Heart of England NHS
NHS Foundation Trust

## Heart of England NHS Foundation Trust

# Annual Report and Accounts

## 2016/17

Building **healthier** lives

**Heart of England NHS Foundation Trust**
**Annual Report and Accounts 2016/17**
Presented to Parliament pursuant to Schedule 7, paragraph 25 (4)(a) of the National Health Service Act 2006

# Contents

# Section 1 **Performance Report**


This covers the period 1 April 2016 to 31 March 2017

Section 1

# Performance Report

## Overview

### About the Trust

Heart of England NHS Foundation Trust (HEFT) is one of the largest acute hospital trusts in the country, serving a diverse population of 1.2 million across Birmingham East and North, Solihull, Sutton Coldfield and South Staffordshire.

Operating from three acute hospital sites (Heartlands, Good Hope and Solihull), a number of community locations and Birmingham Chest Clinic, the Trust also runs a number of smaller 'satellite' units, ensuring patients can be treated closer to home.

Birmingham Heartlands NHS Trust was formed in 1992 and became the first acute trust in the city. The following year it merged with Yardley Green Hospital and acquired Birmingham Chest Clinic. In 1995, after merging with Solihull Hospital, the Trust was renamed Birmingham Heartlands and Solihull NHS Trust (Teaching). In 2005, it achieved foundation trust status and took the name it is known by today. In 2007, Good Hope Hospital joined the fold. Since 2011 there has also been a varied portfolio of community healthcare services for Solihull residents. There are also satellite renal units to serve patients who live in the surrounding area, including Castle Vale, Balsall Heath, Solihull, Lichfield and Sutton Coldfield.

In 2016/17, HEFT dealt with:

- 267,793 A&E attendances
- 88,713 day case and elective spells
- 856,556 outpatient attendances
- 76,674 emergency spells and
- Supported 10,242 births

The Trust is situated amongst a number of other large West Midlands providers of healthcare, including University Hospitals Birmingham NHS Foundation Trust, Sandwell and West Birmingham Hospitals NHS Trust and University Hospitals Coventry and Warwickshire NHS Foundation Trust.

HEFT has a workforce of 10,565 staff and is recognised as a centre of excellence for thoracic surgery, vascular, bariatric and pathology services, as well as the treatment of MRSA and other infectious diseases. The Trust specialises in treating a range of conditions including heart and kidney disease, cancer and HIV/AIDS. It is also home to the West Midlands Adult Cystic Fibrosis Centre and a nationally renowned weight management clinic and research centre.

As one of the region's most research active hospitals, doctors and other medical staff are involved in more than 500 current projects aiming to find new and better ways of treating patients.

Funding for services comes mainly from local Clinical Commissioning Groups (CCGs) and NHS England. The Trust's income in 2016/17 was £709.1m.

### Strategy for 2016/17

Like the majority of trusts across England, HEFT is encountering increasing demand for acute services from a growing, ageing and diverse population. Whilst working to adapt to an ever changing NHS, its priority remains to provide the highest quality care for its patients.

Since the appointment of Rt Hon Jacqui Smith and Dame Julie Moore as Interim Chair and Chief Executive of HEFT in late October 2015, work has continued to focus on:

- Governance
- Urgent care
- Scheduled care
- Information management and technology
- Culture and engagement
- Financial stability

During 2016/17 the Trust has been concentrating on sustaining the improvements made during 2015/16, particularly around its performance. More details on the Trust's performance can be found in the Performance Analysis section from page 14 and the Quality Account in Section 3.

At the end of the financial year, the Trust remains under a series of enforcement actions from Monitor (now part of NHS Improvement) which were issued between October 2014 and October 2015. Information relating to these is available to view via the following link: https://www.gov.uk/government/groups/heart-of-england-nhs-foundation-trust

## Case for Change

Following the decisions of the Boards of Directors of University Hospitals Birmingham (UHB) and HEFT in July 2016, a mandate was given to develop a Case for Change for the two organisations to become a single entity. The next step in this process is the submission of a Notification document to the Competition and Markets Authority (CMA) which is expected to take place in April 2017.

The Case for Change will continue to be developed during 2017/18, with input from a wide range of staff, patients and stakeholders associated with the two trusts, into a Full Business Case for consideration by both Boards of Directors.

### HEFT's Performance and the UHB Intervention

Historically, HEFT was a well-respected, financially healthy organisation that provided quality care: hospitals and services where patients chose to be treated and where talented individuals chose to work. However, in 2012, HEFT suffered a decline in its operational and financial performance, resulting in its inability to deliver the quality of care, operational and financial performance that its patients, staff and the public expect. In October 2015, Monitor (now NHS Improvement) instigated a UHB-led intervention to stabilise the rapid operational and financial decline, as well as governance failures. This was the third attempt to put in place a recovery plan for the organisation.

Since October 2015, the interim Chair and executive management team from UHB, alongside the remaining HEFT Executive/Non-executive Directors (NEDs) and four newly-appointed NEDs, have delivered the stability, structure, governance and financial leadership necessary to enable the Trust's staff to focus once again on delivering quality care for their patients. However, the current interim arrangement is not sustainable; the improvements, while significant, are not embedded, and delivering the full range of potential benefits is not deemed possible unless the organisations come together as a single, legal entity.

### Rationale for Merger

The Boards of HEFT and UHB have given consideration to a range of options for the future of the two trusts, their relationship and the impact on patients and the provision of sustainable, high quality health care for the people of Birmingham, Solihull and South Staffordshire.

**Figure 1**

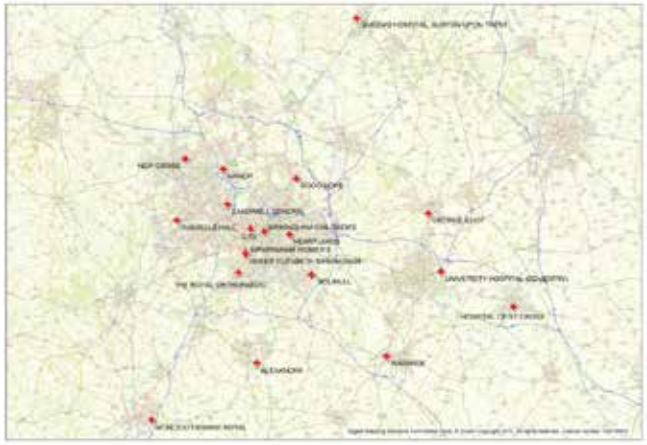


Figure 1 shows the geography of the two trusts' hospitals, other local acute hospitals and the surrounding area.

Whilst the interim arrangements have delivered considerable performance, financial and governance improvements to HEFT, both Boards believe that they are not sustainable. Over time there will be a risk of confusion of accountabilities as executives and senior staff report to two Boards; there is a duplication of lines of governance which is, at best, wasteful of time and resources and, at worst, poses potential conflicts of interest. Furthermore, and most importantly, it has become clear that further significant patient benefits and organisational efficiencies can only be delivered by becoming one organisation (see benefits below).

For this reason, both Boards agreed that the status quo is unsustainable.

A second option would be for the UHB management team to revert to UHB. Both Boards believe that this would not only risk the progress that has been made in HEFT over the last fifteen months, but given the history of the Trust before the intervention, could put the future viability of the Trust, its operational and financial performance, in considerable jeopardy; this would have an extremely detrimental effect on patients and other providers in the local health system.

In considering the case for becoming a single legal entity, the Boards envisaged the following

potential benefits. The new trust could:

- Consolidate the extensive performance gains made to date at HEFT under a single Board that is widely recognised for its outstanding leadership.
- Deliver direct clinical benefits to patients through the integration of appropriate clinical services and electronic systems to standardise clinical practice, protocols and quality standards which, in turn, should reduce variation and improve patient safety and outcomes.
- Pool the best talent from both organisations and use staff more effectively across all sites, providing greater career and developmental opportunities for staff – and better retention of staff.
- Benefit from the integration of the administrative, education and training, financial and logistic and procurement services of both trusts. The new trust will, over time, be able to re-invest, sustaining the provision of clinical services across its sites enabling further development.
- Maximise the use of the experience of research and development, existing relationships with academic partners and the new combined, diverse patient population to become world leading in medical research and innovation.
- Create a more resilient organisation including financial sustainability, better able to influence and act as a supportive strategic partner within the BSol STP and the wider West Midlands economy and healthcare market.

In developing the case to become a single legal entity, the Boards have emphasised the need to demonstrate clear clinical benefits and have involved clinical staff of both trusts throughout the process.

### Quality Benefits

One organisation will create more equitable patient access to better quality and integrated healthcare across Birmingham, Solihull and South Staffordshire. The merged organisation will provide beneficial local and regional effects within the acute healthcare market and is aligned with regional and national healthcare strategies.

A Benefits Case has been developed from the "ground up", following engagement with over 130 clinicians and clinical managers within both trusts and with key stakeholders outside the organisations, such as NHSI.

During the Intervention it was identified that two clinical services, neurology and interventional radiology, were in immediate need of stabilisation and actions have already been taken in these specialties. Stabilisation in a third, plastic surgery, is also currently being addressed.

While a number of specialties have been reviewed, five have been worked up in detail to demonstrate the possibilities a merged organisation presents in terms of service improvement. They identify benefits which represent real improvements for existing and future patients and commissioners.

The cases used are:

- **Gastroenterology and liver medicine:** potential improved access; shorter more bespoke patient pathways; greater acute bed capacity; development of primary care provision.
- **Nephrology and renal medicine:** opportunities to share good practice; more home haemodialysis; improved training; greater business bargaining power; expansion of some services for example renal and HIV.
- **Vascular surgery:** collaboration of expertise to deliver world-class service to combined catchment area; focussed delivery across primary, secondary and tertiary care.
- **Cardiology:** harmonised access to and delivery of care; reduced length of stay and reduction in acute admissions; robust acute services 24/7; improved outreach and community follow-up.
- **Diabetes:** enhanced care delivery in community settings; more informed patient population; uniform access to care; reduced acute admissions.

## Sustainability and Transformation Plan

Health and care leaders in Birmingham and Solihull are working together to develop proposals (a Sustainability and Transformation Plan – STP) to support a healthier future for the people the Trust serves. The STP shows the system's thinking and proposals for the future of health and care services for Birmingham and Solihull.

