	2	83.1%	94.4%
	SAU	SGH	14	5+1 on mid shift	6	4	91.4%	100.0%	2	2	1	95.8%	103.2%
	temporary ward L5	SGH	20	6	6	4	88.9%	86.7%	3	3	2	109.4%	102.4%
	P2	SGH	20	5	5	3	93.3%	98.8%	4	4	3	96.0%	96.7%
	N3	SGH	33	5	5	3	92.6%	98.8%	4	4	3	104.6%	110.0%
	L3	SGH	33	5	5	3	94.0%	98.8%	4	4	3	93.3%	95.6%
	CCS	City		Staff flexed to the dependency/number of patients in the units			96.7%	96.7%	Staff flexed to the dependency/number of patients in the units			84.4%	86.7%
	CCS	SGH					92.3%	95.4%				91.6%	96.7%

	Ward	site	No. Beds	Morning shift RN's expected	Afternoon /Evening shift RN's expected	Night shift RN's expected	Percentage day time fill rate during April 2016	Percentage night time fill rate during April 2016	Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during April 2016	Percentage night time fill rate during April 2016
Community & Therapies	Henderson	RH	24	3	3	3	98.3%	96.7%	3	3	3	102.2%	97.0%
	Elisa Tinsley	RRH	24	3	3	3	89.4%	98.3%	0	0	0	100.0%	97.8%
	McCarthy	City	24	3	3	2	95.2%	100.0%	3.5	3.5	3	134.4%	174.9%
	D43	City	24	6	6	4	92.9%	97.7%	5	5	2	95.8%	100.0%
	D47	City	20	2	2	2	87.8%	100.0%	0	0	0	N/A	N/A
	Leasowes	RH	20	3	3	2	66.7%	100.0%	3	3	2	117.2%	100.0%

	Ward	site	No. Beds	Morning shift RN's expected	Afternoon /Evening shift RN's expected	Night shift RN's expected	Percentage day time fill rate during April 2016	Percentage night time fill rate during April 2016	Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during April 2016	Percentage night time fill rate during April 2016
Surgery B	Eye ward	City	10	2	2	2	101.6%	100.0%	1	1	0	91.6%	118.2%

	Ward	site	No. Beds	Morning shift RN's expected	Afternoon /Evening shift RN's expected	Night shift RN's expected	Percentage day time fill rate during April 2016	Percentage night time fill rate during April 2016	Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during April 2016	Percentage night time fill rate during April 2016
Womens & Children's	L G	SGH	14	3	3	2	98.3%	85.0%	1	1	1	193.3%	100.0%
	L1	SGH	26	5	5	4	66.2%	105.2%	3	3	2	98.1%	92.5%
	D19	City	8	3	3	2	84.7%	73.7%	1	1	0	136.0%	70.0%
	D27	City	18	4	3	2	94.7%	88.3%	2	2	1	90.4%	93.3%
	Maternity	City	42	6	5	4	110.5%	90.6%	4	4	2	93.8%	91.3%

Equality and Diversity - Annual Audit of Training

This equality and Diversity audit is based upon staff accessing training via the e-study leave process during the period of 1 January 2015 - 31 December 2015. The total number of approved training applications during this period was 2014. The data is based against the whole Trust workforce position (minus medical staff).

Table 1 shows the breakdown of applicants by gender. Blue represents the whole Trust workforce position. The audit provides evidence to support that there is no bias or inequity when staff are applying for training based on their gender. N = 2014

Gender	**Trust FTE %**	**Training Applications FTE %**
Female	81.08%	81.18%
Male	18.92%	18.82%
Grand Total	**100.00%**	

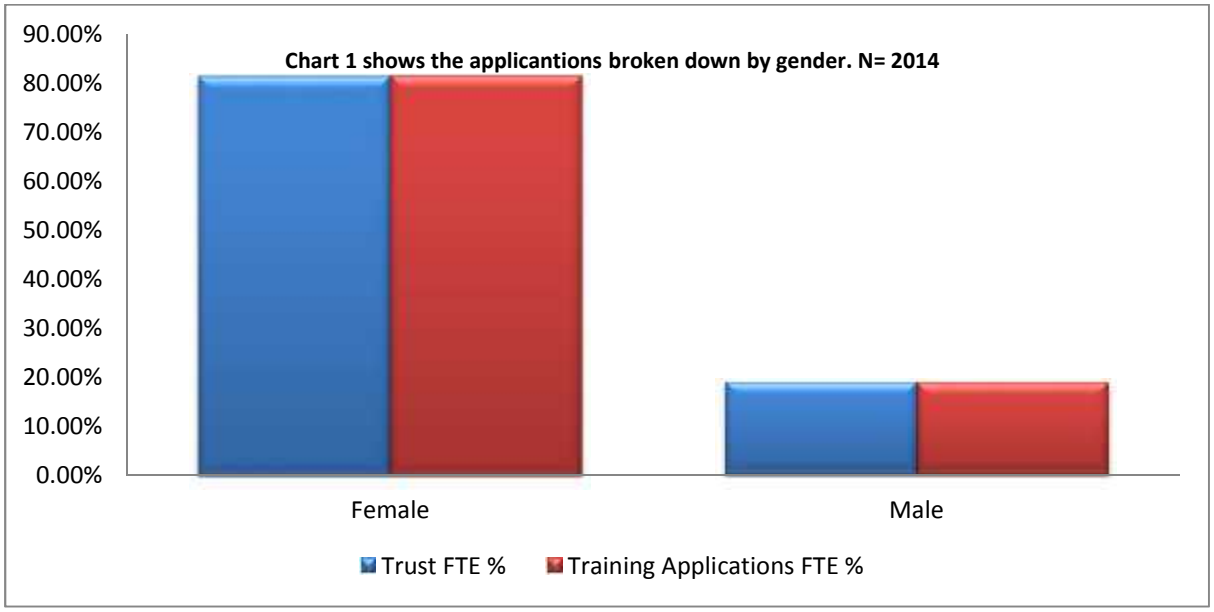


Table 2 represents the age profile of applicants against the Trust WTE profile. The audit shows that staff within the 21-45 year profile are accessing more training and development opportunities per capita than those in the 45-70 year profile. This can be accounted for by young people starting out on their careers and more experienced staff developing their skills for senior positions such as advanced practice, management and leadership. The more aged employees having accessed these types of development at an earlier stage in their career are maintaining their knowledge and skills. N = 2014.

Age Band	**Trust FTE %**	**Trg Apps FTE %**
16-20	0.90%	0.12%

21-25	6.89%	8.35%
26-30	11.41%	16.13%
31-35	10.68%	13.54%
36-40	12.06%	15.87%
41-45	13.00%	15.70%
46-50	14.78%	12.64%
51-55	15.61%	10.98%
56-60	10.20%	5.36%
61-65	3.66%	1.03%
66-70	0.72%	0.28%
71-75	0.09%	0.00%
Grand Total	**100.00%**	

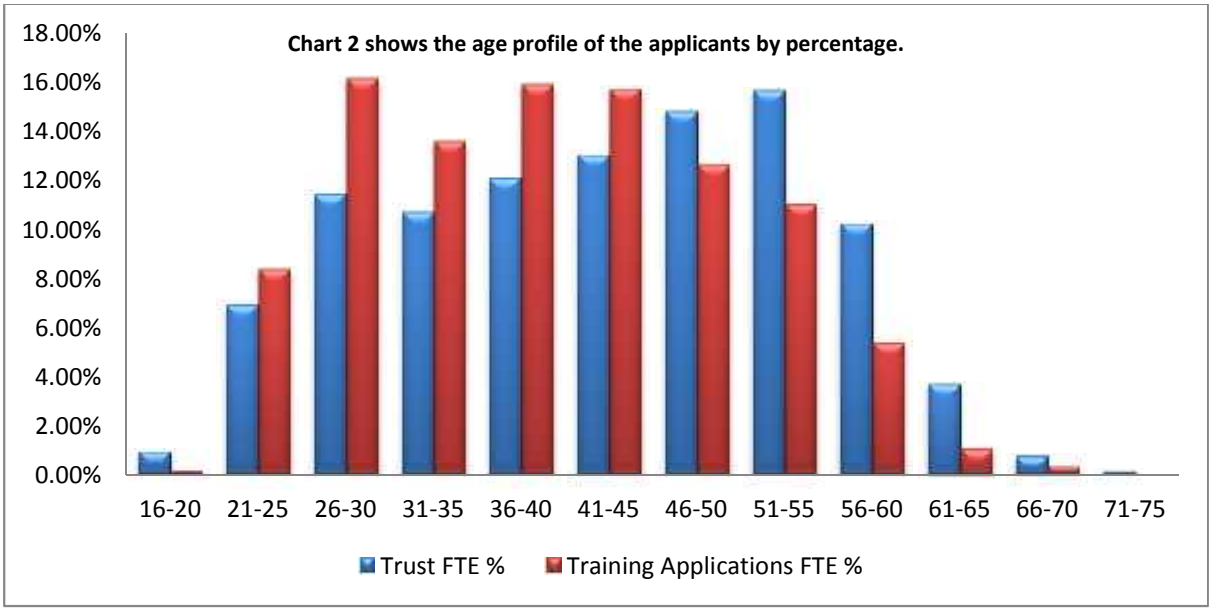


Table 3 gives the breakdown in relation to ethnicity. N = 2014

Grouped Ethnicity	**Trust FTE %**	**Training Applications FTE %**
Asian	17.15%	17.46%
Black	11.08%	9.50%
Mixed Heritage	2.22%	2.14%
Not Stated	8.16%	6.33%
Other Ethnic Group	1.83%	2.23%
White	59.55%	62.33%
Grand Total	**100.00%**	

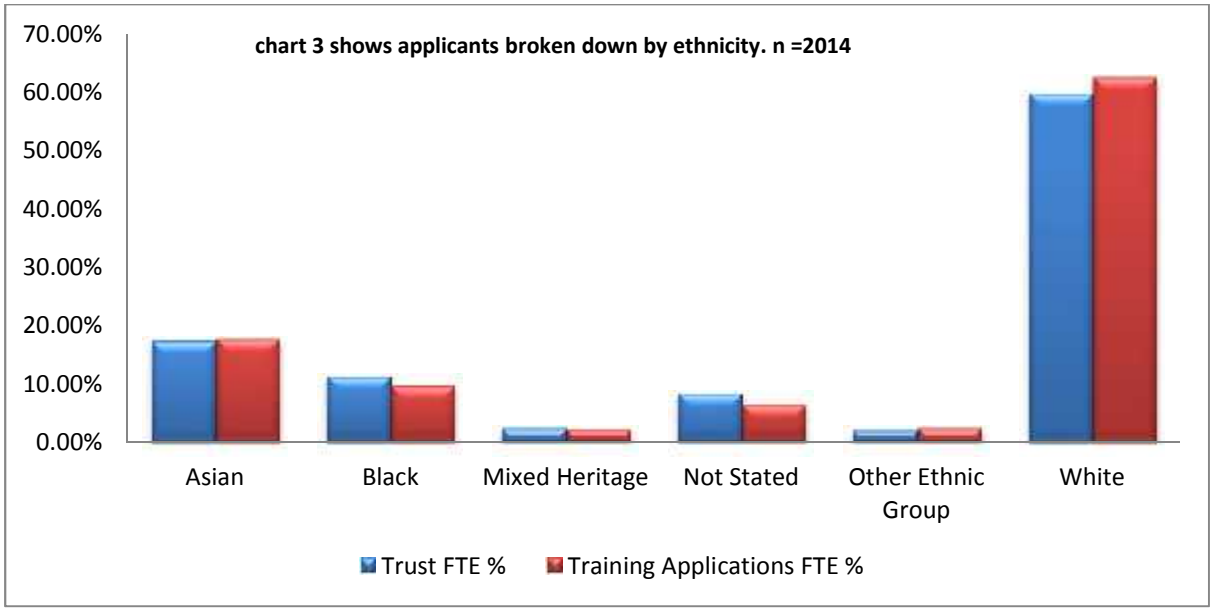


Table 4 gives the breakdown by disability. N = 2014

Disability	**Trust FTE %**	**Training Applications FTE %**
No	72.71%	77.99%
Not Declared	24.48%	18.76%
Yes	2.81%	3.25%
Grand Total	**100.00%**	

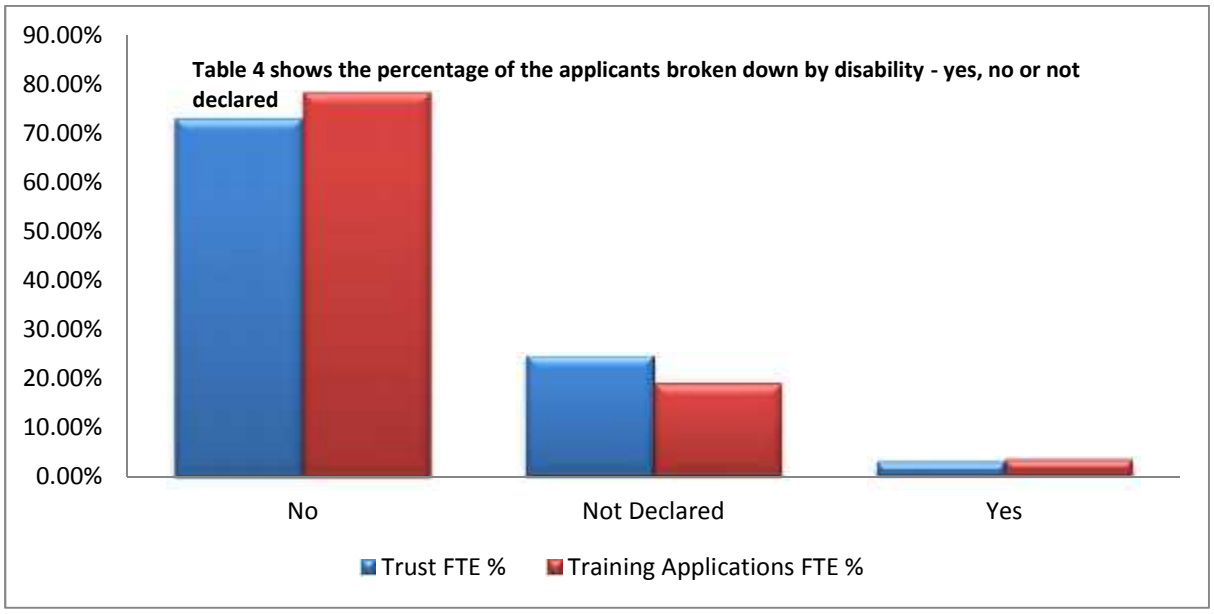


Table 5 covers the religious belief of all study leave applicants. The variance in 'I do not wish to disclose my religion or belief' could be down to people ticking that box on their initial

employment form but forgetting that they selected this option and actually declared their religion on the training application form. N = 2014

Religious Belief	Trust FTE %	Training Applications FTE %
Atheism	5.33%	7.20%
Buddhism	0.29%	0.40%
Christianity	42.50%	47.16%
Hinduism	1.93%	2.32%
I do not wish to disclose my religion/belief	36.09%	27.41%
Islam	3.84%	4.61%
Judaism	0.04%	0.00%
Other	5.23%	6.36%
Sikhism	4.75%	4.54%
Grand Total	**100.00%**	

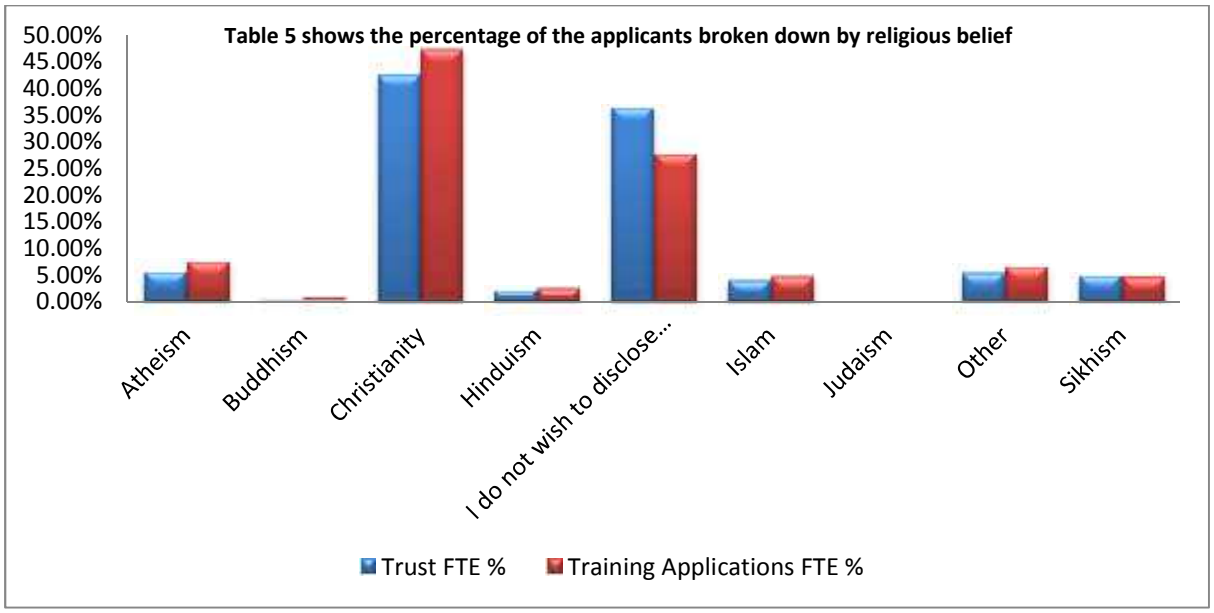
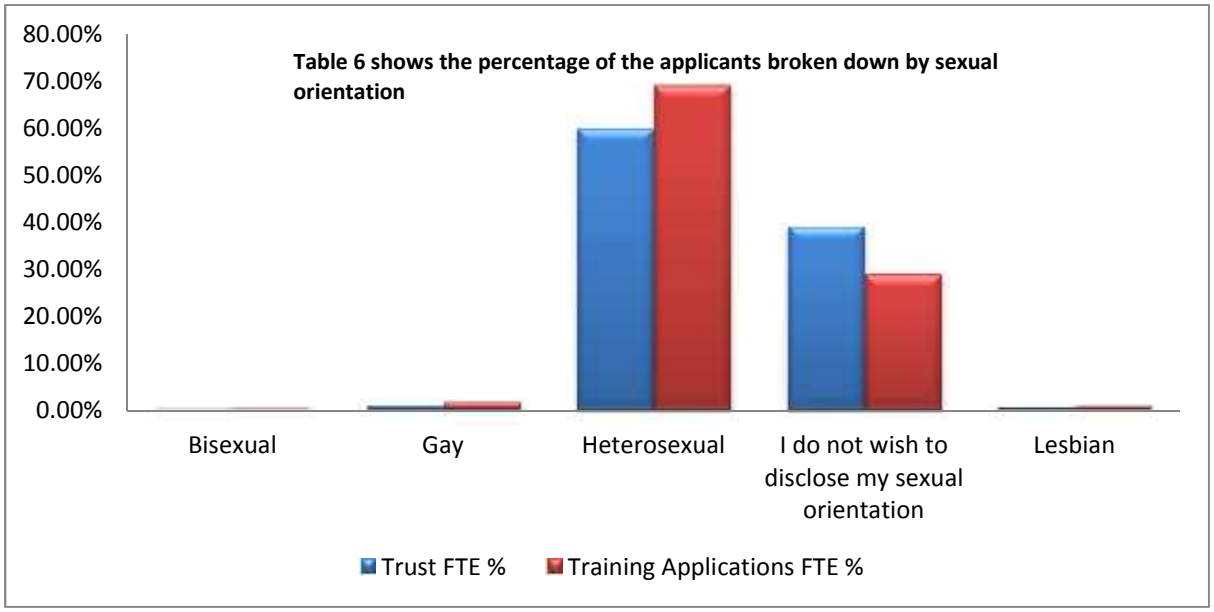


Table 6 covers sexual orientation. The likely explanation for the discrepancy in 'I do not wish to disclose my sexual orientation' is the same as in the previous table.

Sexual Orientation	Trust FTE %	Training Applications FTE %
Bisexual	0.23%	0.24%
Gay	0.76%	1.44%
Heterosexual	59.72%	68.86%
I do not wish to disclose my sexual orientation	39.00%	28.90%

Lesbian	0.29%	0.55%
Grand Total	**100.00%**	



Conclusion

The audit has shown that staff accessing study leave and training across the Trust are not being discriminated against by protected characteristics and have the same equality of opportunity as every other group and staff member. Where there are some anomalies there is reasonable explanation for this occurrence.

Group	Role	Pay Band	Position Title	Occupational Group	Funded Establishment 31.03.16	Staff in Post at 31.03.16	Vacancies as 31.03.16	Number of Conditional Offers made in April '16	Actual Leavers 15/16	Turnover Rate	Forecasted Number of Leavers by 31.3.17	Estimated Recruitment Target by 31.03.17	RAG Assessment
Community and Therapies	Staff Nurse	5	Community Staff Nurse , Staff Nurse	Nursing and Midwifery Registered	150	119	31	1	4	3%	4	34	M
Corporate - Estates & New Hospital Project	Multi Skilled Mechanical Craftsperson	4	Multi Skilled Mechanical Craftsperson	Estates and Ancillary	10	7	3	0	4	57%	4	4	H
Corporate - Estates & New Hospital Project	Estates Officer	6	Estates Officer	Estates and Ancillary	4	2	2	0	1	50%	1	2	H
Corporate - Operations	Clinical Coder	3	Clinical Coder	Administrative and Clerical	4	2	2	0	0	0%	0	2	H
Imaging	Radiographer	5	Radiographer - Generic [PTA0056]	Allied Health Professionals	31	17	14	0	11	66%	11	14	H
Imaging	General Manager - Imaging	8B	Group General Manager - Imaging [C1302]	Administrative and Clerical	1	0	1	0	1	100%	1	1	H
Imaging	Consultant	Consultant	Consultant (Radiology)	Medical and Dental	26	23	3	0*	2	9%	2	2	L
Imaging	Sonographer	7	Sonographer	Allied Health Professionals	14	12	2	0	2	16%	2	3	H
Medicine & Emergency Care	Group Director of Operations- M&EC	9	Group Director of Operations- M&EC	Administrative and Clerical	1	0	1	0	0		0	1	H
Medicine and Emergency Care	Staff Nurse	5	Staff Nurse	Nursing and Midwifery Registered	454	379	75	4	69	18%	69	124	H
Medicine and Emergency Care	Emergency Medicine Consultant	Consultant	Consultant	Medical and Dental	18	12	6	0	2	14%	2	8	H
Medicine and Emergency Care	Acute Physican	Consultant	Consultant	Medical and Dental	8	6	2	0	2	36%	2	2	H
Medicine and Emergency Care	Emergency Medicine SAS Doctor	SAS Doctor	Specialty Doctor, Trust Grade Doctor - Specialist Registrar Level (Closed)	Medical and Dental	17	13	4	5	6	45%	6	5	H
Pathology	Biomedical Scientist	5 to 6	Biomedical Scientist across all directorates	Healthcare Scientists	83	70	13	4	14	20%	14	11	M
Surgery A	Staff Nurse	5	Staff Nurse	Nursing and Midwifery Registered	207	180	27	0	17	10%	17	26	H
Surgery A	Consultant (Anaesthetics)	Consultant	Consultant	Medical and Dental	43	39	4	0	3	8%	3	3	M
Surgery A	Group General Manager	8B	Group General Manager	Administrative and Clerical	3	1	2	0	1	100%	1	1	H
Surgery B	Staff Nurse	5	Staff Nurse	Nursing and Midwifery Registered	34	33	1	0	9	26%	9	4	L
Women and Child Health	NeoNatal Nurse	6	Sister Charge Nurse	Nursing and Midwifery Registered	20	16	4	0	2	14%	2	4	M
Women and Child Health	Community Midwife	6	Midwife	Nursing and Midwifery Registered	79	57	22	0	13	22%	13	31	H

Group	Role	Pay Band	Position Title	Occupational Group	Funded Establishment 31.03.16	Staff in Post at 31.03.16	Vacancies as 31.03.16	Number of Conditional Offers made in April '16	Actual Leavers 15/16	Turnover Rate	Forecasted Number of Leavers by 31.3.17	Estimated Recruitment Target by 31.03.17	RAG Assessment
Women and Child Health	Health Visitor	6	Health Visitor	Nursing and Midwifery Registered	76	61	15	2	7	11%	7	18	M
					1281	**1048**	**233**	**16**	**169**		**169**	**300**	

Note: The above figures do not take into account Group 16/18 TSP plans. Trajectories will be adjusted for the July 2016 report. Trajectories will be discussed with the Group leads during June '16 to reach an informed and signed up trajectory.
Estimated recruitment target for March '17 takes into account current vacancy position, anticipated turnover and known recruitment activity as at May 2016

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Risk Registers
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Mariola Smallman, Head of Risk Management
DATE OF MEETING:	2 June 2016

EXECUTIVE SUMMARY:

The Trust Risk Register compromises high (red) risks that have been through the validation processes at directorate / group and Executive Committee levels.

The Trust Risk Register was last reported to the Board at its May meeting and Executive Director updates are highlighted where these were provided. No additional risks have been escalated to the Board from the Risk Management or Clinical Leadership committees.

REPORT RECOMMENDATION:

The Board is recommended to:

- **RECEIVE** monthly updates from Executive Directors for high (red) risks on the Trust Risk Register.
- **NOTE** the risks on the High Risk Summary Log, which are managed at clinical group or corporate levels.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	✓	✓

KEY AREAS OF IMPACT *(Indicate with 'x' all those that apply):*

Financial	✓	Environmental	✓	Communications & Media	
Business and market share		Legal & Policy	✓	Patient Experience	✓
Clinical	✓	Equality and Diversity	✓	Workforce	✓

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Aligned to BAF, quality and safety agenda and requirement for risk register process as part of external accreditation programmes.

PREVIOUS CONSIDERATION:

Clinical Leadership Executive: 24 May 2016

FOR INFORMATION

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Trust Risk Register

Report to the Trust Board on 2 June 2016

1. EXECUTIVE SUMMARY

1.1 This report includes the Trust Risk Register and an update on the implementation of the electronic risk system.

2. TRUST RISK REGISTER (TRR)

2.1 Clinical Group and Corporate Directorate risks were reviewed at Risk Management and Clinical Leadership Committees. There are no additional risks escalated to the Board from the Risk Management or Clinical Leadership committees. The Trust Risk Register is at **Appendix A**.

2.2 As a reminder, the options available for handling risks are:

Terminate	Cease doing the activity likely to generate the risk
Treat	Reduce the probability or severity of the risk by putting appropriate controls in place
Tolerate	Accept the risk or tolerate the residual risk once treatments have been applied
Transfer	Redefine the responsibility for managing the risk e.g. by contracting out a particular activity.

3. HIGH RISKS MANAGED BY CLINICAL GROUPS OR CORPORATE DIRECTORATES

3.1 A summary of high risks (i.e. red rating at initial score), which are managed at Clinical Group / Corporate Directorate levels and do not feature on the Trust Risk Register is at **Appendix B**. These risks may have been rated as high within the local Groups / Directorates because they are perceived to be high risk within their areas based on a variety of factors, including cost of mitigating the risk, potential numbers of patients or staff affected, organisation impacts, potential penalties or loss of income, etc. The risks reflect themes that are subject to both local and corporate scrutiny at Executive and Board committees, such as: patient safety, finance and performance, workforce, etc.

3.2 There are 29 in total and just under half of the risks that are rated high at the initial risk rating stage relate to operational matters (staff levels/recruitment; performance; demand/capacity). Approximately a third relate to clinical risks across a wide variety of issues. The Clinical Groups /

Corporate Directorates with the highest numbers of high risks (at initial risk rating stage) are Surgery A (8); Medicine and Emergency Care (5); and Surgery B (4). There are 7 high risks (at initial risk rating stage) maintained by Corporate Directorates which are aggregated / Trust-wide risks. Clinical Groups / Corporate Directorate level risk registers are subject to local challenge and confirm discussions; matters for escalation are highlighted through the Risk Management Committee and Clinical Leadership Committee.

3.3 The majority of the high risks that do not feature on the TRR have control potential "Treat" which indicates that there are actions in progress or planned. "Tolerate" relates to risks that may be reliant on actions from other areas not related to the service affected. "Terminate" relates to risks where the actions are intended to completely resolve the matter.

3.4 The expected date of completion relates to current actions. Where the initial and current risk scores are the same this may be because although local workaround / contingency measures are in place the identified actions required to mitigate the risk are not yet implemented.

4. ELECTRONIC RISK SYSTEM

4.1 Implementation of the electronic risk system is ongoing. Implementation of the electronic risk system is ongoing.

4.2 Risk register reports at various levels, including the Trust Risk Register, are available for all staff to access on the Connect Intranet System. Additional risk reports include archive summaries at ward/department level and a detailed risk report, which includes status of individual actions and a summary of risk review history. Risk review and action notification emails are now in place.

4.3 Further development of risk report library is planned.

5. RECOMMENDATION(S)

5.1 The Board is recommended to:

- **RECEIVE** monthly updates from Executive Directors for high (red) risks on the Trust Risk Register.
- **NOTE** the risks on the High Risk Summary Log, which are managed at clinical group or corporate levels.

Mariola Smallman
Head of Risk Management

Appendix A: Trust Risk Register
Appendix B: High Risk Summary Log

Trust Risk Register

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
666	Live (With Actions)	Paediatrics	Paediatrics	Incident	Lack of Tier 4 bed facilities for Children-Young people with mental health conditions means that they are admitted to the paediatric ward. There is no specialist medical or nursing MH team to care for their needs with limited access to in/OOH CAMHS support. Whilst safety for the children can be maintained, therapeutic care is compromised and there can be an impact on other children and parents.	4x4=16	Mental health agency nursing staff utilised to provide care 1:1 All admissions monitored for internal and external monitoring purposes. Awareness training for Trust staff to support management of patients is in place Children are managed in appropriate risk free environments	The LA and CCG are looking to develop a Tier 3+ service. An update has been requested through the CCG and a response is awaited. Tier 4 beds are being reviewed nationally.	Rachel Barlow	30/04/2016	04/04/2016	Monthly	4x4=16	Tolerate
566	Live (With Actions)	Emergency Care	Accident & Emergency (S)	Staffing	There is a risk that further reduction or failure to recruit senior medical staff in ED leads to an inability to provide a viable rota at consultant level which may impact on delays in assessment, treatment and patient safety.	4x5=20	Recruitment campaign through local networks, national adverts, head-hunters and international recruitment expertise. Leadership development and mentorship. Programme to support staff development. Robust forward look on rotas through leadership team reliance on locums (37% shifts filled with locums). Registrar vacancy rate 59%. Consultant vacancy rate 35%.	Recruitment ongoing with marketing of new hospital. CESR middle grade training programme to start in April as a "grow your own" workforce strategy.	Rachel Barlow	30/09/2016	18/03/2016	Monthly	3x5=15	Treat

Risks that feature on the Trust Risk Register (TRR) have been escalated and reviewed by management teams through to Clinical Leadership Executive Committee and Trust Board. Trust Board takes the decision whether risks feature on the TRR including approval of requests for risks to be removed from the TRR for them to managed at the relevant Clinical Group / Corporate Directorate.

Trust Risk Register

Sandwell and West Birmingham Hospitals NHS Trust

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
1603	Live (With Actions)	Finance		Costs Not Planned	As a result of significant reliance on non-recurrent measures and balance sheet flexibility to support the Trust's financial performance cash balances have been eroded and there is a risk that this may compromise future investment plans.	4x5=20	Routine medium term financial plan update. Routine cash flow forecasting. Routine monitoring of supplier status avoiding any 'on stop' issues.	Establish and deliver operational plan consistent with living within means to mitigate further cash erosion Establish & progress cash generation programme Determine and progress accelerated programme of surplus asset realisation.	Tony Waite	31/03/2018	22/01/2016	Quarterly	3x5=15	Treat
215	Live (With Actions)	Waiting List Management	Waiting List Management (S)	Performance	Sustained high Delayed Transfers of Care (DTOC) patients remaining in acute bed capacity	4x4=16	ADAPT joint health and social care team in place. Progress made on new pathway. Joint health and social care ward established in October at Rowley.	Confirm plans for a joint health and social care ward to be established and funded on the City site in 2016. Nursing home capacity also a risk and currently unmitigated. EAB and nursing home capacity remain unmitigated risks. System Resilience partners will review demand and capacity of interim bed base and recommend future requirements by end Q1 2016-17.	Rachel Barlow	30/06/2016	18/03/2016	Bi-Monthly	3x4=12	Treat

Trust Risk Register

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
121	Live (With Actions)	Maternity_ Health	Maternity 1	Costs Not Planned	Unpredictable birth activity and the impact of cross charging from other providers against the AN / PN tariff is significantly affecting the financial position of the service impacting on the affordability and quality provision of the service.	4x4=16	Maximisation of tariff income through robust electronic data capture. Robust validation of cross charges from secondary providers.	Options for management of maternity pathways payment between primary and secondary provider for AN/PN care in progress by the Finance Director - with cross provider SLA planned. Risk proposed for removal from TRR when 2016-17 SLA is signed.	Rachel Barlow	30/04/2016	04/04/2016	Monthly	3x4=12	Treat
771	Live (With Actions)	Theatres	Theatres - 1st	Incident	Risk of cancellation on the day due to the unavailability of instrumentation as a result of off-site sterilisation issues due to the 24 hour turnaround process; migration of equipment; lost damaged instruments; lack of traceability.	4x4=16	Audit by Pan Birmingham team of turnaround times. Non conformance discussed daily and investigated. Monthly Theatre users group meeting with Trust and BBraun. Non conformance presented at TUG monthly. TSSU and Theatre practitioner to follow process at BBraun and spot check theatre compliance.	Surgery A Group Director of Operations attending Pan-Birmingham Management Board to escalate issues. Contract review planned Q1.	Rachel Barlow	30/06/2016	18/03/2016	Quarterly	3x4=12	Treat

Risks that feature on the Trust Risk Register (TRR) have been escalated and reviewed by management teams through to Clinical Leadership Executive Committee and Trust Board. Trust Board takes the decision whether risks feature on the TRR including approval of requests for risks to be removed from the TRR for them to managed at the relevant Clinical Group / Corporate Directorate.

Trust Risk Register

Sandwell and West Birmingham Hospitals NHS Trust

Risk Ref No. / Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
						Risk of cancellation on the day due to the unavailability of instrumentation as a result of off-site sterilisation issues due to the 24 hour turnaround process; migration of equipment; lost damaged instruments; lack of traceability. In addition this is compounded by ongoing industrial action 2 strikes have occurred and 2 more planned						
221 Live (With Actions)	Informatics	Informatics Systems (S)	IT Software - Clinical System Failure / Issue	There is a risk of failure of a trust wide implementation of a new EPR due to insufficient skilled resources in informatics, significant time constraints (programme should have started earlier) and budgetary constraints.	4x4=16	Recruitment of suitably skilled specialist resources for EPR Programme and Infrastructure Stabilisation Funding allocated to LTFM Delivery risk shared with supplier through contract Project prioritised by Board and management.	Complete procurement and business case approval to schedule. Development of contingency plans in relation to clinical IT systems will be established, to ensure that if there is any slippage (for example, a TDA query / Legal challenge), there is an alternative and fully considered option. Management time will be given for programme elements such as detailed planning, change management, and benefits realisation	Mark Reynolds	30/06/2016	18/03/2016	Monthly	3x4=12	Treat

Trust Risk Register

Sandwell and West Birmingham Hospitals NHS Trust

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
325	Live (With Actions)	Informatics	Medical Director's Office	Unauthorised Disclosure Of Info	There is a risk of a breach of patient or staff confidentiality due to inadequate information security systems and processes which could result in regulatory and statutory non-compliance.	4x4=16	Prioritised and protected investment for security infrastructure via Infrastructure Stabilisation approved Business Case Information security assessment completed and actions underway.	Complete actions from information security assessment. Complete rollout of Windows 7. Upgrade servers from version 2003	Mark Reynolds	30/09/2016	04/04/2016	Monthly	3x4=12	Treat
331	Live (With Actions)	Maternity_ Health	Community - Midwifery (C)	IT Software - Clinical System Failure / Issue	BadgerNet connectivity problems associated with the use of I Pads is affecting Community Midwives' (CMW) ability to access/ update patient live records.	4x4=16	A proforma has been developed to enable CMWs to send critical information to the IT service desk. CMW have the ability to download patient caseloads whilst online so can access offline via their IPads.	IT Service Desk liaising with maternity and CSUs to install BN client onto GPs PCs. CIO now leading on mitigation plan.	Mark Reynolds	30/06/2016	18/05/2016	Monthly	3x4=12	Treat

Trust Risk Register

Sandwell and West Birmingham Hospitals NHS Trust

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
							Utilisation of local super users and dedicated midwife for day- to- day support. CMW reverts to peer notes for retrospective data entry if unable to input data in real time							
410	Live (With Actions)	Ophthalmology	Outpatients - EYE (S)	Clinical Environment IC Related	Risk of Breach of Privacy and Dignity Standard, Information Governance Risk and Infection Control Risk at Sandwell Outpatient Department as a consequence of poor building design in SGH Ophthalmology OPD. Clean/dirty utility failings cannot be addressed without re-development of the area. Risk that either a patient's health, or privacy/dignity will be compromised as a consequence of poor building design. Clean / dirty utility failings cannot be addressed without re-development of the area.	5x4=20	Reviewing plans in line with STC retained estate Staff trained in IG and mindful of conversations being overheard by nearby patients / staff / visitors	Department reconstruction at SGH with the exception of theatre location. (May 2016)	Rachel Barlow	31/05/2016	13/05/2016	Quarterly	3x4=12	Treat

Trust Risk Register

Sandwell and West Birmingham Hospitals NHS Trust

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
1643	Live (With Actions)	Operations Management		Incident	Unfunded beds staffed by temporary staff in medicine place an additional ask on substantive staff elsewhere, in both medicine and surgery. This reduces time to care, and raises experience and safety risks.	4x4=16	Overseas recruitment drive (pending) Use of bank staff including block bookings Close working with partners in relation to DTOCs Close monitoring and response as required.	Review bed plan and clinical team model in March 2016. Fully implement the assessment for discharge bundle in AMU by May 2016. Develop a plan for the closure of the unfunded beds by the end of March.	Rachel Barlow	01/06/2016	18/03/2016	Monthly	3x4=12	Treat
114	Live (With Actions)	Human Resources	Human Resources	Cost Improvement Not Met	Insufficient policy levers to ensure effective delivery of Trust workforce plan establishment establishment reduction of 1400 WTEs, leading to excess pay costs (1414MARWK03)	4x5=20	The Executive led delivery plan is progressing the reduction of WTEs alongside a change management programme. Learning from previous phases, changes in legislation and broad stakeholder engagement are factored into the delivery plan.	Remaining ask to be identified by the ongoing programme. Early planning & engagement on 2016/2018 workforce change Workshops, consultation and engagement	Raffaela Goodby	31/05/2016	04/04/2016	Quarterly	3x4=12	Treat

Trust Risk Register

Sandwell and West Birmingham Hospitals NHS
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Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
329	Live (With Actions)	Maternity_ Health	Ante-Natal (C)	Service Level Agreement - Operational	Current sonography capacity is restricted resulting in a number of women having dating USS performed > 12/40 and some being outwith the screening window and therefore not receiving screening as per National NSC guidelines which results in the potential for an inequitable service for those women choosing to book at SWBH.	3x5=15	Implemented alternative ways of providing services to minimise impact. Additional clinics as required Use of agency staff by Imaging to cover gaps in the current service. Ongoing review of referrals to ensure inappropriate scans are not being undertaken and requests are in line with best practice guidance.	Recruitment and retention strategy ongoing; 2 vacancies currently with potential recruits in progress. Training programme in place with other specialties. Vascular sub-specialty dependent on agency. Workforce strategy to be determined in April. Training being scoped to support the development of Sonographers and other disciplines in house. Programme to start Q2 2016-17	Rachel Barlow	31/03/2017	04/04/2016	Monthly	5x2=10	Treat
119	Live (With Actions)	Maternity_ Health	Maternity Theatres	Incident	There is not a 2nd on call theatre team for an obstetric emergency between 1pm and 8am. Risk initially red, downgraded to amber due to reduced frequency. In the event that a 2nd woman requires an emergency c/s when the 1st team are engaged, there is a risk of delay which may result in harm or death to mother and/or child.	2x5=10	Monitoring of frequency of near misses On call theatre team available but not dedicated to maternity (but where possible maternity is prioritised) Good labour ward management practices and good communication between teams.	Reviewed by TB who advised the risk will continue to be monitored / tolerated. RMC / CLE discussion with a view to removal from TRR.	Rachel Barlow	30/04/2016	04/04/2016	Monthly	2x5=10	Tolerate

Trust Risk Register

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Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
755	Live (With Actions)	Informatics	Informatics Systems (S)	IT Hardware - Clinical System Failure / Issue	There is a risk that the Trust's integration engine fails, as 50% of the disks have already failed and are not repairable and the current version is unsupported by the supplier. Resulting in inability to transfer key clinical information between key clinical systems, making these systems unuseable (e.g. CDA, eMBS etc).	4x5=20	Business continuity and communications plans in the event of hardware failure have been put in place. Rhapsody V2 has been successfully transferred off the original failed server onto a virtual server. The transition of Rhapsody 2 to Rhaphsody 5 is in progress.	Migrate Rhapsody V2 to current V5 software. This is in progress; 95% completion by end of March 2016. Imaging and Cardiology migrating in line with their local system implementation plans by mid-summer.	Mark Reynolds	31/08/2016	18/03/2016	Monthly	2x5=10	Treat
328	Live (With Actions)	Operations Management	Operations Management	Staffing	Clinical Groups are unable to transact basic business processes because of key person gaps resulting in performance delays and failures.	4x4=16	Investment in high quality agency staff and internal cover of the senior team Deputy COO for Planned Care appointed.	Recruitment to Medicine Director Operations in train. Deputy COO planned care recruited. Deputy COO for Urgent Care vacant and uncovered in Q4.	Rachel Barlow	31/08/2016	04/04/2016	Quarterly	3x3=9	Treat

Trust Risk Register

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Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
768	Live (With Actions)	Operations Management	Elective Access Inpatient (C)	Performance	There is a risk that within a large group of open referrals that there are potentially patients whose clinical or administrative pathway is not fully completed as a result of historical and inadequate referral management which may lead to delayed treatment.	5x3=15	Historical backlog of open referrals closed in Q3 2015. SOP and training in place as part of actions at time. Audit of current open referrals open pathways completed and shows some remaining inconsistencies in referral management practice.		Rachel Barlow	30/04/2016	18/03/2016	Monthly	3x3=9	Treat
228	Live (With Actions)	Informatics	Informatics Systems (S)	IT Hardware - Clinical System Failure / Issue	There is a risk that a not fit for purpose IT infrastructure will result in a failure to achieve strategic objectives and significantly diminishes the ability to realise benefits from related capital investments. e.g. successful move to paperlite MMH, successful implementation of Trust Wide EPR.	5x4=20	Approved Business Case in place for Infrastructure Stabilisation programme (approved by Trust Board June 2015) Specialist technical resources engaged (both direct and via supplier model) to deliver key activities	Complete network and desktops refresh	Mark Reynolds	30/06/2016	18/03/2016	Monthly	3x3=9	Treat

Trust Risk Register

Sandwell and West Birmingham Hospitals NHS Trust

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
							Informatics has undergone organisational review and restructure to support delivery of key transformational activities Informatics governance structures and delivery mechanisms have been initiated to support of transformational activities Infrastructure work to refresh networks and desktops is underway.							
214	Live (With Actions)	Waiting List Management	Waiting List Management (S)	Performance	Lack of assurance of standard process and data quality approach to 18 weeks.	**4x3=12**	SOP in place Substantive Deputy COO for Planned Care appointed and new Head of Elective Access in place. Improvement plan in place for elective access with training being progressed. 52 week breaches continue to be an issue for the Trust. The RCA identified historical incorrect pathway administration and clock stops. There has been no clinical harm caused to patients. The 52 week review was completed with TDA input. The action plan is focused on prospective data quality check points in the RTT pathway, competency and training.	Implement full action plan by Q2 Source e-learning module for RTT with a competency sign off for all staff in delivery chain by Q2 Data quality process to be documented and KPIs to be published from April.	Rachel Barlow	01/07/2016	18/03/2016	Monthly	**3x3=9**	**Treat**

Trust Risk Register

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
533	Live (With Actions)	Scheduled Care	Oncology Medical	Service Level Agreement - Operational	The Trust has excess waits for oncology clinics because of non-replacement of roles by UHB and pharmacy gaps.	3x5=15	Being tackled through use of locums and waiting times monitored through cancer wait team.	100% funding increase proposed by Trust. Strategic partnership working with New Cross and Coventry and Warwick. Actively recruiting two Medical Oncologist for SWBH. Regional networking through the Cancer Network	Roger Stedman	30/06/2016	04/04/2016	Monthly	3x3=9	Treat
330	Live (With Actions)	Gynaecology_Gynaeonco	Gynaecology (C)	Recruitment	Provision of ultra sound support for Gynaecology services is at risk due to difficulties in recruitment and retention of ultra-sonographers which results in the potential for delayed diagnoses, failure to achieve 31 day cancer investigation targets plus impacts on the one-stop community service contract. Group lack confidence that the team will be able to maintain 100% attendance in the	3x4=12	Use of agency staff by Imaging to cover gaps in the current service Robust communication with Imaging for timely alerts when sonography not required in clinics to ensure efficient use of sonography time.	Recruitment and retention strategy ongoing Training being scoped to support the development of sonographers and other disciplines in-house.	Rachel Barlow	31/03/2016	18/03/2016	Monthly	2x4=8	Treat

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Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
					CGS resulting in the contract being at risk.									
534	Live (With Actions)	Scheduled Care	Oncology Medical	Performance	Trust non-compliance with some peer review standards due to a variety of factors, including lack of oncologist attendance at MDTs, which gives rise to serious concern levels.	**3x4=12**	Oncology recruitment ongoing and longer term resolution is planned as part of the Cancer Services project.	Recruit to revised clinic footprint across multi-provider partnership.	Roger Stedman	30/06/2016	04/04/2016	Monthly	**2x4=8**	**Treat**

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Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
173	Live (With Actions)	Admitted Care	Priory 4	Service Level Agreement - Operational	Potential loss of the Hyper Acute Stroke Unit due to an external commissioner led review.	4x4=16	Standard operating procedure agreed and in place for data collection and validation. Outcomes rated well nationally. KPI monitoring in place. Review panel feedback being considered as part of strengthening position as preferred provider. Progressing strategy with Black Country Alliance stakeholders for stroke services locally.	Continued monitoring through SSNAP Progress strategic plan for stroke in the BCA in 2016.	Rachel Barlow	30/04/2016	04/04/2016	Monthly	2x4=8	Tolerate
327	Live (With Actions)	Interventional Radiology	Imaging Management (C)	Recruitment	Reduced ability to provide an Interventional Radiology service as a result of difficulties in recruiting Interventional Radiology consultants, results in delays for patients and loss of business.	4x3=12	Interventional radiology service is available Mon - Fri 9-5pm across both sites. The QE provides an out of hours service for urgent requests. Locum arrangements in place to support workforce plan. Two consultants recruited who will start in 2017.	BCA plans to be delivered to commence in April 2016. PPAC & staff currently being consulted and volunteers for rotas sought. Working on Rota to cover our first commitment Saturday 30th April. Short term increased risk with planned sickness and leave to be reviewed urgently and mitigation determined. Locum cover being investigated Request for carers leave under review.	Rachel Barlow	31/03/2016	06/05/2016	Bi-Monthly	2x3=6	Treat

Risk Ref No.	Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
								Pilot to cover Satureday and Sunday 9-5pm at SWBH, Wolverhampton and Dudley with BCA commenced April 16; SWBH has received it's first OOH patient. To be done on a rotational basis						
332	Live (With Actions)	Maternity_ Health		Vaccination	National shortage of intradermal BCG vaccination leading to a potential increase in babies affected with TB.	5x4=20	Pooling all available vaccines from other areas in the Trust Getting the maximum number of doses out of each vial when opened to prevent unnecessary wastage. Recording of all infants who are discharged who qualify but don't receive the vaccine. All the community midwives informed that infants will be discharged without being vaccinated. Inform parents of eligible infants of the shortage and how to raise any concerns with relevant agencies. Extra vigilance by CMW in observing and referring infants where necessary.	Mitigation plan up to end March successfully completed, however another national shortage is likely.	Rachel Barlow	30/06/2016	04/04/2016	Monthly	2x2=4	Treat

Trust Risk Register

Sandwell and West Birmingham Hospitals NHS Trust

Risk Ref No. / Status	Directorate	Dept.	Type	Risk Statement	Initial risk rating (Likelihood x Severity)	Existing controls	Actions	Lead Owner	Expected completion	Latest review	Review	Current risk score (LxS)	Control potential
						Backlog reduced. All parents offered appointment by end of Feb							
538 Live (With Actions)	Scheduled Care	Oncology Medical	Performance	Differential and extended chemotherapy wait times between sites due to staff vacancies results in inequality of service for patients.	**2x4=8**	Review / amend pathway Staff vacancies recruited to. Latest audit (Nov 15) provides assurance that wait times have significantly improved; 9 days on each site. Monthly monitoring of performance carried out to check that staff recruitment maintains sustainable change.	New system being introduced to equalise waits from beginning of May.	Roger Stedman	31/07/2016	04/04/2016	Monthly	**1x4=4**	**Treat**

High Risk Summary Log

Sandwell and West Birmingham Hospitals NHS
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Risk Ref No.	Risk Statement	Initial risk score (LxS)	Lead Owner	Clinical Group / Corporate Directorate	Expected completion	Source of Internal Review	Review frequency	Current risk score (LxS)	Control potential
Clinical									
772	Risk of patient receiving compromised surgery due to power failure as there is no uninterruptable power supply in the event of a power failure.	4x4=16	Kara Blackwell	Surgery A	30/06/2016	Clinical Group/Corporate Direc	Monthly	4x4=16	Treat
1762	Clinical and business risk due to lack of capacity within current ophthalmic OPD clinics to see follow up patients in a timeframe that has been requested. Currently 4000 backlog patients.	5x4=20	Sarah Hall	Surgery B	30/09/2016	Clinical Group/Corporate Direc	Bi-Monthly	4x4=16	Treat
8	Risk of shortfall in reporting capacity because of high demand for services and finite availabile Radiologist reporting hours, resulting in delayed diagnosis	4x5=20	Jonathan Walters	Imaging	01/07/2016	Clinical Group/Corporate Direc	Monthly	3x5=15	Treat
1723	Risk of disruption to service continuity and quality of care being compromised due to high number of nursing vacancies on the surgical wards at SGH and City.	4x4=16	Kara Blackwell	Surgery A	14/05/2017	Risk Management Committee	Monthly	4x3=12	Treat
1606	Paediatric patients not screened as per the pathway timeframe, due to lack of capacity in Audiology/ENT, which results in delays for treatment (e.g. hearing aid provision, grommets, etc.) and poor outcomes for patients (speech and language delays potentially leading to reduced educational attainment and behavioural issues).	5x3=15	Sarah Hall	Surgery B	31/08/2016	Clinical Group/Corporate Direc	Quarterly	4x3=12	Treat
777	Risk of misdiagnosis as a result of aging Ultrasound machines. 6 out of 7 machines are older than the recommended age for Ultrasound machines. As a result, the image quality is deteriorating, making it visualisation difficult - particulary the fetal heart	4x4=16	Jonathan Walters	Imaging	30/06/2016	Clinical Group/Corporate Direc	Quarterly	3x4=12	Treat
159	Quality of care compromised for HDU and non HDU children because Children requiring HDU 1:1 care may not receive it due to inadequate staffing levels.	4x4=16	Amanda Geary	Women And Child Health	31/05/2016	Clinical Group/Corporate Direc	Monthly	3x4=12	Treat