The delivery of the STP is being led by Dame Julie Moore, Chief Executive of UHB and Interim CEO of HEFT.

The organisations involved in the STP firmly believe that, by working together in a way that they have not done before, they can deliver great changes to the health and wellbeing of its communities.

Outcomes include living longer without illness or having paid employment; as well as those linked directly to treatments and care: survival, numbers of complications, reduced pain and increased mobility.

The immediate joint efforts are needed to simplify the current emergency and urgent care services that operate to allow people to choose the most appropriate service for their needs whether they be simple or more complicated. This will enable people to receive the care they need most effectively and with better experiences and outcomes for everyone. In particular, the way frail and vulnerable people are supported generally and managed when they require urgent care, needs to improve.

In addition, and through the medium and longer term, health and care leaders need to do all they can to help tackle the levels of deprivation within Birmingham and Solihull that have been identified as contributing to poor health and wellbeing within both areas. Nearly half of the Trust's catchment area is among the most deprived in the country. This effort needs to be co-ordinated with wider partnerships which promote business and economic growth.

The priorities of the Local Plan Board, formed from the leaders of local health and local authority organisations and also general practitioner representatives, are as follows:

- To develop community-based models of joined-up care. For defined communities, the aim is to deliver improved access to local services for everyone when their need is urgent, and more supportive and consistent care which aims to keep people well for those who need more support including social care. The new models have not yet been agreed, however, they will involve collaborations between primary care, hospital staff, social care and voluntary and independent sectors.
- Through closer working between providers, to develop a co-ordinated system of hospital services through Birmingham and Solihull that reduces differences which can't be explained, improves efficiency and delivers better outcomes.
- To focus upon the issues faced by children within Birmingham and Solihull – a Maternity, Children and Young People programme will be established. This will include links to other footprint plans as well as maximising the impact of the outstanding Children's Hospital influence within the city.
- To give those with mental health problems, and the services which support them, the same priority as other areas.
- To work with the West Midlands Combined Authority and the two local authority Health and Wellbeing Boards to improve the health and wellbeing of the population, particularly focussing on the wider determinants of health such as employment, education, housing and work.
- To work together on key enablers who will help deliver better health and care including the approach to an accountable care system which will include new payments and measures of success, as well as joint workforce developments, digitalisation and estates.

This means that there will be changes to all parts of health and care services and that people will have to think differently and will have different choices in the future.

## Birmingham and Solihull United Maternity and Newborn Partnership (BUMP)

HEFT became a partner of Birmingham and Solihull United Maternity and Newborn Partnership (BUMP) along with Birmingham Women's and Children's NHS Foundation Trust, Birmingham Community Healthcare NHS Foundation Trust and Birmingham and Solihull Mental Health NHS Foundation Trust during 2016/17.

BUMP will revolutionise maternity and newborn services in the region over the next few years by creating a single point of access for all expectant mums to have the same range of services available, from home births to birthing centres and delivery suites.

## Key Issues and Risks that could affect the Trust in delivering its objectives

The Trust has identified a number of key risks and uncertainties that could affect it in delivering its objectives which are included in its Board Assurance Framework, as follows:

- **Clinical Quality**
  - Failure to have in place a sustainable, embedded organisational governance infrastructure for all divisions set against the Trust's quality and safety strategy and assurance frameworks.
  - Inability of estates infrastructure and equipment to facilitate the provision of safe and effective care, due to deterioration of condition, poor space utilisation and functional suitability.
  - Failure to deliver access standards owing to rising volume of routine secondary care work, delayed Transfers of Care, rising Emergency Department attendances, gaps in community provision and lack of impact from The Better Care Fund.

- **Workforce**
  - Failure to have appropriate leadership skills and capacity at all levels to deliver new ways of working and appropriate ways of leading that promote the Trust safety culture.
  - Failure to retain staff and the inability to recruit sufficient numbers of appropriately skilled, trained and competent staff.

- **Affordability**
  - Significant deterioration of the Trust's underlying financial position resulting in the inability to deliver the Financial Recovery Plan.
  - Lack of a robust infrastructure: IT systems; metrics; workforce information systems; financial modelling and payment methods to allow the Board and management teams to deliver the required programme of change.

Further details of these risks and associated controls are set out in the Annual Governance Statement, from page 68. Further controls are currently under development to mitigate these risks.

## Key Risks to Quality

The Trust's key risks with regard to Quality are included above.

In its Annual Plan submission to NHS Improvement (NHSI), the Trust declared a risk to delivery of one key performance metric in the Risk Assessment Framework – the A&E 4 hour wait.

Reductions in social care capacity, increases in discharge delays and reduced bed capacity all impact on 4 hour performance.

## Going Concern

After making enquiries, the directors have a reasonable expectation that the NHS foundation trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts. Details of this assessment are included in accounting note 2.

**Dame Julie Moore**
**Interim Chief Executive Officer**
**Date: 24 May 2017**

# Performance Analysis

## Performance during the year and performance against key health care targets

At the start of 2015/16 the Trust was under increased scrutiny from Monitor (now known as NHSI) due to the number of indicators in the Monitor Risk Assessment Framework that the Trust was failing to meet. The Trust was non-compliant with the A&E 4 hour wait target, the 18 week Referral to Treatment (RTT) Indicators and three of the cancer targets.

This performance position has changed significantly during 2016/17 with the Trust achieving all of the targets outlined in the Monitor Risk Assessment framework with the exception of A&E performance and Clostridium Difficile (c-diff) rates.

There has been a significant increase in assessment area and AEC (Ambulatory Emergency Care) activity levels through the year. The Trust has not delivered the maximum wait time of four hours in A&E from arrival to admission, transfer or discharge indicator for a number of years and continues to perform below target. Performance was at 91.4% in August 2016 and dropped month on month until February 2017 when performance picked up to 80.12%. NHS England figures show that Emergency Department (ED) performance nationally was at 77.6% for Type 1 units and 85.1% for all units in January 2017 (NHS England Unify data published 9 March 2017).

Performance for Referral to Treatment (RTT) has been consistently above the >92% target month on month during the year. All cancer targets have been achieved each quarter (with one exception: Q1 62 day's referral from NHS screening to treatment).

With regards to infection control, the Trust had a full year trajectory of 64 c-diff cases for the year. There was a total of 76 cases reported.

| Patient Class | 2015/16 | 2016/17 Out-turn | Variance | Variance |
|---|---|---|---|---|
| Accident & Emergency | 261,225 | 267,793 | 6,568 | 3% |
| Assessment area | 18,978 | 20,917 | 1,939 | 10% |
| Emergency | 74,182 | 76,674 | 2,492 | 3% |
| AEC | 9,087 | 10,755 | 1,668 | 18% |
| Day case | 73,498 | 75,331 | 1833 | 2% |
| Elective | 13,700 | 13,382 | -318 | -2% |

## Progress towards targets as agreed with local commissioners and other key quality improvements

The reporting process to Divisions and Board has been reviewed. Compliance against Key Performance Indicators (KPIs) is undertaken through the monthly divisional reporting packs. Each Division receives a report which outlines performance against the key national and local reporting requirements. Monthly performance reports are sent to the Board and Executive level groups. These focus on delivery of key contractual requirements as well as a number of local KPIs. The development of monthly Executive-led Divisional Performance Reviews provides additional scrutiny and assurance on delivery of key indicators.

The Board also receives reports on both clinical quality and care quality, which provide an additional layer of detail on key metrics.

The Trust has a number of contracts including Acute, Specialised Services, Community and Public Health. It is required to monitor delivery of these contractual requirements through the production of Service Quality Performance Reports.

The Trust has shown variable performance against a number of indicators throughout the year and where exceptions are identified; remedial action plans are developed and shared with the Executive team and commissioners.

The Trust has agreed trajectories with the commissioners for improved and sustained performance of the key priority targets for 2017/18.

| National targets and regulatory requirements | Time Period | 2016/17 Performance | 2016/17 Target |
|---|---|---|---|
| Minimise rates of Clostridium difficile | April 16 to March 17 | 76 | ≤64 |
| Reduction of incidence of MRSA bacteraemia (attributable cases) | April 16 to March 17 | 7 | 0 |
| Patients urgently referred with suspected cancer by their GP or dentist waiting no more than 2 weeks for first appointment | April 16 to March 17 | 95.70% | ≥93% |
| Patients urgently referred with breast symptoms (where cancer was not initially suspected) by their GP waiting no more than 2 weeks for first outpatient appointment | April 16 to March 17 | 95.47% | ≥93% |
| Patients waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers | April 16 to March 17 | 99.32% | ≥96% |
| Patients waiting no more than 31 days for subsequent treatment where that treatment is surgery - Surgery Modality | April 16 to March 17 | 99.30% | ≥94% |
| Patients waiting no more than 31 days for subsequent treatment where that treatment is an anti-cancer drug regimen - Anti Cancer Drug Modality | April 16 to March 17 | 99.90% | ≥98% |
| Patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer (including Rare Cancer) | April 16 to March 17 | 88.87% | ≥85% |
| Patients waiting no more than 62 days from referral from an NHS Screening service to first definitive treatment for all cancers - National Screening Service | April 16 to March 17 | 87.82% | ≥85% |
| 18 week incomplete RTT pathways | April 16 to March 17 | 92.45% | ≥92% |
| Maximum waiting time of 4 hours in A&E from arrival, to admission, transfer or discharge | April 16 to March 17 | 85.52% | ≥95% |

## Review of Emergency Medicine

The Trust did not achieve the planned performance trajectory for emergency access during 2016/17. High demand for inpatient care, reduced community capacity and increased time to arrange discharge care packages for patients with more complex needs all contributed to this deviation. Despite not meeting the 95 percent standard, there have been a number of positive improvements within the Emergency Departments and Minor Injuries Unit. These include:

- **Solihull Urgent Primary Care Service**
  The combined walk-in centre and GP practice located adjacent to the North car park at Solihull Hospital closed during October. The Urgent Primary Care Service then opened for business the very next day in the main Hospital Building, adjacent to the Minor Injuries Unit (MIU). This service change was the result of several months of planning and operates closely with the MIU, with a common reception area for unplanned patients.

- **Streaming Nurse**
  Heartlands Hospital has introduced a pre-registration streaming nurse to the Emergency Department. The purpose of this role is to ensure that patients are directed to the most appropriate area of the Emergency Department, reducing the demand on the most acute areas and therefore reducing the time a patient waits to see a clinician. This service will be piloted at Good Hope Hospital from April 2017.

- **Ambulatory Emergency Care Review**
  Demand for inpatient care remains at a very high level. However, there are a significant number of emergency conditions which lend themselves to being treated as an 'Emergency Day Case' enabling patients to go home the same day as they attend. There have been positive developments in this area across all three sites, with an average of 35 new patients being treated in this way every day. There are plans to significantly increase activity in this area during 2017/18.

## Review of Cancer Services

2016/17 was another busy year for cancer services at HEFT. On average, the Trust received more than 2,500 urgent '2 week wait' (2ww) referrals each month, an increase of nearly 7% over the previous year. This means that HEFT continues to be one of the largest and busiest providers of cancer services in the country.

Despite this increase in activity, performance against the key cancer waiting times targets improved significantly throughout the year. The Trust achieved the '2ww GP referral to first seen', '2ww GP referral to first seen for breast symptoms' and '62 day GP referral to first treatment' targets in 11 out of the past 12 months, which is in sharp contrast to both the previous year's performance and the national trend. In Quarter 3 the Trust was in the top 10 providers in the country for performance against the '62 Day GP referral to first treatment' target. This was a significant achievement and further illustrates the impact that has been made by some of the wider Trust changes to its delivery structures and planning processes, and of the hard work of all those involved in delivering cancer care.

This year also saw the introduction of a new internal validation process to support the quality assurance of the Trust's numerous cancer multi-disciplinary teams. This process was undertaken throughout October and November and gave clinical teams the opportunity to meet with members of the Trust Executive to discuss the service, highlight areas of good practice, and jointly agree approaches to further development. The process was well evaluated by all of those involved and will be built upon in future to ensure that there remains a focus on not just the performance, but also the quality, of the cancer services the Trust provides.

## Review of Referral to Treatment (RTT)

The Trust has consistently delivered the 92% incomplete standard since February 2016, demonstrating that sustainability has been achieved this year. This differs from the national picture where a significant number of acute trusts have seen a reduction in their performance and failed to deliver the RTT standard.

Sustainability has been achieved through an action-focussed approach which included:

- Directorate-led trajectories supported by a recovery action plan, which was shared monthly with the commissioners as part of the Contract Review Meeting (CRM).
- Weekly confirm and challenge meetings for those specialities struggling to achieve the standard.
- A weekly patient tracking list (PTL) meeting identifying recovery actions in a forward look approach to support month end delivery.
- Significant investment in Trust-wide RTT training.

- Further development of the RTT database providing a live position to patient level detail and operational reports to support delivery.
- The introduction of the Head of Operational Performance post providing greater leadership, focus and support to all divisions responsible for RTT delivery.

Despite achieving the RTT 92% incomplete standard, the Trust continues to have challenges in the admitted pathway with approximately 1,800 patients waiting for surgery in excess of 18 weeks. The Directorates with the greatest backlogs sit in the larger surgical specialities of Trauma and Orthopaedics, Upper GI surgery, Gynaecology, ENT, Urology and more latterly, Dermatology.

A proportion of the admitted backlog relates to the pressures received over winter months, where a number of medical outliers into surgical speciality beds resulted in high levels of elective cancellations. At the height of the pressures within Good Hope, the day case unit was also used to support the emergency flow, further impacting elective activity. To mitigate the impact of winter pressures, the Trust worked in collaboration with the commissioners to transfer approximately 250 elective patients for the most affected specialities to the private sector under the NHS contract (at no cost to HEFT).

The theatre directorate continues to work with relevant Divisions to maximise their theatre capacity and increase cases per list with a view of reducing the overall admitted backlog. Any lessons learnt are then rolled out to other areas.
There has been an overall reduction in patients waiting greater than 40 weeks for treatment over the last 12 months reducing from approximately 170 patients to 37, demonstrating a greater focus is taking place in proactively managing patients waiting too long to receive their treatment.

The Trust has delivered significant improvements in the RTT standard this year, despite the pressures identified, and Directorates will continue to remain focused to support sustainability.

## Review of Diagnostics

The national diagnostic target is 99%, ensuring all patients receive their diagnostic test within six weeks of request. The diagnostic arm of the pathway supports both Cancer and RTT services. The Trust has consistently delivered the 99% diagnostic standard since February 2016, demonstrating that sustainability has been achieved this year.

Sustainability has been achieved through an action focussed approach which included:

- Directorate-led trajectories supported by a recovery action plan, which was shared monthly with the commissioners as part of the Contract Review Meeting (CRM).
- Weekly/monthly forward look of the patient tracking list (PTL) allowing early identification of capacity shortfalls, giving opportunity to develop mitigation plans.
- The introduction of the Head of Operational Performance post providing greater leadership, focus and support to all divisions responsible for diagnostic delivery.

Whilst the Trust has achieved the 99% diagnostic standard, there remain significant capacity pressures within specialities such as radiology and endoscopy.

Within the radiology department, the challenges have centred on equipment failure, a significant increase in demand and shortage of clinical staff. MRI and ultrasound scans remain a continuing constraint for the service. The radiology department have developed a transformation programme which reviews all aspects of the radiology service, supporting recovery and developing a future proof model. The Trust has actively supported the radiology department with capital investment and a capital rolling replacement equipment programme is underway. The service still relies heavily on a mobile MRI unit and has gradually increased its usage to 17 days per month to accommodate the continual 10% growth that MRI services continue to experience nationally.

Recruitment continues to be a challenge for the service, however interviews for replacement interventional radiology consultants take place at the end of April with a good selection of candidates currently, and a workforce review being undertaken to identify the benefits of appointing advanced practitioners to support the Consultant workload, given the national shortage of radiology consultants.

The endoscopy unit has also experienced capacity challenges and the Vanguard mobile endoscopy unit remains on-site delivering an additional 10 endoscopy sessions per week. In Quarter 3 of last year, the endoscopy service also commissioned an additional endoscopy room at Solihull to meet demand. A further business case is being developed to expand endoscopy services on the Good Hope site; recruitment is underway. The service continues to undertake additional endoscopy sessions at weekends. The additional capacity is currently supported by locum Consultants with a plan to recruit substantively in the near future. The

associated costs of this sit within the current run rate of the Division.

The Trust has delivered significant improvements in the diagnostic standard this year, despite the pressures identified, and Directorates will continue to remain focussed to support sustainability.

## Safeguarding

The Trust is committed to ensuring the safety of children and adults within all services that it provides, giving support to local and national safeguarding children and adults initiatives at all times.

During 2016/17, the Trust has:

- Continued to develop and refine partnership working in the Multi-agency Safeguarding Hubs in Birmingham and Solihull, improving the timeliness of information sharing and increasing capacity for joint decision making for children.
- Expanded the scope and scale of safeguarding supervision and access to advice and support within the organisation, helping to support staff and enhance their decision making.
- Further developed its on-line learning resources to meet the safeguarding educational needs of the whole workforce.
- Maintained safeguarding training levels at over 95% for Level 1 and 2 and over 90% for Level 3.
- Enhanced the safeguarding assessment skills used in the NNU and Community settings with the rollout of specific training.
- Continued to deliver training to support the identification and response to child sexual exploitation and PREVENT (compliance rates now over 80% for both).
- Hosted a Safeguarding Conference which was extremely well attended and evaluated.
- Implemented the Care Act 2014, ensuring staff know the importance of making safeguarding personal and taking into account the wishes and feelings of adult patients during the safeguarding process.
- Implemented the recommendations from the Lamphard Review (2015).
- Continued to lead a well-established safeguarding audit programme which focuses on transition points or areas of identified risk.
- Monitored patterns of safeguarding activity and demonstrated substantial improvements in the quality of information provided in safeguarding referrals throughout the organisation through targeted interventions in key areas.
- Increased mechanisms to provide service user feedback in relation to safeguarding within the organisation.
- Enhanced links with complaints and incidents teams.
- Been able to provide examples of specific cases where children or adults were identified as vulnerable/at risk of abuse or neglect and, due to sharing of information, effective multi-agency responses were put in place to safeguard.
- Enhanced the domestic abuse advice available in the Trust, increased access for patients to specialist advice through partnerships with Women's Aid and increased in-house educational opportunities.

Moving forward, the Trust will continue to review its compliance with all statutory requirements from the Care Act 2014 and the Children Act 2004 and 1989, reporting quarterly internally and to relevant external partners. The team are also focusing on enhancing the learning and development opportunities in relation to the Mental Capacity Act, PREVENT and CSE; increasing ward-based audit and accountability for Mental Capacity Awareness and appropriate use of Deprivation of Liberty Safeguards (DOLS); continuing to enhance user/patient feedback in relation to safeguarding and reviewing all audits to ensure the most critical issues are subject to scrutiny.

## Review of Infection Prevention and Control

HEFT continued to have a robust Infection Prevention and Control programme during 2016/17 which was implemented to meet the increasing demands and emerging challenges.

A trajectory of zero post 48 hour MRSA bacteraemia was set. Nine post 48 hour MRSA bacteraemia were reported with seven deemed to be attributable to the Trust. Two of these were judged to be unavoidable and no common themes were identified following review of the seven cases.

A very challenging trajectory of 64 post 48 hour Clostridium difficile cases was set this year. The Trust has exceeded this with a total of 76 cases. Of these, 18 cases were considered to be avoidable.

## Research

In 2016/17, more than 150 new studies have been given approval to begin within the Trust. There are 30 specialities across the Trust currently taking part in research, with between one and six research active Consultants in each of these areas.

In 2016/17, 5,350 patients have been recruited. Clinical trials remain the largest research activity performed at the Trust, in terms of project numbers. There is a mixed portfolio of commercial and academic studies, the majority of which are adopted on to the National Institute for Health Research (NIHR) portfolio. Non-portfolio work is also undertaken and this comprises of commercial clinical trials, student-based research or pilot studies for future grant proposals.