High Risk Summary Log

Sandwell and West Birmingham Hospitals NHS Trust

Risk Ref No.	Risk Statement	Initial risk score (LxS)	Lead Owner	Clinical Group / Corporate Directorate	Expected completion	Source of Internal Review	Review frequency	Current risk score (LxS)	Control potential
186	Risk of surgical Never Event due to incorrect side/site listed on Ormis theatre system due to transcription errors and lack of IT linkages between systems.	3x5=15	Kara Blackwell	Surgery A	31/08/2017	Clinical Group/Corporate Direc	Monthly	2x5=10	Treat
38	Risk of harm to children if domestic abuse notifications/information not sent to key healthcare practitioners due to lack of domestic abuse expertise in MASH discussions / barnados screening - due to lack of resource.	5x3=15	Debbie Talbot	Corporate Nursing And Faciliti	01/01/2015	Directorate	Monthly	3x3=9	Treat
Financial									
84	As a result of planned care activity being significantly below plan there is a risk that SLA income will under recover and compromise the delivery of key financial targets. This may harm the trust's reputation and compromise future investment plans.	4x5=20	Antony Waite	Finance	30/06/2016	Clinical Group/Corporate Direc	Monthly	5x4=20	Treat
86	As a result of significant on-going reliance on premium rate temporary staffing there is a risk that pay costs will exceed budget and compromise the delivery of key financial targets. This may harm the trust's reputation and compromise future investment plans.	4x5=20	Antony Waite	Finance	30/09/2016	Clinical Group/Corporate Direc	Monthly	4x4=16	Treat
164	As a result of the scale & pace of CIP development and delivery being behind plan there is a risk that costs will exceed budget and compromise the delivery of key financial targets. This may harm the Trust's reputation and compromise future investment plans.	4x5=20	Antony Waite	Finance	31/03/2017	Clinical Group/Corporate Direc	Monthly	4x4=16	Treat
1728	Financial backpay and HMRC penalty if found to have inappropriately engaged GP's working in PCAT and ED - currently working 'off payroll'.	4x4=16	Raffaela Goodby	Workforce And Organisational D	31/05/2016	Workforce Delivery Committee	Monthly	4x3=12	Terminate
Non-Clinical									

High Risk Summary Log

Sandwell and West Birmingham Hospitals NHS
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Risk Ref No.	Risk Statement	Initial risk score (LxS)	Lead Owner	Clinical Group / Corporate Directorate	Expected completion	Source of Internal Review	Review frequency	Current risk score (LxS)	Control potential
16	Risk of inability to provide safe and effective management of patients requiring isolation facilities in CCS at SGH due to insufficient isolation facilities to cope with demand	4x4=16	Kara Blackwell	Surgery A	05/03/2017	Clinical Group/Corporate Direc	Quarterly	3x4=12	Treat
156	Risk of Breaching Information Governance Standards and business risk due to possible loss of data. Data storage capacity for ophthalmic imaging has been exceeded; data stored locally on some machines contravening IG Standards; OCT equipment no longer able to function.	5x4=20	Sarah Hall	Surgery B	30/09/2016	Clinical Group/Corporate Direc	Quarterly	3x4=12	Treat
Operational									
1648	Partial Booking from 01/10/2015. Potential for 'invisible cohort' of patients who are already clock-stopped and 'lost' between diagnostics and OPD appointment - numbers unknown (approx 1000). Potential to impact on demand and capacity modelling thereby causing targets to be failed. Clinical Risk as patients have already been accepted onto clinical pathway and run the risk of being 'lost' or being discharged without the clinical pathway running its course.	4x4=16	Amanda Geary	Medicine And Emergency Care	30/06/2016	Clinical Group/Corporate Direc	Monthly	4x4=16	Treat
1657	Haematology service fragile due to number of staff on OOH rota for both sites due to Band 6 vacancies and training requirements.	4x4=16	Jonathan Walters	Pathology	30/09/2016	Clinical Group/Corporate Direc	Monthly	4x4=16	Tolerate
1647	Safe Staffing risk relating to all adult inpatient areas within Surgery A and Medicine and Emergency Care as staffing levels and skill mix of staff fall below the agreed levels. Potential for inability to deliver safe patient care and decrease in staff morale/turnover plus increase in sickness rate.	5x4=20	Jo Wakeman	Medicine And Emergency Care	30/09/2016	Clinical Group/Corporate Direc	Quarterly	4x4=16	Treat
776	Lack of availability of interventional radiologists leading to delays in treatment of patients requiring nephrostomies and antegrade stents. Also delays in treatment of patients on elective waiting list for procedures such as percutaneous nephrolithomy (PCNL).	4x4=16	U Otite	Surgery A	31/03/2017	Specialty	Quarterly	4x4=16	Tolerate
552	Dermatology Outpatient Service. Patients fail to receive treatment within national targets due to inadequate capacity which highlights viability of service over the long term. Currently there are 2 Consultant vacancies.	4x5=20	Matthew Lewis	Medicine And Emergency Care	30/09/2016	Clinical Group/Corporate Direc	Weekly	3x5=15	Treat

High Risk Summary Log

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Risk Ref No.	Risk Statement	Initial risk score (LxS)	Lead Owner	Clinical Group / Corporate Directorate	Expected completion	Source of Internal Review	Review frequency	Current risk score (LxS)	Control potential
154	Business and clinical risk due to lack of capacity within EAT for Ophthalmology. Lack of capacity within the EAT has resulted in ineffective booking, delays in patient's being booked for surgery and follow up appointments. Could lead to financial penalties due to 18 week breaches and clinical risks due to extended periods between treatment or review.	5x3=15	Sarah Hall	Surgery B	30/12/2016	Clinical Group/Corporate Direc	Quarterly	5x3=15	Treat
525	Backlog of clinical letters to be typed within all specialties in Admitted Care. Delay in progressing patient outcomes from clinics and negative impact on 18 week RTT pathways. Medical Secretary workforce review ongoing at present. Vacancies held due to process. Temporary staff are in place however level of knowledge varies.	5x4=20	Amanda Geary	Medicine And Emergency Care	30/06/2016	Clinical Group/Corporate Direc	Monthly	4x3=12	Treat
112	There is a risk that the development of high performing cohesive teams will not be achieved, due to high levels of sickness absence, which adversely impacts on the delivery of high quality care.	5x3=15	Raffaela Goodby	Workforce And Organisational D	31/03/2017	Clinical Group/Corporate Direc	Quarterly	4x3=12	Treat
1669	There is a risk that cracks in flooring will release spores into the environment, due to uneven and worn out flooring with damp underneath, which results in forcing an unplanned / short notice relocation of the CCS at City Hospital affecting critically unwell patients.	4x4=16	Michelle Harris	Surgery A	30/06/2016	Clinical Group/Corporate Direc	Monthly	3x4=12	Treat
49	Risk that specialist Ultrasound services, including Stroke services, may not be provided due to a lack of specialist trained sonographers.	3x5=15	Jonathan Walters	Imaging	31/03/2017	Clinical Group/Corporate Direc	Monthly	2x5=10	Treat
1655	Risk of delayed admissions to CCS Unit, due to lack of staffing capacity, results in critically unwell patients having to be nursed on a ward thus resulting in poor outcomes for patients. (Evidence supported by Outreach audit and BRAD acuity data.)	3x5=15	Kara Blackwell	Surgery A	/ /	Clinical Group/Corporate Direc	Monthly	2x5=10	Tolerate
774	Risk of unavailability of HDU beds for post surgery cancer pathway patients, due to insufficient capacity and inability to confirm availability as part of the elective theatre planning process, which results in failure to effectively manage the pathway for these patients.	5x3=15	Kara Blackwell	Surgery A	31/05/2016	Clinical Group/Corporate Direc	Quarterly	3x3=9	Treat

High Risk Summary Log

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Risk Ref No.	Risk Statement	Initial risk score (LxS)	Lead Owner	Clinical Group / Corporate Directorate	Expected completion	Source of Internal Review	Review frequency	Current risk score (LxS)	Control potential
135	Risk of inequity of service for patients with learning disabilities, due to withdrawal of funding, which results in potential harm to these patients (interventions can be delayed, Human Rights not followed, wrong interventions, etc.)	5x3=15	Debbie Talbot	Corporate Nursing And Faciliti	01/04/2015	Clinical Group/Corporate Direc	Monthly	3x3=9	Treat
326	Not all shifts have an appropriately trained trauma nurse on duty due to a lack of nurses trained in ATNC or equivalent which could compromise the quality of care.	5x3=15	Jo Wakeman	Medicine And Emergency Care	30/09/2016	Clinical Group/Corporate Direc	Bi-Monthly	4x2=8	Treat

Sandwell and West Birmingham Hospitals NHS
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TRUST PUBLIC BOARD

DOCUMENT TITLE:	**Preparation for Summer Consultation**
SPONSOR (EXECUTIVE DIRECTOR):	**Raffaela Goodby – Director of Organisation Development**
AUTHOR:	**Lesley Barnett – Deputy Director Human Resources**
DATE OF MEETING:	**2nd June 2016**

EXECUTIVE SUMMARY:

This paper is designed to give the Trust Board early sight of the Summer Consultation programme, which will consult on the c 450 WTE roles affected by the 2016-2018 workforce changes. This will have a significant impact on managers and group leaders who are leading schemes and managing change in their service area, as well as corporate teams and group clinical leaders who are leading and managing the processes associated with the changes.

Change happens well when local leaders are engaged in and accountable for the changes happening in their groups and service areas. The summer consultation will be wide ranging and affect multiple groups at the same time. CLE have discussed the summer consultation in their June meeting and the likely impact of a wholesale workforce change.

During June and July there will be a significant time ask of group directors and their managers. Each week there are clear objectives for group leaders in order to consult effectively and efficiently on the 450 WTE reductions, and be ready for 1st October scheme implementation deadline. The full timeline is detailed in appendix 1.

The Summer Consultation will be signed off to proceed by the Trust Board Workforce and OD Committee on 27th June 2016. The initial quality and safety impacts will be discussed at the June Quality and Safety Committee meeting on 24th June 2016. It is anticipated that there will be strong non-executive input in to the sign off and scrutiny process for individual schemes.

A separate paper will be considered in private board that resolves residual costs from workforce change phase 1 and phase 2.

REPORT RECOMMENDATION:

Note the contents of the report and discuss.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		X

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	
Clinical		Equality and Diversity		Workforce	X
Comments:					

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

PREVIOUS CONSIDERATION:

Week commencing 30th May

- Group directors and scheme leads informed of project timelines and expectations
- Group directors to identify appropriate scheme leads for training (the do'ers of workforce change)
- Scheme leads to undertake pre consultation with relevant departments and teams
- Development of scheme sheets with proposed workflow changes
- Working with change team, HR Business Partners and Simon Cook to ensure WTE ask has been met

Week Commencing 6th June

- Groups / TSO to confirm state of readiness to proceed
- Reconciliation of whether there is £30m identified to consult on / come out from 1st October 2016
- Identify further schemes if answer to above is 'no'
- Scheme leads to undertake pre consultation with relevant departments and teams
- L&D providing 'management of change' training and support
- Publish manager's resource guidance including checklist for managers

Week commencing 13th June

- Executive PMO review and scrutinise schemes, are there £30m of schemes?
- Scheme leads to undertake pre consultation with relevant departments and teams
- Scheme leads start to prepare paperwork in ready for consultation
- L&D providing 'management of change' training and support for scheme leads and line managers
- Scheme leads to attend bespoke redundancy selection interview training (if required)

Week commencing 20th June

- Executive PMO review and scrutinise schemes, are there £30m of schemes
- Scheme leads to undertake pre consultation with relevant departments and teams
- **GDOP's to attend launch meeting**
- L&D providing 'management of change' training and support for scheme leads and line managers
- Scheme leads, line managers to attend weekly HR briefing sessions
- Preparing paperwork for Connect / scheme sheets for executive sign off
- Initial quality impact of schemes discussed at Quality and Safety Committee Friday 24thJune 10.30-12pm

Week Commencing 27th June

- Executive PMO review and scrutinise schemes, are there £30m of schemes?
- **Schemes presented at Board Workforce and OD committee on Monday 27th June with approval given to proceed to consultation**
- Scheme leads to undertake pre consultation with relevant departments and teams
- Consultation scheme sheet completion deadline
- Scheme leads and line managers attend specific briefing sessions
- L&D providing 'management of change' training and support for scheme leads and line managers
- Press and communications briefing session for executive and key CLE members

Week Commencing 4th July

- 45 day formal consultation formally launches
- Special JCNC meeting to launch consultation
- All schemes are uploaded on to Connect
- GDOP's to attend weekly meetings
- Scheme leads to attend weekly meetings
- **See attached sheet**

Raffaela Goodby
26th May 2016

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**16-18 Workforce Changes Phase 1 (Easter 2016) Progress Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Raffaela Goodby – Director of Organisation Development**
AUTHOR:	**Lesley Barnett – Deputy Director. Human Resources**
DATE OF MEETING:	**4th May 2016**

EXECUTIVE SUMMARY:

The purpose of this paper is to provide an update to the formal statutory workforce consultation process that commenced on 6th April 2016.

As planned the 'Easter Consultation' process affected staff predominantly from corporate teams and was undertaken with our trade union partners via PPAC. Scheme lead managers attended PPAC to present the detail of their schemes and discuss and answer queries with regards to both the rationale and to consider the consistent implementation of the Trust's Organisational Change Policy.

The consultation process has proceeded as planned, and with the exception of four schemes, has now concluded.

The attached paper provides an update to the consultation process and seeks approval to proceed with those schemes where consultation has been fully completed.

A proposal to close out residual costs from phase Safe and Sound Phase 1& 2 will be considered in private board.

REPORT RECOMMENDATION:

The Board is asked to:

1. approve the implementation of the schemes where consultation has now concluded.
2. Note the delayed schemes and accept an update at a future board.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	✓	

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial	✓	Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	✓
Clinical	✓	Equality and Diversity		Workforce	✓
Comments:					

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

High Quality Care, Effective use of Resources.

PREVIOUS CONSIDERATION:

Workforce Changes 2016-2018: Easter Consultation

The Trust launched a formal statutory 30 day consultation on 6th April 2016 as the first phase of our planned transformation of services, to support our long-term plan. The consultation formally concluded on 5th May 2016.

All workforce change schemes are required to have been fully assessed for quality and safety and have a completed EIA (equality impact assessment), via the Trust's system, TPRS.

This paper is designed to provide an update on progress with the Easter consultation process and to seek Trust Board approval to proceed with schemes where consultation has concluded.

Consultation process

The formal 30 day consultation was launched at a special meeting of the JCNC on 6th April 2016. The staff side were provided with a detailed summary of the proposed schemes, as detailed in Appendix A. One scheme was not tabled in detail at this meeting, Operations, 24 Hour Site Team) but a copy of the scheme template explaining the scheme rationale was included.

An electronic copy of the scheme templates was subsequently published on the intranet Connect in order to provide absolute transparency to all staff, whether they were directly or indirectly affected by the proposed changes.

Consultation took place with PPAC and in detail with individuals with regards to all the schemes presented on 6th April 2016, with the exception of the Operations, 24 Hour Site Team.

Consultation Meetings

As agreed at JCNC, formal consultation meetings have taken place via PPAC. A formal update following the conclusion of the statutory process was undertaken at a JCNC meeting on 4th May 2016. Trade Union representation was comprehensive across the consultation meetings with representation from UNISON, RCN, T&G and UNITE.

The early stage of the consultation process focused on schemes with the potential for compulsory redundancy. Managers responsible for leading these schemes were invited to attend the PPAC to share the scheme rationale and discuss the application of the Trust's Organisational Change Policy and to discuss ring-fencing/selection arrangements. Additional information was requested by the staff side i.e. job descriptions and organisational charts and were provided as appropriate.

The latter part of the consultation process focused on addressing queries from staff side representatives and consideration of schemes that involved a change process other than that of redundancy i.e. on-call proposals and reductions in over-time.

Feedback from the individuals affected by the proposals and key stakeholders has also been taken into consideration by scheme lead managers and logged on issues logs, as well as through feedback from the transparent sharing of scheme proposals, statutory consultation with trade union representatives, staff meetings and individual one-to-one consultation meetings.

Consultation Outcomes

1. <u>Schemes with the Potential for Compulsory Redundancy:</u>
   Broadly there was generally a consensus of opinion regarding the correct application of the Trust's Organisational Change Policy with regards to selection arrangements.

The staff side did not raise any serious concerns with respect to the safety of the proposals and other than the Little Saints nursery closure proposal the schemes in this process have not been changed or amended as a result of the consultation process.

As indicated on appendix A, all schemes in this category are proceeding in accordance with the agreed selection process and to timeline with the following two exceptions:

a) Corporate Group, senior nursing restructure. Both employees concerned have lodged final appeals supported by the RCN, which are scheduled to be heard on 31st May 2016.
b) Closure of Little Saints Day Nursery. The staff have presented an alternative proposal to build and run a smaller day nursery on the City site. This proposal is currently under review and the scheme is on hold.

There were two schemes where agreement on the most appropriate application of the Organisational Change Policy was questioned by the staff side.

a) Estates and New Hospital Project, ES597W
This scheme was presented by Alan Kenny, Director of Estates and New Hospital Project.

The proposal was that the two individuals concerned be ring-fenced to apply for two new posts being created within the structure. The staff side took the view that the new posts were sufficiently similar to the existing posts and that consequently the two post holders were entitled to be simply 'slotted into post'.

The views of the staff side were considered carefully, along-side feedback from the two individuals concerned and a decision was taken to proceed on the basis originally proposed.

b) WO557W, Communications Team.
Whilst the selection process was agreed, the scheme highlighted a potential ambiguity of interpretation of the Organisational Change Policy with regards to the ring-fence entitlement of individuals affected by restructure proposals. This was with regards to 'how many bands above and below' an individual should be eligible to be ringfenced for (in this case a band 4 communications officer to be considered for a band 7 vacancy).

It was agreed with Staffside that the Organisational Change Policy would be reviewed to agree a minor amendment prior to the Q2 consultation.

2. <u>Schemes Proposing Organisational Change other than Compulsory Redundancy:</u>

There are two schemes in this category:

a) ES564 Estates Management On-Call
Consultation successfully concluded on 25th May 2016.

b) Surgery A - Withdrawal of weekend overtime for Anaesthetics Practitioners on the City Site
This scheme proposal involves the removal of a long standing local agreement guaranteeing overtime. The consultation process has been constructive involving both staff side colleagues and individuals, but has not yet concluded. It is anticipated that consultation will conclude in

June and although there has been a small delay, it will not impact adversely on the planned implementation date and associated benefits..

3. Consultation Extension:

There is one scheme where consultation did not commence until 11th May, the Operations, 24 Hours Site Team proposal. In view of this the statutory consultation period was extended for a further 30 days until 9th June 2016.

Conclusion:

That the Trust Board consider and provide approval for the implementation of the attached schemes that have now successfully concluded the necessary consultation process with trade union representatives, employees and stakeholders.

Lesley Barnett – Deputy Director. Human Resources

26th May 2016

Group	TSP Ref	Project Description	Scheme Rationale	Pay Reduction Method	Consultation Outcome
Chief Executive	CE550W	Strategy Workforce Reduction	Redesign of the Strategy team with revised roles for new posts	Natural Wastage	Concluded
Chief Executive	CE552W	Clinical Effectiveness workforce reduction	Disestablishment of vacant Data Clerk post	Natural Wastage	Concluded
Chief Executive	CE555W	Homeless persons workforce reduction	Reduction in funding for 'external sessions' for Homeless project	Pay Cost Savings	Concluded
Corporate Nursing & Facilities	FA631W and FA632W	Realign administrative services within the corporate nursing team	Streamline support to corporate nursing team	Natural Wastage	Concluded
Corporate Nursing & Facilities	FA631W and FA632W	Reduce by 1.00 WTE 8D Deputy Chief Nurse	Reduce the overall responsibilities within the corporate nursing team and reorganisation of lead areas	Compulsory Redundancy	Process at final appeal stage. To be heard on 31st May 2016
Corporate Nursing & Facilities	FA631W and FA632W	Transfer of Trust Bank Service from Corporate Nursing and Facilities to Organisational Development Directorate.	Trust Bank Service is more closely aligned with payroll, ESR and people management services	Not applicable	Concluded
Corporate Nursing & Facilities	FA636W	WTE reduction in the temporary staffing team	Efficiencies made as a result of E-Rostering system	Natural Wastage	Concluded
Estates & New Hospital Project	EST018	EST 018 Review of On-Call provision estates	Reduction in contractual on-call payments and revised management on call rota	Pay Cost Savings	Concluded
Estates & New Hospital Project	ES568W	Admin Pay Budget Reduction	Efficiencies in admin workload	Natural Wastage	Concluded
Estates & New Hospital Project	ES597W	Review of current MMH Project structure to ensure fit for the future beyond MMH	Review of current MMH Project structure to ensure fit for the future beyond MMH	Compulsory Redundancy	Concluded
Imaging	IM575W	Admin Dept. Review (B4s)	Disestablishment of vacant band 4 Medical Secretary post	Natural Wastage	Concluded
Medical Director	MD555	Restructure of Associate Medical Director Role	Restructure of Associate Medical Directors on expiry of 3 year tenure	Job Plan Review	Concluded
Medical Director	MD556	Medical Director's Office – Scheme 3 Restructure of core Team in Medical Directors office	Restructure of core Team and alignment of structure to meet needs of the Medical Director portfolio	Compulsory Redundancy	Concluded
Medical Director	MD559W	Medical Education – scheme 3 - Disestablishment of vacant admin post	Disestablishment of vacant band 3 post in line with proposal for D20 undergraduate training ward not being manned by an administrator throughout the day	Natural Wastage	Concluded
Operations	OP563W	Removal of Band 6 post in Capacity Team	Disestablish Post which has been vacant without any adverse impact to service delivery	Natural Wastage	Concluded
Operations	OP564W	Removal of 2 WTE information posts	Disestablish Post which has been vacant without any adverse impact to service delivery	Natural Wastage	Concluded
Operations	OP565W	Removal of 2 WTE Change team vacancies	Disestablish Post which has been vacant without any adverse impact to service delivery	Natural Wastage	Concluded
Operations		24 Hour Site Team	Integrated community and acute capacity management and 24 hour site management	Pay Cost Savings	Consultation extended until 9th June 2016
Pathology	PA1014W	B7 retirement	Non replacement of band 7 retiree	Natural Wastage	Concluded
Pathology	PA1027W	Band 5 Mortuary Technician	Disestablish Post which has been vacant without any adverse impact to service delivery	Natural Wastage	Concluded
Pathology	PA1027W	0.1 WTE Band 5 BMS	Absorb duties into existing structure	Natural Wastage	Concluded
Pathology	PA1044W	Reduction in Band 3 Hours	Voluntary Reduction in Band 3 hours from 37.5 to 22.5 - Absorb of duties into existing structure	Natural Wastage	Concluded
Surgery A		Removal of Weekend Overtime in Theatres and conversion to established hours	To enable equity and standardisation in the rostering of weekend shifts by specialty and cross site. To comply with removal and reduction TSP plan for rostered overtime.	Pay Cost Savings	Consultation on-going - due to conclude in June 2016
Surgery B		SLA Cessation – Dudley Group of Hospitals		Natural Wastage	Concluded
Workforce & Organisation Development	WO550W	ESR Skill-mix	Skill mix of vacant posts following roll-out of OLM system	Skill Mix of vacant post	Concluded
Workforce & Organisation Development	WO555W	Workforce and strategy redesign disestablish 8D and 8A posts in workforce strategy	Removal of 8d, 8a and 7 posts in Workforce strategy following the completion of the procurement and planning phase of MMH hospital which was signed off in December 2015.	Compulsory Redundancy	Concluded
Workforce & Organisation Development	WO555W	Workforce and strategy redesign disestablish vacant band 7 in workforce strategy	Removal of 8d, 8a and 7 posts in Workforce strategy following the completion of the procurement and planning phase of MMH hospital which was signed off in December 2015.	Natural Wastage	Concluded
Workforce & Organisation Development	WO557W	Communications department restructure	Removal of 3.00 band 4 posts a(2 CR and 1 NW) and creation of 2x band 7 posts The proposed changes will support more effective delivery of communications objectives	Compulsory Redundancy	Concluded
Workforce & Organisation Development	WO558W	Restructure L&D management team	The plan is to utilise the band 8a vacancy to restructure the L&D team creating 3 new B7 posts to support the delivery of the OD activities such as PDR delivery, soft skills development etc.	Skill Mix of vacant post	Concluded
Workforce & Organisation Development	WO559W	Deletion of Band 6 post in L+D	The provision of functional skills training for the apprenticeship programme is likely to include GCSE qualifications and it is expected that this provision will be transferred to Sandwell College. One member of staff will be seconded (initially for 6 months) to support this transition from April, 2016 after which one of the band 6 posts incorporating these duties will no longer be required in the Trust and will therefore be redundant.	Compulsory Redundancy	Concluded
Workforce & Organisation Development	WOXXW	Closure of Little Saints Nursery - City Site	Planned closure of Little Saints Day nursery in the Autumn of 2016 and provision of additional child care places through an extension of the Lyndon Day Nursery building at SGH.	Compulsory Redundancy	Staff alternative proposal under consideration.
Workforce & Organisation Development	WO552W	Medical Staffing	Planned integration of the Medical Staffing Department into the central recruitment department. Through the adoption of a fully automated recruitment administrative service, it is proposed to disestablish a band 3 vacancy	Natural Wastage	Concluded.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Integrated Performance Report
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance
AUTHOR:	Yasmina Gainer, Head Performance Management & Costing
DATE OF MEETING:	

EXECUTIVE SUMMARY:

The report is presented to inform of the performance for the Trust for the period to April 2016.

✓ **IPR – Summary Scorecard for April 2016 (In-Month)**

Summary Scorecard

Section	Red Rated	Amber Rated	Green Rated	None	Total
Infection Control	0	0	6	0	**6**
Harm Free Care	4	0	9	2	**15**
Obstetrics	1	1	5	6	**13**
Mortality and Readmissions	1	0	0	11	**12**
Stroke and Cardiology	3	0	8	0	**11**
Cancer	0	0	9	5	**14**
FFT. MSA, Complaints	7	2	7	6	**22**
Cancellations	3	0	6	0	**9**
Emergency Care & Patient Flow	9	0	5	4	**18**
RTT	5	0	3	5	**13**
Data Completeness	2	0	8	8	**18**
Workforce	10	0	1	12	**23**
Total	**45**	**3**	**67**	**59**	**174**

- April performance has 45 exceptions (red rated indicators) (54 last month)
- Relevant recovery plans are overseen through the executive Performance Management Committee.

Matters to draw to the Committee's attention :

April Delivery

✓ All **cancer** targets met in April as verbally confirmed (pending validation across the shared network)

✓ **RTT** (incomplete pathway) delivered to 92.4% standard in April with no patients breaching the 52 weeks wait time (incomplete pathway only).

✓ **Diagnostic waiting times** have met in April again well above the 1% target

× **ED 4 hour** performance in April was 91.4% with 1,608 breaches in the month breaching the national 95% target as well as the NHSI Improvement Trajectory agreed at 92.5% for April

× **Harm Free care** has exceptions against pressure ulcers, falls and serious incidents and hence the overall patient thermometer

Other – positive delivery

✓ **Infection control** delivers across all indicators in April

✓ **VTE** in April delivery 95.3%

✓ **Staff sickness** in –month rate reduces to 4.4% in April

Requiring attention

- 14 hospital acquired, avoidable pressure sores were reported for the month of April of which: x12 cases were avoidable, hospital acquired pressure ulcers and x2 cases reported within the District Nursing caseload,
- 7x grade 3 and 7x grade 2. Highest grade 3 reported position – Chief Nurse to investigate
- Stroke to thrombolysis - 50% performance in month and representing second consecutive month of failing target against good past performance
- Hip fractures – 71.1% in month and representing second consecutive month of failing target against good past performance; 10 breaches in April including 4 patients where fractures have been missed.
- Falls to be reviewed to ensure that avoidable falls are being monitored correctly
- Cancelled operations (particularly multiple) and theatre utilisation remain above / below expected levels and the full end to end process has to be reviewed to ensure that admin processes are in place and working, most 1st time cancellations were due to doctors' strike action
- VTE Assessments need to be carried out more routinely without prompts by central teams
-

Forward Look – NSHI Improvement Trajectory - Key Access Targets:

The trajectory has been submitted to the NHSI and has been locked in with the CCG for 4 key metrics; The trust will be working on achieving the improvements where applicable or sustaining current performance where already meeting targets.

Q1 Trajectory & Actual Performance

		Apr-16	May-16	Jun-16
A&E	Projection	92.5%	93.1%	93.4%
	Actual Delivery	91.4%		
CAN (62 Days Referral to Treatment)	Projection	85.0%	85.0%	85.0%
	Actual Delivery	TBC		
RTT - Incomplete Pathway (18-weeks)	Projection	92.0%	92.0%	92.0%
	Actual Delivery	92.4%		
Patients Waiting >52 weeks (Incomplete)	Projection	2	2	2
	Actual Delivery	2		
Diagnostic Tests	Projection	0.42%	0.42%	0.39%
	Actual Delivery	0.32%		

Cancer: April delivery verbally confirmed, May currently an issue in Urology being looked into

REPORT RECOMMENDATION:

The Trust Board is asked to consider the content of this report.
Its attention is drawn to the matters above and commentary at the 'At a glance' summary page.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		X

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial	x	Environmental	x	Communications & Media	X
Business and market share	x	Legal & Policy	x	Patient Experience	X
Clinical	x	Equality and Diversity		Workforce	X

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Accessible and Responsive Care, High Quality Care and Good Use of Resources.
PREVIOUS CONSIDERATION:
Operational Management Committee, Performance Management Committee, CLE

Sandwell and West Birmingham Hospitals NHS Trust

Integrated Quality & Performance Report

Month Reported: April 2016

Reported as at: 24/05/2016

Contents

At Glance - April 2016

Infection Control

x2 C. Diff cases reported during the month of April;
x2 cases year to date against the 16/17 target of 2 cases for the month of April
Max x30 cases for the year have been agreed within the CCG Contract 16/17.

No cases of MRSA Bacteraemia were reported in April.

Annual target of zero against this indicator within the CCG Contract 16/17.

MRSA Screening
- Non-elective patients screening 94.3% (compliant with 80% target)
- Elective patients screening 90.5% in month (compliant overall with target 80%);

Elective screening performance compliant in all groups with exception of medicine - scheduled care @ 27% subject to follow up investigation.

MSSA Bacteraemia (expressed per 100,000 bed days) for the month of March & April has been reported as 0.0 against a target rate of 9.42.

Harm Free Care

94.96% compliance with NHS Safety Thermometer indicates slipping narrowly below the target 95.0% in April.

x79 falls reported in April with no falls resulting in serious injury. 22 falls within community and 57 in acute. No serious injury resulting from falls in April.

14 hospital acquired, avoidable pressure sores were reported for the month of April of which: x12 cases were avoidable, hospital acquired and x2 cases reported within the District Nursing caseload . 7x grade 3 and 7x grade 2. April x14 cases represents 16-months high and with significantly increased proportion of grade 3 ulcers. An investigation has been requested from Chief Nurse.

x2 serious incidents reported in April.

No Never Events were recorded in April.

There were no medication error causing serious harm in April.

x1 Open CAS Alerts reported at the end of April, of which none were overdue at the end of April.

Venous Thromboembolism (VTE) Assessments in April needed intensive chasing to achieve the target. April delivery is at 95.3% against the national target of 95% and short of local target of 100%. Lack of timely discharges of patients has caused issues in reporting of the compliance in April and relevant groups have been asked to note and improve on this.
On-going remedial plan is required to secure a more consistent and improved performance this year.

Obstetrics

The overall Caesarean Section rate for March is 26.7% missing the target of 25% for the second months running, however greatly influenced by patient choice.
Elective and Non-Elective rates in month are 9.8% and 16.8% respectively.

Adjusted perinatal mortality rate (per 1000 births) for April is 4.37 (4.76 last month) being below the target rate of 8.

The indicator represents an in-month position and which, together with the small numbers involved provides for some natural variation.

Nationally this is monitored using a 3 year cumulative trend, based on which the Trust is within normal confidence limits.

Early Booking Assessment (<12 + 6 weeks) - SWBH specific definition target of 90% has consistently not been met and for April the delivery is 78.3%; The group has been asked to assess performance and report back on reasons as to why consistently below the target; however, performance is consistently delivering to nationally specified definitions in large part due to significant excess of registrations over births in the Trust.

Breastfeeding initiation is at 74% on a cumulative basis as at quarter 4, below the target of 77% . However, Trust performance is much higher than other local benchmarks and CCG have now signed up to a sustained delivery of 74% in 2016/17, which is a real recognition for the service.

Mortality & Readmissions

The Trust overall RAMI for most recent 12-mth cumulative period is 103 (latest available data is as at January).
The RAMI for weekday and weekend each at 104 and 99 respectively and slightly higher than in previous months, but due to re-basing.

SHMI measure which includes deaths 30-days after hospital discharge is at 98 for the month of December (latest available data).
Consistent with previous months.

Deaths in Low Risk Diagnosis Groups (RAMI) - month of November is 68 (40 last month and 148 before that).
This indicator measures in-month expected versus actual deaths so subject to larger month on month variations.

Crude in-month mortality rate for March is 1.6, and slightly higher to last year same period.
The rolling crude year to date mortality rate remains static at 1.4.

Mortality review rate in February at 69% being step improvement on previous periods following resolution of CDA issues. A local CQUIN is in place for 16/17 to improve performance to Q4 (c72% but awaiting March performance to confirm).

Readmissions (in-hospital) reported 7.9% in March (8.0% previous month) for the month; [8.1% rolling 12 mnths].
For CQC diagnostic group reporting 8.6% rolling 12 months (vs. peer 6.2%).

Stroke Care & Cardiology

Stroke data for April indicates 97.7% of patients spending >90% of their time on a stroke ward which is above the 90% operational threshold;

April admittance to an acute stroke unit within 4 hours 72.7% failing therefore 80% national target resulting in 12 patients breaching. This was partly due to stroke beds being occupied by other patients (4) and partly due to clinical reasons (8).

Pts receiving CT Scan within 1 hour of presentation is at 65.9% in month; being compliant with 50% standard.

Pts receiving CT Scan within 24 hrs of presentation delivery at 97.7% in month just short of the 100% target. 1 breach due to patient's symptoms being vague.

Patients receiving thrombolysis within 60 minutes of admission was at 50% in April against a target of 85%. 2 breaches.

For April, Primary Angioplasty Door to balloon time (<90 minutes) was at 100% and Call to balloon time (<150 minutes) also at 100% hence both indicators delivering against 80% targets;

RACP performance for April is at 100% exceeding the 98% target.
During last year, the Trust has counted referrals this year 'from referral' rather than 'from receipt' and hence the performance has been suppressed by this as GP delays in referring have been counted against the Trust.
The service will implement the guidance from 1st April and count referrals 'from receipt'.

TIA (High Risk) Treatment <24 Hours from receipt of referral delivery as at April is at 100% against the target of 70%.
TIA (Low Risk) Treatment <7 days from receipt of referral delivery at April is 97.6% against a target of 75%.

Cancer Care

The Trust has met all its national cancer targets in March and hence year end as already reported. The 62-day urgent GP referral to treatment target, with overall performance of 90.8% (vs. 85% target). However, it should be noted that this is not a consistent performance against all groups. Medicine remains to address delivery issues.

April projections are that all targets will be met consistent with national targets and the submitted NHSI Improvement Trajectory.

5.5 patients waited more than 62 days in March.

0.5 patients were waiting more than 104 days at the end of March
There is now a national focus on this cohort of patients (104 days waiters) and the trust submits detailed patient level information for this indicator.

Patient Experience - MSA & Complaints

There were no mixed sex accommodation breaches reported during the month of April.

-Inpatients FFT is meeting score target, but significantly below the response rates required, the failure to achieve response rate is a consistent position.
- A&E is missing both targets for scores and response rate in February, which again has been a continuous position during the year.
- Outpatients FFT is below the required score rates.
- Maternity scores routinely compliant with exception of birth element.

The number of complaints received for the month is at 115 (avg for this year is 96), with 3.4 formal complaints per 1000 bed days.
All have been acknowledged within target timeframes.
The level of responses above the agreed timeframe is 3.5% (zero last mnth) which is a worsening on last month, with Surgery B having the highest level of delayed responses.
The oldest complaint on the system is 30 days old.

Patient Experience - Cancelled Operations

The proportion of elective operations cancelled at the last minute was 0.5% for April (0.8% previous mnth) meeting the in-month target of 0.8% and improving to previous months.
Last year delivery was at 0.9% and hence just failing the target of 0.8% hence the improvement in month is a good start in the new year.

No breaches of 28 days guarantee were reported in April and no urgent cancellations took place during the month.

79 [vs. 57 last month] of all cancelled patients experienced multiple cancellations in April and this has increased substantially and 63 of the patients 'cancelled the first time' are linked to the industrial strike. Admin processes are being reviewed for improvement and account for a large number of multiple cancellations.

The number of sitrep declared late cancellations decreased in March to 34 [vs 41 previous mnth] .

Theatre utilisation is consistently below the target of 85% at a Trust average of 74.3%
The theatre capacity and performance is subject to remedial action through Theatres Board and theatre performance reporting will be part of this.

Emergency Care

The Trust's performance against the 4-hour ED wait target in April was 91.4% (88.57% in March) against the 95% national target and against the 92.5% NHSI Improvement Trajectory, which goes up during the year. 1608 breaches were incurred in the month of April. May ED performance as at today stands at 92.74%.

WMAS fineable 30 - 60 minutes delayed handovers at 81 in April (117 in March) decreasing significantly month on month.
Over 60 minutes delayed handovers reported at 2 cases in April (9 cases last month). Handovers >60mins (against all conveyances) are at 0.05% and higher than target of 0.02%.

Fractured Neck of Femur patients delivery for March is at 72.3% below the 85% target. Not all patients were suitable for procedures, but there has been missed fractures which the service is urgently reviewing across the full pathway.

Patient moves out of hours (10pm-6am) excl assessment units at 255 in month , a slight increase to last month.

Whilst April delivery is still below target, there are significant issues across the delivery chain. DTOCs accounted for 454 bed days in April ; of which 234 beds were fineable to BCC

Referral To Treatment

RTT incomplete pathway for April delivered at 92.4% meeting the 92% national target as well as the NHSI Improvement Trajectory.

Admitted and non-admitted RTT pathways continue to be monitored & both under-achieved in April. Non Admitted pathway is expected to recover in July - not all specialities will be meeting it though till September, Dermatology not expected to deliver. For Admitted performance expected from August with T&O behind till September.

There were no breaches of 52 weeks on the incomplete pathway for which the trust is held accountable. However, across the admitted and non-admitted pathway there were 3 breaches.

Diagnostic waits beyond 6 weeks were 0.33% for April, remaining well beneath the operational threshold of 1.00%, but higher than in previous months. The number of patients over the 6 week diagnostic wait time (referral to test actual time over the 6 weeks) is being monitored. Echograms are behind delivery and this is being taken forward with the service.

ASIs (Appointment Slot Issues) arising from e-referrals indicates that no patients have been left un-appointed above required timelines during the month of April.

Data Completeness

The Healthcare and Social Care Information Centre (HSCIC) assess the percentage of Trust submitted records for A&E, Inpatients and Outpatients to the Secondary Uses Service (SUS) for completeness of valid entries in mandatory fields.

The Trust's internal assessment of the completion of valid NHS Number Field within inpatient data sets is below the 99.0% operational threshold (as at March at 98.1%) this is being reviewed across the pathway to correct. Outpatient, Community and A&E data sets continue to exceed their respective thresholds. Inpatient Ethnicity coding has picked up and is for the year at 90.3% just above the standard of 90% target, but OP is failing this indicator (at 86.6%). The 'protective' indicators are low and groups will need to address this.

Open Referrals as at April are at 194k (this excludes patients on the RTT pathway). The occurrence and management of open referrals outside of the RTT pathway is subject to ongoing monitoring and will be prioritised on the Data Quality Management Group for full re-assurance and process management within the groups.

Staff

PDR overall compliance as at the end of April is at 91.1% against the 95% target, an improvement to previous delivery driven by Surgery B's improvement rather than across the board. The Medical Appraisal rate as at April is 87.8% measuring only validated appraisals, not appraisals 'carried out'.

In-month sickness for April is at 4.4% (4.85% last month). The cumulative sickness rate is at 4.9%.

The Trust annualised turnover rate is at 12.8% as at April (13.4% as at March). Specifically, nursing turnover has been recorded at 13.6% for the month, a consistent high trend against this staff group, however small evidence of reduction in turnover over the last months.

Mandatory Training at the end of April is at 88.1.0% overall against target of 95%.
Health & Safety (clinical safety training) related mandatory training is at 96.7% and delivering above the 95% target consistently.

Nurse bank fill rate continuous to be high vs agency, we saw agency shifts drop in April . Details shift plans are worked up to drive visibility on bookings.

CQUIN & Local Quality Requirements 2016/17

2015/16 Full year submissions have been made to the commissioners and both commissioners have now confirmed full delivery except a couple of schemes were delivery was not achieved. 2016/17 CQUINs have been signed off with commissioners and the Trust needs now to engage the appropriate leads into baselining the schemes - this is now planned for June.

Local Quality Requirements 2016/17 are signed off now. This follows detailed Trust reviews over the last few weeks to ensure that the trust and service can deliver without additional resources. National and Operational Quality Requirements for 2016/17 are largely identical to what we have seen in 2015/16. All requirements will be monitored for impacting fines and lack of performance and will report in the form of the SQPR (Service Quality Performance Report).

Community

Community & Therapies indicators are below target on a number of indicators (C&T Group tab).

- DN assessments (especially Dementia) have continued trending downward due to staff not been aware that previous assessments are no longer valid (because time limitations of 1 year or 6 months for dementia). This has already improved and more is expected.
- A new system-based process has been put in place to alert staff about missing KPI assessments whenever a record is opened, this is expected to dramatically improve upon poor KPI scores seen in March as part of preparation for improvement trajectories over 2016-17. Trajectories are being worked up.

Health Visiting performance are in line with targets across a wide range of indicators. The group has already moved to team-based performance monitoring and this has improved a number of targets in recent months; lack of data completion continuous but is continually addressed. A number of indicators is not keeping up the pace of completion, this will be re-enforced as appropriate.

Summary Scorecard - April (Month)

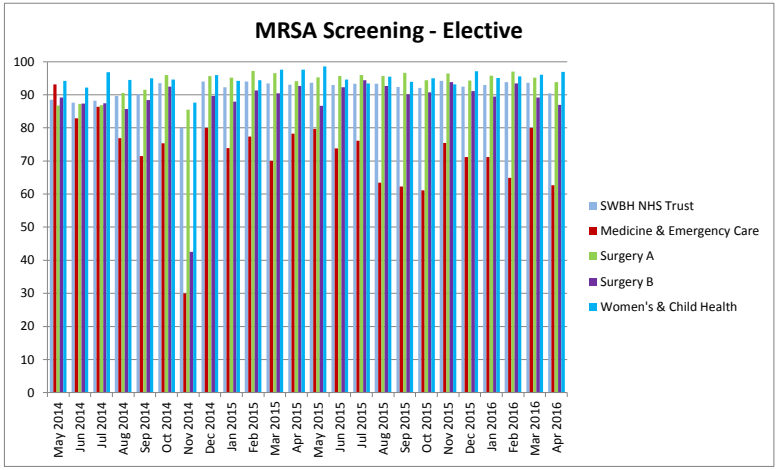
Summary Scorecard

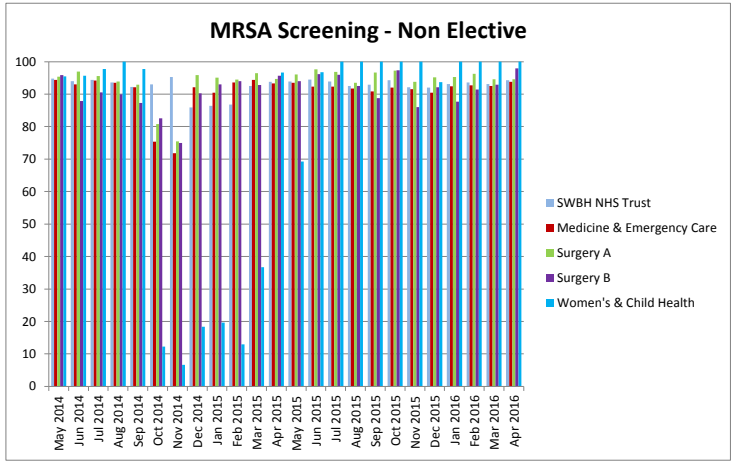
Section	Red Rated	Amber Rated	Green Rated	None	Total
Infection Control	0	0	6	0	**6**
Harm Free Care	4	0	9	2	**15**
Obstetrics	1	1	5	6	**13**
Mortality and Readmissions	1	0	0	11	**12**
Stroke and Cardiology	3	0	8	0	**11**
Cancer	0	0	9	5	**14**
FFT. MSA, Complaints	7	2	7	6	**22**
Cancellations	3	0	6	0	**9**
Emergency Care & Patient Flow	9	0	5	4	**18**
RTT	5	0	3	5	**13**
Data Completeness	2	0	8	8	**18**
Workforce	10	0	1	12	**23**
Total	**45**	**3**	**67**	**59**	**174**

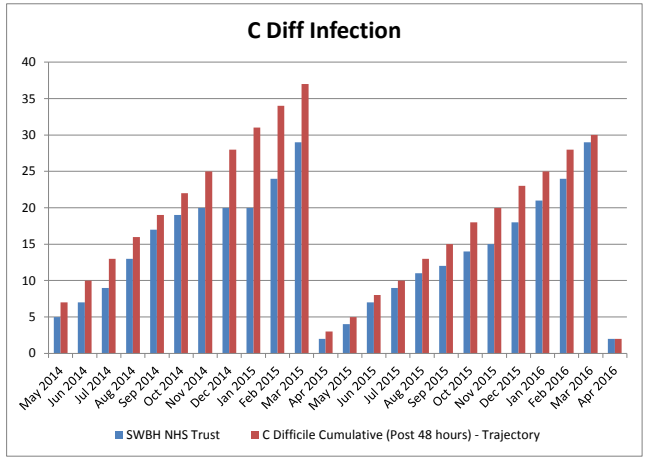
Exceptions are being managed in respective groups and are monitored in Group Reviews and in the Operational Management Committee governed by Performance Committee. As at the end of March the Trust has a number of CCG Exception Reports outstanding, which may result in performance notices rolling into 2016/17.

Patient Safety - Infection Control

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (From Nov 2014) N D J F M A M J J A S O N D J F M A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend
4			C. Difficile	<= No	30	2		Apr 2016	1	1	0	0					2	2	
4			MRSA Bacteraemia	<= No	0	0		Apr 2016	0	0	0	0					0	0	
4			MSSA Bacteraemia (rate per 100,000 bed days)	<= Rate2	9.42	9.42		Apr 2016									0.0	0.0	
4			E Coli Bacteraemia (rate per 100,000 bed days)	<= Rate2	95	95		Apr 2016									14.9	14.9	
3			MRSA Screening - Elective	=> %	80	80		Apr 2016	62.7	93.8	87	96.9					90.5		
3			MRSA Screening - Non Elective	=> %	80	80		Apr 2016	93.8	94.6	98	100					94.3		

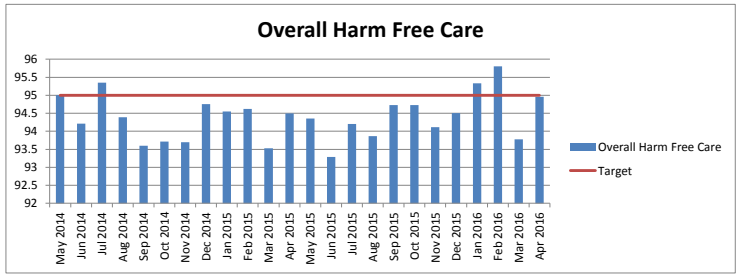


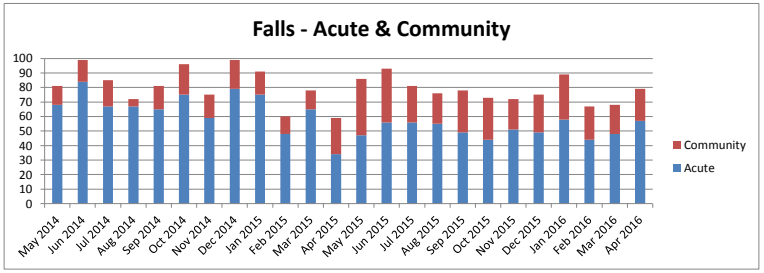


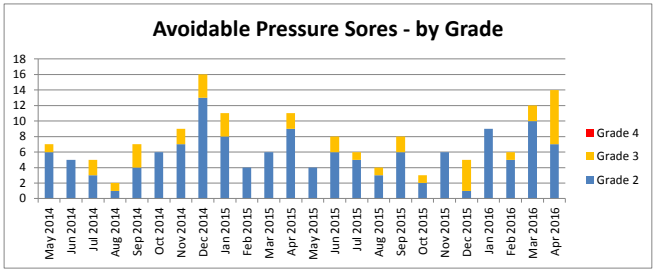


Patient Safety - Harm Free Care

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Nov 2014) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend
8		d	Patient Safety Thermometer - Overall Harm Free Care	=> %	95	95																			Apr 2016									94.96		
8		d	Patient Safety Thermometer - Catheters & UTIs	%			0.25	0.31	0.41	0.40	0.64	0.25	4.00	2.00	1.00	9.00	3.00	3.00	4.00	7.00	4.00	2.00	1.00	3.00	Apr 2016									0.26		
8			Falls	<= No	804	67	75	99	91	64	78	80	106	90	70	76	78	73	72	75	89	67	68	79	Apr 2016	44	7	1	0	3	0	22		79	79	
9			Falls with a serious injury	<= No	0	0	2	1	1	0	1	1	1	1	5	0	1	2	3	1	2	2	2	0	Apr 2016	0	0	0	0		0	0		0	0	
8			Grade 2,3 or 4 Pressure Ulcers (Hospital Aquired Avoidable)	<= No	0	0	9	16	11	4	6	11	4	8	6	4	8	3	6	5	9	6	12	14	Apr 2016	6	6	0	0			2		14	14	
8			Avoidable Grade 2,3 or 4 Pressure Ulcers (DN Caseload Acquired)	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3	2	Apr 2016							2		2	2	
3		d	Venous Thromboembolism (VTE) Assessments	=> %	95	95																			Apr 2016	95.5	93.9	97.8	94.6					95.3		
3			WHO Safer Surgery - Audit - 3 sections (% pts where all sections complete)	=> %	98	98																			Apr 2016	104.2	99.7	99.9	99.2		0.0			100.7		
3			WHO Safer Surgery - brief (% lists where complete)	=> %	95	95																			Apr 2016	99	98	100	100		97			99		
3			WHO Safer Surgery - Audit - brief and debrief (% lists where complete)	=> %	85	85																			Apr 2016	99	95	99	100		97			98.649		
9		d	Never Events	<= No	0	0	0	0	0	0	0	1	1	1	0	0	0	0	0	0	0	1	0	0	Apr 2016	0	0	0	0	0	0	0		0	0	
9		d	Medication Errors causing serious harm	<= No	0	0	0	0	0	0	1	0	0	0	1	0	0	0	1	0	0	0	0	0	Apr 2016	0	0	0	0	-	0	0		0	0	
9		d	Serious Incidents	<= No	0	0	2	3	4	4	6	5	4	7	9	7	5	7	6	2	12	8	5	2	Apr 2016	0	2	0	0	0	0	0	0	2	2	
9			Open Central Alert System (CAS) Alerts	<= No			15	17	10	9	4	8	5	4	8	11	8	7	4	9	7	6	5	1	Apr 2016									1		
9		d	Open Central Alert System (CAS) Alerts beyond deadline date	No	0	0	4	0	1	0	1	0	3	2	0	1	2	2	0	0	2	1	2	0	Apr 2016									0		

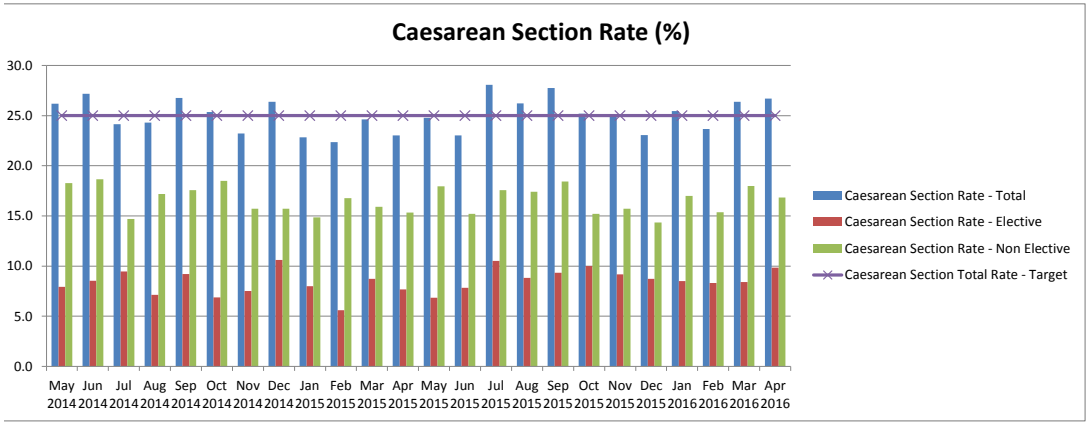


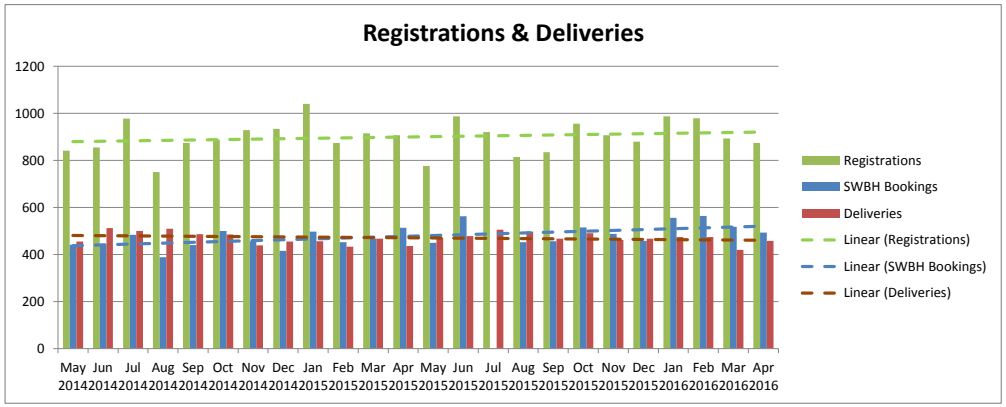




Patient Safety - Obstetrics

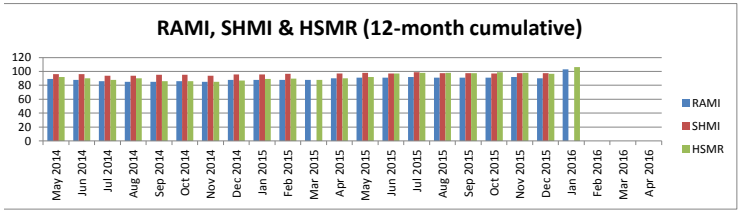
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Nov 2014) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Month	Year To Date	Trend
3			Caesarean Section Rate - Total	<= %	25.0	25.0																			Apr 2016	26.7	26.7	
3			Caesarean Section Rate - Elective	<= %			8	11	8	6	9	8	7	8	11	9	9	10	9	9	8	8	8	10	Apr 2016	9.8	9.9	
3				<= %			16	16	15	17	16	15	18	15	18	17	18	15	16	14	17	15	18	17	Apr 2016	16.8	16.9	
2			Maternal Deaths	<= No	0	0																			Apr 2016	0	0	
3			Post Partum Haemorrhage (>2000ml)	<= No	48	4																			Apr 2016	2	2	
3			Admissions to Neonatal Intensive Care (Level 3)	<= %	10.0	10.0																			Apr 2016	0.87	0.87	
12			Adjusted Perinatal Mortality Rate (per 1000 babies)	<= Rate1	8.0	8.0																			Apr 2016	4.37		
12			Early Booking Assessment (<12 + 6 weeks) - SWBH Specific	=> %	90.0	90.0																			Apr 2016	78.31		
12			Early Booking Assessment (<12 + 6 weeks) - National Definition	=> %	90.0	90.0																			Apr 2016	147.8		
2			Breast Feeding Initiation (Quarterly)	=> %	77.0	77.0	-->		-->	-->		-->	-->		-->	-->		-->	-->		-->	-->		-->	Apr 2016	-	-	
2			Puerperal Sepsis and other puerperal infections (variation 1 - ICD10 O85 or O86) (%) -	<= %			1.5	1.2	1.3	0.5	2.1	2.1	2.1	1.3	1.6	1.6	1.6	1.5	1.3	1.3	0.7	1.6	1.8	1.8	Apr 2016	1.82	1.82	
2			Puerperal Sepsis and other puerperal infections (variation 2 - ICD10 O85 or O86 Not O864) (%)	<= %			1.3	0.8	0.3	0.5	1.5	1.6	1.0	1.3	1.0	1.1	1.3	1.1	1.3	0.3	-	0.8	1.5	1.3	Apr 2016	1.30	1.30	
2			Puerperal Sepsis and other puerperal infections (variation 3 - ICD10 O85) (%)	<= %			1.0	0.4	0.0	0.0	1.2	0.7	0.8	0.9	0.2	0.5	0.8	1.1	1.0	0.0	-	0.8	1.1	1.0	Apr 2016	1.04	1.04	

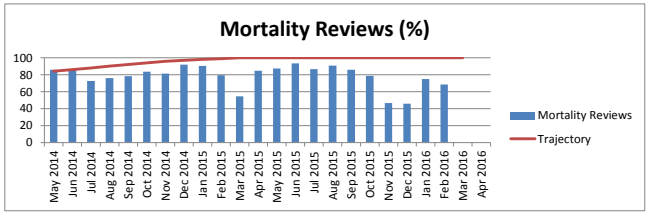


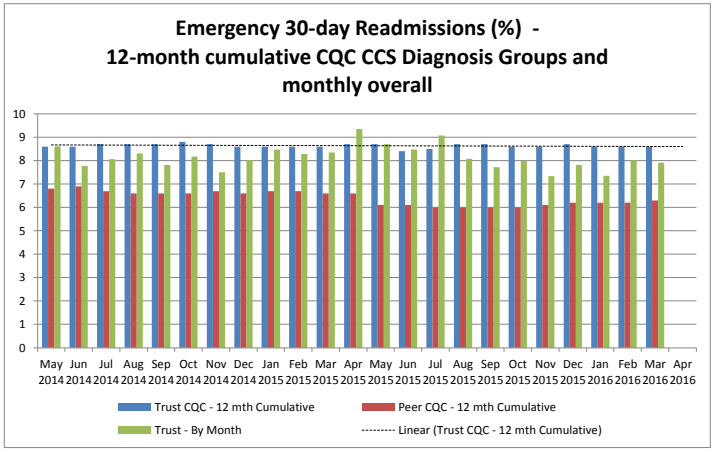


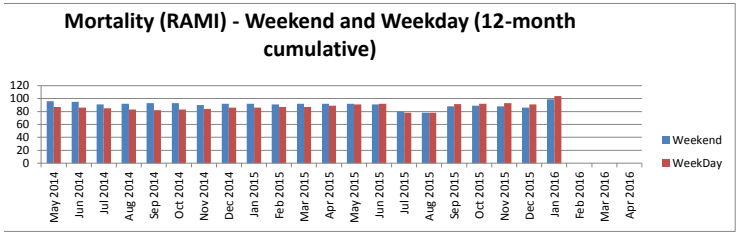
Clinical Effectiveness - Mortality & Readmissions

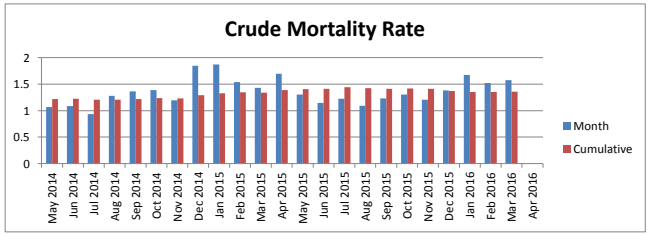
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Nov 2014) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend
5		C	Risk Adjusted Mortality Index (RAMI) - Overall (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	85	88	88	88	88	90	91	91	92	91	91	91	92	90	103	-	-	-	Jan 2016										922	
5		C	Risk Adjusted Mortality Index (RAMI) - Weekday Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	84	86	86	87	87	89	91	92	78	78	92	92	93	91	104	-	-	-	Jan 2016										899	
5		C	Risk Adjusted Mortality Index (RAMI) - Weekend Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	90	92	92	91	92	92	92	91	80	78	88	89	88	86	99	-	-	-	Jan 2016										883	
6		C	Summary Hospital-level Mortality Index (SHMI) (12-month cumulative)	SHMI	Below Upper CI	Below Upper CI	94	96	96	97	-	97	98	97	99	98	97	97	97	98	-	-	-	-	Dec 2015										878	
5		C	Hospital Standardised Mortality Rate (HSMR) - Overall (12-month cumulative)	HSMR			85	87	89	90	88	90	92	97	98	98	98	99	98	97	106	-	-	-	Jan 2016										972.0	
5		C	Deaths in Low Risk Diagnosis Groups (RAMI) - month	RAMI	Below Upper CI	Below Upper CI	76	111	105	94	93	75	84	53	102	44	80	57	148	40	68	-	-	-	Jan 2016									68		
3			Mortality Reviews within 42 working days	=> %	90	90																-	-	-	Feb 2016	67	78	100	0					69		
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (by month)	%			1.2	1.8	1.9	1.5	1.4	1.7	1.3	1.1	1.2	1.1	1.2	1.3	1.2	1.4	1.7	1.5	1.6	-	Mar 2016									1.58		
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (12-month cumulative)	%			1.2	1.3	1.3	1.3	1.3	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	-	Mar 2016										1.40	
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			7.5	8.0	8.5	8.3	8.4	9.4	8.7	8.5	9.1	8.1	7.7	8.0	7.3	7.8	7.4	8.0	7.9	-	Mar 2016									7.91		
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			8.0	8.0	8.1	8.1	8.2	8.2	8.2	8.3	8.4	8.4	8.3	8.3	8.3	8.3	8.2	8.2	8.1	-	Mar 2016										8.27	
5		C	Emergency Readmissions (within 30 days) - CQC CCS Diagnosis Groups (12-month cumulative)	%			8.7	8.6	8.6	8.6	8.6	8.7	8.7	8.4	8.5	8.7	8.7	8.6	8.6	8.7	8.6	8.6	8.6	-	Mar 2016	-	-	-	-						8.62	





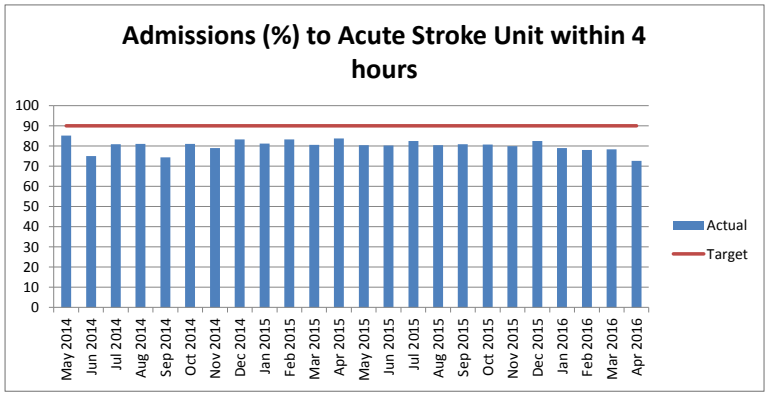


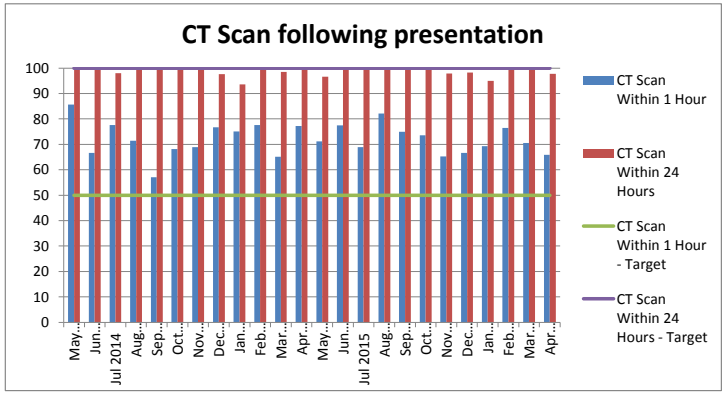


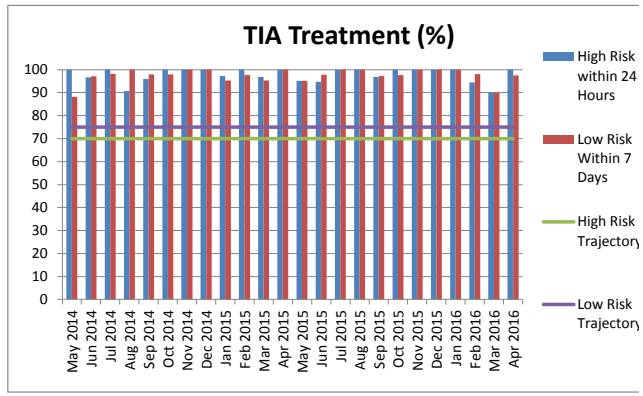


Clinical Effectiveness - Stroke Care & Cardiology

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (Since Nov 2014) N D J F M A M J J A S O N D J F M A	Data Period	Month	Year To Date	Trend
3			Pts spending >90% stay on Acute Stroke Unit	=> %	90.0	90.0		Apr 2016	97.9	97.9	
3			Pts admitted to Acute Stroke Unit within 4 hrs	=> %	90.0	90.0		Apr 2016	72.7	72.7	
3		●	Pts receiving CT Scan within 1 hr of presentation	=> %	50.0	50.0		Apr 2016	65.9	65.9	
3			Pts receiving CT Scan within 24 hrs of presentation	=> %	100.0	100.0		Apr 2016	97.7	97.7	
3			Stroke Admission to Thrombolysis Time (% within 60 mins)	=> %	85.0	85.0		Apr 2016	50.0	50.0	
3			Stroke Admissions - Swallowing assessments (<24h)	=> %	98.0	98.0		Apr 2016	100.0	100.0	
3			TIA (High Risk) Treatment <24 Hours from receipt of referral	=> %	70.0	70.0		Apr 2016	100.0	100.0	
3			TIA (Low Risk) Treatment <7 days from receipt of referral	=> %	75.0	75.0		Apr 2016	97.6	97.6	
9			Primary Angioplasty (Door To Balloon Time 90 mins)	=> %	80.0	80.0		Apr 2016	100.0	100.0	
9			Primary Angioplasty (Call To Balloon Time 150 mins)	=> %	80.0	80.0		Apr 2016	100.0	100.0	
9			Rapid Access Chest Pain - seen within 14 days	=> %	98.0	98.0		Apr 2016	100.0	100.0	



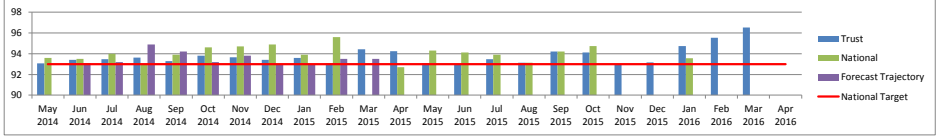




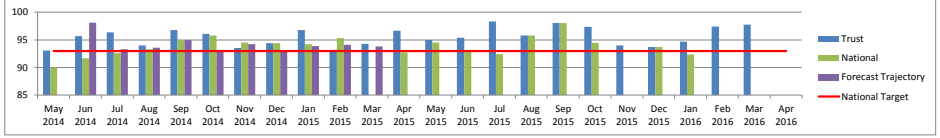
Clinical Effectiveness - Cancer Care

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Nov 2014) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend
1			2 weeks	=> %	93.0	93.0																			Mar 2016	93.3	98.8	100.0	95.4					96.5	94.0	
1			2 weeks (Breast Symptomatic)	=> %	93.0	93.0																		-	Mar 2016		-							97.8	96.3	
1			31 Day (diagnosis to treatment)	=> %	96.0	96.0																			Mar 2016	94.3	100.0	100.0	100.0					98.5	98.3	
1			31 Day (second/subsequent treatment - surgery)	=> %	94.0	94.0									N/A										Mar 2016									100.0	98.9	
1			31 Day (second/subsequent treatment - drug)	=> %	98.0	98.0																			Mar 2016									100.0	99.5	
1			31 Day (second/subsequent treat - radiotherapy)	=> %	94.0	94.0																			Mar 2016									-	100.0	
1			62 Day (urgent GP referral to treatment) Excluding Rare Cancer	=> %	85.0	85.0																			Mar 2016	77.8	91.8	100.0	100.0					90.8	86.6	
1			62 Day (urgent GP referral to treatment) Including Rare Cancer	=> %	85.0	85.0	-	-	-						-										Mar 2016	77.8	91.8	100.0	100.0					90.8	87.2	
1			62 Day (referral to treat from screening)	=> %	90.0	90.0																			Mar 2016	0.0	94.9	0.0	100.0					95.1	97.1	
1			62 Day (referral to treat from hosp specialist)	=> %	90.0	90.0																			Mar 2016	83.9	95.8	0.0	100.0					90.5	90.3	
1			Cancer - Patients Waiting over 62 days	No			-	-	-	-	-	-	-	-	0	12	9	13	6	8	6	10	6	-	Mar 2016	3.0	2.5	0.0	0.0					5.5	67.5	
1			Cancer - Patients Waiting over 104 days	No			-	-	-	-	-	-	-	-	4.5	7.0	4.0	8.0	2.0	3.5	0.0	4.5	0.5	-	Mar 2016	0.0	0.5	0.0	0.0					0.5	34.0	
1			Cancer - Longest Waiter in days	No			-	-	-	-	-	-	-	-	180	147	228	165	138	167	98	154	98	-	Mar 2016	98	117	59	62					98		
1			Neutropenia Sepsis Door to Needle Time Less than 1 Hour	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	Apr 2016	38	0	0	0					38		

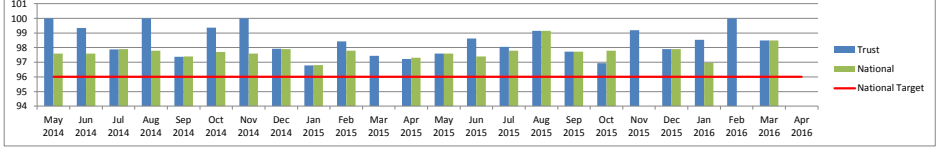
2-week wait from Referral to Date First Seen



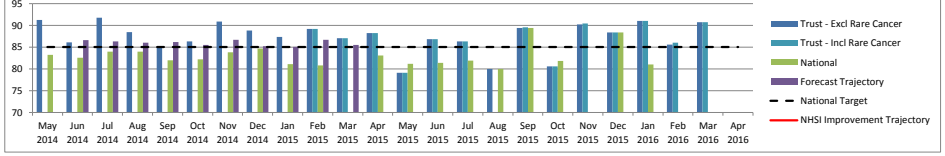
2-week wait from Breast Symptomatic Patients



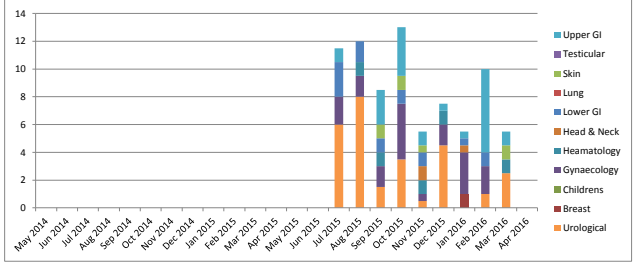
31-day Diagnosis to First Treatment



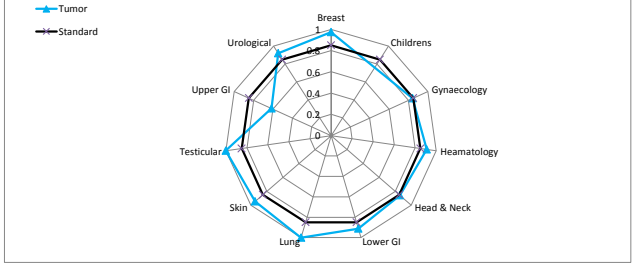
62-day Urgent GP Referral to First Treatment



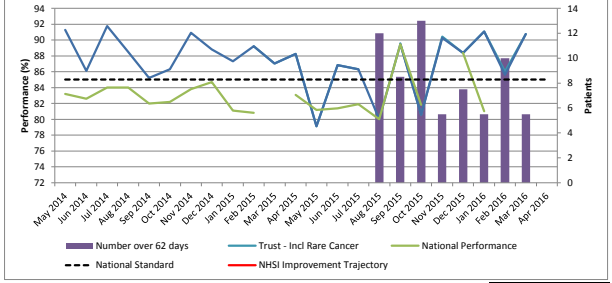
62-day Urgent GP Referral to First Treatment Breach- By Tumour Site



62 Day (Urgent GP referral) wait for first treatment By specialty for previous quarter

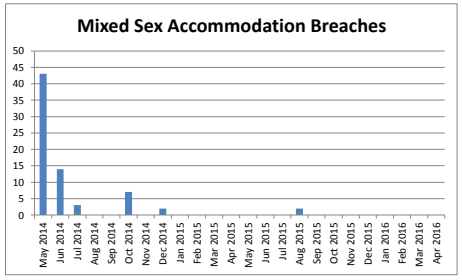


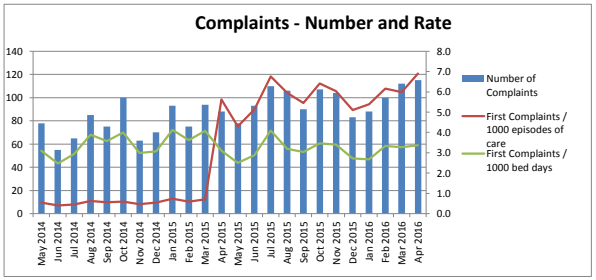
62-day Urgent GP Referral to First Treatment

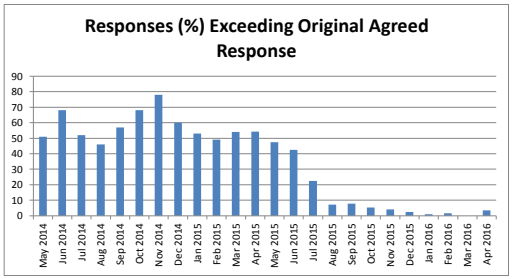


Patient Experience - FFT, Mixed Sex Accommodation & Complaints

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Nov 2014) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend
8		b	FFT Response Rate - Adult and Children Inpatients (including day cases and community)	=> %	50.0	50.0	31	28	33	43	43	29	31	31	28	25	22	27	16	15	15	15	14	17	Apr 2016									17		
8		a	FFT Score - Adult and Children Inpatients (including day cases and community)	=> No	95.0	95.0	73	69	70	68	72	95	95	95	96	95	95	95	93	96	96	95	95	96	Apr 2016									96		
8		b	FFT Response Rate: Type 1 and 2 Emergency Department	=> %	50.0	50.0	18	17	18	21	22	9.9	8.4	7.2	9.4	9.6	7.5	6.8	5.9	5.7	6.3	6	5.3	5.1	Apr 2016	5.11								5.1		
8		a	FFT Score - Adult and Children Emergency Department (type 1 and type 2)	=> No	95.0	95.0	49	49	50	44	52	79	79	79	84	88	83	80	82	81	79	74	74	78	Apr 2016	78								78		
8			FFT Response Rate: Type 3 WiU Emergency Department	=> %	50.0	50.0	-	-	-	-	-	-	-	-	-	-	-	-	0	4	47	2	0	10	Apr 2016	-								0		
8			FFT Score - Adult and Children Emergency Department (type 3 WiU)	=> No	95.0	95.0	-	-	-	-	-	-	-	-	-	-	-	-	0	50	85	0	0	100	Apr 2016	-								100		
8			FFT Score - Outpatients	=> No	95.0	95.0	-	-	-	-	-	-	-	-	-	-	-	-	87	86	90	88	87	87	Apr 2016									87		
8			FFT Score - Maternity Antenatal	=> No	95.0	95.0	-	-	-	-	-	-	-	-	-	-	-	-	100	100	96	100	95	100	Apr 2016									100		
8			FFT Score - Maternity Postnatal Ward	=> No	95.0	95.0	-	-	-	-	-	-	-	-	-	-	-	-	97	97	95	91	91	97	Apr 2016									97		
8			FFT Score - Maternity Community	=> No	95.0	95.0	-	-	-	-	-	-	-	-	-	-	-	-	95	98	96	99	99	99	Apr 2016									99		
8			FFT Score - Maternity Birth	=> No	95.0	95.0	-	-	-	-	-	-	-	-	-	-	-	-	86	82	90	94	93	92	Apr 2016									92		
8			FFT Response Rate - Maternity Birth	=> %	50.0	50.0	-	-	-	-	-	-	-	-	-	-	-	-	121	65	101	65	42	53	Apr 2016									53		
13		a	Mixed Sex Accommodation Breaches	<= No	0.0	0.0	0	2	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	Apr 2016	0	0	0	0		0	0		0	0	
9			No. of Complaints Received (formal and link)	No			63	70	93	75	94	88	78	93	110	106	90	107	104	83	88	100	112	115	Apr 2016	49	24	21	5	3	2	3	8	115	115	
9			No. of Active Complaints in the System (formal and link)	No			359	219	249	266	265	278	225	186	170	174	143	151	145	121	113	128	147	154	Apr 2016	72	24	25	9	3	2	11	8	154		
9		a	No. of First Formal Complaints received / 1000 bed days	Rate1			3.0	3.1	4.1	3.6	4.1	3.1	2.5	2.9	4.1	3.2	3.0	3.5	3.4	2.7	2.7	3.3	3.3	3.4	Apr 2016	2.77	4.36	25.5	0.96					3.37	3.37	
9			No. of First Formal Complaints received / 1000 episodes of care	Rate1			0.5	0.6	0.7	0.6	0.7	5.6	4.3	5.1	6.8	6.0	5.5	6.4	6.0	5.1	5.4	6.2	6.0	6.9	Apr 2016	6.89	8.67	13.8	1.69			0		6.90	6.90	
9			No. of Days to acknowledge a formal or link complaint (% within 3 working days after receipt)	=> %	100	100	100	100	99	98	100	99	100	100	100	100	100	100	100	100	100	100	100	100	Apr 2016	100	100	100	100	100	100	100	100	100		
9			No. of responses which have exceeded their original agreed response date (% of total active complaints)	<= %	0	0	78	60	53	49	54	54	47	42	22	7.1	7.7	5.3	4.1	2.5	0.9	1.6	0	3.5	Apr 2016	4	0	9.52	0	0	0	0	0	3.5		
9			No. of responses sent out	No			26	198	59	52	84	56	115	102	129	77	107	101	94	98	69	81	84	98	Apr 2016	33	22	14	10	4	5	3	7	98		
9			Oldest' complaint currently in system	No			161	182	192	213	234	254	188	210	186	208	136	159	47	59	67	48	30	-	Mar 2016	30	29	28	23	22	17	10	20	30		
14		e	Access to healthcare for people with Learning Disability (full compliance)	Yes / No	Yes	Yes																			Mar 2016	N	N	N	N	N	N	N	N	No		

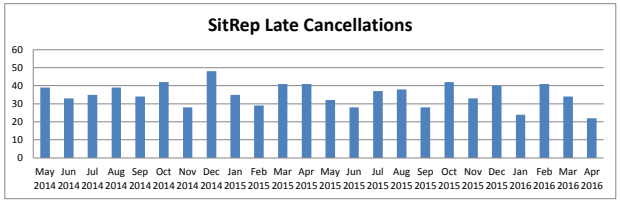


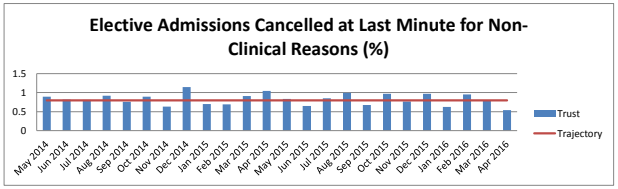


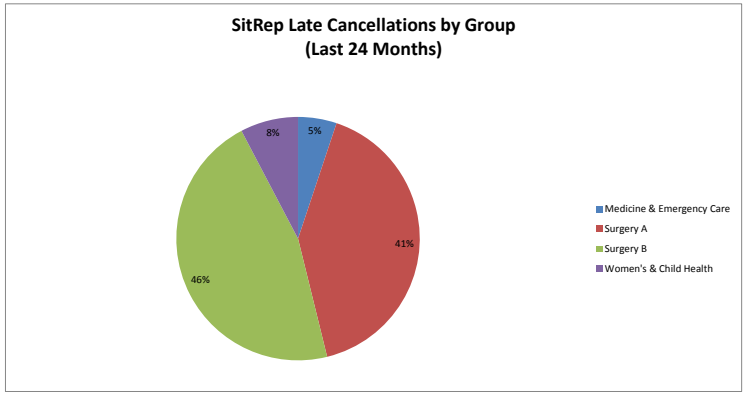


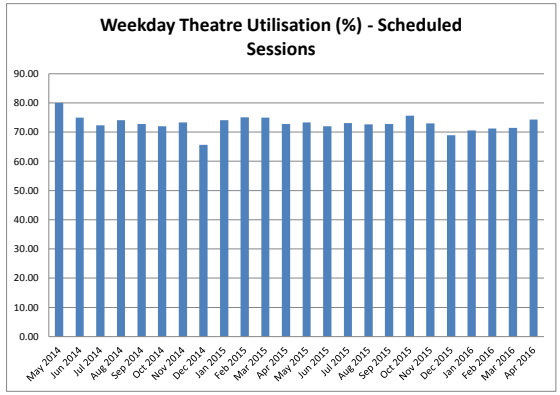
Patient Experience - Cancelled Operations

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Nov 2014) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months	Trend
2			Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																				Apr 2016	0.05	1.00	0.73	1.49					0.5	0.5				
2			Number of 28 day breaches	<= No	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	Apr 2016	0	0	0	0					0	0				
2			No. of second or subsequent urgent operations cancelled	<= No	0	0	0	1	0	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0	Apr 2016	0	0	0	0					0	0				
2			No. of Sitrep Declared Late Cancellations	<= No	320	27	28	48	36	29	41	41	32	28	37	38	28	42	33	40	24	41	34	22	Apr 2016	0	10	8	4					22	22				
3			No. of Sitrep Declared Late Cancellations (Pts. >1 occasion)	<= No	0	0	0	0	0	0	0	0	4	1	0	0	0	0	0	0	0	0	0	0	Apr 2016	0	0	0	0					0	0				
3			Multiple Cancellations experienced by same patient (all cancellations)	<= No	0	0	-	-	-	-	-	46	52	59	46	39	49	50	57	39	63	56	57	79	Apr 2016	23	22	30	4					79					
3			All Cancellations, with 7 or less days notice (expressed as % overall elective activity)	<= No	0	0	-	-	-	-	-	209	204	229	222	211	229	244	238	194	210	228	223	229	Apr 2016	36	81	85	27					229					
3			Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0																				Apr 2016	57.9	76.2	73.9	76.5					74.3					
2			Urgent Cancellations	<= No	0.0	0.0	-	-	-	-	-	11	5	6	0	7	3	9	0	0	0	0	0	0	Apr 2016	0.0	0.0	0.0	0.0					0	0				



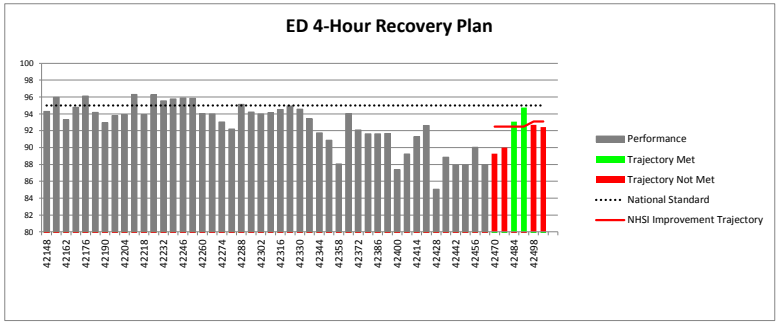


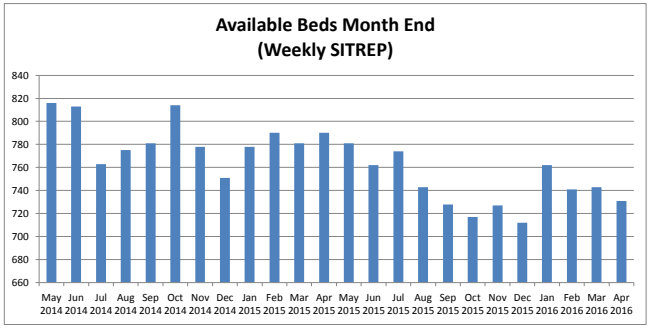


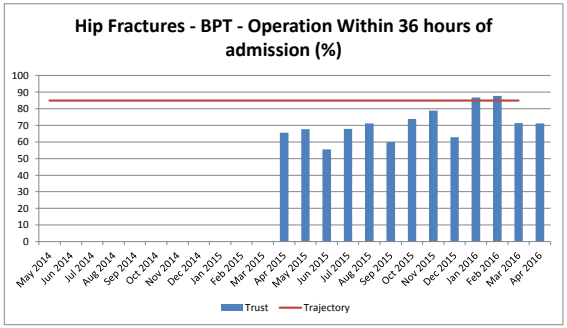


Access To Emergency Care & Patient Flow

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (From) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Unit S	C	B	Month	Year To Date	Trend
2		e	Emergency Care 4-hour waits	=> %	95.00	95.00																			Apr 2016	88.3	92.3	98.3	91.40	91.40	
2			Emergency Care 4-hour breach (numbers)	No			1440	2234	1054	1481	1695	1527	1406	1037	1086	741	1138	1106	1103	1715	1757	1956	2342	1608		Apr 2016	904	665	39	1608	1608	
2		e	Emergency Care Trolley Waits >12 hours	<= No	0.00	0.00																			Apr 2016	0	0		0	0	
3			Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15.00	15.00																			Apr 2016	19	16	14	17	17	
3			Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60	60																			Apr 2016	50	45	115	53	53	
3			Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0																			Apr 2016	8.81	7.54	3.84	7.62	7.62	
3			Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0																			Apr 2016	3.66	3.61	1.79	3.41	3.41	
11			WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	<= No	0	0	159	282	185	149	164	43	116	90	72	58	76	93	67	121	116	97	117	81	Apr 2016	32	49		81	81	
11			WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	<= No	0	0	14	31	7	6	8	9	8	3	3	2	1	1	3	8	10	6	9	2	Apr 2016	2	0		2	2	
11		e	WMAS - Handover Delays > 60 mins (% all emergency conveyances)	<= %	0.02	0.02																			Apr 2016	0.10	0.00		0.05	0.05	
11			WMAS - Emergency Conveyances (total)	No			4168	4470	4001	3829	4182	3981	4214	114	4256	4241	4016	4260	4202	4573	4679	3961	4513	4115		Apr 2016	2009	2106		4115	4115	
2			Delayed Transfers of Care (Acute) (%)	<= %	3.5	3.5																			Apr 2016	0.4	3.9		1.9	2	
2			Delayed Transfers of Care (Acute) (Av./Week) attributable to NHS	<= No	<10 per site	<10 per site																			Apr 2016	1.5	10.8		12		
2			Delayed Transfers of Care (Acute) - Total Bed Days (All Local Authorities)	<= No	0	0	1002	868	1061	922	859	641	698	653	464	494	430	394	497	498	318	426	397	454	Apr 2016	-	-		454.0	454	
2			Delayed Transfers of Care (Acute) - Finable Bed Days (Birmingham LA only)	<= No	0	0	266	225	292	344	348	283	404	286	212	204	193	110	254	267	185	198	232	234	Apr 2016	-	-		234.0	234	
2			Patient Bed Moves (10pm - 6am) (No.) -ALL	No			535	699	544	573	634	567	596	502	545	529	588	601	518	540	632	543	546	563	Apr 2016				563	563	
2			Patient Bed Moves (10pm - 6am) (No.) - exc. Assessment Units	No			257	286	214	258	270	237	293	239	240	237	275	261	209	236	320	269	232	255	Apr 2016				255	255	
			Hip Fractures - Best Practice Tarriff - Operation < 36 hours of admission (%)	=> %	85.0	85.0	-	-	-	-	-														Apr 2016				71	71.1	
			Non-Elective Follow-Up Surgical Procedures > 48 hours (unless clinically appropriate)	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00				-	-	

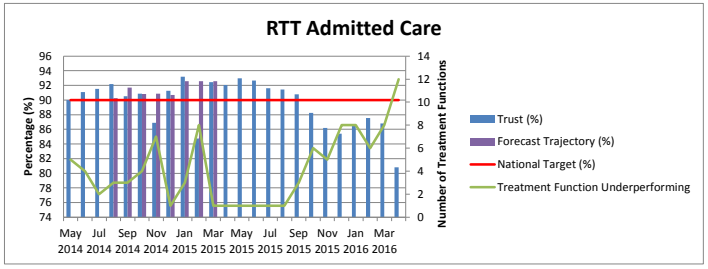


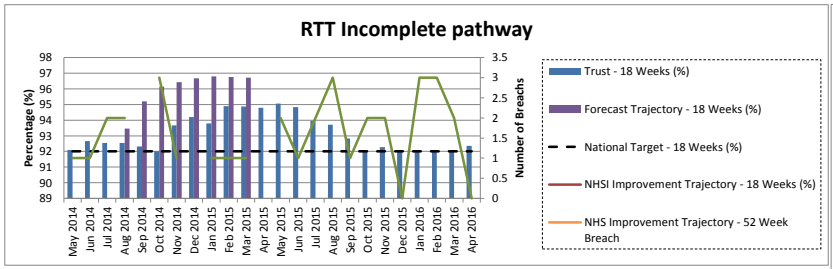


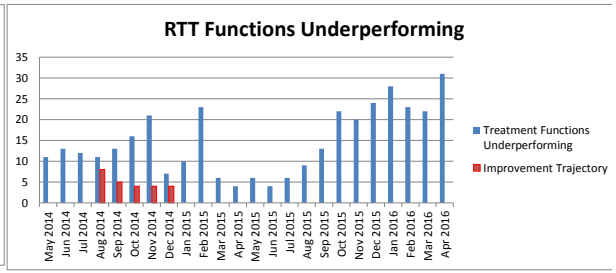


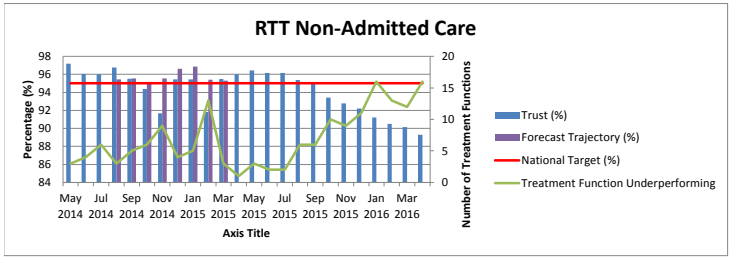
Referral To Treatment

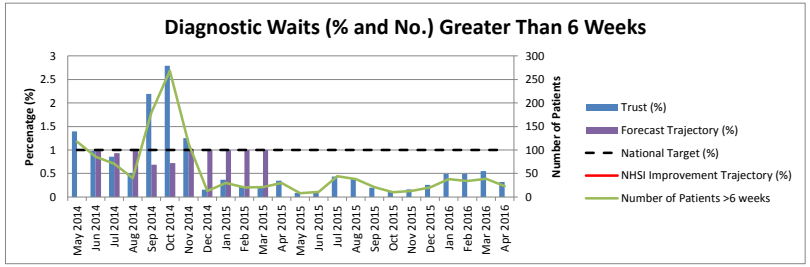
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Nov 2014) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend
2			RTT - Admittted Care (18-weeks)	=> %	90.0	90.0																			Apr 2016	87.9	66.9	83.8	91.5					80.80		
2			RTT - Non Admittted Care (18-weeks)	=> %	95.0	95.0																			Apr 2016	80.6	93.0	89.2	90.6					89.30		
2			RTT - Incomplete Pathway (18-weeks)	=> %	92.0	92.0																			Apr 2016	90.2	90.1	94.2	96.1					92.35		
2			Patients Waiting >52 weeks	<= No	0	0	3	0	4	3	4	1	2	1	3	5	2	4	4	2	4	5	8	3	Apr 2016	0	2	1	0					3		
2			Patients Waiting >52 weeks (Incomplete)	<= No	0	0	1	0	1	1	1	0	2	1	2	3	1	2	2	0	3	3	2	0	Apr 2016	0	0	0	0					0		
2			Treatment Functions Underperforming (Admitted, Non-Admitted, Incomplete)	<= No	0	0	19	8	10	23	6	4	6	4	6	9	13	22	20	24	28	23	22	31	Apr 2016	12	10	6	1.0					31		
2			Treatment Functions Underperforming (Incomplete)	<= No	0	0	5	2	2	2	2	2	2	1	3	2	4	6	6	5	4	4	2	3	Apr 2016	1	2	0	0					3		
2			Acute Diagnostic Waits in Excess of 6-weeks (End of Month Census)	<= %	1.0	1.0																			Apr 2016	0.7	1.4	0.6	0.0		0.0			0.32		
			Acute Diagnostic Waits in Excess of 6-weeks (In Month Waiters)	No			-	-	-	-	-	524	511	699	995	2244	2442	2872	2258	1593	1250	273	281	542	Apr 2016	311	125	-	-		106			542		
			Total ASIs in the month	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	-	Mar 2016	0	0	0	0					0		
			Total ASIs - 2WW	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	0	Apr 2016	0	0	0	0					0		
			Total ASIs - Urgent	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	-	Mar 2016	0	0	0	0					0		
			Failed Appointments within required period (2WW, Urgent Pathway)	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	-	Mar 2016	0	0	0	0					0		

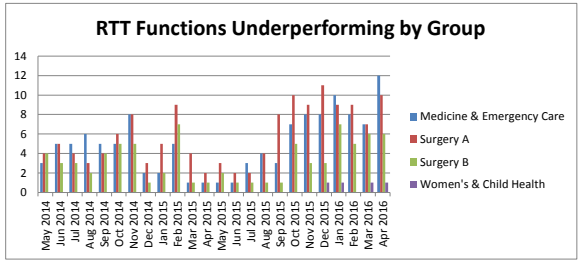






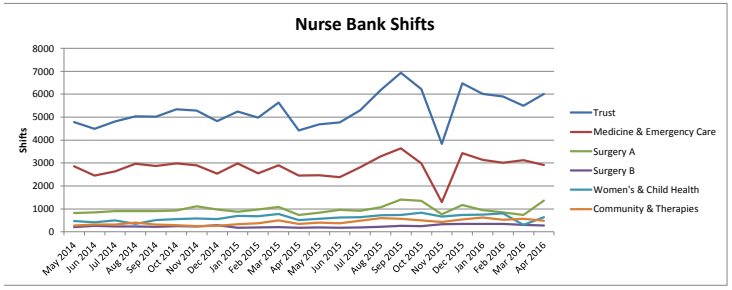


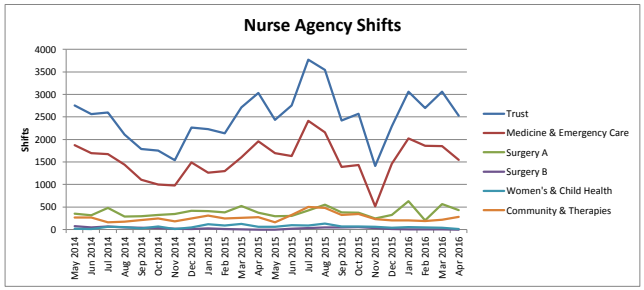


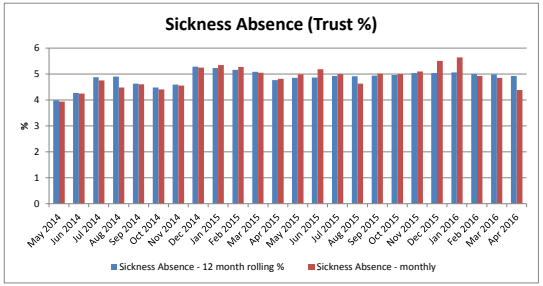


Workforce

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Month - Amber	Previous Months Trend (since Nov 2014) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend
7		b	WTE - Actual versus Plan (FTE)	No				674	685	701	732	689	888	831	733	763																						
3		b	PDRs - 12 month rolling	=> %	95.0	95.0	90.0																					Apr 2016	86.7	88.9	97.0	93.0	93.7	76.9	93.5	94.1		91.1	
7		b	Medical Appraisal and Revalidation	=> %	95.0	95.0	90.0					-	-															Apr 2016	88.0	83.6	89.3	95.2	85.0	80.7	0.0	100.0		87.8	
3		b	Sickness Absence (Rolling 12 Months)	<= %	3.15	3.15	3.8																					Apr 2016	5.7	5.3	3.2	5.4	4.1	4.6	4.7	4.6	4.9	4.9	
3			Sickness Absence (Monthly)	=> %	3.15	3.15	3.8																					Apr 2016	6.0	4.1	2.6	4.3	3.6	5.4	4.2	3.8	4.4	4.38	
3			Return to Work Interviews following Sickness Absence	=> %	100.0	100.0	100.0	-	-	-	-		-	-														Apr 2016	66.7	77.8	77.3	75.0	80.7	57.4	87.4	78.7	75.0	75.0	
3			Mandatory Training	=> %	95.0	95.0	90.0																					Apr 2016	82.3	88.0	87.4	86.6	94.1	87.5	91.6	93.2		88.1	
3			Mandatory Training - Health & Safety (% staff)	=> %	95.0	95.0	90.0																					Apr 2016	94.8	97.0	91.9	94.8	98.4	97.1	98.3	99.1		96.7	
7			Employee Turnover (rolling 12 months)	<= %	10.0	10.0	10.0																					Apr 2016									12.8	12.8	
			Nursing Turnover	%				-	-	-	-	-	-	-	-	-	-	-	-	-	14.6	14.7	14.8	13.8	13.6		Apr 2016									14	14	
7			New Investigations in Month	No				1	0	3	4	5	8	11	5	8	4	5	10	6	2	5	12	9	6		Apr 2016	1	0	0	1	0	0	0	4	6		
7			Vacancy Time to Fill	Weeks				21	20	20	23	22	23	24	26	25	27	25	23	23	23	24	26	23	26		Apr 2016									26		
7			Professional Registration Lapses	<= No	0	0	0.0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		Apr 2016	0	0	0	0	0	0	0	0	0	0	
7			Qualified Nursing Variance (FIMS) (FTE)	No				200	228	238	247	263	221	247	288	303	321	320	279	267	293	272	274	293			Apr 2016									292		
10			Nurse Bank Fill Rate	=> %	100.0	100.0	100.0	82	73	78	78	78	75	81	81	79	80	87	82	90	85	89	71	87	87		Apr 2016	84.9	86.3	96.4	91.4	100.0	100.0	87.9	100.0	87.2	87.2	
10			Nurse Bank Shifts Not Filled	<= No	0	0	0.0	1440	1727	1716	1432	1487	1532	1378	1073	1622	1423	1207	917	780	1178	1356	1069	1128	1100		Apr 2016	710	226	12	65	0	0	87	0	1100	1100	
10			Nurse Bank Use (shifts)	<= No	46980	3915	3915.0																					Apr 2016	2913	1370	274	635	12	170	485	156	6015	6015	
10			Nurse Agency Use (shifts)	<= No	0	0	0.0																					Apr 2016	1546	431	0	8	0	241	282	18	2526	2526	
10			Admin & Clerical Bank Use (shifts)	<= No	0	0	0.0																					Apr 2016	1102	218	144	98	265	120	211	2492	4650	4650	
10			Admin & Clerical Agency Use (shifts)	<= No	0	0	0.0																					Apr 2016	83	56	42	40	0	0	0	113	334	334	
			Medical Staffing - Number of instances when junior rotas not fully filled	<= No	0	0	0.0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		Jan-00	-	-	-	-	-	-	-	-	-	-	
15			Your Voice - Response Rate	No			0.0	17.4	-->	12.6	12.7	-->	-->	-->	13.9	-->	-->	15.3	-->	-->	12.6	-->	-->	-->	-->		Dec 2015	6	8	14	11	19	21	21	15	12.6		
15			Your Voice - Overall Score	No			0.0	3.65	-->	3.57	3.55	-->	-->	-->	3.59	-->	-->	3.51	-->	-->	3.57	-->	-->	-->	-->		Dec 2015	3.37	3.31	3.63	3.63	3.79	3.4	3.72	3.58	3.57		

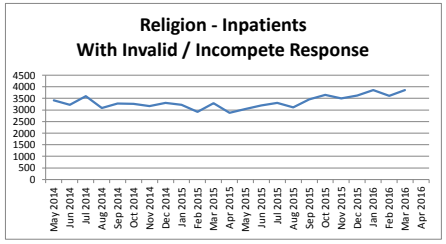


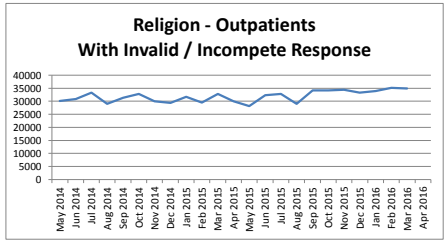


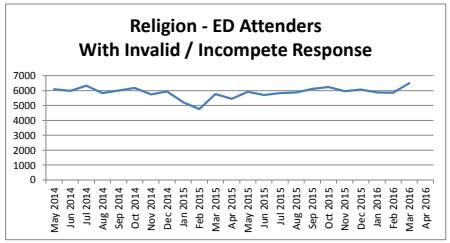


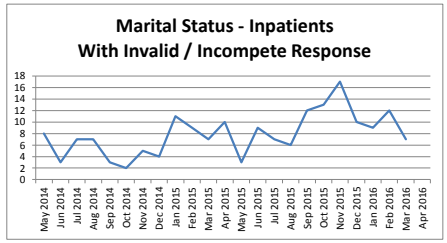
Data Completeness

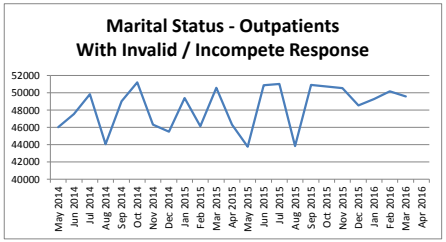
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Nov 2014) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend
14			Data Completeness Community Services	=> %	50.0	50.0																		-	Mar 2016								61.7	61.7		
2			Percentage SUS Records for AE with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0																	-	-	Feb 2016									99.5		
2			Percentage SUS Records for IP care with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0																	-	-	Feb 2016									99.4		
2			Percentage SUS Records for OP care with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0																	-	-	Feb 2016									99.5		
2			Completion of Valid NHS Number Field in acute (inpatient) data set submissions to SUS	=> %	99.0	99.0	95.7	96.0	96.5	96.9	96.6	96.9	96.6	96.3	96.5	95.8	96.5	97.0	97.4	97.0	97.5	96.5	98.1	-	Mar 2016									98.1	96.9	
2			Completion of Valid NHS Number Field in acute (outpatient) data set submissions to SUS	=> %	99.0	99.0	99.5	99.5	99.6	99.6	99.6	99.6	99.6	99.6	99.5	99.4	99.5	99.5	99.5	99.5	99.5	99.5	99.6	-	Mar 2016									99.6	99.5	
2			Completion of Valid NHS Number Field in A&E data set submissions to SUS	=> %	95.0	95.0	96.6	96.2	97.0	96.7	96.8	96.8	96.9	96.9	96.3	96.0	96.7	96.3	97.1	96.8	97.3	97.0	97.1	-	Mar 2016									97.1	96.8	
2			Ethnicity Coding - percentage of inpatients with recorded response	=> %	90.0	90.0																		-	Mar 2016									93.3	94.6	
			Ethnicity Coding - percentage of outpatients with recorded response	=> %	90.0	90.0																		-	Mar 2016									90.7	92.1	
			Protected Characteristic - Religion - INPATIENTS with recorded response	%			74.2	74.5	74.2	75.1	75.0	75.2	74.7	73.8	73.2	72.9	71.6	70.9	71.2	70.8	68.9	70.3	68.6	-	Mar 2016									68.6	71.8	
			Protected Characteristic - Religion - OUTPATIENTS with recorded response	%			62.8	63.1	62.9	63.2	62.2	62.5	62.6	63.0	62.5	61.3	60.8	60.4	59.9	59.3	59.3	58.4	58.1	-	Mar 2016									58.1	60.7	
			Protected Characteristic - Religion - ED patients with recorded response	%			62.3	63.1	64.2	65.8	64.9	65.5	64.4	65.8	64.1	61.8	61.2	61.8	62.9	62.0	63.9	62.3	62.3	-	Mar 2016									62.3	63.2	
			Protected Characteristic - Marital Status - INPATIENTS with recorded response	%			100.0	100.0	99.9	99.9	99.9	99.9	100.0	99.9	99.9	99.9	99.9	99.9	99.9	99.9	99.9	99.9	99.9	-	Mar 2016									99.9	99.9	
			Protected Characteristic - Marital Status - OUTPATIENTS with recorded response	%			42.6	42.8	42.1	42.3	41.7	42.2	41.8	41.6	41.8	41.6	41.6	41.2	41.1	40.7	40.8	40.5	40.5	-	Mar 2016									40.5	41.3	
			Protected Characteristic - Marital Status - ED patients with recorded response	%			42.4	43.8	42.4	42.4	43.5	42.5	41.2	42.6	40.7	40.6	41.1	40.8	42.0	41.5	41.7	42.5	41.2	-	Mar 2016									41.2	41.5	
2			Maternity - Percentage of invalid fields completed in SUS submission	<= %	15.0	15.0																		-	Mar 2016									5.7	5.7	
2			Open Referrals	No			-	-	-	-	-	173,131	180,758	183,245	191,411	203,025	208,990	214,841	222,779	228,862	192,989	187,876	190,396	194,788	Apr 2016	67,205	37,034	63,337	23,294	3,572	288	58		194,788		
			Duplicate Entries	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00									-	-	

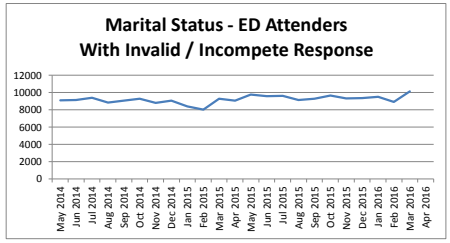




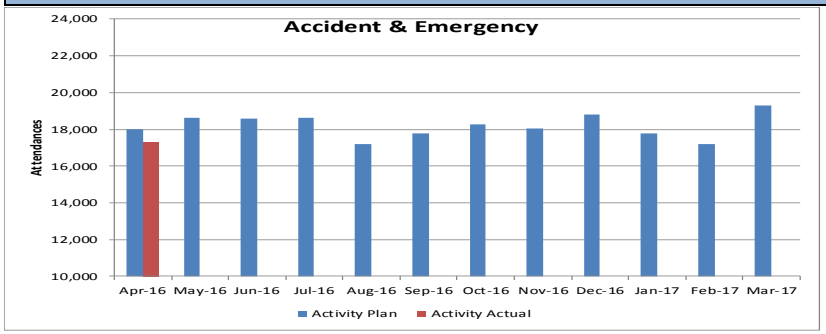




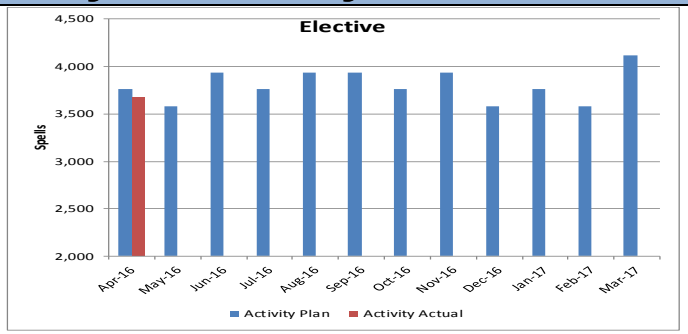




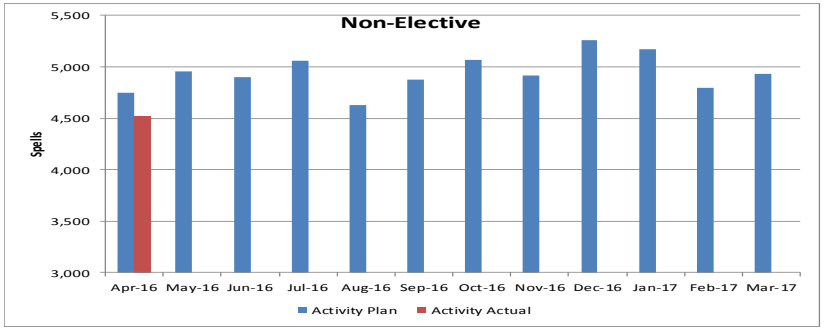
Activity Summary



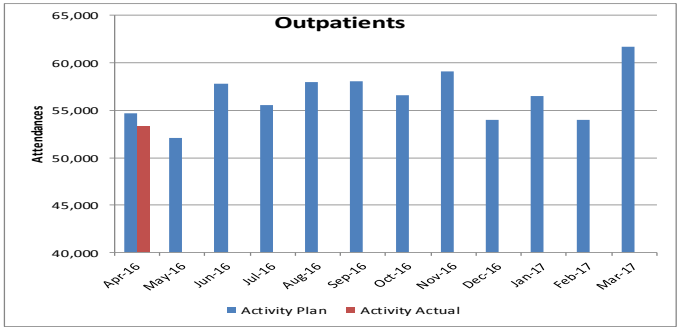
Our emergency departments have under performed in April with the City site having the greatest activity variance at -8% against plan.