During 2016/17, the Trust's highest recruiting specialities based on numbers of patients entered into research projects are diabetes (899), respiratory medicine (608) and thoracic surgery (341). Some of this success is due to HEFT investigator, Dr Mark Thomas, whose Research for Patient Benefit (RfPB) funded study, looking at the identification and management of acute kidney injury, has now completed recruitment. In one of last year's growth areas (mental health), consultant Prof George Tadros has recently obtained funds from the same stream, such that recruitment in this area is likely to rise sharply in 2017/18.

In general surgery, in particular bariatric surgery and obstetrics and gynaecology, the Trust has seen an increase in activity following a period of investment into research infrastructure. Both areas have recruited over 150 patients and have each contributed 4.5% of the Trust's portfolio.

Applications for funding, led either by HEFT or with HEFT co-applicants, continues to be made predominantly to the National Institute for Health Research (NIHR) funding streams and, for the year 2016/17, totalled in excess of £2 million. To date, much of this is still awaiting the outcome; with many NIHR funding streams taking in excess of eight months to inform the researchers of the outcome of their application.

The Research Fellows Forum and Clinical Internship Programme continue to deliver benefits in educational terms for researchers, and this year has also seen the appointment of five Trust-funded doctoral research fellows working in the areas of infectious disease, respiratory, geriatric, renal and diabetes medicine.

The Trust supported NHS Consultant Fellowship posts continue, with new appointments this year in Orthopaedic surgery (Mr Mark Dunbar), general surgery (Ms Olga Tucker), respiratory medicine (Dr Adel Mansur) and Immunology (Dr Thirumala Krishna). The Trust anticipates a portfolio of projects from them in the areas of post-operative recovery, oesophageal cancer, severe asthma, penicillin allergy and telemedicine over the years to come, in conjunction with university partners at Birmingham and Warwick.

This year has also seen the participation of the Trust in a key NIHR/Clinical Research Network led patient experience survey, the results of which demonstrated the value HEFT patients place on participation in research. A grant submission is also planned to work on ways in which patient involvement can be enhanced in future.

Information on the Trust's Research portfolio by Directorate can be found within the Quality Account in Section 3.

## Patient Care

### Arrangements for monitoring improvement in the quality of healthcare and progress towards meeting any national and local targets, incorporating Care Quality Commission assessments and reviews

The Trust continues to have a robust and effective framework in place to provide assurance around the quality of care it offers and to monitor organisational performance.

The Board of Directors and Executive Director-level groups receive monthly performance reports which present performance against national and local targets and priorities. These reports adopt a risk-based approach to reporting to ensure that the consequences of underachievement are highlighted to the Executive Team and Board of Directors as well as the actions that are in place to improve performance. Findings from Care Quality Commission assessments are also reported. The framework provides a good level of assurance and supports effective decision-making.

The Trust also has a Clinical Quality Monitoring Group and a Care Quality Group in place led by the Executive Medical Director and the Executive Chief Nurse respectively. These groups report to the Board of Directors and provide additional assurance and effective accountability around clinical quality and the patient experience. See the Trust's Quality Account in Section 3 for further details.

The Trust has a strong informatics capability with information on key performance indicators and clinical quality priorities available to clinical and management staff on its web-based dashboard.

The Trust's last published announced inspection took place in December 2014. The Trust's overall rating was 'Requires Improvement' and this rating was also applied to the safe, responsive and well-led domains.

The resulting action plan has been implemented and any outstanding issues are being addressed through the new operational structure.

The Trust underwent a more recent CQC announced visit in October 2016. The Trust is still awaiting the report.

## Service Improvements following patient surveys/feedback and Care Quality Commission reports

The Trust encourages and welcomes all feedback from its service users and visitors and acts on any complaints to make improvements whenever possible. Significant gains as a result of feedback have been made this year, more of which is detailed in the following sections.

Moving forward, HEFT has instructed a new contractor for patient surveys, The Picker Institute. The patient experience team is arranging for Picker to run action planning sessions with the Divisional Heads with the results of the most recent inpatient survey. This will also be undertaken with the Maternity survey, which is due to launch in early 2017/18.

## Improvements in patient/carer information

The Trust has recently achieved the Information Standard accreditation, sponsored by NHS England, for the sixth consecutive year, for the Trust's Patient Access and Information database. This database houses clinically approved literature in plain English about the various clinical procedures and other clinical information, relevant to a particular patient's pathway of care. Over 30,000 written pieces of information or leaflets from this database are provided to the Trust's patients each month. When a patient is provided with any such information from the database, it is automatically linked to that patient's electronic record to show that they have been provided with this.

The patient experience team is currently working with colleagues at UHB to share how the system works and also to share and implement areas of good practice in patient and carer information at both Trusts.

## Compliments and Complaints Handling

- **Patient Experience**

The Trust measures patient experience feedback received in a variety of ways, including local and national patient surveys, the NHS Friends and Family Test, complaints, concerns and compliments. There is also a programme of Unannounced Board of Directors visits to randomly chosen wards and departments. A report of the visit, complete with summary of observations, issues and an action plan are provided as part of the Medical Director's Quality Report at each Board of Directors' meeting. This vital feedback is used to make improvements to services and the team is monitoring how these improvements are embedded throughout the Trust.

- **Inpatient Satisfaction**

All inpatients are asked to comment on their experience as a patient. During 2016-17, 36,000 inpatients provided feedback. Patients are asked to rate their satisfaction with the care they received during the daytime and the night time separately. Patients' experiences of weekend services are also monitored.

As an overall measure over the year patients reported 86% satisfaction with their care as a whole (average data April 2016 to March 2017).

The Trust has an online dashboard which all ward areas use to monitor patient, carer and relative's feedback about care provided. This includes both the statistical ratings of their ward and also the specific written comments that are also provided by patients, carers and relatives. Whilst ward areas look at these comments to identify themes to assist in their continuous improvement, in the main these comments tend to be incredibly positive and motivational for staff in clinical areas, in understanding what they have done well.

Clinical leaders are asked to report their patient experience data monthly via ward to Board reporting mechanisms and account for any exceptions in performance.

- **Friends and Family Test (FFT)**

The FFT is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family if they were in need of similar treatment or care. In line with national practice driven by NHS England, the Trust presents results as a percentage of respondents who would recommend the service (either likely or extremely likely to recommend the Trust's care) to their friends and family.

The Trust undertakes this feedback work across inpatient care, the emergency department, maternity services, outpatients, day case surgery and community services.

Through its FFT work, the Trust has received 135,000 comments from patients, carers and relatives about their experiences of care during 2016/17.

The vast majority of these comments have been positive reflections of care and treatment and these comments are used at service level to reinforce these positive examples to follow with staff.

- **Positive Feedback**

Whilst compliments are not routinely collated across the Trust, 115 compliments have been recorded during 2016/17 via the Trust's Patient Services team. These compliments may have been made when a complainant has pointed to something positive in the course of making their complaint. Also positive letters are sometimes forwarded to the Patient Services Team.

Compliments across the organisation are far vaster and come in many forms, usually a thank you card, a verbal thank you or sometimes small gifts of appreciation passed directly to staff teams. There is no routine collation of these, however the comments received via the FFT referred to above, do provide a useful indicator of what drive compliments.

- **National Survey Programme**

The Trust participated in the national inpatient patient experience survey on behalf of the Care Quality Commission (CQC). For more details see the Quality Account in section 3.

- **How the Trust is using feedback**

Feedback, including complaints, tells the Trust that a large proportion of patient experience improvements centre around how well teams communicate with patients, relatives and carers and how systems are built and provide care and treatment with the patient in mind. The continued development of the nursing quality dashboard and the ward to Board assurance framework will assist in this.

Over the year the patient experience team has continued to work closely with the updated Patient Community Panels (PCP) members.

- **Complaints**

Before the start of the year, a rigorous quality assurance process was implemented and embedded. Following this the Trust sought to reduce the live caseload of complaints and improve the timeliness of complaint handling. The Trust has concentrated heavily on how compliant handling is managed, building on the work of the previous year.

During the year, 1,120 complaints were received and 1,309 complaints were closed. Complaints handling training has been provided across the Trust to senior managers, heads of nursing, matrons, and ward sisters/charge nurses. This training has been interactive, using live examples of complaints made. All complaints received are analysed for the themes they contain. From the 1,120 complaints received, 1,936 themes were identified.

Part of the quality review of each complaint focuses on the rigour of any actions to be implemented as a result of each complaint and whether actions are sufficient in order to address the complaint.

## Projects PCP Members were asked to assist with:

| Date | Task | Details |
|---|---|---|
| April 2016 | Quality Review | A quality review took place at Good Hope on Ward 17 in April 2016. Two panel members from the Good Hope panel assisted in interviewing patients. |
| May 2016 | Maternity Surveys | The Patient Engagement Department were approached by senior management in Maternity to ask for panel members' assistance in surveying maternity patients. These are taking place at Good Hope and Heartlands with two members from each panel assisting. |
| September / October 2016 | Open Visiting Surveys | Members were asked to assist with surveying patients, visitors and staff to get their views on the Open Visiting policy that was introduced in the Trust in 2015. |
| September / October 2016 | Telephone calls` | Members were invited to assist with telephoning inpatient wards/areas to find out if the member of staff who answers the phone gives their name, job title, department, and assesses tone of voice and helpfulness. |
| October 2016 | Mock CQC inspections | Two patient panel members/Governors from each panel attended Mock CQC inspections during the first week of October 2016. |
| October 2016 | Improving the experience of patients in pain | Members were invited to take part in a task and finish group around improving the experience for patients in pain. |
| January 2017 | 'Mystery Shoppers' | Members were invited to assist with observing staff in waiting areas in the Trust to observe their customer service skills. |
| January 2017 onwards | Observing hand washing | Members were invited to assist the Infection Control department with observing of hand washing to see if staff and visitors were washing their hands /using alcohol gel when entering wards. |
| March 2017 | PLACE (Patient Led Assessments of the Care Environment) | Members and Governors assisted with PLACE (Patient Led Assessments of the Care Environment) during the week commencing 20 March 2017. |

## Focus on Dementia

The Trust recognises that carers and relatives play a vital role in the care of patients with dementia and is committed to improving how it works with, and supports, carers of patients with this condition.