Elective care performance is currently 2% below plan for month 1. Elective and outpatient care activity levels continue to be addressed through the demand and capacity work being led by the Chief Operating Officer.



Unplanned admissions in total under performed in April against plan by 233 spells however we were only 23 spells lower than April 2015.



Outpatient attendance performance is currently 2.5% below plan for month 1. Elective and outpatient care activity levels continue to be addressed through the demand and capacity work being led by the Chief Operating Officer.

- **Activity and price variance based on average tariff at activity group level**
- Values presented are for the year-to-date period to month 1 (initial cut) and includes the four activity groups and Clinical Groups listed from the contracting dataset and does not include other income present in the ledger

Activity Group	Activity Plan	Activity Actual	Activity Diff	Price Plan Inc MFF	Price Actual Inc MFF	Price Diff Inc MFF	Activity Variance	Price Variance
Accident & Emergency	17,990	14,364	-3,626	£1,755,723	£1,532,733	-£222,990	**-£353,853**	**£130,862**
Elective	3,725	3,642	-83	£3,911,734	£3,580,899	-£330,836	**-£87,058**	**-£243,778**
Non-Elective	4,732	4,463	-269	£7,365,222	£7,658,874	£293,653	**-£418,534**	**£712,186**
Outpatients	48,176	47,311	-865	£5,624,924	£5,201,026	-£423,898	**-£101,039**	**-£322,859**
Grand Total	74,622	69,780	-4,843	£18,657,604	£17,973,532	-£684,072	**-£960,484**	**£276,412**

Clinical Group	Activity Plan	Activity Actual	Activity Diff	Price Plan Inc MFF	Price Actual Inc MFF	Price Diff Inc MFF	Activity Variance	Price Variance
Medicine & Emergency Ca	35,829	31,402	-4,427	£8,659,893	£8,527,317	-£132,577	**-£1,069,998**	**£937,421**
Surgery A	11,027	10,173	-854	£4,560,710	£4,054,786	-£505,924	**-£353,270**	**-£152,655**
Surgery B	22,561	23,056	495	£3,004,206	£2,891,235	-£112,971	**£65,886**	**-£178,857**
Women's & Child Health	5,205	5,149	-57	£2,432,794	£2,500,194	£67,401	**-£26,425**	**£93,826**
Grand Total	74,622	69,780	-4,843	£18,657,604	£17,973,532	-£684,072	**-£1,383,807**	**£699,735**

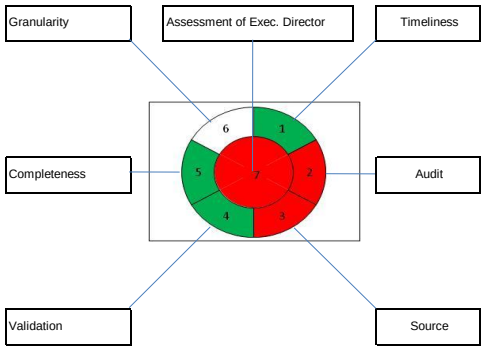
Legend

Data Sources	
1	Cancer Services
2	Information Department
3	Clinical Data Archive
4	Microbiology Informatics
5	CHKS
6	Healthcare Evaluation Data (HED) Tool
7	Workforce Directorate
8	Nursing and Facilities Directorate
9	Governance Directorate
10	Nurse Bank
11	West Midlands Ambulance Service
12	Obstetric Department
13	Operations Directorate
14	Community and Therapies Group
15	Strategy Directorate
16	Surgery B
17	Women & Child Health
18	Finance Directorate
19	Medicine & Emergency Care Group
20	Change Team (Information)

Indicators which comprise the External Performance Assessment Frameworks		
●		NHS TDA Accountability Framework
	a	Caring
	b	Well-led
	c	Effective
	d	Safe
	e	Responsive
	f	Finance
●		Monitor Risk Assessment Framework
●		CQC Intelligent Monitoring

Groups	
M	Medicine & Emergency Care
A	Surgery A
B	Surgery B
W	Women & Child Health
P	Pathology
I	Imaging
C	Community & Therapies
CO	Corporate

Data Quality - Kitemark



Each outer segment of indicator is colour coded on kitemark to signify strength of indicator relative to the dimension, with following key:

Red	Insufficient
Green	Sufficient
White	Not Yet Assessed

The centre of the indicator is colour coded as follows:

Red / Green	As assessed by Executive Director
White	Awaiting assessment by Executive Director

If segment 2 of the Kitemark is Blank this indicates that a formal audit of this indicator has not yet taken place

Medicine Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	Trend
			Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		EC	AC	SC			
Patient Safety - Inf Control	C. Difficile	<= No	30	3																			Apr 2016	1	0	0	1	1	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0																			Apr 2016	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective (%)	=> %	80	80																			Apr 2016	71	89	27	62.7		
Patient Safety - Inf Control	MRSA Screening - Non Elective (%)	=> %	80	80																			Apr 2016	94	92	92	93.8		
Patient Safety - Harm Free Care	Falls	<= No	0	0	50	66	63	42	52	43	47	42	39	41	40	41	41	35	40	35	32	44	Apr 2016	21	18	5	44	44	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	2	0	1	0	1	1	0	1	5	0	1	1	2	0	0	1	1	0	Apr 2016	0	0	0	0	0	
Patient Safety - Harm Free Care	Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	6	7	10	1	1	8	3	6	2	0	6	2	3	4	4	6	4	6	Apr 2016	0	5	1	6	6	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																			Apr 2016	93.8	84.8	99.6	95.5		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	98.0	98.0																			Apr 2016	105.0	100.0	100.0	104.2		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	95.0	95.0																			Apr 2016	99	0	100	99.4		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	85.0	85.0																			Apr 2016	99	0	100	99.4		
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			Apr 2016	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0	0	0	0	0	1	0	0	0	1	0	0	0	1	0	0	0	0	0	Apr 2016	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																			Apr 2016	0	0	0	0	0	
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100	98																	-	-	Feb 2016	68	64	70	67		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			8.9	9.6	10.7	10.0	10.5	11.7	10.5	10.3	11.5	10.7	9.7	9.6	8.6	9.3	9.2	9.4	9.6	-	Mar 2016				9.6		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			10.0	9.9	10.1	10.1	10.2	10.3	10.3	10.3	10.4	10.4	10.3	10.3	10.3	10.3	10.1	10.1	10.0	-	Mar 2016					10.3	

Medicine Group

Section	Indicator		Trajectory		Previous Months Trend																	Data Period	Directorate			Month	Year To Date	
			Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		EC	AC	SC			
Clinical Effect - Stroke & Card	Pts spending >90% stay on Acute Stroke Unit (%)	=> %	90.0	90.0																			Apr 2016		97.9		97.9	97.9	
Clinical Effect - Stroke & Card	Pts admitted to Acute Stroke Unit within 4 hrs (%)	=> %	90.0	90.0																			Apr 2016		72.7		72.7	72.7	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 1 hr of presentation (%)	=> %	50.0	50.0																			Apr 2016		65.9		65.9	65.9	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 24 hrs of presentation (%)	=> %	100.0	100.0																			Apr 2016		97.7		97.7	97.7	
Clinical Effect - Stroke & Card	Stroke Admission to Thrombolysis Time (% within 60 mins)	=> %	85.0	85.0																			Apr 2016		50.0		50.0	50.0	
Clinical Effect - Stroke & Card	Stroke Admissions - Swallowing assessments (<24h) (%)	=> %	98.0	98.0																			Apr 2016		100.0		100.0	100.0	
Clinical Effect - Stroke & Card	TIA (High Risk) Treatment <24 Hours from receipt of referral (%)	=> %	70.0	70.0																			Apr 2016		100.0		100.0	100.0	
Clinical Effect - Stroke & Card	TIA (Low Risk) Treatment <7 days from receipt of referral (%)	=> %	75.0	75.0																			Apr 2016		97.6		97.6	97.6	
Clinical Effect - Stroke & Card	Primary Angioplasty (Door To Balloon Time 90 mins) (%)	=> %	80.0	80.0																			Apr 2016		100.0		100.0	100.0	
Clinical Effect - Stroke & Card	Primary Angioplasty (Call To Balloon Time 150 mins) (%)	=> %	80.0	80.0																			Apr 2016		100.0		100.0	100.0	
Clinical Effect - Stroke & Card	Rapid Access Chest Pain - seen within 14 days (%)	=> %	98.0	98.0																			Apr 2016		100.0		100.0	100.0	
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0																		-	Mar 2016			93.3	93.3		
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Mar 2016			94.3	94.3		
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																		-	Mar 2016			77.8	77.8		
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	-	0	1	4.5	4.5	2.5	1.5	0.5	6	3	-	Mar 2016	-	-	3.00	3.00	24	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	-	0	0	3	4	2	0	0	4.5	0	-	Mar 2016	-	-	0.00	0.00	14	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	-	62	97	228	165	138	104	98	154	98	-	Mar 2016	-	-	98	98		
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0.0	0.0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Apr 2016	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			18	31	30	36	38	41	35	41	53	36	29	43	42	32	34	47	39	49	Apr 2016	17	13	19	49	49	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			149	93	106	126	117	112	104	87	90	74	58	65	65	57	50	65	63	72	Apr 2016	29	20	23	72		
Pt. Experience - FFT,MSA,Comp (Group Sheet Only)	Oldest' complaint currently in system (days)	No			161	182	188	209	230	250	188	210	186	208	136	159	43	46	67	48	30	-	Mar 2016	23	30	22	30		

Medicine Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate			Month	Year To Date	
			Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		EC	AC	SC			
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			Apr 2016	-	-	0.06	0.05		
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Apr 2016	0.0	0.0	0.0	0	0	
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	4	1	0	0	9	8	1	2	4	7	0	0	1	0	2	1	1	0	Apr 2016	0.0	0.0	0.0	0	0	
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	60	62	61	49	48	54	60	46	47	45	33	54	35	32	34	32	31	58	Apr 2016	0.0	0.0	57.9	57.9		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	-	1	2	5	0	0	1	1	0	0	0	0	0	0	Apr 2016	0.00	0.00	0.00	0.00	0	
Emergency Care & Pt. Flow	Emergency Care 4-hour waits (%)	=> %	95.0	95.0																			Apr 2016	88.3	92.3	Site S/C	90.4	90.4	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			1181	1913	940	1242	1412	'	'	'	'	'	'	'	'	'	'	1560	1908	1246	Apr 2016	1213	0	33	1246	1246	
Emergency Care & Pt. Flow	Emergency Care Trolley Waits >12 hours	<= No	0	0																			Apr 2016	0.0	0.0	Site S/C	0	0	
Emergency Care & Pt. Flow (Group Sheet Only)	Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15.0	15.0												-	-	-	-				Apr 2016	19.0	16.0	Site S/C	17	17	
Emergency Care & Pt. Flow (Group Sheet Only)	Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60.0	60.0												-	-	-	-				Apr 2016	50.0	45.0	Site S/C	47	47	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0																			Apr 2016	8.8	7.5	Site S/C	8.2	8.2	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0																			Apr 2016	3.7	3.6	Site S/C	3.6	3.6	
Emergency Care & Pt. Flow	WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	<= No	0	0	159	282	185	149	164	43	116	90	72	58	76	93	67	121	116	97	117	81	Apr 2016	32	49		81	81	
Emergency Care & Pt. Flow	WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	<= No	0	0	14	31	7	6	8	9	8	3	3	2	1	1	3	8	10	6	9	2	Apr 2016	2	0		2	2	
Emergency Care & Pt. Flow	WMAS - Turnaround Delays > 60 mins (% all emergency conveyances)	<= %	0.02	0.02																			Apr 2016	0.10	0.00		0.05	0.05	
Emergency Care & Pt. Flow	WMAS - Emergency Conveyances (total)	No			4168	4470	4001	3829	4182	3981	4214	114	4256	4241	4016	4260	4202	4573	4679	3961	4513	4115	Apr 2016	2009	2106		4115	4115	
RTT	RTT - Admittted Care (18-weeks) (%)	=> %	90.0	90.0																			Apr 2016	0.0	89.8	86.5	87.9		
RTT	RTT - Non Admittted Care (18-weeks) (%)	=> %	95.0	95.0																			Apr 2016	0.0	78.7	81.7	80.6		
RTT	RTT - Incomplete Pathway (18-weeks) (%)	=> %	92.0	92.0																			Apr 2016	0.0	93.7	88.2	90.2		
RTT	Patients Waiting >52 weeks	<= No	0	0	0	0	0	1	1	0	0	0	0	1	0	0	1	1	1	3	4	0	Apr 2016	0	0	0	0		
RTT	Treatment Functions Underperforming	<= No	0	0	7	2	2	6	1	1	1	1	3	4	3	7	8	8	10	8	7	12	Apr 2016	0	4	8	12		
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0																			Apr 2016	0	0.67	0.61	0.66		

Medicine Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																Data Period	Directorate			Month	Year To Date	
			Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		EC	AC	SC			
Data Completeness	Open Referrals	No			-	-	-	-	-	60,571	63,010	62,950	66,143	70,955	72,441	75,035	78,201	80,663	67,608	65,055	65,979	67,205	Apr 2016	11,892	17,055	38,258	67205		
Workforce	WTE - Actual versus Plan	No			197	232	242	244	176	200	200	219	236	262	261	217	214	208	204	201	219	220	Apr 2016	106.5	57	52.82	220		
Workforce	PDRs - 12 month rolling (%)	=> %	95.0	95.0																			Apr 2016	87.91	88.6	80.13		86.7	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0						-													Apr 2016	75	92.86	90.32		88.0	
Workforce	Sickness Absence - 12 month rolling (%)	<= %	3.15	3.15																			Apr 2016	5.73	5.92	5.08	5.67	5.67	
Workforce	Sickness Absence - In month	<= No	3.15	3.15	-	-	-	-	-	-	-												Apr 2016	6.53	6.82	3.60	6.02	6.02	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100	100	-	-	-	-		-	-												Apr 2016	64.9	73.6	49.3		66.73	
Workforce	Mandatory Training (%)	=> %	95.0	95.0																			Apr 2016	81.81	82.14	83.31		82.3	
Workforce	New Investigations in Month	No			0	0	1	2	2	2	1	1	2	1	3	0	0	1	1	6	4	1	Apr 2016	1	0	0	1		
Workforce	Nurse Bank Fill Rate %	=> %	100	100	-	-	-	-	72	2528	3008	2311	3287	3019	4330	2700	1185	3654	3001	3002	4159	3992	Apr 2016				85		
Workforce	Nurse Bank Shifts Not Filled (number)	<= No	0	0	-	-	-	-	1031	1136	1055	771	1146	977	811	594	217	749	925	700	748	710	Apr 2016				710		
Workforce	Nurse Bank Use	<= No	34560	2880																			Apr 2016				2913	2913	
Workforce	Nurse Agency Use	<= No	0.00	0.00																			Apr 2016				1546	1546	
Workforce	Admin & Clerical Bank Use (shifts)	<= No	0.00	0.00																			Apr 2016				1102	1102	
Workforce	Admin & Clerical Agency Use (shifts)	<= No	0.00	0.00																			Apr 2016				83	83	
Workforce	Medical Staffing - Number of instances when junior rotas not fully filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00				-	-	
Workforce	Your Voice - Response Rate (%)	No			9	-->	-->	6	-->	-->	-->	6	-->	-->	6	-->	-->	6	-->	-->	-->	-->	Dec 2015	6.0	5.0	10.0	6.0		
Workforce	Your Voice - Overall Score	No			3.76	-->	-->	3.57	-->	-->	-->	3.49	-->	-->	3.45	-->	-->	3.37	-->	-->	-->	-->	Dec 2015	3.44	3.56	3.10	3.37		

Surgery A Group

Section	Indicator	Measure	Trajector Month	Previous Months Trend N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Directorate GS	SS	TH	An	Month	Year To Date	Trend
Patient Safety - Inf Control	C. Difficile	<= No	1																			Apr 2016	0	0	0	1	1	1	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0																			Apr 2016	0	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80																			Apr 2016	94.5	94.1	0	0	93.8		
Patient Safety - Inf Control	MRSA Screening - Non Elective	=> %	80																			Apr 2016	94.1	95.6	0	100	94.6		
Patient Safety - Harm Free Care	Falls	<= No	0	6	6	0	4	4	5	9	5	4	2	4	2	6	11	13	6	11	7	Apr 2016	4	3	0	0	7	7	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	Apr 2016	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	4	0	0	2	0	0	1	1	1	2	1	1	1	2	0	1	6	Apr 2016	4	2	0	0	6	6	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0																			Apr 2016	94.7	90.9	0	98.7	93.9		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	98.0																			Apr 2016	100	99.3	0	100	99.7		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	95.0																			Apr 2016	100	0	98.2	0	98.4		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	85.0																			Apr 2016	100	0	94.6	0	95.2		
Patient Safety - Harm Free Care	Never Events	<= No	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	1	0	0	Apr 2016	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Apr 2016	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0																			Apr 2016	2	0	0	0	2	2	
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	98.0																	-	-	Feb 2016	50	88.9	0	100	77.8		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	<= %		6.3	6.4	7.3	7.0	6.4	7.7	8.2	7.9	7.3	7.8	7.8	7.3	7.4	8.7	7.6	7.2	7.9	-	Mar 2016					7.9		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	<= %		6.6	6.7	6.7	6.8	6.7	6.8	6.8	6.8	6.9	7	7.2	7.3	7.4	7.6	7.583	7.6	7.7	-	Mar 2016						7.2	

Surgery A Group

Section	Indicator	Measure	Trajector Month	Previous Months Trend N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Directorate GS	SS	TH	An	Month	Year To Date	
Clinical Effect - Cancer	2 weeks	=> %	93.0																		-	Mar 2016	98.8		0.0		98.75		
Clinical Effect - Cancer	2 weeks (Breast Symptomatic)	=> %	93.0																		-	Mar 2016	97.8				97.76		
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0																		-	Mar 2016	100.0		0.0		100		
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0																		-	Mar 2016	91.8		0.0		91.8		
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No		-	-	-	-	-	-	-	-	0	10	3	5	2	5	2	2	3	-	Mar 2016	-	-	-	-	2.5	29	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No		-	-	-	-	-	-	-	-	4	6	1	2	0	4	0	0	1	-	Mar 2016	0.5	-	0	-	0.5	17	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No		-	-	-	-	-	-	-	-	180	147	173	124	98	167	75	74	117	-	Mar 2016	117	-	0	-	117		
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0	0	2	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	Apr 2016	0	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No		13	7	15	9	16	16	8	16	16	15	15	18	18	11	16	14	19	24	Apr 2016	13	8	3	0	24	24	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No		78	53	45	40	45	46	27	32	23	26	23	23	24	15	17	23	26	24	Apr 2016	12	10	2	0	24		
Pt. Experience - FFT,MSA,Comp	Oldest' complaint currently in system (days)	No		143	171	192	213	234	254	97	157	108	122	125	27	47	46	29	29	29	-	Mar 2016	26	29	0	0	29		
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8																			Apr 2016	1.54	-	0	1.31	1		
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	Apr 2016	0	0	0	0	0	0	
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	6	33	11	13	17	12	10	8	21	13	13	17	8	16	5	19	6	10	Apr 2016	8	0	0	2	10	10	
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	77	71	78	79	75	78	78	79	80	78	78	78	78	72	74.05	76	77	76	Apr 2016	77.0	72.6	0.0	95.7	76.17		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No		-	-	-	-	-	2	0	0	0	7	2	8	0	0	0	0	0	0	Apr 2016	0	0	0	0	0	0	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No		94	121	43	108	127	-	-	-	-	-	-	-	-	-	-	49	65	68	Apr 2016	45	23	0	0	68	68	
Emergency Care & Pt. Flow	Hip Fractures BPT (Operation < 36 hours of admissions	=> %	85	-	-	-	-	-														Apr 2016		71.1			71.1	71.1	

Surgery A Group

Section	Indicator	Measure	Trajector Month	Previous Months Trend N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Directorate GS	SS	TH	An	Month	Year To Date
RTT	RTT - Admittted Care (18-weeks) (%)	=> %	90.0																			Apr 2016	80.2	49.7	0.0	0.0	66.9	
RTT	RTT - Non Admittted Care (18-weeks) (%)	=> %	95.0																			Apr 2016	93.8	91.8	0.0	0.0	93.0	
RTT	RTT - Incomplete Pathway (18-weeks) (%)	=> %	92.0																			Apr 2016	92.2	87.9	0.0	0.0	90.1	
RTT	Patients Waiting >52 weeks	<= No	0	2	0	3	1	2	1	0	0	0	2	1	1	0	0	1	1	0	2	Apr 2016	0	2	0	0	2	
RTT	Treatment Functions Underperforming	<= No	0	7	4	5	8	4	2	3	2	2	4	8	10	9	11	9	9	7	10	Apr 2016	4	6	0	0	10	
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0																			Apr 2016	0.8	0.0	1.9	0.0	1.35	
Data Completeness	Open Referrals	No		-	-	-	-	-	32,829	34,523	35,269	36,991	39,612	40,315	40,565	41,714	42,539	36,195	35,305	35,734	37,034	Apr 2016	21,046	12,554	0	3,434	37034	
Workforce	WTE - Actual versus Plan	No		76	66	62	70	70	88	97	103	110	120	122	116	107	112	120.4	102	102	103	Apr 2016	35.9	21.2	23	20.2	102.6	
Workforce	PDRs - 12 month rolling	=> %	95.0																			Apr 2016	85.7	84.9	94.0	88.4		88.9
Workforce	Medical Appraisal and Revalidation	=> %	95.0						-													Apr 2016	88.2	93.8	0	77.5		83.6
Workforce	Sickness Absence - 12 month rolling (%)	<= %	3.15																			Apr 2016	5.8	3.6	6.3	4.8	5.3	5.3
Workforce	Sickness Absence - In Month	<= No	3.15	-	-	-	-	-	-	-												Apr 2016	4.8	2.6	5.5	2.6	4.1	4.1
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100	-	-	-	-		-	-												Apr 2016	78.9	54.5	86.5	77.5	77.8	77.8
Workforce	Mandatory Training	=> %	95.0																			Apr 2016	86.2	81.2	91.0	90.6		88.0
Workforce	New Investigations in Month	No		1	0	1	1	2	3	3	1	2	1	0	3	0	0	1	1	1	0	Apr 2016	0	0	0	0	0	
Workforce	Nurse Bank Fill Rate	=> %	100.0	-	-	-	-	76	71	80	82	76	76	86	85	86	82	77.86	57	83	86	Apr 2016					86.34	86
Workforce	Nurse Bank Shifts Not Filled	<= No	0	'	'	'	'	335	313	247	197	347	303	272	220	117	232	269	202	223	226	Apr 2016					226	226
Workforce	Nurse Bank Use	<= No	826																			Apr 2016					1370	1370
Workforce	Nurse Agency Use	<= No	0																			Apr 2016					431	431
Workforce	Admin & Clerical Bank Use (shifts)	<= No	0																			Apr 2016					218	218
Workforce	Admin & Clerical Agency Use (shifts)	<= No	0																			Apr 2016					56	56
Workforce	Medical Staffing - Number of instances when junior rotas not fully filled	<= No	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00					-	-

Surgery A Group

Workforce	Your Voice - Response Rate	No		11	-->	-->	9	-->	-->	-->	10	-->	-->	10	-->	-->	8	-->	-->	-->	-->	Dec 2015	-	-	-	9	**8**	
Workforce	Your Voice - Response Score	%		3.6	-->	-->	3.4	-->	-->	-->	3.6	-->	-->	3.4	-->	-->	3.3	-->	-->	-->	-->	Dec 2015	-	-	-	3.49	**3.31**	

Surgery B Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate		Month	Year To Date	Trend
			Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		O	E			
Patient Safety - Inf Control	C. Difficile	<= No	0	0																			Apr 2016	0	0	0	0	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0																			Apr 2016	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80	80																			Apr 2016	64	94	87.0		
Patient Safety - Inf Control	MRSA Screening - Non Elective	=> %	80	80																			Apr 2016	98	98	98.0		
Patient Safety - Harm Free Care	Falls	<= No	0	0	0	1	1	0	0	0	0	2	1	0	0	1	2	1	1	1	1	1	Apr 2016	1	0	1	1	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Apr 2016	0	0	0	0	
Patient Safety - Harm Free Care	Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Apr 2016	0	0	0	0	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95	95																			Apr 2016	98	98	97.8		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	98	98																			Apr 2016	100	100	99.94		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	95	95																			Apr 2016	100	100	100		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	85	85																			Apr 2016	99	100	99.46		
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			Apr 2016	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0																			Apr 2016	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																			Apr 2016	0	0	0	0	
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100	97	-	-	-	-	N/A	N/A	N/A	N/A		N/A		N/A	N/A	N/A	N/A		-	-	Feb 2016	100	0	100		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			4.9	5.0	2.9	4.5	5.5	5.7	4.4	3.4	5.7	3.6	5.3	5.0	4.4	6.1	3.1	5.8	4.9	-	Mar 2016			4.9		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			4.8	4.8	4.7	4.5	4.5	4.5	4.6	4.6	4.6	4.5	4.7	4.7	4.6	4.7	4.7	4.8	4.8	-	Apr 2016				4.6	

Surgery B Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate		Month	Year To Date	
			Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		O	E			
Clinical Effect - Cancer	2 weeks	=> %	93	93																		-	Mar 2016		100	100.0		
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96	96		-										#DIV/0!						-	Mar 2016		100	100		
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85	85												#DIV/0!				#DIV/0!		-	Mar 2016		100	100.0		
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	-	0	0	0	0	1	0	0.5	0	0	-	Mar 2016	-	0	0	1.5	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	-	0	0	0	0	0	0	0	0	0	-	Mar 2016	-	0	0	0	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	-	62	51	62	0	104	54	84	0	59	-	Mar 2016	-	59	59		
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Apr 2016	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			11	14	14	12	16	14	9	6	15	15	16	18	18	17	9	14	19	21	Apr 2016	19	2	21	21	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			47	33	35	35	36	39	35	17	17	22	19	24	25	21	15	14	19	25	Apr 2016	24	1	25		
Pt. Experience - FFT,MSA,Comp	Oldest' complaint currently in system (days)	No			138	109	102	123	144	164	135	102	126	148	83	106	34	57	25	21	28	-	Mar 2016	28	10	28		
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			Apr 2016	0.6	1	0.73		
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Apr 2016	0	0	0	0	
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	11	7	24	11	8	15	17	16	10	14	8	19	15	11	11	14	14	8	Apr 2016	4	4	8	8	
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85	85	73	68	74.1	72	75.2	73.3	71.4	73.1	73.9	70.5	73.6	75	75.1	73.8	74.5	74.8	72.5	73.9	Apr 2016	76	67	73.93		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	-	0	0	1	0	0	0	0	0	0	0	0	0	0	Apr 2016	0	0	0	0	
Emergency Care & Pt. Flow	Emergency Care 4-hour waits (%)	=> %	95	95																			Apr 2016	98		98.3	98.3	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			27	25	8	8	39	-	-	-	-	-	-	-	-	-	-	13	33	41	Apr 2016	39	2	41	41	
Emergency Care & Pt. Flow	Emergency Care Trolley Waits >12 hours	<= No	0	0	-	-	-	-															Apr 2016	0		0	0	
Emergency Care & Pt. Flow (Group Sheet Only)	Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15	15												-	-	-	-				Apr 2016	14		14	14	
Emergency Care & Pt. Flow (Group Sheet Only)	Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60	60												-	-	-	-				Apr 2016	115		25	115	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5	5																			Apr 2016	3.8		3.84	3.84	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5	5																			Apr 2016	1.8		1.79	1.79	

Surgery B Group

Surgery B Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Directorate O	Directorate E	Month	Year To Date	
RTT	RTT - Admittted Care (18-weeks) (%)	=> %	90	90																			Apr 2016	82.8	85.7	83.8		
RTT	RTT - Non Admittted Care (18-weeks) (%)	=> %	95	95																			Apr 2016	89.0	90.2	89.2		
RTT	RTT - Incomplete Pathway (18-weeks) (%)	=> %	92	92																			Apr 2016	93.8	94.9	94.2		
RTT	Patients Waiting >52 weeks	<= No	0	0	1	0	0	1	1	0	1	0	3	2	1	3	3	1	2	1	3	1	Apr 2016	1	0	1		
RTT	Treatment Functions Underperforming	<= No	0	0	5	1	2	7	1	1	2	1	1	1	1	5	3	3	7	5	6	6	Apr 2016	2	4	6		
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1	1																			Apr 2016	0	0.6	1		
Data Completeness	Open Referrals	No			-	-	-	-	-	58,186	60,484	61,192	63,016	65,129	66,371	67,982	70,005	71,194	62,182	60,870	61,989	63,337	Apr 2016	52,323	11,014	63337		
Workforce	WTE - Actual versus Plan	No			27	30	32	29	28.5	35.3	35.1	46.6	43.1	49.7	57.2	57.7	59.1	61.1	57.8	50	46.7	41.5	Apr 2016			41.5		
Workforce	PDRs - 12 month rolling	=> %	95	95																			Apr 2016	98	94		97.0	
Workforce	Medical Appraisal and Revalidation	=> %	95	95						-													Apr 2016	92	75	89.3	89.29	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			Apr 2016	3.5	2.4	3.15	3.15	
Workforce	Sickness Absence - In Month	<= %	3.15	3.15	-	-	-	-	-	-	-												Apr 2016	3.1	1.3	2.57	2.57	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100	100	-	-	-	-		-	-												Apr 2016	73	77	77.33	77.33	
Workforce	Mandatory Training	=> %	95	95																			Apr 2016	86	92		87.36	
Workforce	New Investigations in Month	No			0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	1	0	Apr 2016			0		
Workforce	Nurse Bank Fill Rate	=> %	100	100	-	-	-	-	100	99	99.6	98.4	98.2	96.9	96	97	97.6	93.5	97.3	95.9	97.1	96.4	Apr 2016			96.41	96.41	
Workforce	Nurse Bank Shifts Not Filled	<= No	0	0	-	-	-	-	1	2	1	3	4	7	13	7	27	23	11	14	10	12	Apr 2016			12	12	
Workforce	Nurse Bank Use	<= No	2796	233																			Apr 2016			274	274	
Workforce	Nurse Agency Use	<= No	0	0																			Apr 2016			0	0	
Workforce	Admin & Clerical Bank Use (shifts)	<= No	0	0																			Apr 2016			144.0	144.0	
Workforce	Admin & Clerical Agency Use (shifts)	<= No	0	0																			Apr 2016			42.0	42.0	
Workforce	Medical Staffing - Number of instances when junior rotas not fully filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	

Surgery B Group

Workforce	Your Voice - Response Rate	No			17	-->	-->	14	-->	-->	-->	12	-->	-->	15	-->	-->	14	-->	-->	-->	-->	Dec 2015	7	31	**14**	
Workforce	Your Voice - Overall Score	No			3.52	-->	-->	3.54	-->	-->	-->	3.59	-->	-->	3.63	-->	-->	3.63	-->	-->	-->	-->	Dec 2015	3.6	3.7	**3.63**	

Women & Child Health Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	Trend
			Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		G	M	P	C			
Patient Safety - Inf Control	C. Difficile	<= No	0	0																			Apr 2016	0	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0																			Apr 2016	0	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80.00	80.00																			Apr 2016	97				96.9		
Patient Safety - Inf Control	MRSA Screening - Non Elective	=> %	80.00	80.00																			Apr 2016	0	100			100.0		
Patient Safety - Harm Free Care	Falls	<= No	0	0	0	0	0	0	0	1	2	1	0	1	2	0	1	0	2	0	1	0	Apr 2016	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Apr 2016	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	0	0	0	2	0	0	0	0	0	1	0	0	0	0	0	0	0	0	Apr 2016	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																			Apr 2016	97	93			94.6		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	98.0	98.0																			Apr 2016	99	99			99.2		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	95.0	95.0																			Apr 2016	100	0			100.0		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	85.0	85.00																			Apr 2016	100	0			100.0		
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			Apr 2016	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0																			Apr 2016	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																			Apr 2016	0	0	0	0	0	0	

Women & Child Health Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate				Month	Year To Date	
			Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		G	M	P	C			
Patient Safety - Obstetrics	Caesarean Section Rate - Total	<= %	25.0	25.0																			Apr 2016		27			26.7	26.7	
Patient Safety - Obstetrics	Caesarean Section Rate - Elective	%			8	11	8	6	9	8	7	8	11	9	9	10	9	9	8	8	8	10	Apr 2016		9.9			9.9	9.9	
Patient Safety - Obstetrics	Caesarean Section Rate - Non Elective	%			16	16	15	17	16	15	18	15	18	17	18	15	16	14	17	15	18	17	Apr 2016		17			16.9	16.9	
Patient Safety - Obstetrics	Maternal Deaths	<= No	0	0																			Apr 2016		0			0	0	
Patient Safety - Obstetrics	Post Partum Haemorrhage (>2000ml)	<= No	48	4																			Apr 2016		2			2	2	
Patient Safety - Obstetrics	Admissions to Neonatal Intensive Care	<= %	10.0	10.0																			Apr 2016		0.9			0.9	0.9	
Patient Safety - Obstetrics	Adjusted Perinatal Mortality Rate (per 1000 babies)	<= Rate1	8.0	8.0																			Apr 2016		4.4			4.4		
Patient Safety - Obstetrics	Early Booking Assessment (<12 + 6 weeks) (>=%) - SWBH Specific	=> %	90.0	90.0																			Apr 2016		78			78.3		
Patient Safety - Obstetrics	Early Booking Assessment (<12 + 6 weeks) (%) - National Definition	=> %	90.0	90.0																			Apr 2016		148			147.8		
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100.0	97.0			-				N/A			N/A	N/A			N/A		N/A	-	-	Feb 2016	0	0	0		0.0		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			6.8	7.2	6.6	7.4	6.9	7.4	6.9	7.1	7.1	4.4	4.5	6.4	5.9	4.8	4.7	6.7	5.5	-	Mar 2016					5.5		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			6.5	6.6	6.5	6.6	6.7	6.7	6.7	6.8	6.9	6.7	6.6	6.6	6.5	6.3	6.1	6.1	5.9	-	Mar 2016						6.5	
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0																		-	Mar 2016	95		100		95.4		
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Mar 2016	100				100.0		
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																		-	Mar 2016	100				100.0		
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	-	0	1.5	1.5	4	0.5	1.5	3	2	0	-	Mar 2016	0	-	0	-	0	14	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	-	1	1	0	2	0	0	0	0	0	-	Mar 2016	0	-	0	-	0	4	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	-	123	130	98	146	89	71	104	97	62	-	Mar 2016	62	-	0	-	62		

Women & Child Health Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	
			Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		G	M	P	C			
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Apr 2016	0				0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			12	7	11	9	11	7	9	14	14	12	10	9	10	15	17	4	13	5	Apr 2016	1	4	0	0	5	5	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			33	12	21	27	32	28	28	20	18	17	13	13	13	14	20	6	17	9	Apr 2016	0	0	0	0	9		
Pt. Experience - FFT,MSA,Comp	Oldest' complaint currently in system (days)	No			123	151	52	73	94	113	128	96	50	57	57	27	24	28	25	25	23	-	Mar 2016	19	23	3	0	23		
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			Apr 2016	2.1		-		1.5		
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Apr 2016	0				0	0	
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	7	7	1	5	7	6	4	2	2	4	7	6	9	13	6	7	13	4	Apr 2016	4				4	4	
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	77	80	77	78	79	76	78	74	75	76	79	76	76	72	74	71	78	76	Apr 2016	76	-			76.5		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	-	8	3	0	0	0	0	0	0	0	0	0	0	0	Apr 2016	0	-	0	-	0	0	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			36	82	5	30	16	-	-	-	-	-	-	-	-	-	-	15	6	16	Apr 2016	13	0	3	0	16	16	
RTT	RTT - Admittted Care (18-weeks)	=> %	90.0	90.0																			Apr 2016	92				91.5		
RTT	RTT - Non Admittted Care (18-weeks)	=> %	95.0	95.0																			Apr 2016	91				90.6		
RTT	RTT - Incomplete Pathway (18-weeks)	=> %	92.0	92.0																			Apr 2016	96				96.1		
RTT	Patients Waiting >52 weeks	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Apr 2016	0				0		
RTT	Treatment Functions Underperforming	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	1	1	Apr 2016	1				1		
RTT	Acute Diagnostic Waits in Excess of 6-weeks	<= %	0.1	0.1																			Apr 2016	0				0.0		

Women & Child Health Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Directorate G	M	P	C	Month	Year To Date
Data Completeness	Open Referrals	No			-	-	-	-	-	19,676	20,814	21,841	23,178	25,152	26,342	27,705	29,256	30,745	23,372	23,021	22,929	23,294	Apr 2016	7,053	10,221	6,006	14	23294	
Workforce	WTE - Actual versus Plan	No			59	66	67	68.6	66.9	67.9	70.8	87.2	95.8	111	96.6	85.7	82.5	98.9	96.9	94.7	91.8	87.3	Apr 2016	19	46	24	0	87.3	
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			Apr 2016	96	92	94	0		93.0
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0						-													Apr 2016	95	100	91	0		95.2
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			Apr 2016	5.2	5.9	4.1	14	5.4	5.4
Workforce	Sickness Absence - in month	<= %	3.15	3.15	-	-	-	-	-	-	-												Apr 2016	3	5.3	1.4	0	4.3	4.3
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	-	-	-	-		-	-												Apr 2016	83	72	78	50	75.04	75.04
Workforce	Mandatory Training	=> %	95.0	95.0																			Apr 2016	90	85	88	0		86.6
Workforce	New Investigations in Month	No			0	0	0	1	1	1	3	2	2	1	1	1	1	0	0	1	0	1	Apr 2016	0	1	0	0	1	
Workforce	Nurse Bank Fill Rate	=> %	100	100	-	-	-	-	90	93.6	95.4	91.9	93.9	90.9	94.7	94.2	96.1	87.4	93.5	90.8	92.9	91.4	Apr 2016					91.4	91.4
Workforce	Nurse Bank Shifts Not Filled	<= No	0	0	-	-	-	-	81	37	35	53	50	68	51	48	394	95	54	74	60	65	Apr 2016					65	91
Workforce	Nurse Bank Use	<= No	6852	571																			Apr 2016					635	635
Workforce	Nurse Agency Use	<= No	0	0																			Apr 2016					8	8
Workforce	Admin & Clerical Bank Use (shifts)	<= No	0	0																			Apr 2016					98	98
Workforce	Admin & Clerical Agency Use (shifts)	<= No	0	0																			Apr 2016					40	40
Workforce	Medical Staffing - Number of instances when junior rotas not fully filled	0	0																										
Workforce	Your Voice - Response Rate	No			12	-->	-->	9	-->	-->	-->	13	-->	-->	12	-->	-->	11	-->	-->	-->	-->	Dec 2015	15	5	17	13	11	
Workforce	Your Voice - Overall Score	No			3.65	-->	-->	3.53	-->	-->	-->	3.66	-->	-->	3.64	-->	-->	3.63	-->	-->	-->	-->	Dec 2015	3.7	3.7	3.6	3.5	3.6	

Women & Child Health Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																Data Period	Directorate				Month	Year To Date	
			Year	Month	3	8	5	3	1										1	6	1		G	M	P	C			
WCH Group Only	HV (C1) - No. of mothers who receive a face to face AN contact with a HV at =>28 weeks of pregancy	No			-	-	-	-	-	17	26	56	97	124	118	111	159	167	207	193	-	-	Feb 2016				193	193	1275	
WCH Group Only	HV (C2) - % of births that receive a face to face new birth visit by a HV =<14 days	=> %	95.0	95.0	-	-	-	-	-	82.6	81	86.7	88.3	87.9	90.7	89.9	88.9	88.2	87.6	-	-	-	Jan 2016				88	87.64	88.25	
WCH Group Only	HV (C3) - % of births that receive a face to face new birth visit by a HV >days	%			-	-	-	-	-	17	15.9	8.8	5.87	9.69	9.04	8.51	9.19	8.82	7.69	-	-	-	Jan 2016				7.7	7.69	8.92	
WCH Group Only	HV (C4) - % of children who received a 12 months review by 12 months	=> %	95.0	95.0	-	-	-	-	-	59.2	61.7	71.1	77.7	82	87.4	92.3	93.3	91.9	97.5	90.3	-	-	Feb 2016				90	90.29	86.58	
WCH Group Only	HV (C5) - % of children who received a 12 months review by the time they were 15 months	%			-	-	-	-	-	88.4	78.8	77.3	86.7	86.1	84.5	91	-	-	-	-	-	-	Oct 2015				91	91.02	86.23	
WCH Group Only	HV (C6i) - % of children who received a 2 - 2.5 year review	=> %	95.0	95.0	-	-	-	-	-	85.1	80.2	91.4	89.8	82	92.9	95.1	93	94.5	95.8	88.9	-	-	Feb 2016				89	88.89	90.93	
WCH Group Only	HV (C6ii) - % of children who receive a 2 - 2.5 year review using ASQ 3	%			-	-	-	-	-	76.9	71.5	78.3	79.2	70	84.7	83.2	84.4	80.5	90.2	84.2	-	-	Feb 2016				84	84.18	79.94	
WCH Group Only	HV (C7) - No. of Sure Start Advisory Boards / Children's Centre Boards witha HV presence	=> No	100	100	-	-	-	-	-	1	1	1	1	1	1	1	1	1	1	1	-	-	Feb 2016				1	1	11	
WCH Group Only	HV (C8) - % of children who receive a 6 - 8 week review	=> %	95.0	95.0	-	-	-	-	-	74	74.3	79.1	83.5	94	93	96.5	97.1	93.9	97.9	93.6	-	-	Feb 2016				94	93.58	91.98	
WCH Group Only	HV - % of infants for whom breast feeding status is recorded at 6 - 8 week check	=> %	100	100	-	-	-	-	-	63.3	65.3	65	77.7	88.5	83.1	80.2	84.7	91.9	98.6	99.3	-	-	Feb 2016				99	99.35	85.46	
WCH Group Only	HV - % of infants being breastfed at 6 - 8 weeks	%			-	-	-	-	-	38.7	38.7	38.7	33.6	31.4	32.3	27.6	30.7	36.8	37.9	35.6	-	-	Feb 2016				36	35.62	33.63	
WCH Group Only	HV - % HV staff who have completed mandatory training at L1,2 or 3 in child protection in last 3 years	=> %	95.0	95.0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Feb 2016				-	-	-	
WCH Group Only	HV - No. of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 10 - 14 day developmental check	No			-	-	-	-	-	-	-	-	347	397	333	360	358	353	335	-	-	-	Jan 2016				335	335	2483	
WCH Group Only	HV - % of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 10 - 14 day developmental check	=> %	100	100	-	-	-	-	-	88	87.2	85.8	92.3	98.5	86	94.7	98.6	97.2	96.3	-	-	-	Jan 2016				96	96.26	93.97	
WCH Group Only	HV - No. of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 6 - 8 week developmental check	No			-	-	-	-	-	-	-	-	359	374	340	365	337	376	366	-	-	-	Jan 2016				366	366	2517	
WCH Group Only	HV - % of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 6 - 8 week developmental check	=> %	100	100	-	-	-	-	-	74.1	80.9	79	99.7	95.4	94.7	94.1	91.8	98.2	99.7	-	-	-	Jan 2016				100	99.73	94.34	
WCH Group Only	HV - No. of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 9 - 12 months developmental check	No			-	-	-	-	-	-	-	-	315	340	275	321	257	316	352	-	-	-	Jan 2016				352	352	2176	
WCH Group Only	HV - % of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 9 - 12 months developmental check	=> %	100	100	-	-	-	-	-	76.2	68.8	66.3	98.4	95.8	81.1	89.4	83.4	92.4	89.6	-	-	-	Jan 2016				90	89.57	87.9	
WCH Group Only	HV - movers into provider <1 year of age to be checked =<14 d following notification to HV service	No			-	-	-	-	-	0	0	0	84	31	27	42	56	51	-	-	-	-	Dec 2015				51	51	291	

Women & Child Health Group

WCH Group Only	HV - all untested babies <1 year of age will be offered NBBS screening & results to HV.	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00				-	-	