A regular carers' survey is utilised as an audit tool to measure carers/relatives' experiences and the support provided to them in both inpatient and outpatient areas. There has been an increasing recognition of the importance of delirium as a common, serious and potentially avoidable harm in the hospital for people with dementia.

Some highlights in activity undertaken during the year are as follows:

- All crockery on the Solihull and Good Hope sites is now dementia friendly.
- Training - a one and a half hour session on dementia is now provided for all new nurses as part of induction. A full day programme on dementia and delirium is delivered once per month on all three sites. The team is aiming for 100% attendance to the sessions for all nursing teams, with plans to extend this to therapies, medical and administrative teams for a full multidisciplinary approach to dementia within the Trust. A metric is also being developed for all wards to assist in the measurement and monitoring of compliance as part of KPIs.
- 'Eat, Drink, Move' end of bed boards supporting staff in giving optimal fundamental care are being rolled out across the three sites.
- Making ward environments dementia friendly – this includes the introduction of specially designed signage, toilets and clocks. The wards also utilise day rooms for activities to help keep patients active with the use of volunteers.
- Over 50 Health Care Assistants have received two days training in supporting patients with dementia and delirium with complex and distressed behaviour.
- The Dementia and Delirium Outreach Team have developed a delirium pathway on the Solihull site including the Enhanced Recovery at Home pilot. This innovative project provides 24 hour care for patients' with an on-going delirium within their own homes enabling safe and timely discharge and the optimum opportunity for recovery.
- The Trust recognises, and has promoted the use of, the "About Me" booklet to help gain a better understanding from relatives and carers regarding the patient's requirements. This is also assisting with recognising pain in patients with dementia.
- Good Hope wards 11 and 9 have amended their housekeeper/activities co-ordinator role so patients have a planned activity to meet the needs of the most vulnerable patients - simple investment in games, books and arts materials, along with Bingo, occupies the minds of the patients and maintains a calm nature.

## Focus on Stroke

The Trust completed a large re-organisation of stroke services in February 2015 and has worked to be recognised as one of the best performing trusts in the region. During 2016/17, the Trust has continued to perform very well, providing high quality hyper-acute stroke care at Birmingham Heartlands Hospital for all emergency stroke admissions across HEFT. Specific changes have been made to improve the efficiency of the admission pathway on this site to reduce the amount of time patients spend in A&E and allow patients to access stroke specialist care sooner. Time to administer thrombolysis, which is critically important, has been reduced and by working closely with the team at UHB, the HEFT stroke team has achieved a more accessible and co-ordinated pathway for mechanical thrombectomy. Different ways of working have improved the amount of therapy received by patients following their stroke at Heartlands, Solihull and Good Hope Hospitals and there is also increased access to psychology support at all three sites to help patients with their recovery.

## End of Life Care

The Trust's quarterly end of life care notes audits, alongside participation in the National Care of the Dying in Hospital audit and a gap analysis for End of Life Care undertaken in October 2016, all highlighted that, whilst, in the vast majority of end of life patients, pain relief was addressed, discussions regarding diagnosis and prognosis were held and relatives were fully involved in communication, there were a number of key areas that could be improved. A significant amount of work has been undertaken over the last year to address these areas.

The Trust has signed up to the Transforming Care in Acute Trust programme. Key enablers identified within the TRANSFORM programme have been recognised, alongside other nationally available guidance, and a new suite of documentation has been devised to support high quality end of life care delivery for patients affected by life limited illness and their carers.

Documentation covers recognition of limited prognosis and recognition of days to live plans. Alongside documentation development, key metrics have been devised, both of which are

currently being piloted on an identified ward at Heartlands. Trust-wide roll out is planned thereafter.

A new pathway for those who wish to die at home has been devised and has been in use across HEFT acute services since Oct 2016. This helps enable patients who have expressed such a wish to achieve this in a timely way.

Since April 2016, the Trust has operated a 7-day a week Specialist Palliative Care Clinical Nurse Specialist Service from 9am to 5pm. 24/07 medical out-of-hours telephone advice has also been formalised.

Other key works include:

- Work being undertaken with UHB to progress the installation of an Electronic Palliative Care Co-ordination (EPACCS) system for cross sector communication as, currently, teams are mostly reliant on non-electronic information transfer.
- Schwartz Rounds are currently active within the Trust.
- A Trust End of Life Care Policy has been devised and is under consultation.
- A Trust End of Life Care Steering Group is in formation.
- An integrated acute/community strategy is planned, following stakeholder events throughout last year.
- Work is being undertaken to review opportunities for new end of life models of care across acute and community services.

In response to an identified lack of End of Life Care mandatory training across the Trust, a large portfolio of work has been undertaken throughout the year to address this. This includes:

- An integrated education programme for acute and community trust staff, devised earlier this year, in partnership with the Solihull Macmillan and Marie Curie, West Midlands Clinical Nurse Specialist team.
- Delivery of 'Introduction to ReSPECT' sessions four times throughout the year, targeting the Palliative Care team, and local hospice teams. A further number of sessions including communication skills related to the ReSPECT form have been run throughout the year.
- Consultant-led teaching includes FY1/ FY2 teaching involving Palliative Care case discussions, and third year medical students. The Palliative Care team has also participated in the Trust's medical clinical meetings.
- A link Nurse/Champion role has been formalised this year and, initially, has been rolled out across Good Hope, with plans in place to roll out trust wide.
- A number of End of Life Care topics are currently under construction for delivery via the Trust's Moodle platform.

This is in addition to:

- An End Of Life Care (EOLC) degree module (five day accredited course) for registered nurses, and a single standalone EOLC study day.
- An EOLC and Bereavement study day for Health Care Assistants, which runs every two months.

Palliative Care team members attend a variety of network meetings, including the West Midlands Palliative Care Physician's meeting, the Palliative Care Audit and Guidelines Group (SPAGG), the West Midlands Expert Advisory Group, Palliative and EOLC focussed CCG meetings, Solihull EOLC Quality Forum meetings and WM SPC EAG meetings. There are also links with members of the West Midlands Clinical Network, and members of the NHS England EOLC team.

## Bereavement

HEFT has a centralised bereavement care service that co-ordinates the completion of final death certification documentation for patients who have died whilst in the care of the Trust. The bereavement staff provide information and guidance for bereaved relatives on registration of death, funeral arrangements and Coroner involvement where necessary. This individualised service is respectful of the needs of deceased patients and their families of all faiths and none. Close working relationships have been developed between bereavement office staff and HM Coroner, Register Office, funeral directors and cemeteries, and crematoria staff at Birmingham City Council, to ensure there is effective communication along the whole of the bereavement pathway.

The Trust is an early adopter of the death certification reforms and has identified medical examiners – consultants who are available to look at the circumstances of each death, advise junior doctors of cause of deaths and speak with families about the circumstances of the death and any questions or concerns that they may have.

The Trust also has an agreement with Cruse Bereavement Care to provide follow up bereavement support for bereaved relatives following the death of a loved one.

The bereavement service team provides training and education for staff on the care of dying and deceased patients and their relatives, and undertakes audits of the service provided.

## Multi-faith Chaplaincy Service

Religion is one of the equality monitoring data characteristics the Trust has routinely collected from patients. Please visit the following web link for more information: http://www.heartofengland.nhs.uk/wp-content/uploads/Copy-of-Religion-Data-010116_311216.pdf

The multi-faith chaplaincy team provides services to the whole hospital community and the Trust's in-house male and female chaplaincy staff and volunteers regularly visit the wards and departments within the three hospital sites, to be alongside any person in need of spiritual, pastoral and religious care.

The Chaplaincy team offers a confidential listening and supportive ear and can be contacted by patients, relatives and hospital staff at any time it is felt that spiritual care is needed.

The chaplaincy team also works closely with Trust departments and services to organise staff and patient memorial services and other annual Trust services. The team is supported by a number of chaplaincy volunteers from various religious backgrounds, who contribute to patient care and also regularly hold religious events such as Eid and Diwali celebrations. These events are open to all Trust staff and contribute to raising cultural and religious awareness of the diverse communities the Trust staff provide healthcare services to.

The Trust provides multi-faith prayer facilities on the three hospital sites. Regular services of prayer, as well as Holy Communion and Roman Catholic Mass, are offered.

## Equality and Diversity

The Board of Directors remains committed to promoting inclusion and diversity for both patients and staff, tackling all forms of discrimination and removing inequality in the provision of health services and employment. Meeting the diverse needs of diverse communities the Trust serves remains a key priority. The Trust continues to use the Equality Delivery System (EDS2) Framework to develop, implement and monitor its Equality Objectives to meet the requirements of the Public Sector Equality Duty and to identify areas for improvement.

In 2016/2017, the team's priorities were to:

- Improve its understanding, recognising that equality monitoring is central in understanding whether people from all backgrounds are being treated fairly.
- Have a greater input into service design and transformation. Undertaking equality impact assessments increased understanding of policies and practices affect different groups of people.
- Improve patient experience and accessibility. The key to measuring the success of actions is to ensure that patients have the opportunity to share their experience and feedback.
- Develop more inclusive leadership. By training and educating staff, more inclusive leaders can be developed to drive forward inclusion and diversity, and support a fully inclusive culture.
- Promote partnership working. Collaborative working with local health economy partners and other organisations helps to promote health and wellbeing and to tackle health inequalities within Birmingham.

The highlights for patients and staff in 2016/2017 included:

- Becoming active partners of the Local Health Economy Group, working in collaboration to share equality data and promote and challenge inequalities.
- Establishing an Inclusion Steering Group and the Rainbow Friends Network (staff LGBT forum) to effectively engage patients and staff to address issues that differentially affect people from one or more of the protected characteristic groups; and to promote non-discriminatory culture within the organisation.
- Black History Month was celebrated to honour the achievements and contribution Black and Minority Ethnic communities make to society and especially to the NHS.
- Further development of the Acute Liaison Learning Disability Health Facilitation Service for patients.
- Facilitating 10,391 face to face and telephone interpreting sessions in 50 languages, including BSL (British Sign Language).
- Equality and Diversity/Human Rights training was provided to 8,803 staff Trust-wide.

Mainstreaming equality is central to the work undertaken by the Equality and Diversity leads within the Trust in patient care and workforce areas. The principles of fairness, equality, respect and dignity for patients and staff is widely promoted through training, Equality and Diversity services, and events to ensure patients and staff are not discriminated against.

## Stakeholder Relations

The Board of Directors recognises the importance of effective communication with a wide range of stakeholders, including Birmingham City

Council's and Solihull Metropolitan Council's Health, Wellbeing and the Environment Overview and Scrutiny Committees, whose members make occasional visits to the Trust.

# Review of Environmental Matters

## Energy and Sustainability

The Trust's three hospital sites have recorded the following energy consumptions:

- Heartlands Hospital: 64.7 GJ/100m3
- Solihull Hospital: 69.28 GJ/100m3
- Good Hope Hospital: 85.75 GJ/100m3

Currently, this falls below the NHS Estates Department of Health target of 55-65 GJ/100 cu.m. by an average of eight percent.

The Trust has full year reports for 2016/17, which show an average energy increase of eight percent for the full year against the 2007/08 financial year, which is the baseline year for NHS carbon reduction targets. This is an average of less than one percent per year for the last nine years. Despite the long term investment activities described below, energy increases are inevitable and are attributable to both increased activity and improved technologies, for example, new scanners, which invariably lead to greater energy demand.

Energy costs and consumption are monitored on a monthly basis and data stored on TEAM Software, an industry recognised database.

Energy procurement is carried out via Crown Commercial Services (CCS), ensuring Office Journal of the European Union (OJEU) compliance and effective purchasing. Both gas and electric are procured on a flexible contract which is deemed to be the most effective method of purchase.

The Trust has a legal obligation to comply with the European Union Emissions Trading Scheme, of which the Heartlands site is a registered participant. This involves reporting all fuel usage and is designed to encourage participants to reduce their CO2 emissions. The Trust has elected to opt out of the main scheme into the 'Small Emitters and Hospitals' scheme. It is anticipated that this will save the Trust in the order of £770k over a seven year period between 2013 and 2020.

The Trust has embarked on a long term investment of energy and sustainable efficiency, which has resulted in the development of three Combined Heat and Power (CHP) schemes (one per site) and a four year Sustainable Development Framework, and to continue to review new initiatives

Further energy initiatives include: replacement of the Solihull Building Management System (BMS) in its entirety and major upgrades of the existing BMS systems at Heartlands and Good Hope Hospitals.

## Carbon Footprint

The Trust recognises its corporate responsibility to take care of the environment. The NHS Sustainability Development Unit (SDU) and Department of Health set out an ambition for the NHS to be a leading low carbon and sustainable health care system in 2009. This included an interim target of 10 percent reduction in carbon emissions by 2015 from 2007 levels and a further target of 80 percent by 2050. In order to meet these targets, the Trust has invested heavily in CHP at all three sites. A tri-generation CHP system, installed during 2006/7 at Heartlands, has guaranteed savings of £260k per annum and a reduction in carbon emissions of 1,600 tonnes per annum.

The Solihull CHP scheme launched in 2010. This enabled the site to generate guaranteed savings of £350k per annum and helped reduce carbon emissions of 2,000 tonnes per annum. The final CHP scheme at Good Hope became operational in 2014, with guaranteed savings of £550k per annum and carbon emission savings of 2,600 tonnes per annum.

A four year Sustainable Development Framework was commissioned in 2013 and has seen two phases implemented. Both of these phases operate on guaranteed savings and, whilst Maintenance and Verification (M&V) reports for year two are still being finalised, the schemes, which consist of major lighting upgrades, variable speed drives, insulation, high efficiency pumps, energy display meters and solar PV, are set to deliver guaranteed savings of £850k per annum with carbon reductions of 3,500 tonnes per annum for Phase I and guaranteed savings of £200k per annum with carbon reduction of 900 tonnes per annum for Phase II. The next step is to develop Phase 3 of the Energy & Sustainability Programme.

## ISO 14001 – an international standard

As for all organisations, the Trust has a financial, legal and moral interest in ensuring that its environmental performance is monitored as part of its overall strategic operations and day to day activities, an Environmental Management System (EMS) provides assurance to the Trust that its Aspects *(anything that it does which has the potential to interact with the environment)* are risk assessed and controlled. It also ensures that any Impacts (anything that it does that has interacted with the environment – normally pollution) are

mitigated and where possible, potential breaches of relevant legislation are eliminated.

Both Good Hope and Solihull Hospitals have become fully accredited to ISO 14001 in the last 18 months. Heartlands Hospital is currently being scoped with the aim of having the site accredited by 1 April 2018.

## Facilities

### Waste Management

In 2014, the Trust introduced recycling, to reduce the amount of municipal waste it produces, which, at that time was 1,400 tonnes per annum. In 2014/15 the Trust recycled 154 tonnes, it recycled 451 tonnes in 2015/16 and has recycled in excess of 680 tonnes for the present reporting period.

The new clinical waste contract included a trial of SRCL's Bio System (Reusable Sharps Containers), which commenced in July/August 2016, with the aims of reducing cost for sharps containers and reducing carbon footprint of burning plastics. The trial has been successful and has been rolled out across the Trust, with the last site, Solihull, receiving the service in February 2017.

In 2016/17, the Trust signed up to a reuse service called Warp-it. Warp-it gives the Trust the ability to advertise unwanted assets easily and conveniently, providing opportunities to reduce procurement and waste. The aim is to make savings by improving internal sharing of surplus office equipment and office furniture.

### Transport

During 2016, Facilities completed the Trust's vehicle fleet review, the aim being to rationalise the number of vehicles required for service delivery. This saw a reduction from 33 to 20 vehicles. The Trust continues to work alongside Network Smart, participating in the smarter choice group; the group is run by Birmingham City Council, Solihull Council, and includes the recently renamed Transport for West Midlands. The aim is to identify and encourage both employees and visitors to explore alternative methods of travel to and from the hospitals.

Throughout the year, the Trust has taken part in numerous cycle to work projects, some of which include bicycle maintenance courses, travel to work road shows and employee surveys.

Public information screens have been installed in reception areas and Emergency Departments at all three hospital sites, to inform both employees and visitors of real time bus departures.

With help from the Travel Group, some new easy-to-read site maps that include local bus and rail networks have been developed – these are available at main reception areas on all three sites.

### Catering

The Central Production Unit at Solihull produces approximately 35,000 to 40,000 patient meals per week. Food is cooked fresh each day; it is then chilled and distributed to each hospital site. The cook chill method used is strictly controlled and monitored throughout the process using the HACCP (Hazard Analysis, Critical Control Points) system.

During the last two years, the restaurant at Good Hope, The Orchard, was refurbished completely, transforming the look and providing a good place to eat for staff and visitors. In 2016, the Seasons Restaurant at Solihull was refurbished to the same standard and design as Good Hope. In 2016, the coffee shops on both sites have also had a makeover and, in particular, the Emergency Department coffee shop at Good Hope now boasts an outside seating area.

It is important to the Trust that the organisation helps lead the way by reducing the amount of foods high in fat, sugar and salt that patients, staff and visitors eat. The catering team has looked at the food and drink provided and now offers drinks with less sugar and food with less fat and salt.

The catering team, in conjunction with colleagues from UHB, has recently agreed a new five-year deal with a vending contractor to provide a new range of vending machines and products. Every machine will provide more healthy options and offer various payment options, such as contactless, chip and pin, Apple pay and cash.

### Portering

In May 2016, the Trust-wide Portering service introduced a new Portering task management system called CARPS (Computer Aided Radio Personal System), specifically designed to assist the Portering team in the efficient allocation and performance monitoring of the support functions, such as patient transfers, transporting goods and specimen and blood collections. Along with the introduction of CARPS, Facilities also replaced all of its analogue two-way radio communication with a new digital radio system.

April 2017 will see the Trust-wide introduction of a web-based portal allowing the wards and departments to log and monitor progression of their own tasks.

### Cleaning

During 2016/17, the Housekeeping Standardisation Group met monthly and worked towards standardising the consumables, chemicals and working practices within the Housekeeping services. Job Descriptions, uniforms, work schedules and cleaning practices were discussed, changed and implemented.

The group also completed a table of responsibilities, which provides a framework for determining all cleaning frequencies and individual responsibilities for cleaning the various elements of the patient environment. A Cleaning Management Policy has also been developed and approved.

The Trust has a duty to ensure high standards of cleanliness are being achieved and maintained. In order to achieve these standards, technical audits are undertaken in conjunction with the facilities compliance monitoring team and housekeeping supervisors, in accordance with the National Specification of Cleanliness in the NHS.

### Security

G4S Secure Solutions, the Trust's security service provider, has introduced a risk assessment management tool system, 'Risk 360', which enables the security team to record incidents on their hand-held units at source, providing a more in-depth level of recording and enabling more accurate reporting and analysis of incidents. The security team still report through the Trust's incident reporting system, Datix, when an incident has occurred.

Several additional CCTV cameras have been installed across the Trust's three hospital sites and upgrading of existing cameras and systems has continued, with significant investment having been made recently at Good Hope Hospital.

### Car Parking

Several improvements have been made to the Trust's car parking facilities over the past 12 months, including the upgrade of the software in the pay on foot machines across all three hospital sites, in preparation for the introduction of new coins and notes. Additional speed bumps have been introduced at Heartlands, in line with health and safety, to help reduce speeding at the Yardley Green Road entrance. Barriers have been installed at additional staff car parks to ensure that only staff who possess valid parking permits can access these designated car parks.

Improvements have also been made in line with the British Parking Association's recommendations, including relining of roadways and parking spaces, resurfacing, additional signage and grounds maintenance which, in turn, have helped the Trust gain Park Mark Accreditation for all parking facilities.

## Major Capital Developments

### Ambulatory Care and Diagnostic Centre (ACAD)

Following a review of the Estate, and Heartlands site in particular, the need for significant investment was identified and agreed in principle with NHSI/Department of Health/Treasury to address the appropriate highest priority clinical requirements and facilitate subsequent development for the remainder; this has led to the Trust planning to develop an updated Ambulatory Care and Diagnostic Centre (ACAD).