Pathology Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate					Month	Year To Date	Trend
			Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		HA	HI	B	M	I			
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			Apr 2016	0	0	0	0	0	0	0	
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Mar 2016	-	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Mar 2016	-	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	-	0	-	-	-	-	-	-	-	-	-	Mar 2016	-	-	-	-	-	-		
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			0	2	3	1	5	0	2	3	0	2	0	1	2	0	2	4	2	3	Apr 2016	2	0	0	0	1	3	3	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			5	5	8	7	6	4	6	5	2	3	0	2	2	1	1	4	3	3	Apr 2016	2	0	0	0	1	3		
Pt. Experience - FFT,MSA,Comp	Oldest' complaint currently in system (days)	No			111	90	96	117	138	73	92	27	23	18	0	25	4	11	5	21	22	-	Mar 2016	13	22	0	0	0	22		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016	-	-	-	-	-	-	-	
Data Completeness	Open Referrals	No			-	-	-	-	-	1,700	1,743	1,808	1,870	1,957	3,276	3,293	3,318	3,414	3,312	3,294	3,420	3,572	Apr 2016	1,417	1	1,641	0	513	3,572		
Workforce	WTE - Actual versus Plan	No			27	27	24	16	16	20.4	22.8	32.5	34	33.7	40.3	40.1	39.2	38.2	32.5	22.9	30.3	25.7	Apr 2016	3.6	5.1	14	4.1	1.3	26		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			Apr 2016	87	100	90	98	100		93.66	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0						-													Apr 2016	40	100	100	100	100		85	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			Apr 2016	5.8	1.5	4.4	3.3	4.5	4.1	4.1	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15	-	-	-	-	-	-	-												Apr 2016	4.8	1.0	4.7	2.4	0.4	3.55	3.55	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	-	-	-	-		-	-												Apr 2016	81	97	75	92	100	80.7	80.7	
Workforce	Mandatory Training	=> %	95.0	95.0																			Apr 2016	91	99	93	94	100		94.1	
Workforce	New Investigations in Month	No			0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	Apr 2016	0	0	0	0	0	0		
Workforce	Admin & Clerical Bank Use (shifts)	<= No	0	0																			Apr 2016						265	265	
Workforce	Admin & Clerical Agency Use (shifts)	<= No	0	0																			Apr 2016						0	0	
Workforce	Your Voice - Response Rate	No			31	-->	-->	12	-->	-->	-->	21	-->	-->	24	-->	-->	19	-->	-->	-->	-->	Dec 2015	15	28	12	26	57	19		
Workforce	Your Voice - Overall Score	No			3.74	-->	-->	3.76	-->	-->	-->	3.69	-->	-->	3.58	-->	-->	3.79	-->	-->	-->	-->	Dec 2015	3.6	3.7	3.8	3.8	4.1	3.79		

Imaging Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Directorate DR	IR	NM	BS	Month	Year To Date	Trend
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			Apr 2016	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0																			Apr 2016	0	0	0	0	0	0	
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	<= No	0	0	1.0	3.0	1.0	1.0	-	-	2.0	2.0	2.0	1.0	1.0	1.0	-	-	1.0	2.0	-	-	Mar 2016					-		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	=> %	0	0	5.0	7.0	8.0	9.0	9.0	9.0	11.0	12.0	13.0	13.0	14.0	15.0	14.0	11.0	11.0	12.0	12.0	-	Mar 2016						4.3	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 1 hr of presentation (%)	=> %	50.0	50.0																			Apr 2016			65.9		65.91	65.91	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 24 hrs of presentation (%)	=> %	100.0	100.00																			Apr 2016			97.7		97.73	97.73	
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Mar 2016	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Mar 2016	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	-	0	-	-	-	-	-	-	-	-	-	Mar 2016	-	-	-	-	-		
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Apr 2016	0	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			2	2	3	2	1	0	4	3	5	8	4	1	2	1	3	6	5	2	Apr 2016	2	0	0	0	2	2	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			10	8	9	7	5	0	5	5	7	11	7	3	2	0	3	6	5	2	Apr 2016	2	0	0	0	2		
Pt. Experience - FFT,MSA,Comp	Oldest' complaint currently in system (days)	No			72	75	83	75	96	123	102	27	24	43	62	29	3	0	6	27	17	-	Mar 2016	17	0	0	0	0		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016	-	-	-	-	-	-	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			52	45	41	49	51	-	-	-	-	-	-	-	-	-	-	49	62	36	Apr 2016	36	0	0	0	36	36	
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0																			Apr 2016	0				0		
Data Completeness	Open Referrals	No			-	-	-	-	-	132	148	151	173	178	198	208	231	248	259	271	286	288	Apr 2016	288	0	0	0	288		
Workforce	WTE - Actual versus Plan	No			15	21	21	33	34	41	46	58	59	56	50	48	45	40	44	44	46	49	Apr 2016	24	1.2	6.1	5.5	48.5		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			Apr 2016	67.7	100	88.5	87.3		76.9	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0																			Apr 2016	84	0	100	50		80.7	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			Apr 2016	3.1	6.4	1.8	5.6	4.61	4.61	
Workforce	Sickness Absence - in month	<= %	3.15	3.15																			Apr 2016	5.0	10.1	2.5	5.7	5.42	5.42	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0																			Apr 2016	60.7	92.9	77.6	22.9	57.4	57.4	
Workforce	Mandatory Training	=> %	95.0	95.0																			Apr 2016	83.8	94.5	89.1	89.9		87.5	
Workforce	New Investigations in Month	No			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	Apr 2016					0		
Workforce	Nurse Bank Use	<= No	288	24																			Apr 2016					170	170	
Workforce	Nurse Agency Use	<= No	0	0																			Apr 2016					241	241	
Workforce	Admin & Clerical Bank Use (shifts)	<= No	0	0																			Apr 2016					120	120	
Workforce	Admin & Clerical Agency Use (shifts)	<= No	0	0																			Apr 2016					0	0	
Workforce	Your Voice - Response Rate	No			33	-->	-->	18	-->	-->	-->	19	-->	-->	24	-->	-->	21	-->	-->	-->	-->	Dec 2015	18	0	61	11	21		
Workforce	Your Voice - Overall Score	No			3.73	-->	-->	3.28	-->	-->	-->	3.41	-->	-->	3.11	-->	-->	3.40	-->	-->	-->	-->	Dec 2015	3.3	0	3.8	3.9	3.4		
Imaging Group Only	Unreported Tests / Scans	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-								
Imaging Group Only	Outsourced Reporting	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-								
Imaging Group Only	IRMA Instances	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-								

Community & Therapies Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate			Month	Year To Date	Trend
			Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		AT	IB	IC			
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80.0	80.0																			Apr 2016	0	0	0	0		
Patient Safety - Harm Free Care	Falls	<= No	0	0	17	21	22	16	13	30	47	37	25	27	29	29	21	26	31	23	20	22	Apr 2016	0	21	1	22	22	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	1	2	1	1	0	Apr 2016	0	0	0	0	0	
Patient Safety - Harm Free Care	Grade 3 or 4 Pressure Ulcers (avoidable)	<= No	0	0	3	5	2	1	3	3	1	1	3	2	0	0	2	0	3	0	7	2	Apr 2016	0	2	0	2	2	
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			Apr 2016	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0																			Apr 2016	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																			Apr 2016	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Apr 2016	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			1	1	2	1	1	0	1	2	1	3	5	4	4	2	3	6	7	3	Apr 2016	1	2	0	3	3	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			12	3	4	3	6	0	7	6	4	5	7	5	5	5	3	6	7	11	Apr 2016	5	3	3	11		
Pt. Experience - FFT,MSA,Comp	Oldest complaint currently in system (days)	No			81	75	61	82	103	158	0	99	118	140	10	21	40	59	10	25	10	-	Mar 2016	9	10	3	10		

Community & Therapies Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate			Month	Year To Date	
			Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		AT	IB	IC			
Workforce	WTE - Actual versus Plan	No			71	75	76	72.2	77.4	174	92.8	77.3	85.3	87.7	114	124	103	105	94.7	100	106	102	Apr 2016	15	54	32	102.04		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			Apr 2016	96	93	92		93.5	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			Apr 2016	3.1	5.3	4.8	4.7	4.7	
Workforce	Sickness Absence - in month	<= %	3.15	3.15	-	-	-	-	-	-	-												Apr 2016	3.6	3	5.4	4.19	4.19	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	-	-	-	-		-	-												Apr 2016	97	87	84	87.44	87.44	
Workforce	Mandatory Training	=> %	95.0	95.0																			Apr 2016	95	89	92		91.6	
Workforce	New Investigations in Month	No			0	0	0	0	0	1	3	0	0	0	0	0	4	0	0	2	0	0	Apr 2016				0		
Workforce	Nurse Bank Fill Rate	=> %	100	100	-	-	-	-	93	89.5	94.2	89.2	89	89.7	92.2	90.6	95.6	88	88.4	78.3	89.3	87.9	Apr 2016	-	-	-	87.87	87.87	
Workforce	Nurse Bank Shifts Not Filled	<= No	0	0	-	-	-	-	36	41	31	46	72	62	56	48	19	78	90	78	86	87	Apr 2016	-	-	-	87	87	
Workforce	Nurse Bank Use	<= No	5408	451																			Apr 2016				485	485	
Workforce	Nurse Agency Use	<= No	0	0																			Apr 2016				282	282	
Workforce	Admin & Clerical Bank Use (shifts)	<= No	0	0																			Apr 2016				211	211	
Workforce	Admin & Clerical Agency Use (shifts)	<= No	0	0																			Apr 2016				0	0	
Workforce	Your Voice - Response Rate	No			32	-->	-->	28	-->	-->	-->	26	-->	-->	31	-->	-->	21	-->	-->	-->	-->	Dec 2015	30	21	18	21		
Workforce	Your Voice - Overall Score	No			3.88	-->	-->	3.76	-->	-->	-->	3.77	-->	-->	3.68	-->	-->	3.72	-->	-->	-->	-->	Dec 2015	3.6	3.7	3.8	3.72		

Community & Therapies Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Directorate AT	IB	IC	Month	Year To Date
Community & Therapies Group Only	DVT numbers	=> No	730	61	42	47	54	53	55	56	53	67	64	78	59	44	0	24	47	65	51	-	Mar 2016				51	608
Community & Therapies Group Only	Therapy DNA rate OP services	<= %	9	9	13.6	12	12.3	13.9	12.9	13.3	12	14.5	10.7	9.85	10.5	11.4	11	10.5	11.3	9	8.06	9.9	Apr 2016				9.9	9.9
Community & Therapies Group Only	FEES assessment	<= No	100	8	3	2	14	1	2	0	2	0	0	-	-	-	-	-	-	-	-	-	Jul 2015				0	2
Community & Therapies Group Only	ESD Response time	<= Hr	48	48					-	-	-	-	-	-	-	-	-	-	-	-	-	-	Feb 2015				0	0
Community & Therapies Group Only	STEIS	<= No	0	0	0	1	0	0	-	-	-	0	0	0	0	1	0	1	2	1	1	0	Apr 2016				0	0
Community & Therapies Group Only	Rapid response to AMU, RRTS	<= mins	60	60	82	86	79	98	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Feb 2015				98	864
Community & Therapies Group Only	Avoidable weight loss	<= %	20.0	20.0	0	9	0	0	8	0	25	20	0	-	-	-	-	-	-	-	-	-	Jul 2015				0.0	11.8
Community & Therapies Group Only	Green Stream Community Rehab response time for treatment (days)	<= No	11.0	11.0	12.3	13.1	9.5	12.1	13.7	16	14	11	15	15	12	15	17	17	16	24	24	23	Apr 2016				23	23
Community & Therapies Group Only	DNA/No Access Visits	%			1	1	1	1	-	-	-	-	6	1	1	-	1	1	1	1	0	1	Apr 2016				0.66	
Community & Therapies Group Only	Falls Assessments - DN service only	%			45	45	62	54	65	47	55	50	46	44	43	42	41	46	52	55	54	61	Apr 2016				61.34	
Community & Therapies Group Only	Pressure Ulcer Assessment - DN service only	%			48	46	63	57	65	51	55	51	48	44	43	44	33	48	54	56	58	64	Apr 2016				64.17	
Community & Therapies Group Only	MUST Assessments - DN Service only	%			11	10	19	18	-	22	22	24	21	23	23	23	23	26	28	32	32	37	Apr 2016				37.03	
Community & Therapies Group Only	Incident Rates - per 1000 charge	Rate1			4	4	5	4	-	4	5	5	4	4	####	####	####	####	####	####	####	-	Mar 2016				0	
Community & Therapies Group Only	Dementia Assessments - DN Service only	%			52	51	61	62	-	46	56	40	48	45	50	43	50	29	28	31	21	40	Apr 2016				39.77	
Community & Therapies Group Only	48 hour inputting rate	%			85	86	89	83	-	87	89	92	91	94	90	90	94	94	93	94	94	93	Apr 2016				93.45	
Community & Therapies Group Only	Making Every Contact (MECC)	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	7	128	Apr 2016				20.88	20.88
Community & Therapies Group Only	Avoidable Grade 2,3 or 4 Pressure Ulcers (DN Caseload aquired)	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3	2	Apr 2016				2	2
Community & Therapies Group Only	Avoidable Grade 2 Pressure Ulcers (DN caseload acquired)	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3	4	Apr 2016				4	4
Community & Therapies Group Only	Avoidable Grade 3 Pressure Ulcers (DN caseload acquired)	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	2	Apr 2016				2	2
Community & Therapies Group Only	Avoidable Grade 4 Pressure Ulcers (DN caseload acquired)	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	Apr 2016				0	0

Corporate Group

Section	Indicator	Measure	Trajectory Year		Trajectory Month		Previous Months Trend N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Directorate CEO	F	W	M	E	N	O	Month	Year To Date	Trend
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No					6	6	15	5	6	5	7	8	6	15	11	13	8	5	4	5	8	8	Apr 2016	1	0	1	1	0	0	5	8	8	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No					25	12	21	16	18	14	12	14	9	16	16	16	9	8	4	4	7	8	Apr 2016	1	0	1	1	0	0	5	8		
Pt. Experience - FFT,MSA,Comp	Oldest' complaint currently in system (days)	No					104	104	123	145	138	158	99	121	53	24	27	29	27	25	21	26	20	-	Mar 2016	-	-	-	-	-	-	-	20		
Workforce	WTE - Actual versus Plan	No					203	168	175	200	220	260	267	110	99.6	103	100	92.2	89.3	97.8	81.9	83.2	96.4	102	Apr 2016	10.7	0.52	-5	16.2	-2.01	48.3	33.7	102.37		
Workforce	PDRs - 12 month rolling	=> %	95.0	90.0	95.0	90.0																			Apr 2016	97	77	97	92	99	95	93		94.1	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	90.0	95.0	90.0						-						#DIV/0!							Apr 2016			95					100.0	100	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.75	3.15	3.75																			Apr 2016	2.69	2.88	3.48	3.03	3.74	5.49	4.71	4.55	4.55	
Workforce	Sickness Absence - in month	<= %	3.15	3.75	3.15	3.75	-	-	-	-	-	-	-												Apr 2016	1.13	2.51	3.39	3.56	2.60	4.51	3.53	3.75	3.75	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.00	100.0	100.00	-	-	-	-		-	-												Apr 2016	89.0	73.5	54.1	83.5	63.6	85.2	77.7	78.7	78.7	
Workforce	Mandatory Training	=> %	95.0	90.0	95.0	90.0																			Apr 2016	96	93	96	96	98	91	94	93.2	93	
Workforce	New Investigations in Month	No					0	0	1	0	0	1	0	1	2	1	1	5	0	1	2	2	2	4	Apr 2016	0	0	0	1	0	3	0	4		
Workforce	Nurse Bank Use	<= No	1088	1088.00	91	91.00																			Apr 2016								156	156	
Workforce	Nurse Agency Use	<= No	0	0.00	0	0.00																			Apr 2016								18	18	
Workforce	Admin & Clerical Bank Use (shifts)	<= No	0	0.00	0	0.00																			Apr 2016	-	-	-	-	-	-	-	2492	2492	
Workforce	Admin & Clerical Agency Use (shifts)	<= No	0	0.00	0	0.00																			Apr 2016	-	-	-	-	-	-	-	113	113	
Workforce	Your Voice - Response Rate	No					21	-->	-->	15	-->	-->	-->	16	-->	-->	19	-->	-->	15	-->	-->	-->	-->	Dec 2015	67	24	25	20	15	9	10	15		
Workforce	Your Voice - Overall Score	No					3.49	-->	-->	3.48	-->	-->	-->	3.50	-->	-->	3.46	-->	-->	3.58	-->	-->	-->	-->	Dec 2015	3.65	3.44	3.77	3.76	3.59	3.47	3.35	3.58		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Security Management Policy
SPONSOR (EXECUTIVE DIRECTOR):	Colin Ovington Chief Nurse
AUTHOR:	Pat Russell Security Adviser
DATE OF MEETING:	2nd June 2016

EXECUTIVE SUMMARY:

This document outlines the importance of security to the Trust and reinforces the opinion that security management is the responsibility of all managers and staff. The Policy sets out the Trust's security direction until 2020 and identifies how regulatory and legislative changes in recent years have ensured security services are provided to a high standard. The framework proposed by NHS Protect recommend for security management has four guiding principles:

- Governance
- Inform and Involve
- Prevent and Deter
- Hold to Account

Its purpose is to improve levels of safety for staff, patients and the public
It aims to ensure the best use of integrated security systems
The implementation plan outlines the role of the Local Security Management Specialist over a rolling 12 month period in meeting the objectives of the document.
The policy provides an organisational risk profile and the control measures that are in place for each risk.
To protect the assets of the Trust against fraud, dishonesty, vandalism and damage
To develop and maintain working relationships with local stakeholders, NHS Protect, Police and other local agencies.

Board members may be aware that we have now appointed full time leadership for our security arrangements, this role will be key to consistent progression of the security team and the security arrangements necessary to make sure that patients, staff, visitors and our buildings are kept safe and secure. Delivery of the objectives in this policy is dependent upon the whole security team working in different ways to support managers undertaking their responsibility. To enable this there will be a review of the security team working arrangements in quarter two to ensure that the deployment and hours of peak activity are supported and that we consider efficiency and effectiveness of the team comprehensively.

REPORT RECOMMENDATION:

The board are requested to approve the security policy and to agree to the Quality and Safety Committee receiving additional information and updates on progress during the year.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	X	

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial		Environmental	X	Communications & Media	x
Business and market share		Legal & Policy	X	Patient Experience	x
Clinical		Equality and Diversity		Workforce	x

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Key Objective – Good use of resources

Care Quality Commission

- Regulation 13 – Safeguarding service users from abuse and improper treatment
- Regulation 15(1) – Premises and equipment.

PREVIOUS CONSIDERATION:

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST
(INCORPORATING MIDLAND METROPOLITAN HOSPITAL)

PROTECTIVE SECURITY
SECURITY MANAGEMENT POLICY
2016 - 2020

Plan author	Security Adviser
Accountable Executive Lead	Chief nurse
Approving body	Operational Management Committee
Policy reference	SWBH/XXX/NNN [Assigned by Trust policy-Co-ordinator]

ESSENTIAL READING FOR THE FOLLOWING STAFF GROUPS:
1 – All staff

STAFF GROUPS WHICH SHOULD BE AWARE OF THE POLICY FOR REFERENCE PURPOSES:
1 – All staff

POLICY APPROVAL DATE:
Month and Year

POLICY IMPLEMENTATION DATE:
May 2016

DATE POLICY TO BE REVIEWED:
May 2019

DOCUMENT CONTROL AND HISTORY

Version No	Date Approved	Date of implementation	Next Review Date	Reason for change (e.g. full rewrite, amendment to reflect new legislation, updated flowchart, etc.)
1				

PROTECTIVE SECURITY
SECURITY MANAGEMENT POLICY

KEY POINTS

1. This document outlines the importance of security to the Trust and explains how it underpins the Trust's achievement of its objectives and future planning. It reinforces the opinion that like Health and Safety, security management is the responsibility of all managers and staff.

2. The Policy sets out the Trust's security strategic direction until 2020 and identifies how regulatory and legislative changes in recent years have ensured security services are provided to a high standard. It identifies the 4 NHS Protect Principles that security management work to:

    - Governance
    - Inform and Involve
    - Prevent and Deter
    - Hold to Account

3. Its purpose is to improve levels of safety for staff, patients and the public

4. It aims to ensure the best use of integrated security systems

5. The implementation plan outlines the role of the Local Security Management Specialist over a rolling 12 month period in meeting the objectives of the document.

6. The policy provides an organisational risk profile and the control measures that are in place for each risk.

7. To protect the assets of the Trust against fraud, dishonesty, vandalism and damage

8. To develop and maintain working relationships with local stakeholders, NHS Protect, Police and other local agencies.

PLEASE NOTE THAT THIS LIST IS DESIGNED TO ACT AS A QUICK REFERENCE GUIDE ONLY AND IS NOT INTENDED TO REPLACE THE NEED TO READ THE FULL POLICY

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

(Incorporating Midland Metropolitan Hospital)
Protective Security – Security Management Policy - 2014 - 2020

C O N T E N T S

Foreword by the Chief Executive

Security of people and property in the Trust is the concern of all who work in or use the service. The Trust Board will ensure that all possible measures are taken to deliver a properly secure environment for the benefit of all those who work, or receive treatment, within the Trust. This document explains the approach that will be taken to reach this objective.

The Trust's strategic direction over coming years means that we have to make significant changes to the way in which healthcare is organised and delivered and this has implications for the safety and security of our patients, visitors and our staff. Trust assets must be safeguarded against a range of physical threats, including crime (theft, criminal damage, arson, assaults on staff etc), natural hazards (e.g. flooding), and national security threats such as terrorism. Creating an effective structure for engaging with these issues and ensuring high standards of professionalism within this work are key building blocks to ensure real and lasting improvements in the future.

Physical assaults and abuse of staff are particular concerns that are rightly prioritised within our approach to managing security. All those who work so hard to deliver quality patient care and services have the right to do so without fear of violence. Violent or abusive behaviour will not be tolerated and we will press for all appropriate measures to be taken against individuals guilty of such acts where it is appropriate to do so.

Developing and maintaining a pro-security culture where all staff, patients and visitors take responsibility for the safety of people and property within such a large and diverse organisation is no small task. I recognise that we will need the support and assistance of many different stakeholder groups in dealing with the challenges that we will face in continuing with this work.

Everyone working within the Trust has a responsibility to be aware of these issues and to assist in preventing security related incidents or losses. Reductions over time in losses or incidents through the consequences of violence, theft, damage or arson will lead to more resources being freed up for the delivery of better patient care and contribute to creating and maintaining an environment where staff, professionals and patients feel and ***are*** secure.

Toby Lewis

Chief Executive

1. INTRODUCTION

1.1 The management of security underpins the achievement of Sandwell and West Birmingham Hospitals NHS Trust's (known as 'the Trust' hereafter) objectives. The Trust believes that effective security management is imperative not only to provide a safe and secure environment and improved quality of care for service users and staff, it is also significant in the business planning process where a more competitive and successful edge and public accountability in delivering health services is required. Security management is the responsibility of all managers and staff.

1.2 The Trust is committed to working in partnership with staff to make security management a core organisational process and to ensure that it becomes an integral part of the Trust philosophy and activities. The Security Policy represents a developing and improving approach to security management which will be achieved by building and sustaining an organisational culture, which encourages appropriate risk taking, effective performance management and accountability for organisational learning in order to continuously improve the quality of services.

1.3 NHS Protect (formerly the NHS Security Management Service - SMS) leads on work to identify and tackle crime across the health service to protect NHS staff, patients and resources by providing support, guidance and direction to the NHS. This work enables effective prevention, disruption and enforcement action to take place against criminals and criminal activity.

1.4 In order to reduce crime, it is necessary to take a multi-faceted approach that is both proactive and reactive. The Management of Physical Security Policy is an important part of the Security Policy and clearly defines responsibilities for security throughout the Trust. The establishment of these responsibilities ensures that every individual can identify their role and can play their part in the promotion of a positive security culture. The policy also outlines guidance, the national framework and priority areas for the management of physical security of Trust premises to protect:

- Trust property and assets.
- Staff and their property.
- Patients and their property.
- Visitors.

1.5 This document outlines the overarching Security Plan for tackling crime within the Trust and reflects the national policy published by NHS Protect.

2. AIM OF THE POLICY

2.1 This document sets out the strategic direction for security management for the Trust over the next five years - beyond the anticipated opening of the Midland Metropolitan Hospital. The Policy aims to effectively manage crime, through proactive security, effective management systems and the commitment of all managers and staff.

2.2 The Policy has been established to ensure that the Trust fully complies with *'NHS Protect - Standards for Providers - Security Management'* that were introduced on 1 April 2013 under the Health and Social Care Act 2012. The arrangements undertaken previously within Secretary of State's Directions for Dealing with Violence (2003) and Security Management (2004) in April 2013 are now set out in the standard commissioning contract which introduced the requirement to comply with the new security management standards for providers in the NHS - Annex A.

2.3 These new standards are intended to provide information and guidance about safeguards against crime and the loss of or damage to Trust property and equipment, and the consequent disruption of patient care and of business continuity. They are also concerned with protecting the interests and safety of patients, staff, visitors and contractors in respect of offences against persons and property.

3. NHS SECURITY MANAGEMENT, REGULATORY AND LEGISLATIVE CONTEXT

3.1 The security management context in which the Trust is working has changed over recent years to one that is more closely governed and regulated to ensure the delivery of high quality services through a safe and secure environment by means of:

Care Quality Commission:

- Regulation 13 – Safeguarding service users from abuse and improper treatment
- Regulation 15(1) – Premises and equipment.

NHS Protect - Standards for Providers - Security Management – 2012/13.

- Section 17 of the Crime and Disorder Act 1998 requires all local authorities (including NHS Trusts) to exercise their functions with due regard to their effect on crime and disorder, and to do all they reasonably can to prevent crime and disorder.

4. SECURITY PRINCIPLES

4.1 Physical security describes a range of controls that are intended to protect individuals from violence; prevent unauthorised access to sites and / or protectively marked material (and other valuable assets); and reduce the risk of a range of physical threats and mitigate their impact to a level that is acceptable to the organisation. Security must be incorporated into the initial stages of planning, selecting, designing or modifying any building or facility, using appropriate methodologies; putting in place integrated and proportionate control measures to prevent, deter, detect and/or delay attempted 'physical attacks', and to trigger an appropriate response.

4.2 Physical security measures should complement other technical, personnel and procedural controls as part of a 'layered' or 'defence in depth' approach to security that effectively balances prevention, detection, protection and response. For example, perimeter fencing and access control measures may deter an attack because of the difficulties of gaining access; CCTV or intruder alarms might detect an attack in progress and trigger interception; whilst vehicle stand-off, blast resistant glazing and postal screening can minimise the consequences of an attack.

4.3 The following four principles underpin the Policy and are designed to minimise the incidence of crime, and to deal effectively with those who commit crimes against the Trust. These principles apply across the Trust, at all levels:

4.3.1 **Governance.** The Trust will provide leadership for all local anti-crime work by applying an approach that is strategic, co-ordinated, evidence based and intelligence-led by:

- Ensuring that a member of the Executive Board is appropriately trained and responsible for overseeing and providing strategic management and support for all security management work within the Trust.
- Providing sufficient LSMS appropriately trained and approved by NHS Protect and accredited by the professional accreditation board to ensure that

the full range of security management work is undertaken efficiently and effectively.

- Allocating appropriate resources and investment in security management in line with the identified risks.
- Ensuring that security related policies and procedures are kept up to date – principal amongst these are the Trust's Management of Physical Security, Lone Worker, Management of Violence and Aggression and Physical Intervention policies and strategies in relation to Protective Security, CCTV and Access Controls. Such policies and strategies to be consulted through Health and Safety and to Governance Committee.

4.3.2 **Inform and Involve.** The Trust will:

- Actively work in partnership with the Department of Health, commissioners, as well as our key stakeholders, such as our staff, patient groups, the Police, the CPS, local authorities and professional organisations, to coordinate the delivery of our security management work and to take action against those who commit offences against the Trust.
- Inform and involve all those who work for or use the Trust about crime and how to tackle it. This will take place through communications and promotion such as emails, Team Brief, Heartbeat articles and local/national awareness initiatives.
- Provide the LSMS with the information and the intelligence needed in order to be able to prevent, detect and investigate crime.

4.3.3 **Prevent and Deter.** The Trust will:

- Establish a safe and secure environment that has systems and policies in place to: protect NHS staff from violence, harassment and abuse; safeguard NHS property and assets from theft, misappropriation or criminal damage; and protect resources from fraud, bribery and corruption.

- Work towards preventing and deterring crime, to take away the opportunity for crime to occur or to recur and discourage those individuals who may be tempted to commit crime. Successes will be publicised where appropriate so that the risk and consequences of detection are clear to potential offenders. Those individuals who are not deterred should be prevented from committing crime by systems, which will be put in place in line with policy, standards and guidance developed by the Trust and NHS Protect.

4.3.4 **Hold to Account.** The Trust will:

- Lead, within a clear professional and ethical framework, investigations into serious violence and security incidents and will hold to account those who have committed crime against it, seek to apply a wide range of sanctions.

- Seek redress through the criminal and civil justice systems against those who commit security incidents or breaches, whose actions lead to the loss of NHS resources and to ensure that victims are fully supported.

- Seeking redress should be conducted in partnership with the police and other crime prevention agencies.

- Involve NHS Protect with cases which are complex or of national significance through their Legal Protection Unit (LPU).

- The Trust will strive to ensure that recovery of monies lost to crime will be pursued.

5. ACTION

5.1 LSMS Workplan. The key individuals responsible for advising on the development of Security Management at the Trust are the Security Management Director and the Local Security Management Specialist. These individuals shall agree an annual LSMS work-plan in accordance with the work streams identified by NHS Protect and the local requirements of the Trust. The work plan considers the risks to security and controls necessary to mitigate those risks and is submitted to the Trust's Quality and Safety Committee on an annual basis prior to submission to NHS Protect. Progress is reviewed and reported upwards to the Trust Board via the Quality and Safety Committee on a 6-monthly basis.

5.2 Annual Security Report. Will be produced by the LSMS and submitted to the Trust's Quality and Safety Committee and Health and Safety Committee on an annual basis

5.3 Security SWOT Analysis. An analysis of the Trust's security strengths, weaknesses, opportunities and threats (SWOT) relating to security management is at Annex B.

5.4 Security Management Implementation Plan. Specific action in relation to strategic security management work is detailed at Annex C.

5.5 Security Risk. Will be managed in accordance with the Trust's Management of Physical Security Policy; the Organisational Risk Assessment is at Annex D.

5.6 Compliance. Security Management work is undertaken with regard to the requirements of the NHS Security Management Service; the Care Quality Commission; the NHS Litigation Authority, primary and secondary legislation and other guidance as occasionally issued by other statutory bodies etc.

5.7 Working in Partnership with Stakeholders. The LSMS will work in partnership with key stakeholders, particularly with the local police in accordance with the Crime and Disorder Act and also our local communities through such forums as Community Safety Partnerships, the Summerfield Police Liaison Committee, and the local Neighbourhood Watch Committees. Intelligence exchanged between the Trust and these organisations will help inform the Trust of particular areas of concern for which crime prevention strategies can be formulated and implemented locally.

6. IMPLEMENTATION

6.1 The LSMS is responsible for ensuring:

6.1.1 **Implementation.** The implementation of the Security Management Policy, by:

a. The creation and review of all security related policies and procedures to empower staff to deal with security situations as they arise
b. Appropriate assessment of security risks in line with Risk Management Policy
c. Promote completion of incident forms relating to security, reviewing all security incidents, investigation as required and escalating as appropriate.
d. Ensuring assaults against staff are dealt with appropriately by the Police and that staff are fully supported through the process

6.1.2 **Communication.** The Security Management Policy is communicated by way of:

a. Promotion throughout the Trust via the Health & Safety Committee and Team Brief.
b. Through induction training and Conflict Resolution Training

c. Production of quarterly briefs for inclusion in the Trust's Staff newspaper
d. Highlighting successful prosecutions in partnership with the Communications Department.

7. MONITORING AND COMPLIANCE

7.1 NHS Protect may quality audit the Trust's compliance with the NHS Security Management Standards for Providers at any time. Their findings may be reported to the Health and Safety Executive (HSE), National Health Service Litigation Authority (NHSLA) and Care Quality Commission (CQC).

7.2 The Trust's Quality and Safety Committee will monitor anti-crime work across the organisation on a 6-monthly basis by monitoring progress and compliance against the NHS Security Management Standards for Providers; and the appropriate security and safety requirements of the CQC and the NHSLA against the LSMS Security Management Work Plan; progress will also be included within the Annual Security Report.

7.3 The Trust Health & Safety Committee will receive quarterly security management reports and the Annual Security Report from the LSMS. The Committee will also monitor, record and make recommendations where concerns are identified concerning security management and anti-crime work.

8. KEY OUTCOMES OF SUCCESS

8.1 The following indicators will be used to demonstrate that this Policy is implemented effectively:

- Working towards and then maintaining compliance with NHS Protect - Standards for Providers 2013 / 14 - Security Management and any other security management standards subsequently produced.
- Maintaining compliance with CQC regulations 13, 15 and other security related outcomes subsequently produced.
- A year on year reduction in the number of Trust reported violence and aggression incidents.
- A year on year reduction in the number of staff 'experiencing' violence as reported through the National Staff Survey.

9. CONSULTATION & COMMUNICATION WITH STAKEHOLDERS

9.1 All staff could potentially be victims of criminal activity at some time. As such, in addition to those with defined responsibilities in security management all staff are considered to be stakeholders.

9.2 The Trust's Health & Safety Committee is identified as the high level committee identified as primary stakeholders for communicating and consulting with staff on security issues and policy.

9.3 Others consulted include the Security Management Director (Chief Nurse), the Head of Estates, Head of Risk Management, Head of Health and Safety and the Clinical Leadership Executive.

10. TRAINING

10.1 The Trust's LSMS is trained and accredited to carry out their duties in accordance with this policy. The LSMS will attend other training, conferences, seminars as and when deemed necessary to enable them to carry out their duties efficiently and effectively as required by NHS Protect.

10.2 The LSMS is responsible for ensuring that the Security Team Leaders and security officers are at all times properly and adequately notified, trained and instructed (including if reasonably practicable by way of continuing professional development) to a level commensurate with the task that has to be performed.

10.3 All members of staff are made aware of their responsibilities for security through health, safety and security training which forms part of the Trust's mandatory training programme. All new staff are required to attend this training as part of their induction into the Trust and relevant refresher training as identified by Departmental and Trust Training Needs Analysis.

10.4 Training is recorded on the Electronic Staff Record held within Workforce. The process for monitoring compliance with training is undertaken in line with reporting process contained within the Mandatory Training Policy.

10.5 Security management and conflict resolution training for front line staff is included as a component of corporate induction as it is important that all staff know how security affects them and what role they have to play in keeping themselves safe and the Trust secure. Additional conflict resolution training will be provided to staff on a risk evidenced basis.

11. EQUALITY AND DIVERSITY

11.1 The Trust recognises the diversity of the local community and those in its employment. Our aim is, therefore, to provide a safe and secure environment free from discrimination and a place where all individuals are treated fairly, with dignity and appropriately to their need. The Trust recognises that equality impacts on all aspects of its day-to-day operations and has produced an Equality Policy Statement to reflect this. All policies are assessed in accordance with the SWBH Equality Impact Assessment Toolkit, the results for which are monitored centrally.

12. REVIEW

12.1 The Policy will be reviewed on an annual basis to ensure alignment with the Trust's strategic objectives and key priorities.

13. CONCLUSION AND RECOMMENDATION

13.1 The Protective Security Plan identifies the structures and processes that protect people and property as required by legislation and regulatory compliance frameworks.

14. TRUST ASSOCIATED DOCUMENTS

- Trust Access Control Plan 2014 – 2020
- Trust CCTV Plan 2014 - 2020
- Management of Physical Security Policy

- Management of Violence and Aggression Policy
- Physical Intervention Policy
- Lone Working Policy
- CCTV Policy
- Deployment of Armed Police Policy
- Treatment of Prisoners from Birmingham Prison Policy
- Confiscation of Illegal Drugs Policy
- Missing Baby, Child, Young Adult Policy
- Missing Patients Policy
- Lost & Found Property Policy
- Risk Management Policy
- Health & Safety Policy
- Incident Reporting Policy - Policy and Procedure for Reporting, Managing and Investigating Incidents (including Serious Incidents Requiring Investigation (SIRIs)
- Fire Safety Policy
- Standing Financial Instructions and Standing Orders
- Whistle Blowing Policy

15. REFERENCES

The following are important references, although by no means an exhaustive list, in relation to the Policy:

- HMG Security Policy Framework April 2013.
- NHS Protect - Standards for Providers - Security Management.
- Care Quality Commission:
- NHS Security Management Manual. Web-based manual. (Restricted access).
- Tackling Crime against the NHS – A Strategic Approach
- Health & Safety at Work Act 1974

ANNEX A

STANDARD COMMISSIONING CONTRACT – SECURITY RELATED CLAUSES

The clauses relating to counter fraud and security management introduced in 2013 in the standard contract have changed significantly, so that they are applicable to all providers regardless of their size and service type, and are consistent with the duty to promote autonomy. The new arrangements apply to providers as contracts are put in place or renewed. Existing providers continue to work under the current framework until their contract is renewed.

The new clauses are explained below:

Clause 37.1 - requires all providers to put in place appropriate counter fraud and security management arrangements prior to the commencement date of the contract.

Clause 37.2 - requires all providers to carry out a crime risk assessment within one month of the contract commencement date, using the toolkit developed by NHS Protect (see above). The toolkit is designed to ascertain the baseline level of risk to a provider before any action to mitigate that risk has been taken.

Clause 37.3 - requires providers to mitigate any identified risks in line with NHS Protect guidance. Providers will therefore be required to meet the standards set in relation to their level of risk (see above). The provider will be required to report against them as part of the quality assurance process.

Clause 37.4 - enables the commissioner's Local Counter Fraud Specialist (LCFS) or LSMS to review the counter fraud or security management provisions put in place by the provider and requires the provider to implement any modifications recommended.

Clause 37.5 - enables NHS Protect, or a person authorised to act on its behalf, to review the provider's counter fraud and security management provisions and requires providers to implement any modifications recommended by NHS Protect.

Clause 37.6 - requires the provider to report any suspected fraud or corruption involving NHS funds to the LCFS of the relevant NHS body and NHS Protect and any security incident or breach to the LSMS of the relevant NHS body and NHS Protect.

Clause 37.7 - requires the provider to ensure that NHS Protect is given access within five operational days to property, premises, information and staff for the purpose of detecting and investigating cases of fraud and corruption.

ANNEX B

SECURITY MANAGEMENT - SWOT ANALYSIS

Strengths	**Weaknesses**
• LSMS in post working to a clear strategic security management framework. • 24/7 security teams at City and Sandwell Hospitals with wide ranging internal and external CCTV systems, monitoring access control systems, building alarms and emergency telephones. • Incident reporting system and risk management processes in place that identify risks and channels effective mitigation of those risks. • Security policies in place for Physical Security, Physical Intervention, Lone Working, CCTV, Deployment of Armed Police, Treatment of Prisoners from Birmingham Prison, Confiscation of Illegal Drugs, Infant/Child Abduction, Missing Patients, Lost & Found Property • All wards, theatres, ED's, MAU/EAU, Endoscopy, MRI, Pharmacy, Pathology, Nuclear Medicine, Cash Offices, Blood Banks and other Trust critical infrastructure are secure e.g. Switchboard, IT Hubs. • A baby tagging system is in place. • All front line staff receive CRT training and additional conflict management training on a risk evidenced basis.	• Leadership - potential lack of Board awareness of security requirements and issues • Currently in a period of transition bringing together different security cultures – acute and community. • Staff from hospital settings may be inexperienced working in community settings and vice versa as the RCRH model of care is rolled out and the Trust's commitment to sustained community development is rolled out. • No training available for managing patients with 'challenging behaviour'. • Staff reluctance to pursue prosecutions for violence and aggression. • No resources for short-term fast paced anti-crime initiatives. • NHSP withdrawal of support for CJIA training. • NHSP expectations for new standards implementation is resource intensive.
Opportunities	**Threats**
• Development of a Security Plan to set clear objectives and demonstrate assurance for the quality of security management within the Trust beyond opening of MMH and the development of community facilities aligned to the Trust's strategic objectives and key priorities. • Ensure that security is seen as a business enabler, forms an integral part of Trust philosophy, practices and business plans and is viewed as an integral part of the healthcare process. • Enhanced management confidence when subject to internal/external security audits. • Introduce new advanced integrated security technologies, IP networking and operational security working practices for MMH and associated community facilities. • Work with NHSP and other providers to introduce new CRT to manage challenging behaviour and reduce violence against staff. • Improve morale and efficiency of staff and the public image of the organisation that may be affected by the occurrence of security incidents while reducing costly litigation and insurance premiums. • To build strong relationships with the local police force and CPS. • Greater accountability for property, equipment and cash, leading to loss reduction.	• Pace of change and availability of funding and resources does not always allow for suitable security infrastructure to be in place in time or at all. • Care is provided in a range of physical environments, not all of which are owned by the Trust, and which have variable security arrangements. • Ageing population – increase of violence to staff from patients with challenging behaviour. • Reduced policing in West Midlands impacting on their ability to respond to the Trust. • Changing economic climate – possibility of increased theft of Trust property and trespass/damage in Trust unoccupied buildings. • Societal changes – terrorist activity by UK and internationally based individuals and groups.

ANNEX C

SECURITY MANAGEMENT POLICY - IMPLEMENTATION PLAN - 2014 TO 2020

Objective	Lead	Completion date	Action
Complete and submit to NHS Protect the Trust Organisation Crime Profile	LSMS	April (annually)	LSMS to collate information with assistance from other stakeholders i.e. Finance, Estates, HR, etc. and ensure timely submission to NHS Protect.
Prepare Standards for Providers – Security Management documentation to enable submission to NHS Protect	LSMS	June (annually)	LSMS to collate information with assistance from other stakeholders i.e. Finance, Estates/Capital Projects, Workforce, etc and ensure timely submission to NHS Protect.
Develop and implement a compliance framework to support future assessment of Trust compliance with NHSP Standards for Providers – Security Management, ensuring evidence of compliance is contemporary at all times	LSMS	July 2013 and continually thereafter	Develop, implement and maintain a Trust wide system for obtaining, collating and storing required evidence of compliance.
Ensure NHS Protect guidance is reviewed in a timely manner and underpins the Trusts strategic direction / delivery for Security	LSMS	Ongoing/routine	Remain abreast of all published guidance and advise the Trust concerning required actions
Prepare Annual Violence Against Staff Report for submission to NHS Protect	LSMS	June (annually)	LSMS to develop and submit to NHS Protect for action, SMD/H&S Committee for information and Audit & Risk Committee for compliance.
Prepare LSMS Annual Security Workplan to enable submission to NHS Protect June	LSMS	April (annually)	LSMS to develop Workplan against the security standards of NHS Protect, the CQC and NHSLA and submit to SMD for approval, H&S Committee for information and Audit & Risk Committee for compliance.
LSMS to undertake work set out in the LSMS Workplan	LSMS	April (annually)	LSMS to work towards achieving objectives with the assistance of key staff members.

Objective	Lead	Completion date	Action
Report on progress of work set out in the LSMS Workplan	LSMS	October (annually)	LSMS to provide report on progress to the Audit & Risk Committee for compliance purposes.
Complete Annual Security Report	LSMS	June (annually)	LSMS to develop and submit Annual Security Report (covering the LSMS Workplan and Exception Report if appropriate) to SMD for approval, H&S Committee for information and Audit & Risk Committee for compliance.
Develop Protective Security - Security Management Plan 2014-20 for the Trust	LSMS	December 2014	Develop a policy that meets the requirements of the Trust with options (as appropriate) should MMH not be built.
Develop Protective Security - CCTV Plan 2014-20 for the Trust	LSMS	December 2014	Develop a policy that meets the requirements of the Trust with options (as appropriate) should MMH not be built.
Develop Protective Security - Access Control Plan 2014-20 for the Trust	LSMS	December 2014	Develop a policy that meets the requirements of the Trust with options (as appropriate) should MMH not be built.
Work with stakeholders to undertake 'routine' security related risk assessments ensuring identified risks are appropriately escalated	LSMS	Ongoing/routine	LSMS to advise stakeholders on appropriate course of action so that risks can be reduced or mitigated wherever possible.
Undertake corporate physical security risk assessments for the provision of a secure environment ensuring identified risks are appropriately escalated.	LSMS	April (annually)	LSMS to identify, develop and deliver a programme of physical security improvements in conjunction with Estates/Capital Projects where resources and investment permit.
Identify physical security requirements for MMH, community facilities, agile working and reconfiguration / refurbishment of buildings and relocation of services making best use of integrated security systems and IP networks.	LSMS	Ongoing/routine	Work collaboratively with Estates/Capital Projects, provide physical security advice and incorporate within the design stage wherever possible to reduce costs.
Ensure Trust security related policies remain contemporary and that a review of content is	LSMS	Ongoing / routine	Regular review and evaluation of security related policies ensuring content is risk/evidence based and reflects

Objective	Lead	Completion date	Action
undertaken as a minimum every three years or as required			legislation/guidance.
Provide advice concerning the development of Trust wide security related training.	LSMS	Ongoing	Work with Head of L&D to ensure security mandatory training, Conflict Resolution Training (including Challenging Behaviour, Breakaway and MAPA training) is provided where appropriate and reflects appropriate guidance at all times.
LSMS to respond to reported assault on staff at earliest opportunity	LSMS	Ongoing	Work with Ward/Dept to ensure that staff are treated and fully supported by ward manager / matron if they have been assaulted / traumatised, patients cared for, staff replacement considered, Police called where appropriate, log/crime numbers obtained and statements/impact statement provided, violent/extremely agitated patients risk assessed, care plans amended and MH involvement where required
LSMS to further develop effective relationships with Police, CPS, other agencies and stakeholders to ensure that action is taken against those who commit crime at the Trust.	LSMS	Ongoing/routine	Work with agencies to apply sanctions, seek redress, recover financial losses and publicise successful prosecutions internally/externally as appropriate.
Ensure that NHSP Alerts and other crime prevention information is issued to staff and engage with the public.	LSMS	Ongoing/routine	LSMS to distribute to relevant staff groups to raise awareness of security risks and incidents and appropriate course of action to take through secure email, Heartbeat, Team Brief and engage with staff/the public to raise the profile of security management work / anti-crime measures through security awareness events.
LSMS to attend agreed LSMS training & development	LSMS	Quarterly and as required	Attend all required LSMS training including Regional LSMS quarterly meetings, CPNI training and other training/professional development as required.

Sandwell and West Birmingham Hospitals NHS Trust

1111CSEC07 - ORGANISATIONAL (CORPORATE) SECURITY RISK ASSESSMENT

Assessor: Trust Security Adviser	**Risk Assessment No:** **1111CSEC07**	**Overall Risk Assessment Score** (highest original corporate risk score)**: After all Mitigation: 12 (3 x 4)** **(See individual corporate security risk assessments)**	
Area / Speciality **Facilities**	**Date of Assessment:** **7 Mar 13** **Date of Assessment Review:** **1 Mar 2016**	**Location of Risk:** **Trustwide**	**Type of risk** (e.g., clinical, non clinical, finance) **Non-Clinical**

Organisational Risk Assessment for Physical Security of People, Property and Places

Purpose

To provide an overview of the corporate security risk assessments and countermeasures to a range of hazards, threats and vulnerabilities that may affect:

- The safeguarding of Staff, Patients and Visitors
- Trust property/assets
- Financial risk from potential loss of life / serious injury / litigation
- Financial risk from disruption / reduction / loss of service delivery / business continuity
- Financial risk from loss of income to Trust

- Trust reputation from adverse publicity
- Private property

to ensure the continuing provision of healthcare in a safe and secure environment. This could be as a result of a terrorist incident or other major incident off-site resulting in large numbers of acute/medical self-presenters, or in response to other significant security incidents / breaches / criminal activity on-site e.g. fire, infant abduction, treatment of gang/terrorism related ballistic/blade injuries in A&E, bomb threat, armed hostage taking, missing patient, human diseases, theft and criminal damage etc.; Major Incident Declared (On-Site) e.g. mass public disorder, or an environmental disaster e.g. tornado, flooding. Major Incident Declared off-site e.g. attacks on crowded places and transport systems, CBRN incidents.

Drivers

The Terrorist Threat*:* There is no direct terrorist threat to the NHS however a terrorist attack resulting in multiple casualties could impact on the Trust. The current threat level from international terrorism is ***Severe***; this means that ***a terrorist attack is highly likely****.* The current threat level on the mainland from terrorism related to Northern Ireland is ***Substantial;*** this means that ***a terrorist attack is a strong possibility***. As the threat level changes (upwards), the dynamic urgency to implement additional controls will accelerate concomitantly.

Local Crime: The level of crime and anti-social behaviour for the area in/around Trust Hospital sites is generally ***above average*** compared to the rest of England and Wales – source Police.UK. However, reductions in Police staffing and significantly reduced 999 response times will initially require the Trust to 'stand alone' in dealing with a Major or other serious incident.

Legislation/Policy/Guidance*: NHS Protect Security Management Standards and Security Management Manual (Confidential);* Civil Contingencies Act 2004; NaCTSO Counter Terrorism Protective Security Advice for Health (2009); NHS Protect Guidance for Lockdown 2009 and Security Management Standards 2013;NHSLA Standard 3.1b: Secure Environment (Lockdown) (2010/11); NHS Interim Guidance: Planning for the Evacuation and Sheltering of People in Healthcare Sector Settings (2009);); HBN 00-07: Resilience Planning for the Healthcare Estate Section 2.13 (2007); HSAW 1974: Safe and Secure Environment; Articles 5 and 12, Human Rights Act 1997: West Midlands Conurbation Resilience Forum Community Risk Register.

	Target/Threat	Offender	Control measures in place	Assessment of risk and outstanding Actions
People	Physical Assault	Family members, Visitors Patients Staff	Policy Conflict-Resolution Training Security Service Signage Sanctions	Risk is determined on a geographical / service basis through assessment of: • departmental physical controls; • departmental procedural controls; • corporate physical controls; • corporate procedural controls; and actions given to departmental services.
	Verbal Assault	Family members Visitors Patients Staff	Policy Conflict-Resolution Training Security Service Signage Sanctions	
	Community Staff/Lone Workers	Patients Family members Other parties	Policy Conflict-Resolution Training	
	Intrusion	Unauthorised person.	Security Service	

	Target/Threat	Offender	Control measures in place	Assessment of risk and outstanding Actions
		Potential thief / arsonist	Access / egress controls Intrusion detection systems CCTV systems Security lighting Signage ID cards/name badges Local Procedure	
	Abduction	Estranged family member Other parties	Policy Security Service Access / egress controls CCTV systems Baby abduction alarm system Security lighting	

	Target/Threat	Offender	Control measures in place	Assessment of risk and outstanding Actions
Property	Theft-organisational major	Staff Organised thief	Security Service Secure storage Access / egress controls Medical devices asset management CCTV systems Security lighting Intrusion detection systems ID cards/name badges	Risk is determined on a geographical service basis by considering vulnerabilities and assessment of: • departmental physical controls; • departmental procedural controls; • corporate physical controls; • corporate procedural controls; and actions given to departmental services.
	Theft-organisational moderate and minor, e.g. Small medical equipment and disposables, multimedia equipment.	Staff Organised thief Opportunist Thief	Security Service Secure storage Access / egress controls Medical devices asset management CCTV systems Security lighting	

	Target/Threat	Offender	Control measures in place	Assessment of risk and outstanding Actions
			Intrusion detection systems ID cards/name badges	
	Theft- personal property, money, clothes	Staff Organised thief Opportunist Thief	Security Service Access / egress controls CCTV systems Security lighting Intrusion detection systems Secure storage - lockers Office/desk locks Signage ID cards/name badges	

	Target/Threat	Offender	Control measures in place	Assessment of risk and outstanding Actions
	Drugs, medication and prescription forms	Staff Organised thief Opportunist thief	Security Service Access / egress controls Secure storage – general Secure storage – CD Access management – CD ID cards/name badges	
	Hazardous substances - Schedule	Staff Organised thief	Security Service Access / egress controls Secure storage Access management Annual CTSA Audit CCTV systems Security lighting Intrusion detection systems	

	Target/Threat	Offender	Control measures in place	Assessment of risk and outstanding Actions
			ID cards/name badges	
	Hazardous substances - other	Staff Organised thief Opportunist thief	Policy Security Service Access / egress controls Secure storage CCTV systems Security lighting ID cards/name badges	

	Target/Threat	Offender	Control measures in place	Assessment of risk and outstanding Actions
Organisation	Terrorism incl domestic extremism Mass public disorder Mass casualties Major Incident on-Site Major Incident Off-Site Technological events Environmental events Loss of Business/Increased Costs Low Morale All affecting the continuing provision of healthcare and potentially Trust reputation	Staff Members of the public	Major Incident Plan Mass Casualty Plan Security Service Health Emergency Planning Officer Communications Department Access / egress controls Physical barriers CCTV systems Security lighting Public address systems Intrusion detection systems ID cards/name badges Development of Lockdown Risk Profiles, Policy and implementation of additional associated physical security measures	Risk is determined on a geographical / service basis by considering vulnerabilities and through assessment of: • departmental physical controls; • departmental procedural controls; • corporate physical controls; • corporate procedural controls; and actions given to departmental services.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD - PRIVATE

DOCUMENT TITLE:	**Draft Annual Report and Quality Account**
SPONSOR (EXECUTIVE DIRECTOR):	**Toby Lewis, Chief Executive**
AUTHOR:	**Ruth Wilkin, Director of Communications**
DATE OF MEETING:	**2 June 2016**

EXECUTIVE SUMMARY:

Attached is the draft Annual Report and Quality Account. There is a nationally prescribed format in terms of content. The Board is asked to consider and adopt the Annual Report and Quality Account which will be presented at the Annual General Meeting.

REPORT RECOMMENDATION:

The Board consider and adopt Annual Report and Quality Account.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	x	

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial	X	Environmental		Communications & Media	x
Business and market share		Legal & Policy		Patient Experience	x
Clinical	**x**	Equality and Diversity	x	Workforce	x
Comments:					

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

PREVIOUS CONSIDERATION:

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Listening and learning





Integrated Annual Report and Accounts 2015/16

Incorporating the Quality Account and the Trust charity annual accounts

Where EVERYONE Matters

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Contents

Front cover images

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

1. Introduction

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

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

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

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

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

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

Richard Samuda
Chairman

Toby Lewis
Chief Executive

About Sandwell & West Birmingham Hospitals NHS Trust

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

Our teams are committed to providing compassionate, high quality care from City Hospital on Birmingham's Dudley Road, from Sandwell General Hospital in West Bromwich, and from our intermediate care hubs at Rowley Regis and at Leasowes in Smethwick (which is also our stand-alone Birth Centre's base). The Trust includes the Birmingham and Midland Eye Centre (a supra-regional eye hospital), as well as the Pan-Birmingham Gynae-Cancer Centre, our Sickle Cell and Thalassaemia Centre, and the regional base for the National Poisons Information Service – all based at City. Inpatient paediatrics, most general surgery, and our stroke specialist centre are located at Sandwell. We have significant academic departments in cardiology, rheumatology, ophthalmology, and neurology. Our community teams deliver care across Sandwell providing integrated services for children in schools, GP practices and at home, and offering both general and specialist home care for adults, in nursing homes and hospice locations. Our new hospital – the Midland Met – is currently under construction and will be open in Autumn 2018. It is located on Grove Lane, on the Smethwick border with west Birmingham.

Over the last year:

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

One of the 'home from home' rooms in our 'midwife led' birth centre Serenity.

In 2016 we displayed a banner describing the future of services in Sandwell & West Birmingham Hospital NHS Trust.

2. Performance Report

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

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

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

Performance Overview

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

1. Complaints improvement

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

2. Community Care Quality Commission rating

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

3. A learning organisation

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

4. Securing the new Midland Metropolitan Hospital

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

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

5. Completing the redevelopment of Rowley Regis Hospital

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

6. Tackling readmission rates

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

7. Delivering our goals for public health

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

8. Cancer standards

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

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

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

9. End of life care

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

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

This year we have been awarded the new End of life contract for Sandwell and West Birmingham starting in April 2016. This will see exciting advancements in end of life care which includes the implementation of a new coordination hub. The hub will provide a single point of access for patients, relatives and professionals for advice, information and appropriate signposting or treatment where required. The hub will coordinate services from health, social care, the voluntary sector and local hospices to enable patients to receive improved care at the end of life and die in a place of their choosing. The hub will also be supported by a new urgent response team who will visit patients at home at a time of crisis to prevent the need for unnecessary hospital admissions.

10. Positive feedback on our medical training programme

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

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

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

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

How we performed against our priorities

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

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

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

Priorities we did not fully deliver

Reducing delayed discharges and discharge before lunch

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

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

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

Corporate services

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

Implement the new tariff regime

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

Financial balance

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

Tackling sickness absence

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

Respiratory medicine

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

Our 'capacity plan'

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

Achieving the gains promised within our 10/10 programme

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

Tackling caseload management in community teams

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

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

Effective management of our risks

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

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

The Trust continues to implement an electronic risk system. This enables clinical groups and corporate directorates to import their risk registers and update actions directly. This will become fully operational in quarter 1 of 2016/17.

Partnerships with a purpose

Forming the Black Country Alliance on Black Country Day

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

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

Voluntary Sector collaboration

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

GP partnerships

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

Local authority partnerships

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

Right Care Right Here

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

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

Terry Cordrey, ADAPT Project Lead.

Our commissioners

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

How our groups performed

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

Community & Therapies

Budget: £48million
Headcount: 935 staff

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

Key Achievements

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

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

Listening and learning

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

Future plans

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

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

Imaging

Budget: £17.1million
Headcount: 297 staff

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

During the year we completed:

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

Key Achievements

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

Listening and learning

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

Philip Bonehill, Imaging Support Worker, by the old CT scanner at City Hospital. We agreed a managed equipment service so that our patients benefit from the most up to date diagnostic care.

Future plans

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

Pathology

Budget: £19.4million
Headcount: 328 staff

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

The last year has seen a number of new initiatives in our Pathology Department where key objectives are to ensure clinical science improves patient care and experience.

Key achievements

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

Listening and learning

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

Biomedical Scientist Nisha Gomez in her lab at Sandwell Hospital.

Future plans

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

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

Surgery A

Budget: £61.7million
Headcount: 1,039 staff

The Surgery A group includes trauma & orthopaedics, general surgery, breast surgery, plastic surgery, vascular surgery, urology, anaesthetics and critical care. This is a large group providing surgery and critical care for our patients. General surgery and orthopaedics is mainly delivered from Sandwell, plastic and urology is delivered from both the City and Sandwell sites and there are critical care wards at both main acute sites. We treat patients who present to our A&E departments with acute surgical or orthopaedic emergencies, besides performing a large number of elective operations. Over the last year we've seen 43,892 new attendances and 45,391 reviews.

Key achievements

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

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

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

Listening and learning

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

Future plans

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

Surgery B

Budget: £28.3million
Headcount: 395 staff

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

Key achievements

- In BMEC theatres we are now in our second year of supporting apprentices through the year long Clinical Health Care level 2 programme. Our two students in 2015/16 have felt part of the team and believe their confidence has increased with dealing with other people. Due to complete in August 2016 – one apprentice wants to carry on with ODP training and the other into nurse training – both fantastic examples of helping to develop our local community to believe in themselves and continue a career within the caring professions. Our Eye ward has supported another apprentice through the administration pathway, developing many transferable skills and this apprentice has been successful in securing an interview for a ward clerk position, again, highlighting the success of this scheme.

Bushra Mushtaq was appointed Clinical Director for Opthalmology.

- Safety is paramount within Surgery B and in BMEC Theatres we were delighted to see our hard work recognised at the Annual SWBH Awards, winning the Patient Safety Award. The culture within theatres has developed so that all staff consistently follow correct processes for ensuring the right patient is operated on each and every time. All staff feel empowered to raise concerns and call a 'hard stop' in the knowledge that they will always be supported.

- As part of a review of our service provision, it was identified that the Intravitreal Injection Service (where anti vegf treatments are injected into the back of the eye to help reverse the progress of macular degeneration) could move from a doctor-led to a nurse -led service. With support from Ziad Abdel Karim (Advanced Nurse Specialist) and Ms Bushra Mushtaq (CD for Ophthalmology) five staff have been assessed as competent and are administering up to 650 injections a month. New models of working, with nurses and allied health professionals utilising their skills, is seen as being integral to the success of our services.

- The Trust has developed a clever online web-based tool, designed to enable patients to be managed in a community setting with quicker implementation of altered clinical management plans. Previously, optometrists and dentists were unable to use the NHS e-Referral Service as GPs did, in order to receive timely responses from speciality consultants about clinical queries regarding their patients. Timely guidance (received within one working day) means safer care for patients and reduced demand on specialist clinic appointments.

- A pioneering treatment for a blinding eye disease developed at BMEC has been awarded a £560,000 research grant. A project to develop software to monitor patients with blinding inflammatory eye disease uveitis has been given a Health Improvement Challenge Grant by the Wellcome Trust.

- The Trust has become the first in the UK to use 3D technology in eye surgery, by trialling a £60,000 system at BMEC. Traditionally, eye surgeons use a surgical microscope to perform eye surgery, which requires the surgeon to hold the same posture for many hours, depending on the complexity of the surgery. With this new 3D technology, surgeons can look at the large monitor and see the different layers of the eye in higher definition. By using this technique, surgeons can perform intricate surgery much more precisely, thus improving the surgical outcomes for patients.

Listening and learning

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

Future plans

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

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

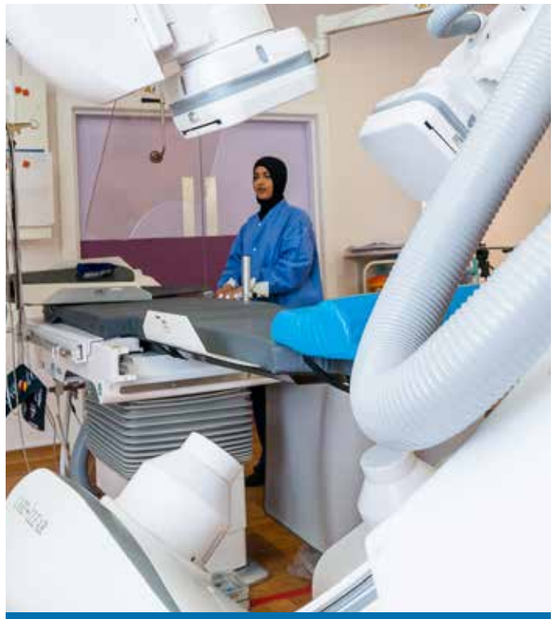
Medicine and Emergency Care

Budget: £107.5million
Headcount: 1,575 staff

The medicine and emergency care group includes over 301 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, RAID and toxicology. The directorate of admitted care covers elderly care, stroke, neurology, neurophysiology, cardiology and all ward clinical teams. The directorate of scheduled care covers gastroenterology, respiratory, dermatology, diabetes and renal, rheumatology and immunology and haematology/oncology.

Key achievements

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



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

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

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

Future plans
The Fixing our Future project aims to review our care model to help us meet the future demands of our patients. The general objective of this project is to make sure that we can provide outpatients clinics that will be as close as possible to where patients are or where they want to be seen. This will play a vital role in helping us deliver the Trust's vision "Right Care Right Here". We will also be setting up a centralised medical infusion unit which will deliver constant and appropriate care for patients requiring intravenous and subcutaneous treatment by nursing staff of appropriate skill set. The medical infusion suite (MIS) is based in a central location on the main spine of City hospital previously known as the surgical assessment unit. It is proposed that a single infusion unit will operate at Midland Metropolitan Hospital which will open in October 2018. Establishing the medical infusion units (MIS) at City hospital will facilitate a simple change of location in 2018.

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

Women's and Child Health

Budget: £48million
Headcount: 935 staff

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

Key achievements

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

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

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

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

provision. As well as investigations such as scans being more widely available in community venues, pregnant women will have access to their maternity records via online technology by 2020 as we look to be a beacon of excellence in maternity care which continues to receive positive feedback from women. We will do all of this while continuing to work with the community who use our services to achieve outcomes that are important to them as well as promoting healthy outcomes to all.

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

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

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

Corporate

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

Budget: £82.3million
Headcount: 1,702 staff

Key achievements

Improvements in facilities

Over the last year we have substantially reorganised our catering service within facilities to provide a better service for patients and staff. One initiative is the introduction of a range of dementia friendly crockery in contrasting colours and deeper more user-friendly bowls to help avoid spillage. We've also introduced out of hours hot food vending machines at Sandwell and City Hospitals, which provide healthier options of favourite dishes such as beef stew, Chinese chicken and spaghetti bolognese, for anyone who would like a tasty hot meal overnight. We've also opened another Costa Coffee outlet on City Hospital site, in a bid to reduce queues at peak mealtimes.

Move to Trinity House

As the financial year drew to a close in March this year, around 500 support staff opened the next chapter in their working lives with a move to new office accommodation in 'Trinity House', formerly the maternity building at Sandwell Hospital. Teams in information, finance, HR, communications and IT are among some that have made the move – many from offices on the City Hospital site, and others from buildings located across the Sandwell Hospital site. The move is part of the long term plan to base our support function on our Sandwell site, in time for the opening of the new Midland Met hospital on Grove Lane in Smethwick. Staff have already found benefit in the move, with many welcoming the opportunity to be in a central location, in close proximity to other support teams they work alongside.

IT Infrastructure

We have invested significantly in information technology with a major infrastructure upgrade to improve the resilience, capacity and capability of our systems. We began our procurement process for a new Electronic Patient Record and will confirm our agreed supplier within the year ahead.

Research & Development

A team of researchers from the Trust and the University of Birmingham are among those in receipt of a prestigious award of almost £2 million from Arthritis Research UK to investigate the role of the microbiome in arthritis. It has long been suggested that the bacteria which live in our gut, mouth, and elsewhere on our bodies may affect the immune system and lead to the development of certain diseases, including rheumatoid arthritis, however exactly how changes to the microbiome lead to disease remains to be established. This award brings together an international multi-disciplinary team of researchers with partners from Birmingham, Oxford and UCL, as well as collaborators in the US at Harvard University, New York University and Mount Sinai Hospital, New York. The contribution of our Trust will be to recruit patients via our dedicated early inflammatory arthritis clinic, which has been running since 2000. This is one of several large grants awarded to staff at the Trust over the last 12 months and represents an important contribution towards the delivery of our research and development plan.

Whistleblowing

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

Future plans

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

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

We are currently working as an Alliance inside the Black Country Alliance (BCA) to reform how corporate services operate. This is with plans to have created efficient transactional services that benchmark well against peers within the BCA. External support means this is well under way, but there are still plans to develop a rationalisation plan, as well as monitoring KPIs to make sure they are being met across the board. Furthermore, our corporate teams have relocated to one central location at Sandwell Hospital, in the aim of providing a more integrated service.

Deputy Chief Finance Officer, Tim Reardon talking through future plans in finance.

Quality and Performance Analysis

Incorporating our Quality Account 2015/16

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

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

Jasbir Hayer, on Priory 3 ward at Sandwell Hospital.

William Ricketts, Community Respiratory patient.

Statement of directors' responsibilities in respect of the Quality Account

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

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

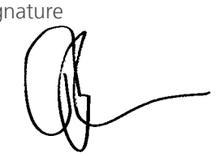
The Trust's directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

Signature

Richard Samuda

Chairman

Signature



Toby Lewis

Chief Executive

How we measure quality

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

Data quality improvements

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

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

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

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

Peer Group

The peer group we have used for benchmarking is a mix of Foundation Trusts, non-Foundation Trusts, local and inner City Trusts with a geographical spread and similar levels of activity to Sandwell and West Birmingham NHS Trust.

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

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

Services provided / subcontracted

During 2015/16 we provided and/or subcontracted 44 NHS services. We have reviewed all the data available on the quality of the care in these services. Where we have subcontracted any activity, it would only be to a provider, who like which us was registered with the CQC but has no conditions attached to that registration. Agreements between the Trust and the subcontracted providers require that the same high standards of care are given when giving care on our behalf. The health benefit and activity data undergo the same level of scrutiny as that delivered in the Trust. The Income Generated by the NHS services reviewed in 2015/16 represents 100% of the total income generated from the provision of NHS services by Trust.

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

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

Family and Friends Test

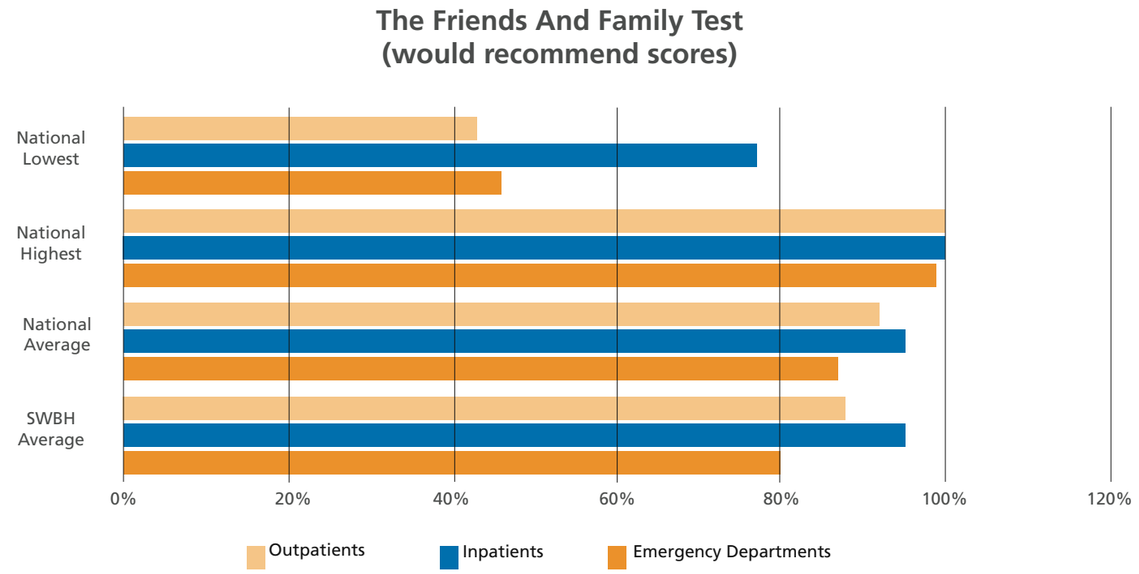
The Family and Friends Test (FFT) - would reccomend scores gives us important feedback from people who use our services. During 2015/16, the Trust expanded the FFT survey to other parts of the organisation including Outpatients, Day Surgery areas and Children's services. We use a blended methods approach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

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

Family and Friends Test (FFT) - would recommend scores

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

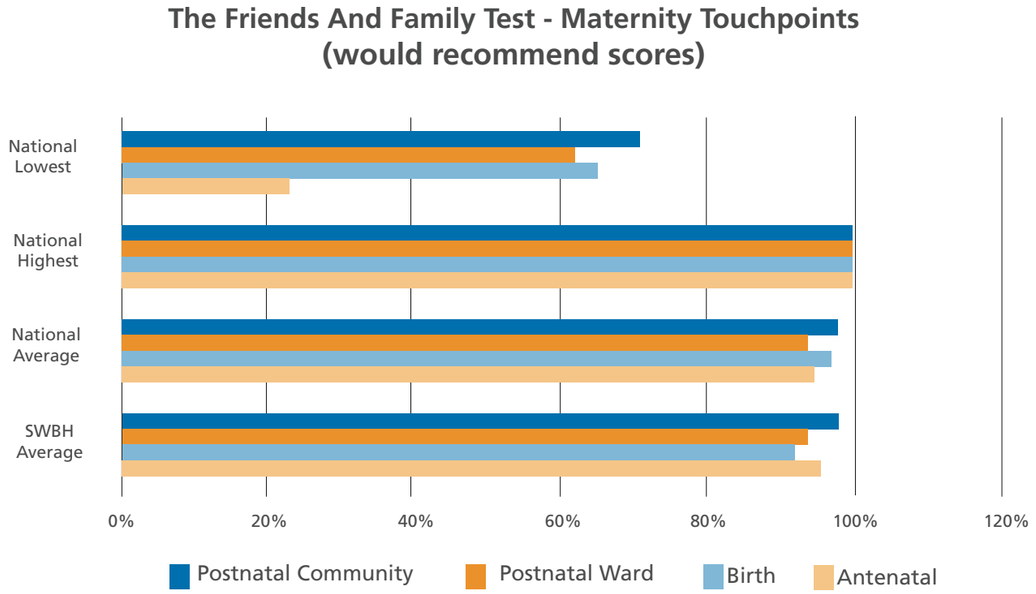
SWBH ED score	National Average	National lowest	National Highest
80%	87%	46%	99%



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

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

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



National Patient Surveys

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

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

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

National Women's Experience of Maternity Care Survey 2015

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

Scores out of ten, higher is better.

Midwife Dominika Korsten with 28-weeks pregnant Emma Ingram.

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

Patient Stories to the Trust Board

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

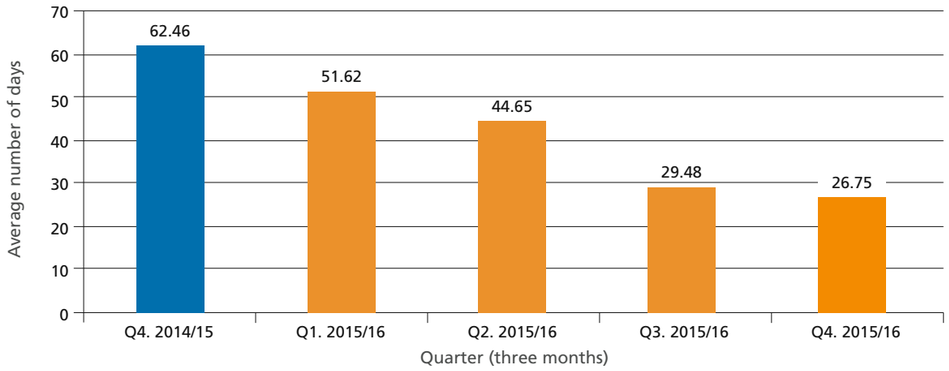
Complaints

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

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

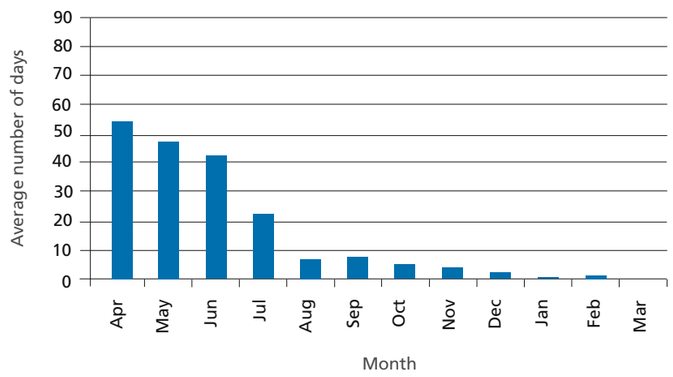
	2014/15	2015/16
Formal complaints received	837	929

Average number of days to respond to complaints by quarter



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

Response (%) Exceeding Original Agreed Response 2015/16



The most common themes of complaints

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

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

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

Patient Advice and Liaison Service

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

The most common themes of PALS enquiries

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

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

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

Patient Reported Outcome Measures (PROMs)

PROMs assess the quality of care delivered to NHS patients from the patient perspective. Currently these cover four clinical procedures where the health gains following surgical treatment is measured using pre- and post-operative surveys. The Health & Social Care Information Centre publish national PROMs data every month with additional organisation-level data made available each quarter. Data is provisional until a final annual publication is released each year. The tables below shows the percentage of patients reporting an improvement in their health status following the procedure and the average adjusted health gain achieved compared against the average for England.

Percentage reporting improvement

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

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

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

In response, the Trust has taken the following action:

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

How we performed in 2015/16: Against our standards

KPI (Key Performance Indicators) 2015/16

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

Children's Safeguarding

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

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

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

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

Jayne Clarke, Trust Child Safeguarding Lead.

Jacqui Ennis - Learning Disability Nurse Specialist.

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

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

Safeguarding Adults

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

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

Readmissions

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

Outpatient Care

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

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

Community caseloads

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

Focused care

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

Ten out of ten

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

Quality Improvement Half Days

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

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

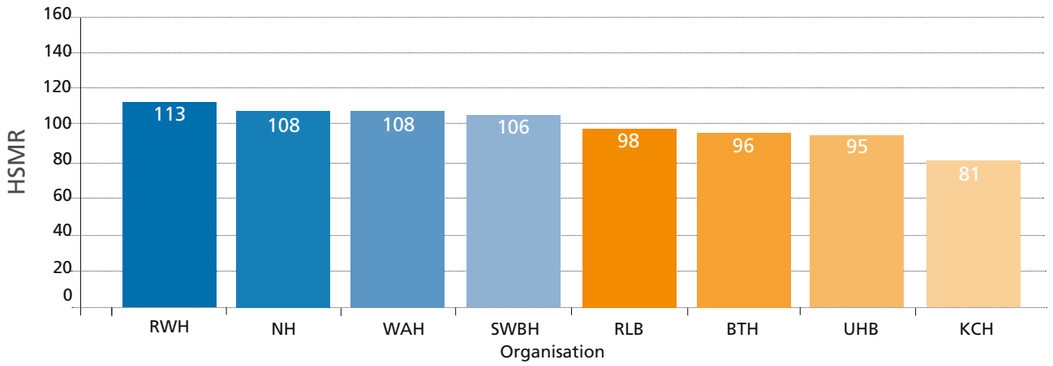
Mortality

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

HSMR (Hospital Standardised Mortality Ratio)

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

HSMR in comparison with our peers.



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

RAMI (Risk Adjusted Mortality Index)

This is a methodology developed by Caspe Healthcare Knowledge Systems (CHKS) to compute the risk of death for hospital patients on the basis of clinical and hospital characteristic data. It is a ratio of the observed number of deaths to the expected number of deaths that occur within a hospital. The Trust's RAMI for the most recent 12 month cumulative period (December 2015) is 90 and flagging marginally outside of statistical confidence limits which is above the National HES peer RAMI of 82. The aggregate RAMI for the City site is within statistical confidence limits with a RAMI of 82, and the Sandwell site with a RAMI of 96, which is outside of statistical confidence limits. Mortality rates for the weekday and weekend low risk diagnosis groups are within or beneath the statistical confidence limits. This data is derived from HED for the Summary Hospital Level Mortality Indicator (SHMI).

SHMI (Summary Hospital-level Mortality Indicator)

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

Mortality comparisons against national results

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

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

Trust Mortality Review System

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

	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	YTD
Death	146	120	105	371	119	97	114	330	127	116	133	376	163	137	152	452	1529
Reviewed	132	105	98	335	104	88	98	290	100	54	62	216	122	90	42	254	1095
% Reviewed	90	87	93	90	87	90	85	87	78	46	46	57	74	65	27	56	71
% Cumulative Reviewed	90	89	90	90	89	89	89	89	87	82	78	78	77	76	71	71	71

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

Reducing avoidable deaths

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

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

End of life (palliative) care

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

Deaths of patients with involvement from specialist palliative care services

Diagnostic care coding= Z5.15. The table below provides information relating to the number of deaths at the Trust where there was a diagnosis of Palliative Care made.

Total number of deaths	Palliative Care	%
2229	471	21.13

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

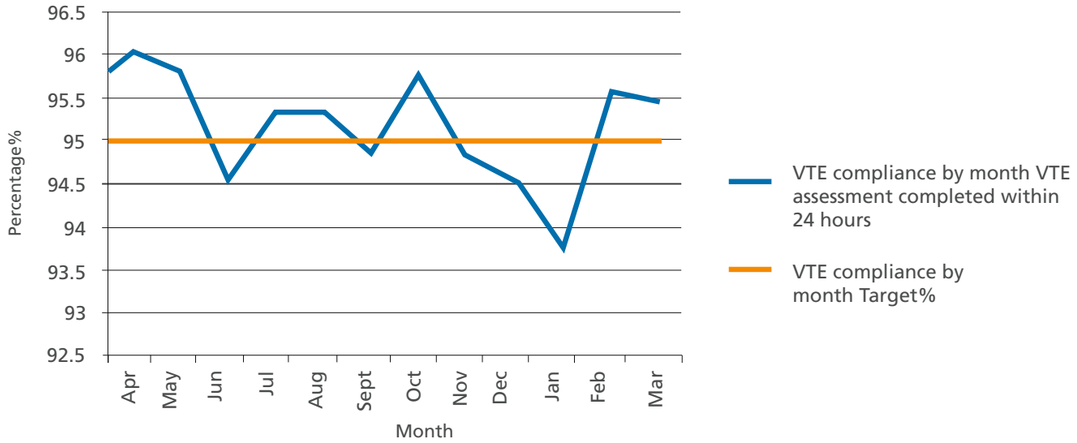
Venous thrombo-embolism (VTE)

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

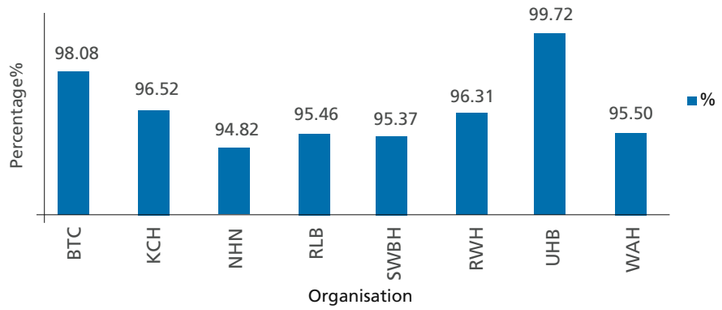
We report our achievements for VTE against the national target (95%) and report this as a percentage. The calculation is based on the number of adults admitted to hospital as an inpatient and of that number, how many had a VTE assessment within 24 hours. Following an audit of our VTE assessments last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

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

VTE assessments completed within 24 hours 2015/16



VTE assessments compared to peers (higher is better)



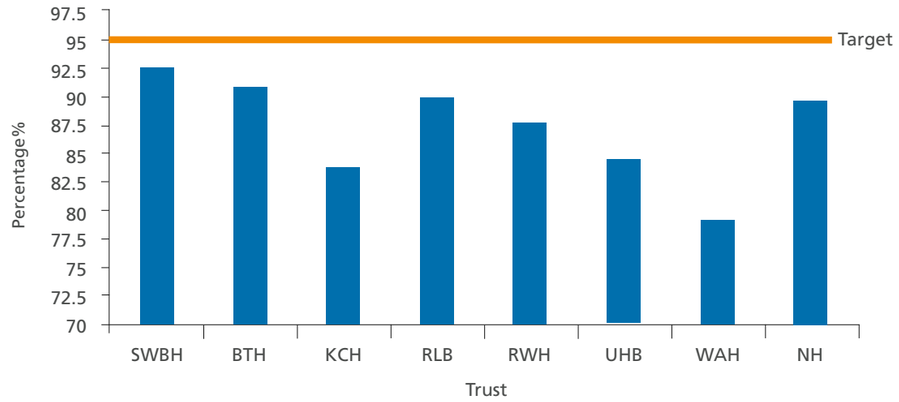
Data from NHS England – reporting period April 2015 – December 2015

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

Emergency four hour waits

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

ED 4-hour waits - 2015/16 (Higher is better – target 95%)

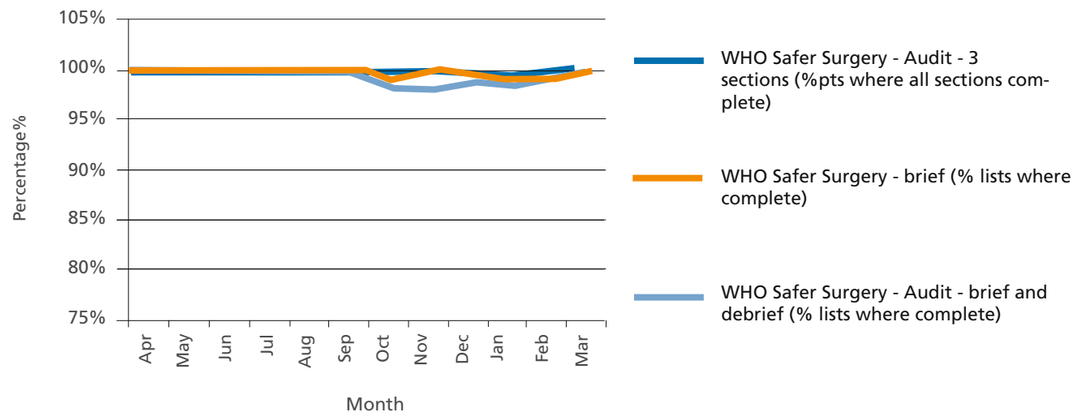


(Peer Group Performance up to 21/2/16)

WHO Safer Surgery Checklist

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

WHO Safer Surgery 2015/16



Harm free care

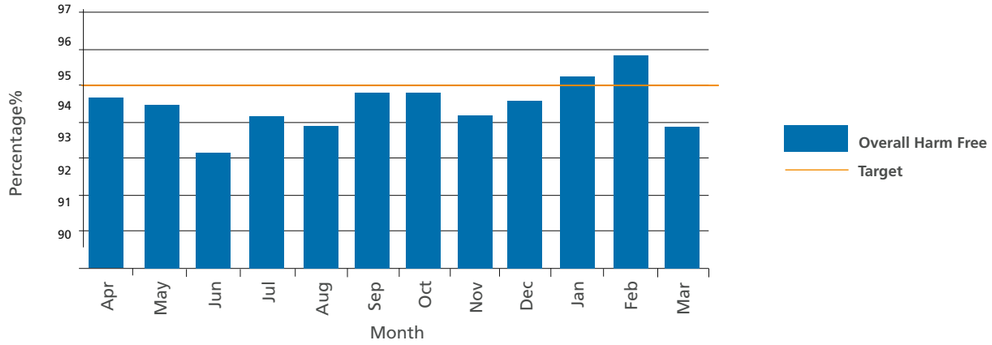
The Trust continues to undertake monthly prevalence audits looking at four harms – pressure ulcers, falls, catheter related UTIs and DVT- results show 94% of our patients suffer no harm whilst in our care. During Q4 we have reached the national target of 95% - of the patients who do suffer harm. This is rarely more than one harm and the harms are reviewed via the incident reporting framework with local and corporate learning. For example we are implementing a 'blue pillow' approach to heel elevation – an idea commenced by Newton 4 ward.

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

Harm free care by peer with national average

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

Overall Harm Free Care



Pressure ulcers

Pressure ulcer prevention remains one of the key priorities within the Trust 10 out of 10 safety standards with a clear focus on assessment of all patients to identify if someone is at risk of developing pressure damage and implementing preventative strategies to prevent pressure ulcers developing.

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

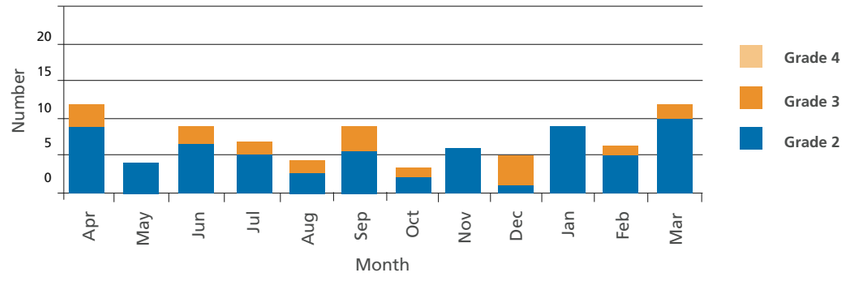
During 2015 there was investment in new mattresses at City site which has meant patients have no delays in receiving pressure relief and do not need to be disturbed when they may be at a critical time in their illness. Traditional pressure reliving air mattresses remain available when clinically indicated.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

During the year the Tissue Viability team have had a focus of working with the Community nurses to promote the message of pressure ulcer prevention, this included a pressure ulcer awareness event and attending local resident meetings to talk about pressure ulcers and how to prevent them, this activity was welcomed by Agewell and gave an opportunity for the public to ask advice on prevention within a social setting. The Tissue Viability team has also been working with Sandwell Clinical Commissioning Group and have extended our training provision to include training for local Practice Nurses and Nursing home Nurses in Sandwell Community, these days provided a platform to raise awareness of pressure ulcer prevention as practice Nurses are often the first Health care professionals patients will have contact with.

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

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

Avoidable Pressure Sores 2015/16

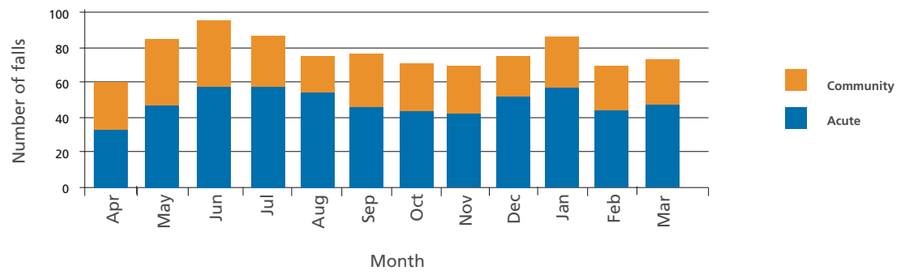


Falls

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

We investigate and review each fall to ensure any learning points are shared with staff and that practice is reviewed to reduce the risk of repetition for that patient or others. All staff receive prevention of falls training on induction and annual mandatory training). We are currently undertaking a project of reviewing medication of those patients that are of high risk of falling. Our newly appointed Dementia Lead will also have a focus on falls prevention and will be working closely with the clinical areas to identify themes around falls, for example, a high proportion of our falls are patients with dementia /delirium. We are also working with the Risk Department to design a questionnaire for clinical staff to complete at the time of the fall to help us investigate why the fall happened, whether it could have been avoided where we care for the patient appropriately post fall, and where there are any lessons to learn for the organisation. This will be launched with clinical staff in Spring 2016.

Falls 2015/16



Infection Prevention and Control

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

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

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

Blood culture contamination rates

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Blood culture contamination rates by site (Target = 3%)	City	2.4%	2.9%	1.7%	2.5%	3.2%	2.9%	2.9%	2.0%	1.7%	2.6%	3.7%	3.2%
	S.Well	3.5%	3.3%	3.9%	3.1%	4.1%	4.0%	1.5%	4.8%	4.1%	3.1%	6.0%	3.4%
	It needs to be recognised that due to the clinical condition of some patients there is a risk of obtaining an unavoidable blood contaminant. However, any Clinician identified as taking a contaminated blood culture is required to attend for further training to reiterate practices. In addition to this, since Aug 2014 the IPCS have introduced a training programme for all new doctors to the Trust.												

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

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

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

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

Information Governance Toolkit (IGT) attainment levels

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

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

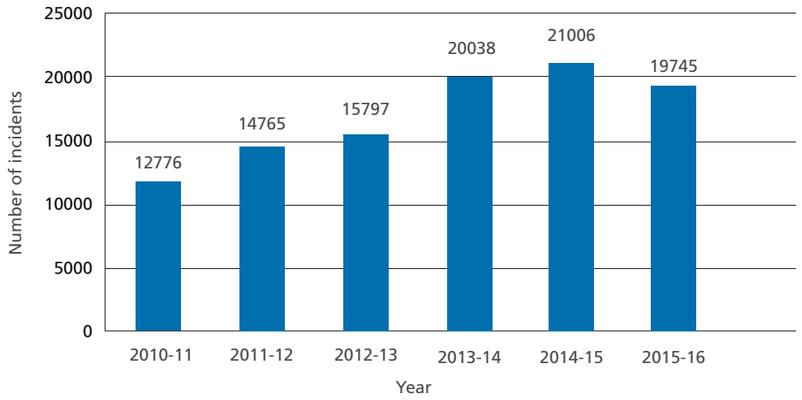
Date	Average rate of reporting per 100 admissions	Best reporter/ 100 admissions	Worst reporter/ 100 admissions	Number of incidents resulting in severe harm	Percentage of incidents resulting in severe harm	Number of incidents resulting in death	Percentage of incidents resulting in death
2011/12	6.29	9.82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

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

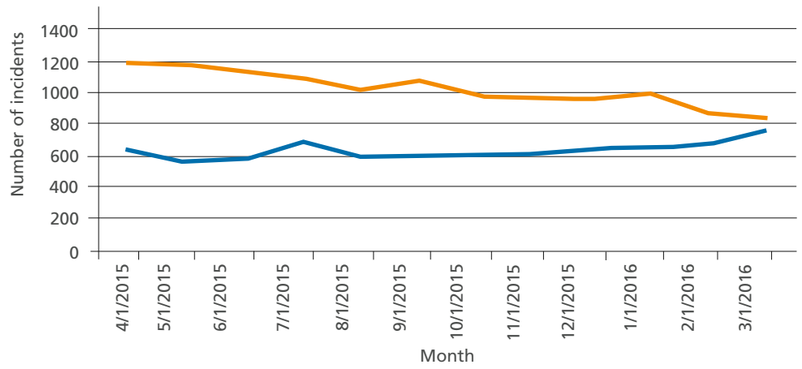
Incident reporting

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

Total incidents reported by financial year



Incidents reported during 2015-16 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 2015/16 is shown in the following table. This does not include pressure sores, fractures or serious injuries resulting from falls, ward closures, some infection control issues, personal data or health and safety incidents.

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

Never Events

During 2015/16 four never events were reported. A never event is a serious untoward incident that has either caused or has the potential to cause serious harm that should never happen if the proper procedures are carried out to prevent them from happening.

Never events reported in 2015/16

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

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

How we performed against external measures

Our Care Quality Commission improvement plan

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

1. Improve how we learn across our organisation, spreading good practice and identifying why some wards, teams and departments are better able to deliver outstanding outcomes for patients – the solution to our issues is already being implemented somewhere in our Trust.
In 2015 we introduced our quality improvement half days (QIHDs) that offer protected time for teams to learn, cancelling all non-emergency services.

2. Ensure that we consistently deliver the basics of great care, with disciplined implementation of policies on handwashing, medicines security, end of life decision making, and personalised care observations – we have to get this right every time.
Our "ok to ask" campaign enabled everyone in the Trust to feel comfortable questioning and challenging each other in our basic standards of care.

3. Tackle our sickness and vacancy rates if we are to reduce gaps in our care, and ensure that all of our staff have time and space to be trained and to develop their skills – being fully staffed matters.
We have not achieved our ambitions on cutting absence due to sickness this year although some teams have sustained low levels and others have dramatically improved. We have changed many of our recruitment processes to fill vacancies with the right people more quickly including open days where recruitment checks and job offers can be made within a day, and guaranteed jobs for our student nurses who have passed their relevant competencies and assessments.

4. We need to build on our best practice around local management and leadership, empowering capable local managers, and reducing hierarchies between executive and departmental leaders – communication can be better here and must be two-way.
We have continued the second year of investment in our leadership programme supporting the top leaders in the Trust to be able to successfully lead and deliver our 2020 vision. Our monthly your Voice survey engages every employee in feedback that is acted on by directorate and group leaders.

5. We need to do even more to evidence how our incident, risk management, and safety data inform the decisions that we make and the priorities that we set – we know where our issues are, and need to address them more quickly when they are identified.
We have published all of our risk registers on our intranet site so that they are readily available to all staff. Anyone can view anyone's risk register. This has helped to facilitate greater understanding among groups of staff.

CQC Improvement Plan Summary

We have progressed the actions in the Trust improvement plan that we published in March 2015 when the CQC published their report and ratings of Trust services. The Trust was overall rated as "requires improvement". The majority of actions have been completed successfully. During the first half of 2015/16 we will complete all of our actions and in the later part of the year we will seek assurance that our actions have achieved the desired outcome to improve the quality of care for our patients.

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

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

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

CQUINs (Commissioning for Quality and Innovation)

The Trust is contracted to deliver a total of 20 CQUIN schemes during 2015 / 2016. Seven schemes are nationally mandated, a further five have been agreed locally, five identified by the West Midlands Specialised Commissioners and three by Public Health. The collective financial value of the schemes is c.£8.8m. [value of achievements to be included]

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

External Visits

Care Quality Commission inspection of community children's services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Inspection by the Human Tissue Authority

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

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

Making of a post mortem examination;

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

The HTA found that:

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

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

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

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

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Audits and Research

Participation in clinical audits

During 2015/16 we participated in 37 national clinical audits and three national confidential enquiries covering NHS services which the Trust provides. SWBH has reviewed all the data available to them on the quality of care in all of these services. During that period Sandwell and West Birmingham NHS Trust participated in 97% of national clinical audits and 100% national confidential enquiries of which it was eligible to participate in. The national clinical audits and national confidential enquiries that Sandwell and West Birmingham NHS Trust participated in and for which data collection was completed during 2015/16, are listed 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%
Vital signs in children (Care in Emergency Departments)	Yes	100%
Diabetes (National Paediatric Diabetes Audit)	Yes	100%
Paediatric Asthma (British Thoracic Society Audit)	Yes	99%
National Pregnancy in Diabetes Audit	Yes	97%
Cystic Fibrosis Registry	Yes	100%
Acute care		
Emergency use of oxygen(British Thoracic Society Audit)	Yes	100%
Hip, knee and ankle replacements (National Joint Registry)	Yes	98%
Severe trauma (Trauma Audit & Research Network)	Yes	60%
Adult Critical Care (Case Mix Programme)	Yes	100%
National COPD Audit (Secondary Care)	Yes	100%
National Complicated Diverticulitis Audit	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	67%
Procedural sedation in adults (Care in the Emergency Department)	Yes	100%
VTE in lower limb immobilization	Yes	100%
Long term conditions		
Diabetes (National Diabetes Audit) Adult	Yes	100%
Diabetes (National Foot care Audit)	Yes	100%
Inflammatory Bowel Disease (IBD)	No	NA
Rheumatoid and early inflammatory arthritis	Yes	Ongoing
National COPD Audit (Pulmonary Rehabilitation)	Yes	100%
UK Parkinson's Disease Audit	Yes	75%
Heart		
Acute Myocardial Infarction & other ACS (MINAP)	Yes	93%
Heart Failure (Heart Failure Audit)	Yes	50%
Cardiac Rhythm Management Audit	Yes	100%
Acute stroke (SSSNAP)	Yes	90%+
Cardiac arrest (National Cardiac Arrest Audit)	Yes	100%
Coronary angioplasty (NICOR Adult Cardiac interventions audit)	Yes	100%
Cancer		
Lung cancer (National Lung Cancer Audit)	Yes	100%
Bowel Cancer (National Bowel Cancer Audit Programme)	Yes	100%
National Prostate Cancer Audit	Yes	100%
Oesophago- gastric cancer (National O-G Cancer Audit)	Yes	100%
Blood and Transplant		
National Comparative Audit of Blood Transfusion (Audit of patient blood management in scheduled surgery)	Yes	100%
National Comparative Audit of Blood Transfusion (Use of blood in haematology)	Yes	100%
Older people		
Falls and Fragility Fractures Audit Programme (FFFAP) – National Hip Fracture Database	Yes	100%
FFFAP- Inpatient falls	Yes	100%
FFFAP- Fracture Liaison Service Database	Yes	0ngoing

National Audits	Participated Yes /No	Percentage of eligible cases submitted
Other		
Elective Surgery (National PROMs Programme)	Yes	78%
National Ophthalmology Audit	Yes	100%
National Confidential Enquiries (Clinical Outcome Review Programmes)		
Medical & surgical programme - National Confidential Enquiry into Patient Outcome & Death (NCEPOD) The Trust participated in the following studies in 2015/16: Acute pancreatitis Physical and mental health patient in acute hospital Non invasive ventilation	Yes Yes Yes	92% Ongoing Ongoing
Maternal, infant and newborn clinical outcome review programme	Yes	100%
Child Health Clinical Outcome Review Programme - Chronic neurodisability - Young people's mental health.	Yes	 Ongoing Ongoing

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

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

Karim Raza, Director of Research and Development.

Participation in clinical research

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

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

Our priorities for 2016/17

Strategic Objective	Priorities for 2016-17	How will we achieve it?
Safe, High Quality Care	Reducing readmissions	Continue to identify patients at risk. Outcomes will be a 2% fall in re-admission rates at Sandwell compared to the 2014/15 baseline.
	Improving outpatient the experience of outpatients	Improve care so that patients experience a maximum wait of six weeks, elimination of clinic rescheduling and 98% patient satisfaction rate. We expect to reduce did not attend (DNA) rates by 2%.
	Achieving the gains promised within our 10/10 programme	We will focus on a 100-day roll out in our assessment units during the first quarter of the year and investing in ward managers to support delivery.
	Meeting the improvement requirements agreed with the Care Quality Commission	In the first half of the year we will ensure we complete the remaining outstanding tasks in the Improvement Plan and in Q3 we need to ensure benefits have been gained from that work.
	Tackling caseload management in community teams	We will make sure that nursing caseloads at team level are reduced to the median in the Black Country. Patient contact time will be increased by 10% among district nurses, health visitors and midwives.
Accessible and Responsive	Meet national wait time standards, and deliver from a guaranteed maximum six week outpatient wait	Achieve 93% or better for four hour waits in our emergency departments from Q2. Achieve the 18 week referral to treatment standard consistently. Eliminate open pathway referral issues seen in prior years. Deliver the 62-day standard in specific tumour groups.
	Double the number of safe discharges each morning, and reduce by at least a half the number of delayed transfers of care in Trust beds	Have fewer than 15 delayed transfers of care in Trust bed base with 40% of discharges taking place before midday.
	Deliver our plans for significant improvements in our universal Health Visiting offer, so 0-5 age group residents receive high standards of professional support at home	Deliver our contractual standards and establish our new partnership model with Sandwell Metropolitan Borough Council so that it delivers effective health visiting care for families.
	Work within our agreed capacity plan for the year ahead, thereby cutting did not attend (DNA) rates, cancelled clinic and operation numbers, largely eliminate use of premium rate expenditure, and accommodating patients declined NHS care elsewhere	Cut did not attend (DNA) rates by 2%. Ensure all specialties by October 2016 achieve a recurrent balance between demand and capacity.
Care Closer to Home	Ensure that we improve the ability of patients to die in a location of their choosing, including their own home	Make sure there is an increase in the proportion of patients identified as being on the planned pathway >72 hours before passing and Increase the proportion of patients able to die in place of their choosing.
	Respiratory medicine service sees material transfer into community setting, in support of GPs	Establish the community respiratory service so that we see a reduction in unplanned readmissions for respiratory patients at Sandwell.

Our priorities for 2016/17

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

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

Our Quality Plan Goals

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

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

Our Safety Plan Commitments

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

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

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

CQUINS 2016/17

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

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

Partner statements

Healthwatch Sandwell

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

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

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

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

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

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

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

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

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

Healthwatch Birmingham

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

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

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

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

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

We note that appointment issues are a prominent theme in both complaints and PALS enquiries. This corresponds with some of the feedback we have received this year about SWBH. Several patients and carers have commented on issues they have had with appointments via our feedback centre. These issues have included: poor communication around appointment cancellation and rearrangement, long waiting times in clinic, and comments on the disorganisation of the appointment system. Given these issues, we are encouraged to see that the priorities for 2016/17 include a commitment to improve the outpatient experience and cut cancelled clinic and operation numbers. We request clear evidence to be provided of progress against these priorities in next year's Quality Account.

We also note that 12 per cent of all complaints received by the Trust in 2015/16 have been about the attitude of staff. This year we have received mixed feedback about staff at SWBH. We have had several positive comments about the care patients have received from staff at the Trust. However, we have also received a significant number of negative comments about staff, particularly around attitude and communication. We would therefore appreciate information on whether there are any initiatives planned to improve in this area.

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

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

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

Sandwell and West Birmingham CCG

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

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

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

In terms of Harm Free Care, the CCG Governing Body has kept aware that the Harm Free Care score of 94% is just below the 95% target and target will continue to be monitored. It is encouraging however to note that the Trust are continuing to the reduce the number of serious pressure ulcer incidents, with zero being reported in Q4.
Regarding External Visits, the CCG recognises the excellent achievement of the Trust in receiving an 'Outstanding' rating for Community Childrens services by the CQC.
In terms of Never Events, there were four never events reported by the Trust this year. Although these are events that should never happen, the CCG was fully informed and involved in the investigative process and acknowledge the actions taken by the Trust to help prevent these incidents happening again in future.