The new facility is intended to provide an efficient, safe, sustainable and high quality environment for the delivery of many of the Trust's ambulatory, outpatient and diagnostic services. Subject to whole life value for money parameters, the aspirations are for a Building Research Establishment Environmental Assessment Method (BREEAM) 'excellent' and 'A' rated energy efficient building solution.

Currently in the early stages of design, the new ACAD development is intended to accommodate the following services:

- Outpatient Radiology (MRI, CT, Ultrasound and X Ray)
- General Outpatient Clinics
- ENT
- Audiology
- Therapies
- Fracture Clinic
- Endoscopy
- Urology
- Day Surgery
- Interventional Radiology
- Vascular Clinics
- Outpatient Phlebotomy
- Pre-operative Assessment
- Cardiology ECCG and ECHO testing

The Process Design Team (PDT) has worked with clinical and operational teams over the past few months to re-design safe and efficient processes and pathways that will improve the experience of patients and staff alike. These are being incorporated into the design of the proposed new modern clinically focussed building.

A series of transition projects are planned over the next two to three years to ensure that the new building, when open, is used to its optimum potential and provides a safe, quality environment for patients to receive care.

## Additional Endoscopy Room at Solihull Hospital

The Trust has created an additional Endoscopy procedure room with added decontamination facilities within the Day Procedures unit at Solihull Hospital. A programme of works was undertaken and the additional room was operational in September 2016.

## Ambulatory Emergency Care (AEC) Heartlands Hospital

The current AEC facilities are being re-located to the existing Medical Day Hospital (MDH), within the main hospital footprint. This will allow for an increase in the treatment spaces within AEC and an increased number of consulting spaces in the MDH. The project is expected to be completed in summer 2017.

## Birmingham Chest Clinic

The ownership of the building that houses the Chest Clinic has changed to a commercial organisation. The Trust is working with the new owner to improve the environment and reduce costs to the Trust which includes a review of space utilisation with the aim to reduce the footprint required to deliver the service.

## Meadow Centre Relocation

Plans are in place to relocate the current specialist paediatric service from the Meadow Centre building to Chelmsley Wood Primary Care Centre.

# Financial Review

For the financial year 2016/17, the Trust has delivered a total deficit of £11.3m excluding impairment losses (accounting adjustments to reflect a reduction in asset values). This is £2.3m better than the Trust's control total maximum deficit of £13.6m that was agreed with NHSI and represents a significant improvement on the deficit of £46.1m that was reported in the previous financial year.

The net impact of asset impairments is £11.5m and, after this is included, the Trust has reported an overall deficit of £22.8m.

During the year, the Trust began the implementation of the three-year Financial Recovery programme, developed in conjunction with Ernst and Young, and agreed with NHSI in May 2017. This has resulted in the delivery of a stretching cost improvement programme, culminating in the significantly decreased income and expenditure deficit.

The Trust prepares its accounts in accordance with International Financial Reporting Standards (IFRS) and International Finance Reporting Interpretations Committee (IFRIC) interpretations, as endorsed by the European Union, applicable at 31 March 2017 and appropriate to NHS Foundations Trusts. There have been no amendments to the accounting standards in 2016/17 and minimal changes to HM Treasury requirements, although the Trust is now required to record impairment reversals impacting the income statement to be recorded in cost line rather than as income. Otherwise, the Trust's accounting policies remain largely unchanged.

## Income

There was a 5% increase in the Trust's total income to £709.1m, due to a combination of a 2% growth in clinical revenue and £25.2m of new income from the Sustainability and Transformation Fund (STF) provided by the Department of Health. The STF scheme was introduced in an attempt to bring the provider sector back to a position of financial sustainability and is linked to the Trust hitting its control totals and agreed performance targets. The Health and Social Care Act 2012 requires that the Trust's principal activity is to deliver goods and services for the purposes of the National Health Service in England. The revenue generated from NHS patient care activity is £624.6m, of which only £0.5m is derived in NHS Wales, Scotland and Northern Ireland. Therefore, revenue from the provision of goods and services for the purposes of the NHS in England, at 90% of total income, is significantly ahead of the minimum 50% requirement.

The Trust's principal source of income is contracts with the Clinical Commissioning Groups (CCGs) that, for 2016/17, were under the Payment by Results regime, where prices are based on the national tariff and planned volumes are paid for monthly by commissioners with subsequent adjustments for over or under performance.

There are a number of other income sources to the Trust. The Education and Training income of £22.6m supports the costs of training doctors, nurses and other healthcare professionals and, in doing so, supports the quality of care provided at the Trust. The research and development income of £4.6m is a combination of Department of Health income and grants and income from commercial establishments and research institutions that contributes to the improvement of healthcare, both in the Trust and in the wider healthcare environment. The remainder of the Trust's income sources are not directly linked to patient care and include items such as catering, accommodation revenues and other services provided to third parties.

## Expenditure

The Trust's total expenditure in the year was £731.9m. As in previous years, staff costs are the largest component of expenditure, accounting for 60% of operating expenses.

As part of the financial recovery programme and implied efficiency in tariff, the Trust was required to deliver a significant programme of cash releasing efficiency savings in the 2016/17 year. A detailed programme of schemes across all divisions has been monitored throughout the year, with reports to the Financial Recovery Programme Board, leading to delivery of actual savings of £25.1m in the year.

The Trust has complied with the cost allocations and charging requirement set out in HM Treasury and Office of Public Sector information guidance.

## Expenditure on consultancy

During 2016/17, the Trust spent £1.6m on consultancy.

## Statement of Financial Position

The Trust began the year with a cash balance of £31.5m, which was significantly lower than

in previous years and was showing a decreasing trend. The Trust has applied cash management measures that have stabilised the rate of reduction and has resulted in a cash balance of £19.2m at the end of March 2017.

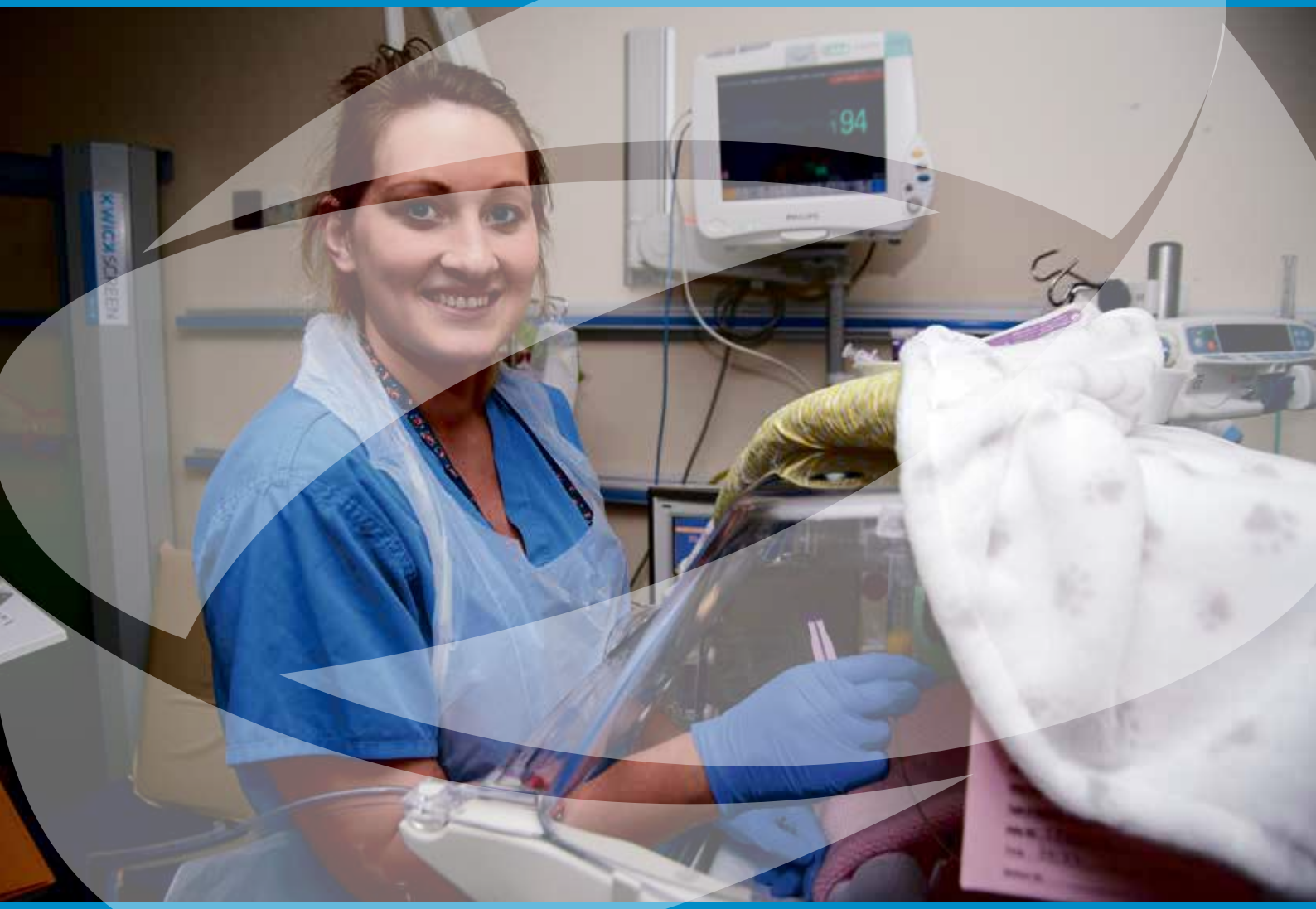
In the 2016/17, the Trust incurred £14.6m of capital expenditure, including £5.7m on ICT schemes to upgrade the data and voice infrastructure, £2.5m improving the estate and £1.9m on enabling works to improve radiology facilities across all three sites.