Alesha McIntosh, Sickle Cell patient in the SCAT Centre at City Hospital.

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

making **everyone** matter

The Trust Charity

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

The raising of income to support;

1 – Infrastructure

- Improving the trust's environment and making capital improvements to facilities.

- Supporting integrated care across the estate of SWBH and allied providers

2 - Education

- Supporting the educational development of clinical and non-clinical staff.

- aims to secure the long term future of health and social care in Sandwell and West Birmingham

- to support education within the local community

3 – Innovation

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

4 – Community resilience

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

Grant Programme

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

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

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

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

The launch of the new A&E Advocacy Project in November last year which saw the hiring of two new Independent Domestic Violence Advisors, Ansa Javid (far left) and Eve Philips (far right).

Fundraising

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

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

The Midland Metropolitan Hospital

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

Looking ahead

In the year ahead we will:

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

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

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

3. Accountability Report

Corporate Governanace Report

Directors' Report

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

Non-Executive Directors: Board and committee attendance

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

Executive Directors: Board and committee attendance

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

Key	
a/ b	a= the number of meetings attended b= the total number of meetings with apologies submitted for the meetings not attended
*	Stepped down from their position as Non-Executive Director in July 2015
**	Appointed as full NEDs from 1 June 2015

The Trust Executive Group is:

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

Rachel Barlow, Chief Operating Officer who is a member of the Trust Board.

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

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

Register of interests

Name	Interests Declared
Chairman	
Richard Samuda	• Director – 'Kissing It Better' • Non Executive Director – Warwick Racecourse
Non-Executive Directors	
Olwen Dutton	• Partner – Bevan Brittan LLP • Fellow – Royal Society of Arts • Member – Lunar Society • Member – Council of the Birmingham Law Society • Member – Labour Party
Paramjit Gill	• Trustee South Asian Health Foundation • Trustee – Healthy Hearts • Clinical Academic at University of Birmingham collaborating with colleagues based at the Trust on a number of research studies • Academic Lead, NIHR Clinical Research Network: West Midlands • General Practitioner
Michael Hoare	• Director-Metech Consulting • Director CCL Group
Harjinder Kang	• Managing Consultant – PA Consulting Group
Robin Russell	• School Governor – Birchfield Community School
Waseem Zaffar	• Elected Councillor – Lozells & East Handsworth Ward (Birmingham City Council) • School Governor at Heathfield Primary School. • Member of Unite the Union and the Labour Party. • Director at Simmer Down CIC.
Sarindar Singh Sahota OBE (ceased to be a NED in July 2015)	• Trustee – Acorns Hospice • Member – Court of University of Birmingham • Trustee – Nishkam Schools Trust • Director – Asian Business Forum • Member – Smethwick Delivery Board • Chair – Birmingham City Council Citizen-Led Quality Board for Assessment and Support Planning
Gianjeet Hunjan (ceased to be a NED in August 2015)	• College Finance and Administration Team Manager – University of Birmingham • Lay Member – Advisory Committee on Clinical Excellence Awards – West Midlands • Lay Member – NHS Midlands and East Workforce Deanery • Governor – Oldbury Academy • Governor – Ferndale Primary School
Executive Directors	
Toby Lewis (Chief Executive)	• Board member – Sandwell University Technical College • Independent member - Council of Aston University
Rachel Barlow (Chief Operating Officer)	• None
Kam Dhami (Director of Governance)	• None
Raffaela Goodby (Director of Organisation Development)	• Board member in PPMA (public sector people manager's association) member's association • E4S Practitioner Board member (voluntary national body)
Colin Ovington(Chief Nurse)	• None
Roger Stedman (Medical Director)	• Partner – Excel Anaesthesia (private anaesthesia services)
Tony Waite (Director of Finance & Performance Management)	• None

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Toby Lewis
(Chief Executive)
2 June 2016

ANNUAL GOVERNANCE STATEMENT 2015/2016

SCOPE OF RESPONSIBILITY

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

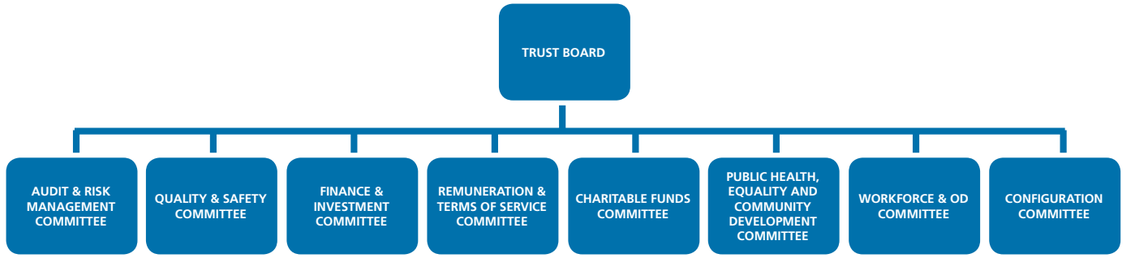
Our internal controls continue to reflect a commitment to work in partnership and in doing so having effective mechanisms in place to manage risks and interdependencies. 2015-16 saw the strengthening of the Black Country Alliance in which we work ever more closely with counterparts in Dudley and Walsall. There is a real momentum building around this work and in my next Annual Governance Statement I will be able to draw attention to the impact that the work we have started this year is having on patient care across the region. This includes work we are undertaking jointly around shared interventional radiology services with Dudley and Wolverhampton and rheumatology services with Walsall. We are also working closely with other partners such as Wolverhampton, Coventry, Warwick and UHB to deliver improved oncology services across the region. The Board is clearly sighted on, and regularly challenges, the governance arrangements in place to secure the Trust's position within the partnerships it participates in.

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

THE GOVERNANCE FRAMEWORK OF THE ORGANISATION

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

Figure 1



2015 saw us say goodbye to two longstanding Board members Dr Sarinder Singh Sahota OBE and Gianjeet Hunjan. They have been replaced by Councillor Waseem Zaffar a Councillor for Lozells & East Handsworth Ward who is championing the need for us to continue to effectively engage the communities we serve and Robin Russell who is an experienced Finance Director and chairs the Trust's Audit and Risk Committee. The membership and attendances at Trust Board and its committees for the year are outlined in appendix 1.

The Board's governance model continues to evolve in a planned and structured way to ensure focus and delivery against the Trust's key priorities:

- The Quality and Safety Committee has retained a strong focus on safe staffing and the quality of care. During this year the Trust has finalised its two remaining pillars of its medium term transformation plans with the publication of the Quality and Safety Plans. The committee is refocussing its forward plan to directly monitor the implementation and impact of these plans going forward.
- The Finance and Investment Committee retains a sharp focus on the Trust's financial position and the measures being taken to ensure the Trust manages the financial challenges that continue to face the NHS locally and nationally. It is also focussed on the Trust's investment in improving care and the physical environment across all of the Trust's sites as the Trust moves towards the opening of the Midland Metropolitan Hospital.
- The Workforce and OD Committee retain important oversight of the Trust's workforce transformation proposals that will be implemented through 2016-17. The committee also has oversight of the actions being taken to address skill shortages in areas for which there is a national as well as local shortage.

- The Configuration Committee played an important role in oversight of the stages leading up to the financial close and commencement of the build for the Midland Metropolitan Hospital. During 2016-17 the focus of the new Major Project Authority (MPA) Committee, which supersedes the Configuration Committee, will be to have oversight of all of the key transformation projects to ensure delivery, project alignment and effective flagging of interdependencies.
- The Charitable Funds Committee has oversight of the work underway to develop a single Charity Fund and the relaunch due during 2016. The committee also retains oversight of how the funds are invested, how the money is being spent and importantly the impact for patients and the wider community of the spend from the Trust charities.
- The Public Health, Equality and Community Development Committee has focussed on volunteering, equality and diversity objectives and oversight of progress against the Public Health Plan.

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

Operationally, the Trust delivers care through seven Clinical Groups, each then sub-divided into directorates. The corporate group comprises seven directorates. The vast majority of clinical services report to the Board through the Chief Operating Officer. The Group Directors, along with the Executive Directors, comprise the Clinical Leadership Executive. This monthly body, chaired by myself, directs the operational plan for the organisation. It is supported in this task by a series of cross-cutting committees.

The important role of the Clinical Leadership Executive continues to evolve. CLE has commenced a series of leadership sessions to shape its role and influence going forward and alongside a series of master classes will continue to develop and equip the Trust's top leaders to drive forward the ambitions of the Trust.

Risk assessment

The Trust 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.

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

New risks escalated to the Board in year have included risks in respect of IT system failures, reduced ability to provide interventional radiology services and reliance on non-recurrent measures and balance sheet flexibilities to support the Trust's financial performance. Risks that have been the subject of repeated challenge by the Board have included the management of sickness absence and the impact on infants of a national BCG vaccine shortage.

Risks that have been removed during 2015-16 include High Dependency Unit one to one care as staffing levels were increased and are monitored monthly, risks to trauma patients requiring traction leading to delays which has been resolved since the fitting of new trauma tables and the risk around failure to achieve TDA sign off for the annual plan return and submission.

The Trust continues to implement an electronic risk system. This enables clinical groups and corporate directorates to import their risk registers and update mitigating actions directly on to the system. This will become fully operational in quarter 1 of 2016-17.

Risk and control framework

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

The Trust has a clearly developed annual plan, with specific milestones and performance indicators which are reviewed by the Board each quarter. On a monthly basis the Board receives the Integrated Performance Report which sets out progress against a suite of performance indicators shown at Trust, group and directorate level. These are worked through in depth at a monthly Performance Management Committee meeting which I chair. In addition the Board considers the Board Assurance Framework on a quarterly basis which tracks progress against the agreed annual plan priorities of the Trust. I am satisfied by how our systems escalate operational and financial performance matters through to the relevant management level and ultimately the Board to ensure that matters are quickly flagged, addressed and long term mitigating actions put in place. Clinical Groups are performance assessed against the same Trust indicators and issues are performance managed with individual groups and operational owners via group reviews.

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

Accounts, including our quality account

As in prior years, we have a clear and well understood process for settling our financial and quality accounts. Last year we were given an unqualified opinion in respect of the 2014-15 Trust accounts. An internal review of the 2015-16 draft suggests compliance with mandated guidance.

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

Information security and data protection

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

The Trust's latest Information Governance Toolkit self-assessment declaration has led to an improvement on the previous year's score with the self-assessment score now at 86%. During 2015-16 there was a specific focus in terms of IT infrastructure and security for the purposes of increasing resilience across these along with policy and procedure compliance checks.

Data quality

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

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

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

Other data quality issues that have been flagged with the Audit and Risk Committee over the past year have included have included obstetrics CS ratio and elective and non-

Trust fraud poster.

Sophie Coster, Counter fraud specialist.

elective where there was a comprehensive and robust policy in place but issues around timeliness and validation, duplicated entries in respect of falls and serious injury and patient upgrades not formally being documented in respect of cancer waits. Action plans have been put in place to address these issues.

Counter-fraud and probity

The Trust is supported through its Internal Audit function by a Counter Fraud service that reports routinely to the Audit & Risk Management Committee. The service, whose annual work plan is approved by the Audit & Risk Management Committee, is proactive in its role countering fraudulent activity within the Trust. This proactive engagement has included activities during November 2015 linked to fraud awareness month including a counter fraud message to all staff via payslips. The Trust continues to successfully prosecute former Trust employees who have found to have committed fraud.

During 2015 a focussed quality assessment was undertaken at the Trust by NHS Protect in respect of compliance with the 2016/16 standards for fraud, bribery and corruption. This resulted in the Trust being rated as partially compliant in respect of the requirements to inform and involve and compliant in respect of holding to account. In respect of inform and involve it was recognised that staff received training as part of their induction but that potentially more should be done in respect of staff who had been employed with the Trust for over 5 years.

Whistleblowing and duty of candour

The Trust continues to invest in an independent reporting system which enables staff to raise whistleblowing concerns. Work undertaken in terms of counter fraud suggests that there remains a need for further awareness raising of this system. Matters that are raised as whistleblowing concerns have been considered and addressed. I remain confident that as a Trust we continue to meet the requirements in respect of the duty of candour.

Safeguarding and DOL

I remain satisfied that we have sufficient arrangements in place to prevent issues of deprivation of liberty. Safeguarding remains a key priority for the Board and the Trust as a whole with comprehensive polices and training in place.

Equality and diversity

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

REVIEW OF EFFECTIVENESS OF RISK MANAGEMENT AND INTERNAL CONTROL

In 2014-15 I identified five areas of ongoing concern within the Annual Governance Statement. These were as follow:

- The Trust's Improvement Plan reflecting the CQC review of the organisation and the Trust's overall rating of requires improvement. Progress against the improvement plan has been considered and challenged at our public Board meetings. As of March 2016 we were in the position of 43 of the recommendations and issues arising from the CQC report having been delivered with the issues addressed. In 11 areas improvements/ changes have been implemented but further evidence is needed around the impact of these changes for patients.

Specific examples of what has changed following the inspection include:

1. the 'ok to ask' campaign – the campaign encourages all staff to feel confident and supported in challenge risky behaviour. This was in response to the recommendation around following through on findings of safety audit data.
2. fully operational Medstations at A&E Majors and shortly to be installed at A&E minors at City Hospital. There was a recommendation around consistent systems for safe medicine storage which this addresses. These have yet to be rolled out on the Sandwell General Hospital site.
3. the introduction of VitalPac to Emergency Departments which provides electronic taking of vital signs alongside improved sepsis screening. This was in response to a recommendation in respect of consistent use of patient early warning scorecards.
4. significant improvements in the timeliness of responding to complainants. All complaints are now consistently responded to within target timescales with a significant fall in the length of the response times for the oldest live complaint.

- Despite clear and evidenced progress having been made against the majority of recommendations there remain eight areas where further work or a different approach may be required to succeed. These include embedding the Ten out of Ten safety checklist, improving mandatory training compliance, and further strengthening discharge processes to meet the patient's preferred place of care / death. Least progress has been made in relation to ward related matters such as the introduction of patient centred care plans, drug storage installations at Sandwell General Hospital and ensuring patient / carer agreement with their care plan is obtained. This will continue to be a focus for the Board into 2016-17 with internal and clinical audit time given to investigating progress. This hence remains an issue going into 2016-17.
- Do Not Resuscitate documentation has been a continued focus of attention 2015-2016 to ensure that the practice common in much of the Trust is consistently achieved organisation wide. There remains work to do in this area, and as such continues to be a live risk for us. It is our intention to ensure consistent outstanding practice across the Trust.
- We have a strong Trust level business continuity plan. Significant work has been undertaken around Trust business continuity planning during the year. IT failures, junior doctors' strikes and power outages at the City Hospital site have enabled the testing of our business continuity planning during the course of the year. There remain concerns and assurance gaps in respect of both local planning, ensuring protection against known risks and effective communication channels. We will work to close those assurance gaps during the coming year. An Emergency Preparedness, Resilience & Response Group has been established. This meets on a monthly basis and reports into the Operational Management Committee. Following reviews of recent incidents, further work is required to develop a corporate standardised approach to the command & control of all incidents and business continuity events.
- Our continued reform of financial functions has identified opportunity to strengthen further our systems, and controls, in respect of non-pay expenditure. Cost improvements remain central to our LTFM going forward so renewed focus is needed during 2016-17.
- Sufficient progress has been made in respect of the governance of small to medium scale capital project implementation to the point that I now consider this matter closed. Strengthened project management and overall delivery has seen delivery to timescale of important projects.

In addition 2 further areas of concern are worthy of inclusion in my Governance Statement. These are:

The resilience of our IT infrastructure has come into sharp focus during the past year. In January 2016 there was a significant deterioration in the responsiveness of the Clinical Data Archive (CDA) which meant an inability to use the system on occasions which resulted in significant operational disruption. The internal review of this incident highlighted the use of old unsupported operating systems, ineffective prioritisation of core systems and a loss over time of in house expertise. The

Trust continues to invest in its IT infrastructure but until such a time as new systems are implemented there remain risks which will need to be effectively managed and mitigated.

- HR data quality is an additional risk I wish to flag. Internal audit reports over the past year have highlighted risks in respect of compliance with HR polices and procedures in respect of leave approval and compliance with sickness absence requirements. Sickness absence management in particular is a key priority as we look to make ongoing efficiency savings across the Trust including reducing bank and agency expenditure. Issues have also arisen during the year in respect of time lags in recording people's successful completion of mandatory training. There will be a real focus across the Trust in respect of managing sickness absence through quarter 1 of 2016-17 and concerted action to remedy HR data quality issues.

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

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

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

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

Our systems for exercised control over safe clinical practice is extensive, and the strong infection control and mortality position achieved by the Trust suggests that they are effective. VTE assessments have shown compliance with national targets but still fall short of the local target of 100%. All national cancer targets had begun to be met from January 2016 including 62 day urgent GP referral to treatment targets. In respect of RTT targets were met at the end of the year.

Concluding remarks

I have highlighted within my statement matters relating to data quality, counter fraud and risk management and internal controls and how both I and the Trust Board have sight of, and are addressing these. Within this context I have set out some specific control issues that are a focus currently and for the coming year. On that basis I am able to confirm that there are effective systems in place for the discharge of statutory functions with these having been checked for irregularities and to ensure they are legally compliant. These systems of internal control underpin our priorities for continuing to enhance the quality of care we deliver to the communities of Sandwell and West Birmingham.

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

Date 2 June 2016

Remuneration and Staff Report

Remuneration Report

The Trust has a Remuneration and Terms of Service Committee, whose role is to advise the Board about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors. The Committee meets as required.

Membership of the Committee is comprised of the Trust's Chair and all Non-Executive Directors. At 31 March 2016, these were:

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

During 2015/16, the composition of the Committee changed;

Remuneration for the Trust's Executive Directors is set by reference to job scope, personal responsibility and performance, and taking into account comparison with remuneration levels for similar posts, both within the National Health Service and the local economy. Whilst performance is taken into account in setting and reviewing remuneration, there are no arrangements in place for 'performance related pay'. The granting of annual inflationary increases are considered and determined by the remuneration committee on an annual basis. In 2015-2016 no inflationary rises were approved.

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

During 2015/16, the composition of the Board members also changed; Executive Director Raffaela Goodby was appointed as an employee of the Trust on 1st December 2015

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

Raffaela Goodby, Director of Organisation Development.

Richard Samuda, Trust Chairman.

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

Notes to Salaries and Allowances of Senior Managers

1. Raffaela Goodby was seconded to the Trust for the period 11/2/15 to 30/11/15 at which point the appointment was made on a substantive basis and employed direct by the Trust. The payments listed under salary represent the total salary paid during 2015-16 without any additional costs. The invoiced cost incurred by the Trust while employed at Birmingham City Council for the period 1/4/15 to 30/11/15, inclusive of National Insurance and VAT was in the banding £95k-100k. Salary received during direct employment with the Trust from 1/12/15 to 31/3/16 was in the band £30-35k
2. Non-Executive Directors - do not receive pensionable remuneration and therefore do not accrue any pension related benefits.
3. Pension Related Benefits are a nationally determined calculation designed to show the in year increase in notional pension benefits, excluding employee contributions, which have accrued to the individual. Changes in benefits will be dependent on the particular circumstances of each individual.
4. The banded remuneration listed for Roger Stedman Medical Director, includes salary in the banding £xx-£xx for his Clinical rol

Pensions

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

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pensions payable from the scheme. CETV's are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

Real Increase in CETV

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

PENSION BENEFITS								
Name and title	Real increase in pension at age 60	Real increase in Lump sum at pension age	Total accrued pension at pension age at 31st March 2016	Lump sum at pension age related to accrued pension at 31st March 2016	Cash Equivalent Transfer Value at 31st March 2016	Cash Equivalent Transfer Value at 31st March 2015	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000	To nearest £000
Toby Lewis, Chief Executive	2.5-5.0	0	40-45	120-125	609	639	0	0
Antony Waite, Director of Finance & Performance Management	0-2.5	0-2.5	45-50	135-140	844	783	52	0
Colin Ovington, Chief Nurse	0-2.5	0-2.5	50-55	160-165	1080	1043	25	0
Roger Stedman, Medical Director	0-2.5	0	40-45	115-120	675	663	3	0
Rachel Barlow, Chief Operating Officer	0-2.5	0	30-35	90-95	491	468	17	0
Kam Dhami, Director of Governance	0-2.5	0	30-35	95-100	529	508	15	0
Raffaela Goodby, Director of Workforce & Organisation Development (from 11 February 2015) - Pension Scheme Member from 1 December 2015	0-2.5	0	0-5	0	4	0	4	0

Pay Multiples

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

The banded remuneration of the highest paid director in the Trust in the 2015/16 was £180,000 (2014/15, £180,000). This was seven times (2014/15, seven) the median remuneration of the workforce, which was £25,298 (2014/15, £26,974).

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

Total remuneration includes salary and any additional payments for overtime, additional activities and enhancements but excludes any severance pay, employer pension and national insurance contributions. Employees of the Trust do not receive performance related pay nor benefits in kind.

The Trust's average workforce numbers totalled 6879, and the change in average number of WTE employed across the year was a reduction of 231. The change in WTE employed from March 2015 to March 2016 was a reduction of 98. This has not resulted in any material changes to the composition of the workforce.

The basic pay of the Trust's most highly paid individual has increased between 2014-15 and 2015-16 by 27% (from £213,556 to £272.256,). However, this includes elements of pay that are wholly variable and may change significantly from one year to another for this and any other individuals in receipt of them.

The vast majority of Trust employees are subject to national pay settlements and have, in accordance with those national settlements, received a non-consolidated inflationary increase in pay in 2015-16 of 1%. Where applicable, employees have continued to make incremental progression within existing pay scales. Pay settlements have not had a material effect on the calculation of the pay multiple above.

Off-payroll engagements as of 31 March 2016, for more than £220 per day and that last longer than six months

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

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

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

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

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

Staff Report

Our workforce

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

Staff engagement

The organisation is widely acknowledge for its long term commitment to improve employee engagement and current acts on staff feedback through one of the most comprehensive real-time staff feedback systems in the country, known as 'Your Voice'. This year the survey has improved its response by being available for completion on wards and in front line areas on iPads. The responses have informed the Trust's action plans on sickness, safety, security, education and learning as well as learning from incidents. Our Trust again took part in the national NHS engagement survey which saw some positive increases in our employee engagement since last year including our staff's view of the Trust on advocating and quality of care.

- Care of patients/service users is my organisations top priority is up 9% from last year to 72%
- My organisation acts on concerns raised by patients service users up 8% from last year to 72%
- If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation is up by 6% to 61%
- I would recommend my organisation as a place to work is up 5% from last year to 51% - still a long way to go and below national average of 54%
- View of staff on organisation acting fairly with regard to career progression/promotion is 87% up 4% from last year
- Discrimination from patients showing downward trend

Health and wellbeing

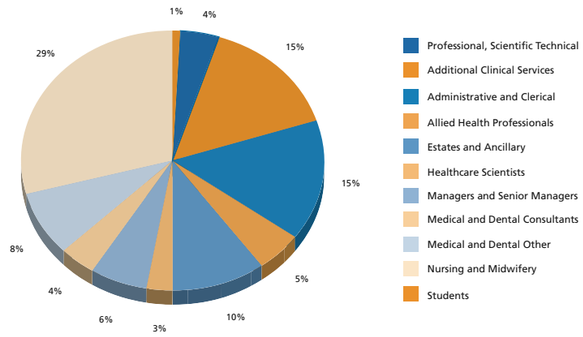
Sickness absence remains above the Trust's target with the current year to date figure at 5.02% which is a slight decrease on last year's figure. The past year has seen some of the clinical groups develop a strong grip on sickness, and robust executive leadership is now in place by the Director of Organisation Development. Surgery B remain as the leaders in managing sickness, with significant progress made by Community and Therapies and Imaging to improving their position in the past 12 months. The Flu Jab Campaign was the most successful in the region with 73.3% of our patient facing staff taking up the free flu jab, against a national average of frontline healthcare workers of 50.8% The campaign has won national awards and been featured as a positive case study on the NHS Employers Website. 'Flu Fighter Fred' was an honoured guest at the annual staff awards and the work of the Occupational Health Team and the peer vaccinator programme was recognised and celebrated. The Trust continue to focus on healthy eating and wellbeing campaigns including the 'Go Green' campaign which has reduced the number of chips sold in the Trust by half in the past 12 months. This will continue to be a focus in 2016/17 as an important contribution to the health and wellbeing of our workforce.

Staff safety and security

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

Ben Mears, the Trust's new Security Manager.

Workforce Profile 2015/16



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

Workforce profile inc sex of directors and employees

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

Senior managers by band

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

Education plan

During this year the Trust developed and launched an ambitious 3 year education learning and development plan. The plan sets out the journey the Trust will take to becoming a learning organization , working with education establishments, partners and community groups to commission and deliver learning opportunities to all of our 7000 colleagues. The aims and objectives are centered on attracting talented people to our Trust, induction and the first 100 days, developing and retaining skilled colleagues and how we develop senior leaders and specialists.

Appraisal and revalidation

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

Recruitment activity

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

Sickness absence data and actions

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

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

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

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

Listening to our staff

We implement the largest staff survey programme, Your Voice, in the NHS, polling every member of staff four times a year. Your Voice asks for staff opinions through questions that generate a score for engagement, advocacy, motivation and involvement that can be compared by directorate. Each survey has an anonymous comments field so that staff can share their suggestions.

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

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

Support for disabled employees

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

Apprentice programme

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

Equality, Diversity and Inclusion

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

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

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

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

Sustainability Report 2015/16

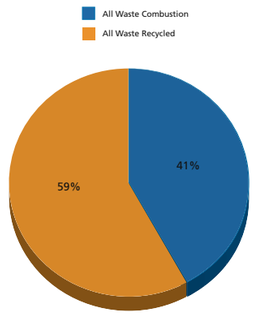
A sustainable health care system is achieved by delivering high quality care and improved public health without exhausting resources or causing excessive environmental damage. As a consumer of resources, Sandwell and West Birmingham Hospital NHS Trust recognise that we have a responsibility to work in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

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

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

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

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



Our Sustainability Plans

As part of the Trust's Public Health Plan, in 2014 we set the following targets for 2017; to stabilise energy consumption, reduce the amount of waste we send to landfill, and improve on our NHS Good Corporate Citizen Assessment score – all of which have been achieved. Encouraged by this we have made further progress in improving sustainable travel, including more facilities for cyclist and trialling an electric vehicle. We also have a growing number of Sustainability Champions who help increase the awareness of sustainability throughout

Birmingham Treatment Centre.

Sandwell Hospital.

Rowley Regis Hospital.

Leasowes Intermediate Care Centre.

Our finances and investments

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

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

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

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

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

These duties are further explained as follows:

Breakeven Duty

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

As has been the case in previous years, the presentation of financial results requires additional explanation owing to adjustments generated by valuation updates to the Trust's assets as well as changes to the accounting treatment for donated and government grant funded capital assets. These technicalities are explained in the detailed notes to the Trust's published 2015/16 Statutory Accounts (separate document).

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

Figure 6.1

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

Although impairments and reversals are not counted towards measuring I&E performance, they must be included in the Statutory Accounts and on the face of the Statement of Comprehensive Income (SOCI). Impairments and reversals transactions are non-cash in nature and do not affect patient care budgets. However, it is important that the Trust's assets are carried at their true values so that users of its financial statements receive a fair and true view of the Statement of Financial Position (Balance Sheet). DH holds allocations centrally for the impact of impairments and reversals.

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

CRL

Further detailed information on capital spend is shown below at Figure 6.5. The CRL sets a maximum amount of capital expenditure a trust may incur in a financial year (April to March). Trusts are not permitted to overshoot the CRL although the Trust may undershoot. Against its CRL of £19.860m for 2015/16, the Trust's capital expenditure was £19.820m, thereby undershooting by £0.040m and achieving this financial duty.

EFL

The EFL is a control on the amount a trust may borrow and also determines the amount of cash which must be held at the end of the financial year. Trusts are not allowed to overshoot the EFL although the trust is permitted to undershoot. Against its EFL of £1.217m, the Trust's cash flow financing was £1.431m, thereby undershooting by £0.214m and achieving this financial duty.

Capital Cost Absorption Rate

The capital cost absorption rate is a rate of return on the capital employed by the Trust which is set nationally at 3.5%. The value of this rate of return is reflected in the SOCI as PDC dividend (as shown in Figure 6.1), an amount which trusts pay back to DH to reflect a 3.5% return. The value of the dividend/rate of return is calculated at the end of the year on actual capital employed being set automatically at 3.5% and accordingly the Trust has achieved this financial duty.

Income from Commissioners and other sources

The main components of the Trust's income £443.698m in 2015/16 are shown below in Figure 6.2 which shows an overall decrease of £2.892m, 0.65%.

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

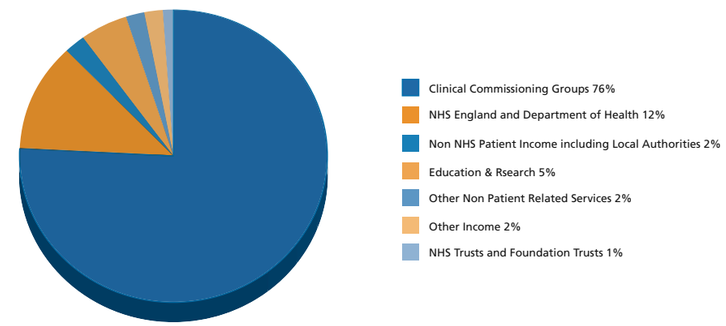
Figure 6.2

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

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

Income by catergory 2015/16

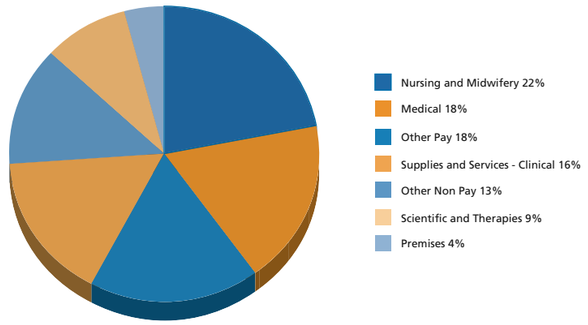


Expenditure

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

Figure 6.4

Expenditure by category 2015/16

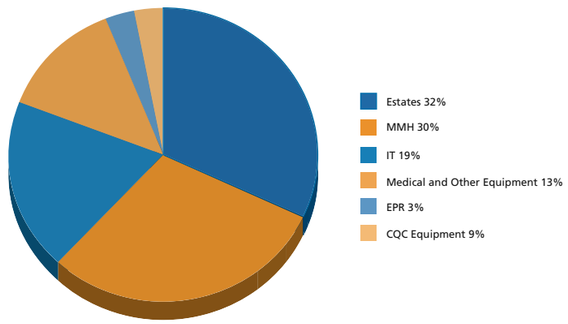


Use of Capital Resources

Capital expenditure differs to day to day operational budgets and involves tangible and non-tangible items costing more than £5,000 and having an expected life of more than one year. In total, the Trust spent £19.820m on capital items during 2015/16. A breakdown of this expenditure is shown in the pie chart below.

Figure 6.5

Capital spend 2015/16



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

Staff Sickness

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

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

Audit

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

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

As far as the Directors are aware, there is no relevant audit information of which the Trust's Auditors are unaware. In addition the Directors have taken all the steps they ought to have taken as directors to ensure they are aware of any relevant audit information and to establish that the Trust's Auditor is aware of that information.

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

FINANCIAL STATEMENTS

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

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

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

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

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

By order of the Board

Toby Lewis
(Chief Executive)
2 June 2016

Anthony M Waite
(Director of Finance & Performance Management)
2 June 2016

Statement of Comprehensive Income for year ended 31 March 2016

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

Other Comprehensive Income

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

Financial performance for the year

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

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

a) The revenue cost of bringing PFI assets onto the balance sheet (due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009/10) - NHS Trusts' financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to PFI, which has no cash impact and is not chargeable for overall budgeting purposes, should be reported as technical. Where there is a positive financial consequence, the performance figures are not adjusted.

b) The Trust is required to revalue its Land and Buildings on a regular basis as a result of the IFRS implementation and this has resulted in an impairment of its Land and Buildings of £44.5m, £36.2m of which was absorbed by the Revaluation Reserve which has been built up over a number of years. However, an impairment of £8.3m has been recognised in the I&E account (represented as £7.0m impairments and £1.3m IFRIC12 impairments) Impairments are specifically excluded from measurement of the Trust's financial performance.

c) Due to change in accounting requirement, elimination of donated and government grant reserve has resulted in the Trust recording income of £0.527m. Income resulting from the application of this change which has no cash impact and is not chargeable for overall budgeting purposes is removed as a technical adjustment. In addition the revenue impact of depreciation, £0.248m, relating to Donated assets was previously offset by a release from the Donated Asset Reserve. Following revision to the reporting manuals this cost is charged to the Trusts expenditure without any offset. This is therefore not considered part of the Trusts operating position and is adjusted. The net impact of these two adjustments is reported above as a technical adjustment to the Financial Performance of the Trust of (£0.279m)

Statement of Financial Position as at 31 March 2016

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

The notes on pages 100 to 122 form part of this account.

The financial statements on pages 87 to 89 were approved by the Board on 2nd June 2016 and signed on its behalf by

Chief Executive: Date:

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

	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Other reserves £000s	Total reserves £000s
Balance at 1 April 2015	**162,210**	**(13,758)**	**43,179**	**9,058**	**200,689**
Changes in taxpayers' equity for 2015-16					
Retained surplus/(deficit) for the year		(4,254)			**(4,254)**
Net gain / (loss) on revaluation of property, plant, equipment			0		**0**
Net gain / (loss) on revaluation of intangible assets			0		**0**
Net gain / (loss) on revaluation of financial assets			0		**0**
Net gain / (loss) on revaluation of available for sale financial			0		**0**
Impairments and reversals			(36,230)		**(36,230)**
Other gains/(loss) (provide details below)				0	**0**
Transfers between reserves		19	(19)	0	**0**
Reclassification Adjustments					
Transfers between Reserves in respect of assets transferred under absorption	0	0	0	0	**0**
On disposal of available for sale financial assets			0		**0**
Reserves eliminated on dissolution		0	0	0	**0**
Originating capital for Trust established in year	0				**0**
Permanent PDC received - cash	0				**0**
Permanent PDC repaid in year	(500)				**(500)**
PDC written off	0	0			**0**
Transfer due to change of status from Trust to Foundation Trust	0	0	0	0	**0**
Other movements	0	0	0	0	**0**
Net actuarial gain/(loss) on pension				0	**0**
Other pensions remeasurement				0	**0**
Net recognised revenue/(expense) for the year	**(500)**	**(4,235)**	**(36,249)**	**0**	**(40,984)**
Balance at 31 March 2016	**161,710**	**(17,993)**	**6,930**	**9,058**	**159,705**
Balance at 1 April 2014	**161,640**	**(19,484)**	**41,899**	**9,058**	**193,113**
Changes in taxpayers' equity for the year ended 31 March 2015					
Retained surplus/(deficit) for the year		4,585			4,585
Net gain / (loss) on revaluation of property, plant, equipment			0		0
Net gain / (loss) on revaluation of intangible assets			0		0
Net gain / (loss) on revaluation of financial assets			0		0
Net gain / (loss) on revaluation of assets held for sale			0		0
Impairments and reversals			2,421		2,421
Other gains / (loss)				0	0
Transfers between reserves		1,141	(1,141)	0	0
Reclassification Adjustments					
Transfers to/(from) Other Bodies within the Resource	0	0	0	0	0
Transfers between revaluation reserve & retained earnings reserve in respect of assets transferred under absorption		0	0		0
On disposal of available for sale financial assets			0		0
Originating capital for Trust established in year	0				0
New temporary and permanent PDC received - cash	570				570
New temporary and permanent PDC repaid in year	0				0
Other movements	0	0	0	0	0
Net actuarial gain/(loss) on pension				0	0
Other pension remeasurement				0	0
Net recognised revenue/(expense) for the year	**570**	**5,726**	**1,280**	**0**	**7,576**
Balance at 31 March 2015	**162,210**	**(13,758)**	**43,179**	**9,058**	**200,689**

Statement of Cash Flows for the Year ended 31 March 2016

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

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2015-16 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.2 Acquisitions and discontinued operations

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

1.3 Movement of assets within the DH Group

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

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

1.4 Charitable Funds

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact. The Board of Sandwell and West Birmingham Hospitals NHS Trust acts as a corporate Trustee for the Charitable Funds, however it has confirmed that the Charitable Funds are not material to the Trust accounts and has therefore not consolidated.

1.5 Critical accounting judgements and key sources of estimation uncertainty

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

1.5.1 Critical judgements in applying accounting policies

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

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the Trust has established that as it is the corporate trustee of the Sandwell and West Birmingham Hospitals NHS Trust Charities, charity number 1056127, it effectively has the power to exercise control so as to obtain economic benefits.

Total donations received during 2015 / 2016 were £1.161m and total resources expended were £1.918m which are only 0.43% of the Trust's Exchequer Funds.

IAS 1, Presentation of Financial Statements, says that specific disclosure requirements set out in individual standards or interpretations need not be satisfied if the information is not material and this guidance is reiterated in the NHS Manual for Accounts 2015-16.

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

PFI Asset Valuation

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

NOTES TO THE ACCOUNTS

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

1.5.2 Key sources of estimation uncertainty

Property Valuation

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

1.6 Revenue

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

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

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

1.7 Employee Benefits

Short-term employee benefits

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

Retirement benefit costs

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

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

1.8 Other expenses

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

NOTES TO THE ACCOUNTS

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

1.9 Property, plant and equipment

Recognition

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

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

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.
Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:
- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

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

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

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

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

Subsequent expenditure

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

NOTES TO THE ACCOUNTS

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

1.9 Property, plant and equipment

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

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

Valuation
All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.
Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:
● Land and non-specialised buildings – market value for existing use
● Specialised buildings – depreciated replacement cost

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

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

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

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

NOTES TO THE ACCOUNTS

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

1.16 Private Finance Initiative (PFI) transactions
HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received
The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'

PFI Asset
The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the NHS trust to the operator for use in the scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the NHS trust's Statement of Financial Position.

NOTES TO THE ACCOUNTS

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

1.16 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the NHS trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the NHS trust's Statement of Financial Position.

NOTES TO THE ACCOUNTS

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

Other assets contributed by the NHS trust to the operator

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

1.17 Inventories

Inventories are valued at the lower of cost and net realisable value using the *[first-in first-out/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 rate of xx% in real terms (xx% for employee early departure obligations).

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

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

NOTES TO THE ACCOUNTS

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

1.20 Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at Note 23

1.21 Non-clinical risk pooling
The NHS trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.22 Carbon Reduction Commitment Scheme (CRC)
CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.23 Contingencies
A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.24 Financial assets
Financial assets are recognised when the NHS trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through profit and loss
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the NHS trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset. *[Disclose how fair value is determined.]*

Held to maturity investments
Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

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

NOTES TO THE ACCOUNTS

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

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

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the NHS trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly.

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

1.25 Financial liabilities
Financial liabilities are recognised on the statement of financial position when the NHS trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

Financial guarantee contract liabilities
Financial guarantee contract liabilities are subsequently measured at the higher of:

- The amount of the obligation under the contract, as determined in accordance with IAS 37 *Provisions, Contingent Liabilities and Contingent Assets*; and
- The premium received (or imputed) for entering into the guarantee less cumulative amortisation.

Financial liabilities at fair value through profit and loss
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the NHS trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

Other financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.26 Value Added Tax
Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.27 Foreign currencies
The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

1.28 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 32 to the accounts

NOTES TO THE ACCOUNTS

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

1.29 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

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

1.30 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had The Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.31 Subsidiaries

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

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

1.32 Associates

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

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

1.33 Joint arrangements

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

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

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

1.34 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

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

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

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

2. Revenue from patient care activities

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

3. Other operating revenue

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

4. Overseas Visitors Disclosure

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

5. Operating expenses

	2015-16 £000s	2014-15 £000s
Services from other NHS Trusts	**1,020**	573
Services from CCGs/NHS England	**0**	86
Services from other NHS bodies	**2,146**	2,736
Services from NHS Foundation Trusts	**7,434**	7,401
Total Services from NHS bodies*	**10,600**	10,796
Purchase of healthcare from non-NHS bodies	**1,596**	1,438
Purchase of Social Care	**0**	
Trust Chair and Non-executive Directors	**66**	85
Supplies and services - clinical	**71,033**	73,094
Supplies and services - general	**6,485**	5,819
Consultancy services	**852**	2,230
Establishment	**3,884**	4,764
Transport	**1,527**	1,619
Service charges - ON-SOFP PFIs and other service concession arrangements	**863**	1,006
Service charges - On-SOFP LIFT contracts	**0**	0
Total charges - Off-SOFP PFIs and other service concession arrangements	**0**	0
Total charges - Off-SOFP LIFT contracts	**0**	0
Business rates paid to local authorities	**1,299**	1,799
Premises	**16,207**	16,801
Hospitality	**0**	0
Insurance	**110**	98
Legal Fees	**49**	191
Impairments and Reversals of Receivables	**515**	(9)
Inventories write down	**57**	50
Depreciation	**12,714**	13,126
Amortisation	**232**	237
Impairments and reversals of property, plant and equipment	**8,278**	(263)
Impairments and reversals of intangible assets	**112**	0
Impairments and reversals of financial assets	**0**	0
Impairments and reversals of non current assets held for sale	**0**	0
Internal Audit Fees	**197**	193
Audit fees	**91**	133
Other auditor's remuneration [detail]	**27**	7
Clinical negligence	**6,476**	6,676
Research and development (excluding staff costs)	**242**	297
Education and Training	**1,206**	1,102
Change in Discount Rate	**(23)**	(14)
Other	**1,020**	1,040
Total Operating expenses (excluding employee benefits)	**145,715**	142,315
Employee Benefits		
Employee benefits excluding Board members	**294,183**	291,090
Board members	**1,333**	1,163
Total Employee Benefits	**295,516**	292,253
Total Operating Expenses	**441,231**	434,568

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

6. Operating Leases

6.1. Sandwell and West Birmingham Hospitals NHS Trust as lessee

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

7. Employee benefits and staff numbers

7.1. Employee benefits

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

Employee Benefits - Gross Expenditure 2014-15	Total £000s	Permanently employed £000s	Other £000s
Salaries and wages	250,736	223,773	26,963
Social security costs	17,819	17,136	683
Employer Contributions to NHS BSA - Pensions Division	25,102	24,393	709
Other pension costs	0	0	0
Termination benefits	79	79	0
TOTAL - including capitalised costs	293,736	265,381	28,355
Employee costs capitalised	1,483	1,483	0
Gross Employee Benefits excluding capitalised costs	292,253	263,898	28,355

7.2. Staff Numbers

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

7.3. Staff Sickness absence and ill health retirements

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

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

7.4. Exit Packages agreed in 2015-16

2015-16

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

2014-15

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

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pensions Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme and are not included in the table.
This disclosure reports the number and value of exit packages agreed in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

7.5. Exit packages - Other Departures analysis

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

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period

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

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

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

7.6. Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

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

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

8. Better Payment Practice Code

8.1. Measure of compliance

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

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

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

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

9. Investment Revenue

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

10. Other Gains and Losses

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

11. Finance Costs

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

12.1. Property, plant and equipment

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

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

12.1. Property, plant and equipment (cont)

Additions to Assets Under Construction in 2015-16

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

12.2. Property, plant and equipment prior-year

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
2014-15	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Cost or valuation:									
At 1 April 2014	44,171	167,905	967	0	99,496	3,712	25,061	1,992	**343,304**
Additions of Assets Under Construction			0	6,303	4,043	121	2,364	5	**6,303**
Additions Purchased	0	4,255	0	0	51	0	0	0	**10,788**
Additions - Non Cash Donations (i.e. Physical Assets)	0	0	0	0	0	0	0	0	**51**
Additions Leased (including PFI/LIFT)	0	206	0	0	(2,169)	0	(63)	0	**206**
Disposals other than for sale	0	0	(69)	0	0	0	0	0	**(2,232)**
Revaluation	(6,816)	(13,724)	24	0	0	0	0	0	**(20,609)**
Reversal of Impairments charged to reserves	385	2,012	0	0	0	0	0	0	**2,421**
At 31 March 2015	**37,740**	**160,654**	**922**	**6,303**	**101,421**	**3,833**	**27,362**	**1,997**	**340,232**
Depreciation									
At 1 April 2014	7,261	6,856	13	0	78,359	2,921	20,194	1,297	**116,901**
Disposals other than for sale	0	0	0		(2,169)	0	(63)	0	**(2,232)**
Revaluation	(6,816)	(13,724)	(69)		0	0	0	0	**(20,609)**
Impairments/negative indexation charged to operating expenses	0	1,273	12	0	0	0	0	0	**1,285**
Reversal of Impairments charged to operating expenses	(445)	(1,103)	0	0	0	0	0	0	**(1,548)**
Charged During the Year	0	6,698	44	0	4,602	198	1,421	163	**13,126**
At 31 March 2015	**0**	**160,654**	**0**	**0**	**80,792**	**3,119**	**21,552**	**1,460**	**106,923**
Net Book Value at 31 March 2015	**37,740**		**922**	**6,303**	**20,629**	**714**	**5,810**	**537**	**233,309**
Asset financing:									
Owned - Purchased	37,740	139,344	922	6,303	19,902	714	5,810	537	**211,272**
Owned - Donated	0	394	0	0	727	0	0	0	**1,121**
Owned - Government Granted	0	951	0	0	0	0	0	0	**951**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	19,965	0	0	0	0	0	0	**19,965**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2015	**37,740**	**160,654**	**922**	**6,303**	**20,629**	**714**	**5,810**	**537**	**233,309**

12.3. Property, plant and equipment (cont)

The Trust's property assets (land and buildings) were revalued during the year by the District Valuation Service and using Modern Equivalent Asset valuation techniques with a valuation date of 1st April 2015. Valuation was undertaken with reference to the size, location and Service Potential of existing buildings and the basis on which they would be replaced by Modern Equivalent Assets. The Trust also revalued the property assets at 31st March 2016 to recognise any potential changes in indices since the 1st April 2015.

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

Asset lives for currently held assets are as follow:-

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

13. Intangible non-current assets

13.1. Intangible non-current assets

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

13.2. Intangible non-current assets prior year

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

13.3. Intangible non-current assets

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

An intangible asset in respect of Carbon Emission Credits is included in the Trust's accounts to reflect the receipt and consumption of these credits. They are valued at market price at 31st March 2016.

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

	2015-16 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Other	18,434
Changes in market price	(10,156)
Total charged to Annually Managed Expenditure	**8,278**
Total Impairments of Property, Plant and Equipment changed to SoCI	**8,278**
Intangible assets impairments and reversals charged to SoCI	
Unforeseen obsolescence	112
Total charged to Annually Managed Expenditure	**112**
Total Impairments of Intangibles charged to SoCI	**112**
Total Impairments charged to SoCI - AME	**8,390**
Overall Total Impairments	**8,390**

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

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

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

15. Commitments

15.1. Capital commitments

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

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

16. Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with Other Central Government Bodies	1,173	0	6,584	0
Balances with Local Authorities	0	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	32	0
Balances with NHS bodies inside the Departmental Group	10,314	0	11,756	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with Bodies External to Government	4,821	846	37,078	25,591
At 31 March 2016	**16,308**	**846**	**55,450**	**25,591**
prior period:				
Balances with Other Central Government Bodies	1,286	0	3,625	0
Balances with Local Authorities	443	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS bodies inside the Departmental Group	11,156	0	9,500	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with Bodies External to Government	4,243	890	35,653	26,898
At 31 March 2015	**17,128**	**890**	**48,778**	**26,898**

17. Inventories

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

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

18.1. Trade and other receivables

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

The great majority of trade is with NHS Clinical Commissioning Groups (CCG's) . As CCG's are funded by Government to buy NHS patient care

18.2. Receivables past their due date but not impaired

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

18.3. Provision for impairment of receivables

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

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

19. Cash and Cash Equivalents

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

20. Trade and other payables

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

21. Borrowings

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

Borrowings / Loans - repayment of principal falling due in:

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

22. Deferred income

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

23. Provisions

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

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

As at 31 March 2016	130,664
As at 31 March 2015	70,329

Provisions relating to Early Departure Costs covers pre 1995 early retirement costs. Liabilities and the timing of liabilities are based on pensions provided to individual ex employees and projected life expectancies using government actuarial tables. The major uncertainties rest around life expectancies assumed for the cases.

Legal claims cover the Trust's potential liabilities for Public and Employer liability. Potential liabilities are calculated using professional assessment of individual cases by the Trust's insurers. The Trust's maximum liability for any individual case is £10,000 with the remainder being covered by insurers.

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

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

Redundancy provisions covers staff who will be made redundant as part of the Trust's ongoing restructuring scheme

The timing and amount of the cashflows is shown above but it must be pointed out that, in the case of provisions, there will always be a measure of uncertainty. However, the values listed are best estimates taking all the relevant information and professional advice into consideration.

24. Contingencies

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

25. PFI and LIFT - additional information

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

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

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

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

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

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

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

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

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

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

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

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

	2015-16 £000s	2014-15 £000s
No Later than One Year	**2,638**	4,407
Later than One Year, No Later than Five Years	**8,760**	18,760
Later than Five Years	**31,134**	53,769
Subtotal	**42,532**	76,936
Less: Interest Element	**(15,635)**	(49,021)
Total	**26,897**	27,915

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due Analysed by when PFI payments are due	2015-16 £000s	2014-15 £000s
No Later than One Year	**1,306**	1,017
Later than One Year, No Later than Five Years	**3,990**	4,535
Later than Five Years	**21,601**	22,363
Total	**26,897**	27,915

Number of on SOFP PFI Contracts	
Total Number of on PFI contracts	**1**
Number of on PFI contracts which individually have a total commitments value in excess of £500m	**0**

26. Impact of IFRS treatment - current year

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

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

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

27. Financial Instruments

27.1. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with commissioners and the way those commissioners are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The [organisation]'s treasury management operations are carried out by the finance department, within parameters defined formally within the [organisation]'s standing financial instructions and policies agreed by the board of directors. [organisation] treasury activity is subject to review by the [organisation]'s internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the strategic health authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2016 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

27.2. Financial Assets

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

27.3. Financial Liabilities

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

PFI & finance lease obligations relate to amounts payable in respect of the Trust's PFI and finance lease funded assets over the remaining life of the arrangements.

28. Events after the end of the reporting period

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

29. Related party transactions

During the year none of the Department of Health Ministers, trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Sandwell & West Birmingham Hospitals NHS Trust.

The Department of Health is regarded as a related party. During the year 2015/16 Sandwell and West Birmingham Hospitals NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These are listed below

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

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Department for Education and Skills in respect of University Hospitals, Sandwell MBC and Birmingham City Council.

The Trust has also received revenue and capital payments from a number of charitable funds, certain of the trustees for which are also members of the Trust board.

30. Losses and special payments

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

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

The total number of losses cases in 2014-15 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	240,419	205
Special payments	269,749	91
Total losses and special payments	510,168	296

Details of cases individually over £300,000

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

31. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

31.1. Breakeven performance

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

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

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

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

31.2. Capital cost absorption rate

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

31.3. External financing

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

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

31.4. Capital resource limit

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

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

32. Third party assets

The Trust held cash and cash equivalents which relate to monies held by the NHS Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

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

Charity Accounts detail to come

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

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

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

How to find us

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

Birmingham City Hospital (this site includes Birmingham Treatment Centre, Birmingham Eye Centre, the Birmingham Skin Centre, and our midwife-led facility Serenity.) Dudley Road Birmingham West Midlands B18 7QH	**Sandwell General Hospital** Lyndon West Bromwich West Midlands B71 4HJ	**Rowley Regis Community Hospital** Moor Lane Rowley Regis West Midlands B65 8DA
Leasowes Intermediate Care Centre Oldbury Road Smethwick West Midlands B66 1JE	**Halcyon Birth Centre** Oldbury Road Smethwick West Midlands B66 1JE	

Car parking

Car parks are situated near the main entrances of each hospital site. Vehicles are parked and left at the owner's risk. Spaces for disabled badge holders can be found at various points all around our site. The car parks operate a pay by foot facility, except for two pay and display car parks at City Hospital. One is directly in front of the main entrance (for blue badge holders only), and the other is located by Hearing Services.

Reduced car parking charges

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

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

Parking rates from May 2016/17		
Discounted parking charge options For regular visitors and patients there are the following discounted parking charge options: Season tickets Three days unlimited parking - £9.00 One week unlimited parking -£18.00 Three months unlimited parking - £42.00 A £5 refundable deposit is required.	**Blue Badge Holders** The tariff applies to Blue Badge Scheme users. Parking for blue badge holders is located as close to main hospital buildings as possible.	**Patients on benefits** Anyone on a low income who is entitled benefits or receives income support can claim for reimbursement of bus fare can receive a token to allow free exit from hospital car parks. Bring proof of your benefits to any of the main receptions, or to the City Hospital Cash Office (located on the ground floor main corridor).

Patient Advice and Liaison Service (PALS)

By contacting PALS, you can talk to someone who is not involved in your care. You can ask questions, get advice or give your opinions.

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

To make an official complaint

To make a complaint, you can send it in writing to:
Complaints Department
Sandwell & West Birmingham Hospitals NHS Trust
City Hospital
Dudley Road
Birmingham
B18 7QH

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

PALS team members Norma Bayliss and Lorna Turner.

The new car park at Rowley Regis Hospital.

the trust charity

making **everyone** matter

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

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

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

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

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

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

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

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

We're waiting to hear from you!

SWBH Annual Report 2016 printed on 100% recycled paper

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Statements for the Year Ended 31st March 2016
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite (Director of Finance and Performance Management)
AUTHOR:	Tim Reardon (Associate Director of Finance – Compliance)
DATE OF MEETING:	2 June 2016

EXECUTIVE SUMMARY:

This report presents the Trust's financial statements for the year ended 31st March 2016. Those financial statements demonstrate that the Trust met its key financial duties for the financial year 2015/16.

The financial statements have been subject to review by the Trust's external auditors.
KPMG have indicated their intention to issue an unqualified opinion in respect of the financial statements and clean opinion on the trust's arrangements for securing value for money in the use of resources.

The ISA260 report issued by the auditors to those charged with governance draws attention to two particular matters:

1. An unadjusted audit difference of £0.4m in respect of a provision for credit notes on SLA income. This is not material to the audit opinion.
2. The application of a general hospital approach to the MEA valuation of current land and buildings. The auditors are seeking a management representation in respect of this matter.

The ISA260 report has been considered by the Audit Committee. The report has been made available to all members of the Board in support of its consideration of the financial statements.

The Trust is requested to provide a Letter of Representation in support of the financial statements which is attached for the Board's consideration.

REPORT RECOMMENDATION:

The Board is recommended to

1. accept the Audit Committee's recommendation to adopt the financial statements
2. authorise the CEO & FD to sign relevant certificates in regard to those financial statements
3. review the draft Letter of Representation and to challenge and confirm that
   a) That the application of a general hospital approach by the trust's professional valuer in arriving at his MEA valuation is an appropriate representation of the existing service potential of current land and buildings
   b) There are no significant events occurring between 31.03.16 and 02.06.16 which are material to the financial statements as presented
   c) All relevant related parties are disclosed in the financial statements
   d) The proposed representations are fair & complete

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	X	

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial	x	Environmental		Communications & Media	
Business and market share		Legal & Policy	x	Patient Experience	
Clinical		Equality and Diversity		Workforce	

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Good governance and transparency in financial reporting

PREVIOUS CONSIDERATION:

Audit & Risk Management Committee on 1 June 2016

FOR DECISION

Annual Accounts – 2015/16

Key performance summary:

I&E breakeven	**√**	**£3.857m surplus as original plan**
Capital Resource Limit achieved	**√**	**£(214)k undershoot**
External Finance Limit achieved	**√**	**£ (40)k undershoot**
Capital Cost Absorption duty achieved	**√**	**3.5% as target**

Key points to note:

- The Trust is reporting a £3.857m surplus for DH performance measurement purposes. This is consistent with the trust's original plan and represents the fourth best reported surplus of all trusts in England. The trust has relied on the use of contingencies and other flexibilities in the achievement of that surplus. The underlying position is a deficit of c£12m which the trust will address during 2016-18.

- During the year the trust undertook a revaluation of building assets using an alternative modern equivalent asset valuation method. In undertaking this revaluation the trust's professional valuer applied a general hospital [as opposed to acute hospital] approach in assessing the existing service potential of current land and buildings. The use of this method was challenged and confirmed as appropriate by the Audit Committee. The impact of this revaluation was an impairment of £54.6m; of this £18.4m has been taken as a charge to the SOCI and £36.2m to revaluation reserves on the SOFP. Trust officers have confirmed to the Trust's auditors that the instructions provided to the District Valuer Services (DVS) were appropriate.

- Revised land & building indices were issued in Q4 and have informed a routine year end valuation of land and buildings. The impact of these indices gave rise to a revaluation increase of £10.2m (6.9%). This revaluation has been offset against the MEA charge to the SOCI.

- During 2015/16 the trust signed a contract for the Midland Metropolitan Hospital to be delivered under PF2. The notes to the accounts make appropriate disclosure of the future contractual obligations which total £698m over the period of the concession. This represents the nominal value of expected annual payments for the facility and services.

- During April 2016 the trust signed a contract for the provision of a managed equipment service for imaging equipment. The notes to the accounts make appropriate disclosures of the future contractual obligations which total £30m over the period of the concession. This represents the value of annual payments for equipment and maintenance.

- During FY 2015/16 the trust progressed significant workforce change. Trust officers have confirmed that the resulting provisions held for workforce change are complete and sufficient. There are no provisions or disclosures required in 2015/16 in respect of prospective workforce change in 2016/17. Any impact of that shall be recorded in the financial statements for that year.

Sandwell and West Birmingham Hospitals NHS Trust

Annual Accounts for the period

1 April 2015 to 31 March 2016

Statement of Comprehensive Income for year ended 31 March 2016

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

Other Comprehensive Income

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

Financial performance for the year

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

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

a) The revenue cost of bringing PFI assets onto the balance sheet (due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009/10) - NHS Trusts' financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to PFI, which has no cash impact and is not chargeable for overall budgeting purposes, should be reported as technical. Where there is a positive financial consequence, the performance figures are not adjusted.

b) The Trust is required to revalue its Land and Buildings on a regular basis as a result of the IFRS implementation and this has resulted in an impairment of its Land and Buildings of £44.5m, £36.2m of which was absorbed by the Revaluation Reserve which has been built up over a number of years. However, an impairment of £8.3m has been recognised in the I&E account (represented as £7.0m impairments and £1.3m IFRIC12 impairments) Impairments are specifically excluded from measurement of the Trust's financial performance.

c) Due to change in accounting requirement, elimination of donated and government grant reserve has resulted in the Trust recording income of £0.527m. Income resulting from the application of this change which has no cash impact and is not chargeable for overall budgeting purposes is removed as a technical adjustment. In addition the revenue impact of depreciation, £0.248m, relating to Donated assets was previously offset by a release from the Donated Asset Reserve. Following revision to the reporting manuals this cost is charged to the Trusts expenditure without any offset. This is therefore not considered part of the Trusts operating position and is adjusted. The net impact of these two adjustments is reported above as a technical adjustment to the Financial Performance of the Trust of (£0.279m)

The notes on pages 100 to 122 form part of this account.

Statement of Financial Position as at 31 March 2016

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

The notes on pages 100 to 122 form part of this account.

The financial statements on pages 87 to 89 were approved by the Board on 2nd June 2016 and signed on its behalf by

Chief Executive: Date:

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

	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Other reserves £000s	Total reserves £000s
Balance at 1 April 2015	**162,210**	**(13,758)**	**43,179**	**9,058**	**200,689**
Changes in taxpayers' equity for 2015-16					
Retained surplus/(deficit) for the year		(4,254)			**(4,254)**
Net gain / (loss) on revaluation of property, plant, equipment			0		**0**
Net gain / (loss) on revaluation of intangible assets			0		**0**
Net gain / (loss) on revaluation of financial assets			0		**0**
Net gain / (loss) on revaluation of available for sale financial			0		**0**
Impairments and reversals			(36,230)		**(36,230)**
Other gains/(loss) (provide details below)				0	**0**
Transfers between reserves		19	(19)	0	**0**
Reclassification Adjustments					
Transfers between Reserves in respect of assets transferred under absorption	0	0	0	0	**0**
On disposal of available for sale financial assets			0		**0**
Reserves eliminated on dissolution		0	0	0	**0**
Originating capital for Trust established in year	0				**0**
Permanent PDC received - cash	0				**0**
Permanent PDC repaid in year	(500)				**(500)**
PDC written off	0	0			**0**
Transfer due to change of status from Trust to Foundation Trust	0	0	0	0	**0**
Other movements	0	0	0	0	**0**
Net actuarial gain/(loss) on pension				0	**0**
Other pensions remeasurement				0	**0**
Net recognised revenue/(expense) for the year	**(500)**	**(4,235)**	**(36,249)**	**0**	**(40,984)**
Balance at 31 March 2016	**161,710**	**(17,993)**	**6,930**	**9,058**	**159,705**
Balance at 1 April 2014	**161,640**	**(19,484)**	**41,899**	**9,058**	**193,113**
Changes in taxpayers' equity for the year ended 31 March 2015					
Retained surplus/(deficit) for the year		4,585			4,585
Net gain / (loss) on revaluation of property, plant, equipment			0		0
Net gain / (loss) on revaluation of intangible assets			0		0
Net gain / (loss) on revaluation of financial assets			0		0
Net gain / (loss) on revaluation of assets held for sale			0		0
Impairments and reversals			2,421		2,421
Other gains / (loss)				0	0
Transfers between reserves		1,141	(1,141)	0	0
Reclassification Adjustments					
Transfers to/(from) Other Bodies within the Resource	0	0	0	0	0
Transfers between revaluation reserve & retained earnings reserve in respect of assets transferred under absorption		0	0		0
On disposal of available for sale financial assets			0		0
Originating capital for Trust established in year	0				0
New temporary and permanent PDC received - cash	570				570
New temporary and permanent PDC repaid in year	0				0
Other movements	0	0	0	0	0
Net actuarial gain/(loss) on pension				0	0
Other pension remeasurement				0	0
Net recognised revenue/(expense) for the year	**570**	**5,726**	**1,280**	**0**	**7,576**
Balance at 31 March 2015	**162,210**	**(13,758)**	**43,179**	**9,058**	**200,689**

Statement of Cash Flows for the Year ended 31 March 2016

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

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2015-16 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.2 Acquisitions and discontinued operations

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

1.3 Movement of assets within the DH Group

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

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

1.4 Charitable Funds

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact. The Board of Sandwell and West Birmingham Hospitals NHS Trust acts as a corporate Trustee for the Charitable Funds, however it has confirmed that the Charitable Funds are not material to the Trust accounts and has therefore not consolidated.

1.5 Critical accounting judgements and key sources of estimation uncertainty

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

1.5.1 Critical judgements in applying accounting policies

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

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the Trust has established that as it is the corporate trustee of the Sandwell and West Birmingham Hospitals NHS Trust Charities, charity number 1056127, it effectively has the power to exercise control so as to obtain economic benefits.

Total donations received during 2015 / 2016 were £1.161m and total resources expended were £1.918m which are only 0.43% of the Trust's Exchequer Funds.

IAS 1, Presentation of Financial Statements, says that specific disclosure requirements set out in individual standards or interpretations need not be satisfied if the information is not material and this guidance is reiterated in the NHS Manual for Accounts 2015-16.

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

PFI Asset Valuation

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

NOTES TO THE ACCOUNTS

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

1.5.2 Key sources of estimation uncertainty

Property Valuation

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

1.6 Revenue

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

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

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

1.7 Employee Benefits

Short-term employee benefits

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

Retirement benefit costs

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

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

1.8 Other expenses

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

NOTES TO THE ACCOUNTS

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

1.9 Property, plant and equipment

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

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

Valuation
All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.
Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:
● Land and non-specialised buildings – market value for existing use
● Specialised buildings – depreciated replacement cost

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

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

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

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

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

NOTES TO THE ACCOUNTS

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

1.10 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 fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:
- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

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

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

1.11 Depreciation, amortisation and impairments
Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS trust expects to obtain economic benefits or service potential from the asset. This is specific to the 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 their estimated useful lives.

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

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.12 Donated assets
Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.13 Government grants
Government grant funded assets are capitalised at their 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.

NOTES TO THE ACCOUNTS

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

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 on interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

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

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

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

The NHS trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the 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.

NOTES TO THE ACCOUNTS

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

1.16 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the NHS trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the NHS trust's Statement of Financial Position.

NOTES TO THE ACCOUNTS

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

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

1.17 Inventories
Inventories are valued at the lower of cost and net realisable value using the *[first-in first-out/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 rate of xx% in real terms (xx% for employee early departure obligations).

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

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

NOTES TO THE ACCOUNTS

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

1.20 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at Note 23

1.21 Non-clinical risk pooling

The NHS trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.22 Carbon Reduction Commitment Scheme (CRC)

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.23 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.24 Financial assets

Financial assets are recognised when the NHS trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the NHS trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset. *[Disclose how fair value is determined.]*

Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Available for sale financial assets

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

NOTES TO THE ACCOUNTS

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

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

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the NHS trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly.

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

1.25 Financial liabilities
Financial liabilities are recognised on the statement of financial position when the NHS trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

Financial guarantee contract liabilities
Financial guarantee contract liabilities are subsequently measured at the higher of:

● The amount of the obligation under the contract, as determined in accordance with IAS 37 *Provisions, Contingent Liabilities and Contingent Assets* ; and

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

Financial liabilities at fair value through profit and loss
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the NHS trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

Other financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.26 Value Added Tax
Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.27 Foreign currencies
The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

1.28 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 32 to the accounts

NOTES TO THE ACCOUNTS

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

1.29 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

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

1.30 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had The Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.31 Subsidiaries

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

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

1.32 Associates

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

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

1.33 Joint arrangements

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

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

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

1.34 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

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

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

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

2. Revenue from patient care activities

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

3. Other operating revenue

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

4. Overseas Visitors Disclosure

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

5. Operating expenses

	2015-16 £000s	2014-15 £000s
Services from other NHS Trusts	**1,020**	573
Services from CCGs/NHS England	**0**	86
Services from other NHS bodies	**2,146**	2,736
Services from NHS Foundation Trusts	**7,434**	7,401
Total Services from NHS bodies*	**10,600**	10,796
Purchase of healthcare from non-NHS bodies	**1,596**	1,438
Purchase of Social Care	**0**	
Trust Chair and Non-executive Directors	**66**	85
Supplies and services - clinical	**71,033**	73,094
Supplies and services - general	**6,485**	5,819
Consultancy services	**852**	2,230
Establishment	**3,884**	4,764
Transport	**1,527**	1,619
Service charges - ON-SOFP PFIs and other service concession arrangements	**863**	1,006
Service charges - On-SOFP LIFT contracts	**0**	0
Total charges - Off-SOFP PFIs and other service concession arrangements	**0**	0
Total charges - Off-SOFP LIFT contracts	**0**	0
Business rates paid to local authorities	**1,299**	1,799
Premises	**16,207**	16,801
Hospitality	**0**	0
Insurance	**110**	98
Legal Fees	**49**	191
Impairments and Reversals of Receivables	**515**	(9)
Inventories write down	**57**	50
Depreciation	**12,714**	13,126
Amortisation	**232**	237
Impairments and reversals of property, plant and equipment	**8,278**	(263)
Impairments and reversals of intangible assets	**112**	0
Impairments and reversals of financial assets	**0**	0
Impairments and reversals of non current assets held for sale	**0**	0
Internal Audit Fees	**197**	193
Audit fees	**91**	133
Other auditor's remuneration [detail]	**27**	7
Clinical negligence	**6,476**	6,676
Research and development (excluding staff costs)	**242**	297
Education and Training	**1,206**	1,102
Change in Discount Rate	**(23)**	(14)
Other	**1,020**	1,040
Total Operating expenses (excluding employee benefits)	**145,715**	142,315
Employee Benefits		
Employee benefits excluding Board members	**294,183**	291,090
Board members	**1,333**	1,163
Total Employee Benefits	**295,516**	292,253
Total Operating Expenses	**441,231**	434,568

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

6. Operating Leases

6.1. Sandwell and West Birmingham Hospitals NHS Trust as lessee

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

7. Employee benefits and staff numbers

7.1. Employee benefits

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

Employee Benefits - Gross Expenditure 2014-15	**Total £000s**	**Permanently employed £000s**	**Other £000s**
Salaries and wages	250,736	223,773	26,963
Social security costs	17,819	17,136	683
Employer Contributions to NHS BSA - Pensions Division	25,102	24,393	709
Other pension costs	0	0	0
Termination benefits	79	79	0
TOTAL - including capitalised costs	293,736	265,381	28,355
Employee costs capitalised	1,483	1,483	0
Gross Employee Benefits excluding capitalised costs	292,253	263,898	28,355

7.2. Staff Numbers

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

7.3. Staff Sickness absence and ill health retirements

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

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

7.4. Exit Packages agreed in 2015-16

2015-16

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

2014-15

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

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pensions Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

7.5. Exit packages - Other Departures analysis

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

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period

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

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

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

7.6. Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

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

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

8. Better Payment Practice Code

8.1. Measure of compliance

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

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

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

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

9. Investment Revenue

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

10. Other Gains and Losses

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

11. Finance Costs

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

12.1. Property, plant and equipment

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

Revaluation Reserve Balance for Property, Plant & Equipment

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

12.1. Property, plant and equipment (cont)

Additions to Assets Under Construction in 2015-16

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

12.2. Property, plant and equipment prior-year

2014-15	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2014	44,171	167,905	967	0	99,496	3,712	25,061	1,992	**343,304**
Additions of Assets Under Construction				6,303					**6,303**
Additions Purchased	0	4,255	0		4,043	121	2,364	5	**10,788**
Additions - Non Cash Donations (i.e. Physical Assets)	0	0	0	0	51	0	0	0	**51**
Additions Leased (including PFI/LIFT)	0	206	0		0	0	0	0	**206**
Disposals other than for sale	0	0	0	0	(2,169)	0	(63)	0	**(2,232)**
Revaluation	(6,816)	(13,724)	(69)	0	0	0	0	0	**(20,609)**
Reversal of Impairments charged to reserves	385	2,012	24	0	0	0	0	0	**2,421**
At 31 March 2015	**37,740**	**160,654**	**922**	**6,303**	**101,421**	**3,833**	**27,362**	**1,997**	**340,232**
Depreciation									
At 1 April 2014	7,261	6,856	13	0	78,359	2,921	20,194	1,297	**116,901**
Disposals other than for sale	0	0	0		(2,169)	0	(63)	0	**(2,232)**
Revaluation	(6,816)	(13,724)	(69)		0	0	0	0	**(20,609)**
Impairments/negative indexation charged to operating expenses	0	1,273	12	0	0	0	0	0	**1,285**
Reversal of Impairments charged to operating expenses	(445)	(1,103)	0	0	0	0	0	0	**(1,548)**
Charged During the Year	0	6,698	44		4,602	198	1,421	163	**13,126**
At 31 March 2015	**0**	**0**	**0**	**0**	**80,792**	**3,119**	**21,552**	**1,460**	**106,923**
Net Book Value at 31 March 2015	**37,740**	**160,654**	**922**	**6,303**	**20,629**	**714**	**5,810**	**537**	**233,309**
Asset financing:									
Owned - Purchased	37,740	139,344	922	6,303	19,902	714	5,810	537	**211,272**
Owned - Donated	0	394	0	0	727	0	0	0	**1,121**
Owned - Government Granted	0	951	0	0	0	0	0	0	**951**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	19,965	0	0	0	0	0	0	**19,965**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2015	**37,740**	**160,654**	**922**	**6,303**	**20,629**	**714**	**5,810**	**537**	**233,309**

12.3. Property, plant and equipment (cont)

The Trust's property assets (land and buildings) were revalued during the year by the District Valuation Service and using Modern Equivalent Asset valuation techniques with a valuation date of 1st April 2015. Valuation was undertaken with reference to the size, location and Service Potential of existing buildings and the basis on which they would be replaced by Modern Equivalent Assets. The Trust also revalued the property assets at 31st March 2016 to recognise any potential changes in indices since the 1st April 2015.

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

Asset lives for currently held assets are as follow:-

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

13. Intangible non-current assets

13.1. Intangible non-current assets

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

Revaluation reserve balance for intangible non-current assets						
						£000's
At 1 April 2015	0	0	0	0	0	**0**
Movements (specify)	0	0	0	0	0	**0**
At 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**

13.2. Intangible non-current assets prior year

2014-15	IT - in-house & 3rd party software £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 2014	0	2,901	0	185	0	3,086
Additions - purchased	0	0	0	28	0	28
At 31 March 2015	0	2,901	0	213	0	3,114
Amortisation						
At 1 April 2014	0	2,200	0	0	0	2,200
Charged during the year	0	237	0	0	0	237
At 31 March 2015	0	2,437	0	0	0	2,437
Net book value at 31 March 2015	0	464	0	213	0	677
Net book value at 31 March 2015 comprises:						
Purchased		464		213		677
Total at 31 March 2015	0	464	0	213	0	677

13.3. Intangible non-current assets

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

An intangible asset in respect of Carbon Emission Credits is included in the Trust's accounts to reflect the receipt and consumption of these credits. They are valued at market price at 31st March 2016.

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

	2015-16 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Other	18,434
Changes in market price	(10,156)
Total charged to Annually Managed Expenditure	**8,278**
Total Impairments of Property, Plant and Equipment changed to SoCI	**8,278**
Intangible assets impairments and reversals charged to SoCI	
Unforeseen obsolescence	112
Total charged to Annually Managed Expenditure	**112**
Total Impairments of Intangibles charged to SoCI	**112**
Total Impairments charged to SoCI - AME	**8,390**
Overall Total Impairments	**8,390**

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

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

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

15. Commitments

15.1. Capital commitments

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

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

16. Intra-Government and other balances

	Current receivables	**Non-current receivables**	**Current payables**	**Non-current payables**
	£000s	**£000s**	**£000s**	**£000s**
Balances with Other Central Government Bodies	1,173	0	6,584	0
Balances with Local Authorities	0	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	32	0
Balances with NHS bodies inside the Departmental Group	10,314	0	11,756	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with Bodies External to Government	4,821	846	37,078	25,591
At 31 March 2016	**16,308**	**846**	**55,450**	**25,591**
prior period:				
Balances with Other Central Government Bodies	1,286	0	3,625	0
Balances with Local Authorities	443	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS bodies inside the Departmental Group	11,156	0	9,500	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with Bodies External to Government	4,243	890	35,653	26,898
At 31 March 2015	**17,128**	**890**	**48,778**	**26,898**

17. Inventories

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

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

18.1. Trade and other receivables

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

The great majority of trade is with NHS Clinical Commissioning Groups (CCG's) . As CCG's are funded by Government to buy NHS patient care

18.2. Receivables past their due date but not impaired

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

18.3. Provision for impairment of receivables

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

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

19. Cash and Cash Equivalents

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

20. Trade and other payables

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

21. Borrowings

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

Borrowings / Loans - repayment of principal falling due in:

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

22. Deferred income

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

23. Provisions

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

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

As at 31 March 2016	130,664
As at 31 March 2015	70,329

Provisions relating to Early Departure Costs covers pre 1995 early retirement costs. Liabilities and the timing of liabilities are based on pensions provided to individual ex employees and projected life expectancies using government actuarial tables. The major uncertainties rest around life expectancies assumed for the cases.

Legal claims cover the Trust's potential liabilities for Public and Employer liability. Potential liabilities are calculated using professional assessment of individual cases by the Trust's insurers. The Trust's maximum liability for any individual case is £10,000 with the remainder being covered by insurers.

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

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

Redundancy provisions covers staff who will be made redundant as part of the Trust's ongoing restructuring scheme

The timing and amount of the cashflows is shown above but it must be pointed out that, in the case of provisions, there will always be a measure of uncertainty. However, the values listed are best estimates taking all the relevant information and professional advice into consideration.

24. Contingencies

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

25. PFI and LIFT - additional information

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

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

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

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

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

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

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

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

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

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

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

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

	2015-16	2014-15
	£000s	£000s
No Later than One Year	**2,638**	4,407
Later than One Year, No Later than Five Years	**8,760**	18,760
Later than Five Years	**31,134**	53,769
Subtotal	**42,532**	76,936
Less: Interest Element	**(15,635)**	(49,021)
Total	**26,897**	27,915

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due	**2015-16**	2014-15
Analysed by when PFI payments are due	**£000s**	£000s
No Later than One Year	**1,306**	1,017
Later than One Year, No Later than Five Years	**3,990**	4,535
Later than Five Years	**21,601**	22,363
Total	**26,897**	27,915

Number of on SOFP PFI Contracts	
Total Number of on PFI contracts	**1**
Number of on PFI contracts which individually have a total commitments value in excess of £500m	**0**

26. Impact of IFRS treatment - current year

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

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

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

27. Financial Instruments

27.1. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with commissioners and the way those commissioners are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The [organisation]'s treasury management operations are carried out by the finance department, within parameters defined formally within the [organisation]'s standing financial instructions and policies agreed by the board of directors. [organisation] treasury activity is subject to review by the [organisation]'s internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the strategic health authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2016 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

27.2. Financial Assets

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

27.3. Financial Liabilities

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

PFI & finance lease obligations relate to amounts payable in respect of the Trust's PFI and finance lease funded assets over the remaining life of the arrangements.

28. Events after the end of the reporting period

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

29. Related party transactions

During the year none of the Department of Health Ministers, trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Sandwell & West Birmingham Hospitals NHS Trust.

The Department of Health is regarded as a related party. During the year 2015/16 Sandwell and West Birmingham Hospitals NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These are listed below

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

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Department for Education and Skills in respect of University Hospitals, Sandwell MBC and Birmingham City Council.

The Trust has also received revenue and capital payments from a number of charitable funds, certain of the trustees for which are also members of the Trust board.

30. Losses and special payments

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

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

The total number of losses cases in 2014-15 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	240,419	205
Special payments	269,749	91
Total losses and special payments	510,168	296

Details of cases individually over £300,000

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

31. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

31.1. Breakeven performance

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

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

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

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

31.2. Capital cost absorption rate

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

31.3. External financing

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

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

31.4. Capital resource limit

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

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

32. Third party assets

The Trust held cash and cash equivalents which relate to monies held by the NHS Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

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

On SWBH Letterhead

Draft Management Representation Letter

Andrew Bostock
Partner
KPMG LLP
Audit
One Snowhill
Snow Hill Queensway
Birmingham
United Kingdom

02 June 2016

Dear Andrew

This representation letter is provided in connection with your audit of the financial statements of Sandwell and West Birmingham Hospitals NHS Trust ("the Trust"), for the year ended 31 March 2016, for the purpose of expressing an opinion:

i. as to whether these financial statements give a true and fair view of the state of the Trust as at 31 March 2016 and of its income and expenditure for the financial year then ended; and
ii. whether the financial statements have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as being relevant to NHS Trusts in England.

These financial statements comprise the Statement of Financial Position, the Statement of Comprehensive Income, the Statement of Cash Flows, the Statement of Changes in Equity and notes, comprising a summary of significant accounting policies and other explanatory notes.

The Board confirms that the representations it makes in this letter are in accordance with the definitions set out in the Appendix to this letter.

The Board confirms that, to the best of its knowledge and belief, having made such inquiries as it considered necessary for the purpose of appropriately informing itself:

Financial statements

1. The Board has fulfilled its responsibilities for the preparation of financial statements that:

    i. give a true and fair view of the financial position of the Trust as at 31 March 2016 and of its income and expenditure for that financial year; and
    ii. have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as being relevant to NHS Trusts in England.

    The financial statements have been prepared on a going concern basis.

2. Measurement methods and significant assumptions used by the Board in making accounting estimates, including those measured at fair value, are reasonable.

3. All events subsequent to the date of the financial statements and for which IAS 10 *Events after the reporting period* requires adjustment or disclosure have been adjusted or disclosed.

4. The effects of uncorrected misstatements are immaterial, both individually and in aggregate, to the financial statements as a whole. There are no uncorrected adjustments above £250,000 following the audit of the 2015/16 financial statements. The total of unadjusted audit differences is acknowledged to be £0.4m and which is not material to the financial statements.

Information provided

5. The Board has provided you with:

    - access to all information of which it is aware, that is relevant to the preparation of the financial statements, such as records, documentation and other matters;
    - additional information that you have requested from the Board for the purpose of the audit; and
    - unrestricted access to persons within the Trust from whom you determined it necessary to obtain audit evidence.

6. All transactions have been recorded in the accounting records and are reflected in the financial statements.

7. The Board confirms the following:

    i) The Board has disclosed to you the results of its assessment of the risk that the financial statements may be materially misstated as a result of fraud.

    Included in the Appendix to this letter are the definitions of fraud, including misstatements arising from fraudulent financial reporting and from misappropriation of assets.

    ii) The Board has disclosed to you all information in relation to:

    a) Fraud or suspected fraud that it is aware of and that affects the Trust and involves:
        - management;
        - employees who have significant roles in internal control; or
        - others where the fraud could have a material effect on the financial statements; and

    b) allegations of fraud, or suspected fraud, affecting the Trust's financial statements communicated by employees, former employees, analysts, regulators or others.

In respect of the above, the Board acknowledges its responsibility for such internal control as it determines necessary for the preparation of financial statements that are free from material misstatement, whether due to fraud or error. In particular, the Board acknowledges its responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

8. The Board has disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.

9. The Board has disclosed to you and has appropriately accounted for and/or disclosed in the financial statements, in accordance with IAS 37 *Provisions, Contingent Liabilities and Contingent Assets*, all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

10. The Board has disclosed to you the identity of the Trust's related parties and all the related party relationships and transactions of which it is aware. All related party relationships and transactions have been appropriately accounted for and disclosed in accordance with IAS 24 *Related Party Disclosures*.

11. The Board confirms that all intra-NHS balances included in the Statement of Financial Position (SOFP) at 31 March 2016 in excess of £100,000 have been disclosed to you and that the Trust has complied with the requirements of the Intra NHS Agreement of Balances Exercise. The Board confirms that Intra-NHS balances includes all balances with NHS counterparties, regardless of whether these balances are reported within those SOFP classifications formally deemed to be included within the Agreement of Balances exercise.

Included in the Appendix to this letter are the definitions of both a related party and a related party transaction as we understand them and as defined in IAS 24.

12. The Board confirms that:
    a) The financial statements disclose all of the key risk factors, assumptions made and uncertainties surrounding the Trust's ability to continue as a going concern as required to provide a true and fair view.
    b) No events or conditions have been identified that may cast significant doubt on the ability of the Trust to continue as a going concern.

13. The Trust is required to consolidate any NHS charitable funds which are determined to be subsidiaries of the Trust. The decision on whether to consolidate is dependent upon the financial materiality and governance arrangements of the charitable funds. The Board confirms that, having considered these factors, it is satisfied that the charitable funds do not require consolidation as they are not material to the Trust's financial statements.

14. The Trust confirms that the approach to the MEA valuation to apply a General Hospital approach adopted by the professional valuer is an appropriate representation of the existing service potential of the Trust's current land and building assets.

This letter was considered and agreed at the meeting of the Board on 02 June 2016.

Yours sincerely,

Antony M Waite
Finance Director

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BAORD

DOCUMENT TITLE:	**Financial performance – P01 April 2016**
SPONSOR (EXECUTIVE DIRECTOR):	**Tony Waite – Finance Director**
AUTHOR:	**Tim Reardon – Associate Director of Finance**
DATE OF MEETING:	**2nd June 2016**

EXECUTIVE SUMMARY:

Key messages:

- Significant in month deficit reflecting underlying financial position.
- Plan deficit of £7.1m requires to be improved. No meaningful route to in year surplus without STF contribution. To be resolved through finalisation of control total with NHSI.
- Delivery of minimum £19.6m savings programme and income recovery above contract required. Very limited scope for contingency and balance sheet flexibility and which would further erode cash balances. Delivery must be tangible and sustainable.
- Step improvement in monthly run rate income recovery and expenditure reduction required to secure year exit run rate consistent with minimum recurrent financial balance.

Key actions:

- Delivery of step change increase in patient related income underpinned by detailed demand & capacity work.
- Delivery of step reduction in costs through focus on bed reduction, pay & workforce change & procurement cost savings. Underpinned by fit for purpose PMO.
- Delivery of capital programme to time & budget consistent with enabling programme for MMH
- Delivery of working capital management consistent with achievement of EFL
- Development & delivery of liquidity / cash improvement plan.

Key numbers:

- Month deficit £1,657k being £178k adverse to plan.
- Year plan deficit £7.1m; plausible route to moderate that deficit to £4.5m established; control total remains to be agreed with NHSI and which should resolve STF funding and any route to surplus.
- Pay bill £25.4 (vs. £25.4m) in month; Agency spend £1.8m (vs. 2.1m).
- Savings delivery to date £0.7m being in line with plan but below expected scheme value.
- Total in year savings identified to date £17.3m being £2.3m below minimum plan requirement.
- Capex YTD £0.3m being £4.4m below plan. Main element of capital plan is the MMH project funding.
- Cash at 30th April £22.9m being £3.8m below plan due to timing of working capital management.
- FSRR 2 to date being as plan; forecast is as plan at 3.
- Capital Resource Limit (CRL) forecast to be achieved.
- External Finance Limit (EFL) forecast to be achieved.

REPORT RECOMMENDATION:

The Committee is recommended to note the report. Also to REQUIRE those actions necessary to secure the required step change in underlying run rate consistent with the delivery of safe, high quality care.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*: The receiving body is asked to receive, consider and:		
Accept	**Approve the recommendation**	**Discuss**
		x

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***					
Financial	**x**	Environmental		Communications & Media	
Business and market share		Legal & Policy	**x**	Patient Experience	
Clinical		Equality and Diversity		Workforce	**x**
Comments:					

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Effective use of resources
PREVIOUS CONSIDERATION:
Finance & Investment Committee – May 2016

Finance Report

Period 01 2016/17, April 2016

Trust Board
2nd June 2016

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Page Title

Finance Report

Summary & Recommendations

Period 01 2016/17

Statutory Financial Duties	Value	Outlook	Note
I&E plan deficit	£(7.1)m	√	1
Live within Capital Resource Limit	£73.0m	√	2
Live within External Finance Limit	£(63.7)m	√	3

1. I&E outlook requires £7.1m deficit to be improved. Plausible route to moderate established but falls short of return to surplus. Control total remains to be agreed with NHSI.
2. Capex control total includes trust contribution to MMH costs.
3. EFL reflects PDC financing related to MMH. Plan includes gain from effective working capital management to realise cash.

Outlook

- £7.1m deficit dependent on delivery of minimum £19.6m savings in year and recovery of SLA income above contract.
- Route to improve on that deficit to c£4.5m identified and being progressed.
- Control total remains to be finalised with NHSI. This includes resolution of Sustainability & Transformation Funding and which may support return to in year surplus.
- Profile of savings delivery planned to deliver at minimum recurrent balance exit run rate March 2017.

Financial Performance for period to 30th April

- I&E deficit £1,657k being £178k adverse to plan;
- Capex £288k being £4,367k below plan; variance reflects contribution to MMH costs paid May and not accrued end April
- Cash at the end of April is £22,910k being £3,816k less than plan; variance reflects timing in respect of working capital management including the settlement of historic NHS balances

Opportunities & risks

Delivery of plan requires step change in planned care income recovery and step reduction in costs. This is being driven through the following key programmes:

- Demand & Capacity
- Bed reduction
- Pay & workforce change
- Procurement non-pay reduction

These programmes are subject to specific support through the enhanced PMO.

Recommendation

- Note reported P01 position and plan 2016/17 position including step change required in income & costs.
- Ensure plans underpin exit run-rate consistent with at minimum recurrent financial balance by March 2017

Finance Report

Performance to date – I&E and cash

Period 01 2016/17

I&E

The reported I&E deficit at month 1 of £1.657m represents the trading position of the trust and does not benefit from the use of balance sheet flexibility or similar support.

Savings

Progress reported through the Trust's savings management system TPRS indicates delivery below plan in April. The concern remains with regard to the delivery of full year plans with identification of potential schemes is £2.3m short of the level required. Potential schemes will have some risk attached and will be subject to EIA & QIA.

Capital

Capital expenditure to date £0.3m vs £0.7m comparable plan. £3.9m of capex in respect of trust contribution to MMH building costs certified to April were paid in May.

Continuity of Service Risk Rating

Rating of 2 in month consistent with planned rating of 2.

Cash

The cash position reflects timing in respect of working capital management. Lower than planned creditors following extensive work to resolve historic issues in the run up to the year end. Lower capital spend has partially offset this but unresolved NHS debt has prevented this being fully offset. This NHS debt has largely been resolved in May 2016.

Prior year reliance on non-cash contingencies requires continued working capital mitigating action during 2016/17.

Better Payments Practice Code

Performance for has improved for both NHS bodies and non-NHS organisations in month 1 relative to month 12. This was expected due to the resolution of extended disputes at the end of the financial year . The resulting payment of a number of old invoices had the effect of depressing this performance metric in the period they were paid.

The finance team continue to manage the Trust's cash positon, currently there is no expectation that the BPPC measure will be adversely impacted by this activity.

Finance Report

I&E – Full Year

Period 01 2016/17

P01 Year to Date	Annual Plan £'000s	CP Plan £'000s	CP Actual £'000s	CP Variance £'000s	YTD Plan £'000s	YTD Actual £'000s	YTD Variance £'000s	Forecast Outturn £'000s
Patient Related Income	404,558	33,548	32,827	(721)	33,548	32,827	(721)	404,558
Other Income	49,230	4,102	4,331	229	4,102	4,331	229	49,230
Income total	**453,788**	**37,650**	**37,158**	**(492)**	**37,650**	**37,158**	**(492)**	**453,788**
Pay	(296,824)	(25,360)	(25,390)	(30)	(25,360)	(25,390)	(30)	(296,824)
Non-Pay	(143,023)	(12,020)	(11,618)	402	(12,020)	(11,618)	402	(143,023)
Expendiutre total	**(439,847)**	**(37,380)**	**(37,008)**	**372**	**(37,380)**	**(37,008)**	**372**	**(439,847)**
EBITDA	**13,941**	**270**	**150**	**(120)**	**270**	**150**	**(120)**	**13,941**
Non-Operating Expenditure	(24,324)	(2,027)	(1,831)	196	(2,027)	(1,831)	196	(24,324)
IFRIC12	3,332	278	24	(254)	278	24	(254)	3,332
DH Surplus/(Deficit)	**(7,051)**	**(1,479)**	**(1,657)**	**(178)**	**(1,479)**	**(1,657)**	**(178)**	**(7,051)**

The Trust has reported a £7,051k deficit plan in the April return to NHSI and which is reported in the above table.

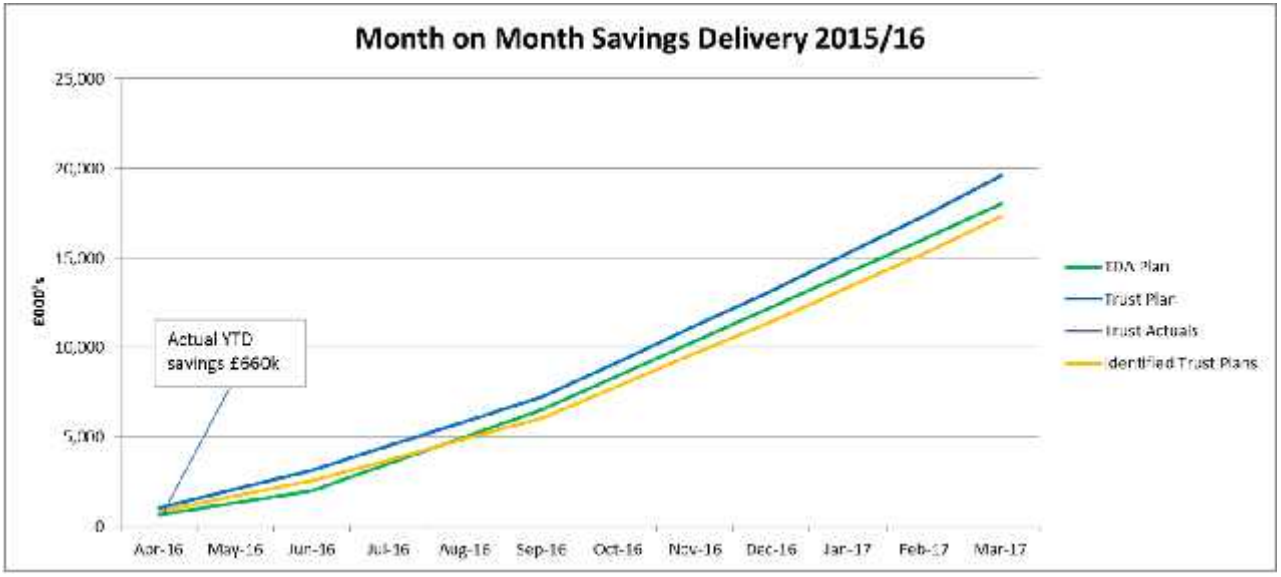
Measures to moderate that deficit have been identified and which may provide improvement to an outturn deficit £4.5m.

Performance in month is £178k adverse to plan. Patient related income was below the level required in Q1, while pay was in line with current quarter plan levels. In both cases there are a step changes in Q2 and Q3 reflecting anticipated improvements in both demand and capacity work as well as CIP delivery. No technical support has been utilised in the current financial year.

Finance Report

CIP achievement

Period 01 2016/17



This chart shows the savings profile in our plan submission to NHSI; the internal Trust plan value savings schemes; the value of those Trust schemes identified to date.

The chart also shows the total savings achieved to date.

£19.6m of CIP scheme savings are necessary to meet the requirements of the trust's plan.

This is a step up from savings delivered in 2015/16 of £14.1m

Identified savings schemes at April indicate that £17.3m of potential savings deliverable in the 2016/17 financial year.

This is £2.3m short of the Trust target of £19.6m.

Savings delivered in P01 April were £660k, being consistent with NHSI plan trajectory but £186k below the in month value of identified savings schemes.

Measurement of success remains delivery of "bottom right" surplus and within that any necessary and sufficient CIPs. Delivery of CIPs to plan is key but not necessarily sufficient to that success.

Finance Report

Capital

Period 01 2016/17

Programme	Year To Date TDA Plan £'000s	Actual £'000s	Gap £'000s	Full Year TDA Plan £'000s	Outlook £'000s	Variance £'000s
Estates	342	269	(73)	15,390	15,390	0
Information	334	3	(331)	8,134	8,134	0
Medical equipment / Imaging	15	7	(8)	1,950	1,950	0
Contingency	30	0	(30)	362	362	0
Sub-Total	**721**	**279**	**(442)**	**25,836**	**25,836**	**0**
Technical schemes	3,928	9	(3,919)	47,141	47,141	0
Donated assets	6	0	(6)	77	77	0
Total Programme	**4,655**	**288**	**(4,367)**	**73,054**	**73,054**	**0**

The above table shows the status of the capital programme, analysed by category, at the end of Period 01. At this stage of the year the view of out-turn is the plan level. The plan is consistent with the 2016/17 CRL and there is no risk cited currently in relation to achievement of plan expenditure.

The largest item of expenditure planned for the year reflects the trust's contribution to the construction costs of MMH. The value of certified work to end April was consistent with plan and payment was made in May. This was not accrued and reflected in the above table. This will be reviewed for P02 reporting.

Finance Report

SOFP

Period 01 2016/17

Sandwell & West Birmingham Hospitals NHS Trust
STATEMENT OF FINANCIAL POSITION 2016/17

	Balance as at 31st March 2016	Balance as at 30th April 2016	TDA Planned Balance as at 30th April 2016	Variance to plan as at 30th April 2016	TDA Plan as at 31st March 2017	Forecast 31st March 2017
	£000	£000	£000	£000	£000	£000
Non Current Assets						
Property, Plant and Equipment	196,384	195,471	196,114	(643)	210,333	210,333
Intangible Assets	386	373	386	(13)	386	386
Trade and Other Receivables	846	771	964	(193)	964	964
Current Assets						
Inventories	4,097	4,097	4,139	(42)	4,139	4,139
Trade and Other Receivables	16,310	15,633	17,615	(1,982)	57,608	57,608
Cash and Cash Equivalents	27,294	22,910	26,726	(3,816)	7,082	7,082
Current Liabilities						
Trade and Other Payables	(54,145)	(49,926)	(52,919)	2,993	(56,329)	(56,329)
Provisions	(1,469)	(1,515)	(373)	(1,142)	(370)	(370)
Borrowings	(1,306)	(1,306)	(1,017)	(289)	(1,017)	(1,017)
DH Capital Loan	0	0	0	0	0	0
Non Current Liabilities						
Provisions	(3,094)	(2,990)	(4,086)	1,096	(3,683)	(3,683)
Borrowings	(25,591)	(25,486)	(25,781)	295	(24,681)	(24,681)
DH Capital Loan	0	0	0	0	0	0
	159,712	**158,032**	**161,768**	**(3,736)**	**194,432**	**194,432**
Financed By						
Taxpayers Equity						
Public Dividend Capital	161,710	161,710	165,418	(3,708)	206,211	206,211
Retained Earnings reserve	(17,987)	(19,667)	(19,658)	(9)	(27,787)	(27,787)
Revaluation Reserve	6,931	6,931	6,950	(19)	6,950	6,950
Other Reserves	9,058	9,058	9,058	0	9,058	9,058
	159,712	**158,032**	**161,768**	**(3,736)**	**194,432**	**194,432**

The table opposite is a summarised SOFP for the Trust including the actual and planned positions at the end of April and the full year.

The Receivables variance from plan is predominantly related to the aged NHS debt position.

Variance from plan for Cash reflects timing differences in respect of working capital management.

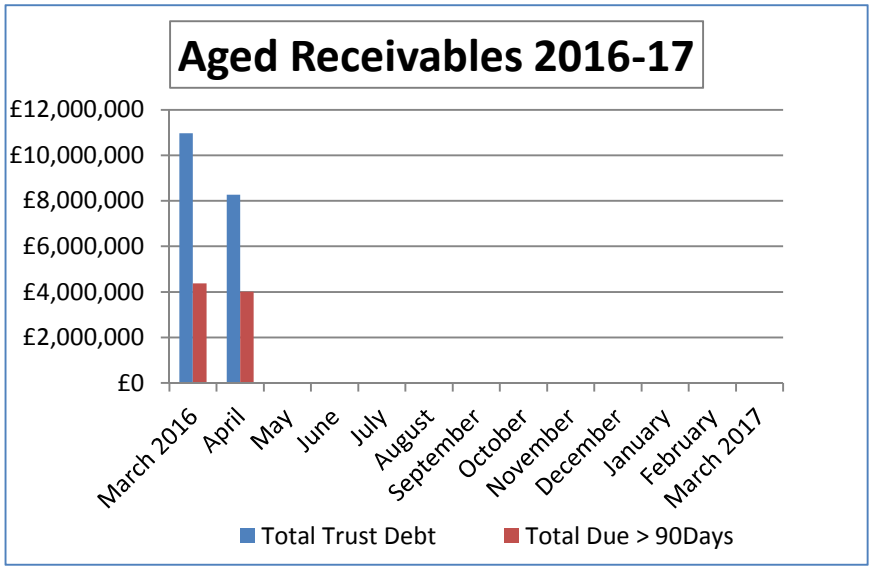
Graphs to represent the profile of Receivables and Payables can be found on slide 20.

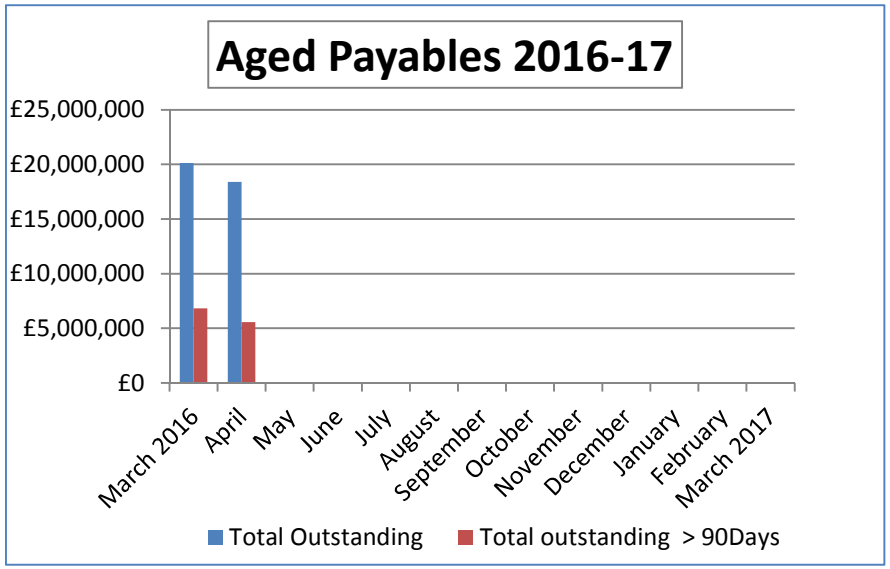
The variance on PDC reflects that the Trust has not drawn down its planned additional PDC . This is subject to on-going discussion with NHSI as to an appropriate profile of draw down such that funds are not drawn in advance of need.

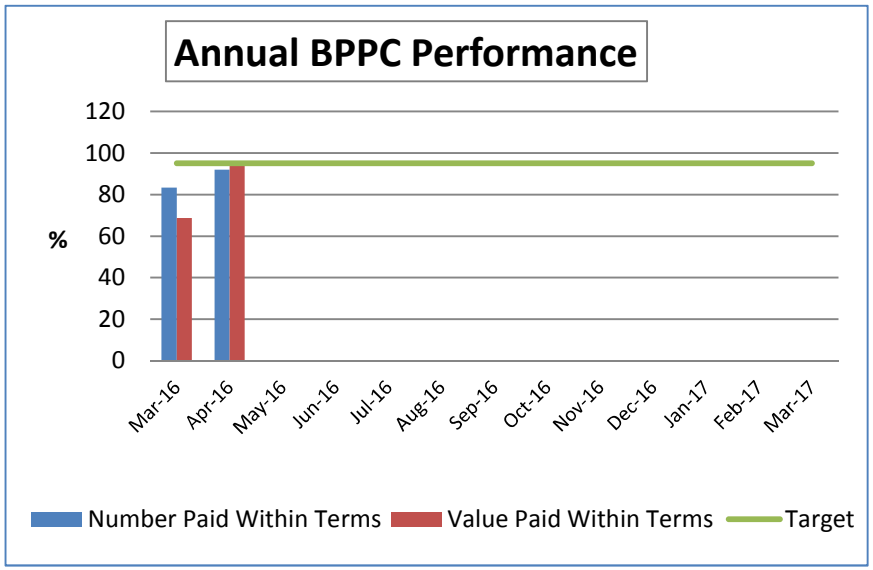
Finance Report

Aged Receivables, Aged Payables, BPPC and Cash Forecast

Period 1 2016/17







Note

- The April debt position shows a decrease that reflects progress made in settling NHS debt, the remaining 90+ Day debt continues to be predominantly represented by NHS Debt that is under discussion at Executive Level for resolution in 2016-17
- The Payables position has reduced during April as the Trust seeks to manage cash and retain BPPC performance. The level of over 90 days liability has reduced as Maternity Pathway and NHS invoices are settled
- BPPC is below target of 95% by volume but at target in value, this reflects improved performance over 15-16. The challenges in maintaining this relate to the Trust P2P process and specifically the use of purchase orders, including receipting.