The Trust performed an interim valuation of its land and buildings as at 31 March 2017, as required under the accounting policies. This valuation was performed using the modern equivalent asset (MEA) valuation methodology. This resulted in an overall decrease of £5.4m in the value of the asset base, compared to the value that it had previously been recorded at. Of this, £3.7m was charged to the Statement of Comprehensive Income (SOCI), comprising an impairment charge of £5.9m, offset partially by reversals of previously charged impairments, where the asset has increased in value, totalling £2.2m. The remainder of the valuation adjustment has been recognised as a £1.8m net decrease in the revaluation reserve. Further details can be seen in notes 11 and 21 of the Annual Accounts.

## Future

The Trust will continue to work through the schemes identified in the Financial Recovery Plan to implement the further savings plans identified. A two-year financial plan was submitted to NHSI in March 2017 in which the Trust moved towards a financial surplus in 2018/19.

# Section 2 **Accountability Report**



This report covers the period 1 April 2016 to 31 March 2017

Section 2

# Accountability Report

## Directors' Report

### Overview

It is the responsibility of the Directors of the Trust to prepare the Annual Report and Accounts. The Board of Directors considers that that Annual Report and Accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.

### Audit Information

So far as each of the Directors is aware, there is no relevant audit information of which the auditors are unaware. Each of the Directors has taken all of the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

### Pensions

The accounting policy for pensions and other retirement benefits are set out in note 1.13 to the financial statements and details of senior employees' remuneration can be found in the Remuneration Report on page 57.

### Disclosures in accordance with Schedule 7 of the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008

Disclosures regarding likely future developments are outlined in the Performance Report. Details of employment of disabled persons, and informing and engaging with staff are included within the Staff Report.

### The Board and Board Committees

The voting Directors serving on the Board during the year ended 31 March 2017 were:

Mr Jonathan Brotherton – Director of Operations
Mr Andrew Edwards – Non-executive Director \ † ‡ •
Mrs Sam Foster – Chief Nurse
Prof Jon Glasby – Non-executive Director \ † ‡ • (no longer member of Audit Committee as of December 2016)
Mrs Jackie Hendley - Non-executive Director \ † ‡ • (appointed 12 June 2016)
Mrs Hazel Wyton – Director of Workforce and Organisational Development
Dr Mike Kinski - Non-executive Director \ † ‡ • (appointed 12 June 2016)
Ms Karen Kneller - Non-executive Director \ † ‡ •
Miss Mehrunnisa Lalani - Non-executive Director \ ‡ • (appointed 1 February 2017)
Mr Julian Miller – Interim Director of Finance
Dame Julie Moore – Interim Chief Executive •
Dr Jammi Rao - Non-executive Director \ † ‡ • resigned 30 June 2016
Dr David Rosser – Interim Medical Director
Prof Michael Sheppard – Non-executive Director \ ‡ • (appointed 12 June 2016)
Rt Hon Jacqui Smith – Interim Chair \ ‡ •

\ Independent † Audit Committee ‡ Remuneration Committee • Nominations Committee

Mr Andrew Edwards was appointed Deputy Chair and Prof Jon Glasby was appointed Senior Independent Director, both with effect from 4 April 2016.

In addition to the Chair, the Board currently comprises six voting Executive Directors and seven voting Non-executive Directors.

The Board is responsible for the overall management and performance of the Trust. There is a formal schedule of matters that are reserved to the Board. That schedule provides a framework for the Board to oversee the Trust's affairs, and it is available to view on the Trust's website; it includes, amongst other things, (1) approval and variation of the Trust's long term objectives and strategy, operating and capital budgets, governance arrangements, systems of internal control, treasury policies, significant changes in accounting policies, standing orders and standing financial instructions, (2) changes to the Trust's capital structure, management and control structure and corporate structure, (3) the appointment and dissolution of Board committees and approval of their terms of

reference, (4) oversight of the Trust's operations and review of its performance, and (5) approval of the annual report and accounts.

Any matters that are not reserved to the Board are delegated to the Chief Executive, who is responsible for the day-to-day management of the Trust. The role of the Governors is set out in the Constitution, which is also available to view on the Trust website, and summarised from page 44.

The Board normally meets in formal public session six times per year, and also on an ad hoc basis when necessary. It is given accurate, timely and clear information, so that it can maintain full and effective control over strategic, financial, operational, compliance and governance issues.

The Directors bring a range of skills and experience to their roles on the Board to ensure the balance, completeness and appropriateness of the Board to the requirements of the Trust. The biographical details of the Directors are as follows:

## Chair and Voting Executive Directors

### Dame Julie Moore, Interim Chief Executive Officer

Julie is a graduate nurse who worked in clinical practice before moving into management. After a variety of clinical, management and director posts, she was appointed as Chief Executive of University Hospitals Birmingham (UHB) in 2006. In October 2015 she was appointed interim Chief Executive of Heart of England NHS Foundation Trust (as well as remaining Chief Executive of UHB), to help lead it out of clinical and financial difficulties.

Julie is a member of the following bodies: The International Advisory Board of the University of Birmingham Business School, the Court of the University of Birmingham and is a Governor of Birmingham City University. She was an independent member of the Office for Strategic Co-ordination of Health Research (OSCHR) from 2009 to 2015 and was a member the Faculty Advisory Board of the University of Warwick Medical School until 2015. In September 2015 she was appointed as a Non-Executive Director of the national Precision Medicine Catapult. She was appointed a trustee of the Prince of Wales Charitable Foundation in 2016. She is a founder member and past Chair of the Shelford Group, the 10 leading academic hospitals in England.

In April 2011 she was asked by the Government to be a member of the NHS Future Forum to lead on the proposals for Education and Training reform and in August 2011 was asked to lead the follow-up report. In September 2013, in recognition of the high quality of clinical care at UHB, Julie was asked by the Secretary of State to lead a UHB team for the turnaround of two poorly performing trusts in special measures and since helped two further trusts. In 2014 she chaired the HSJ Commission on Hospital Care for Frail Older People and she was a member of the expert panel for the 2014 Dalton Review into New Models of Hospital Provision. In 2015 was asked by Lord Victor Adebowale to join the NLGN Commission on Collaborative Health Economies.

Julie was made a Dame Commander of the British Empire in the New Year's Honours 2012. In 2013, she was awarded an Honorary Chair at Warwick University, was included in the first BBC Radio 4's Woman's Hour list of the 100 most powerful women in the UK and is included in the HSJ lists of the most influential clinical leaders, the top 10 CEOs and a national LGBT role model in health. She has Honorary Doctorates from the University of Birmingham and Birmingham City University and in June 2016 received an Honorary Doctorate from Oxford Brookes University specifically to commemorate the University's 125th anniversary of providing nurse education.

### Rt Hon Jacqui Smith, Interim Chair, Heart of England NHS Foundation Trust

In December 2015, Jacqui Smith added to her role as Chair of University Hospitals Birmingham NHS Foundation Trust, being appointed Interim Chair of Heart of England NHS Foundation Trust. Jacqui also chairs the Birmingham Health Partnership which coordinates the research partnership with the University of Birmingham.

Jacqui grew up in Worcestershire and, after reading Philosophy, Politics and Economics at Hertford College, Oxford University; she returned to the County and had a successful teaching career for 11 years in Worcestershire schools.

In 1997, Jacqui was elected as the MP for Redditch and served for 13 years. After a period on the Treasury Select Committee, she was appointed as a Minister in 1999 and became one of the longest serving Ministers in the Labour government. In 2007, Jacqui was appointed as the first female Home Secretary.

Jacqui is also Chair of the Precious Trust – a Birmingham based charity formed with Marcia Shakespeare to support girls at risk of gang violence and of the Advocacy Practice of Westbourne Communications. She is a Trustee of the Kings Fund and also works in Jordan and Egypt supporting parliamentary and political development.

## Dr David Rosser, Interim Deputy CEO (Clinical Quality) and Medical Director

David qualified from University College of Medicine, Cardiff in 1987 and worked in general medicine and anaesthesia in South Wales before moving to London in 1993 to be a Research Fellow in critical care and subsequently Lecturer in Clinical Pharmacology in UCLH.

He was appointed to a Consultant post in Critical Care at University Hospitals Birmingham in 1996. He was later appointed as Specialty Lead for Critical Care in 1998, as Group Director responsible for Critical Care, Theatres, CSSD and Anaesthesia in 1999 and as Divisional Director responsible for 10 clinical services in 2002. David was seconded two days per week to the NPfIT in 2004 and appointed as Senior Responsible Owner for e-prescribing from November 2005 to April 2007.

Appointed as Executive Medical Director of UHB in December 2006, David had responsibilities including Executive Lead for Information Technology. He led the in-house development and implementation of advanced decision support systems into clinical practice across the organisation.

David took up the role of Interim Deputy CEO with responsibility for Clinical Quality at HEFT in November 2015, in addition to the Medical Director role at UHB, and was appointed as Executive Medical Director at HEFT in March 2016, retaining the responsibilities of the MD at UHB and Interim Deputy CEO at HEFT.

## Jonathan Brotherton, Director of Operations

Jonathan Brotherton joined the Trust in September 2014 as Director of Operations and was appointed to the Board of Directors in March 2015.

He joined the NHS in 1992 as a trainee paramedic in Worcestershire working operationally and managerially for 12 years. He graduated from the University of Worcester with a Master's degree in management studies in 2007 and worked in the National Emergency Care Intensive Support Team (ECIST), then at Burton Hospitals NHS Foundation Trust and more recently at University Hospitals Coventry & Warwickshire NHS Trust as Director of Performance before joining HEFT.

## Sam Foster, Chief Nurse

Sam Foster was appointed Chief Nurse at HEFT in September 2014 having been Acting Chief Nurse since September 2013. Prior to this she had been Deputy Chief Nurse at the Trust since 2009. In that post she delivered a key leadership role supporting the then Chief Nurse in professionally leading and enabling 5,500 nursing and midwifery staff to deliver a high standard of care.

Qualifying as a general nurse in 1993, Sam spent her early career working in general medicine, where she furthered her studies by undertaking a BSc in professional studies before moving into critical care and undertaking an MSc in advancing critical care practice. Sam has always had an interest in the development of nurses and nurse leaders, and developed her long-standing interest in the MAGNET accreditation which focuses on nurse retention. Sam has recently completed the Florence Nightingale Leadership scholarship, which included a study tour to America, and attained the Ashridge Business School Executive Programme.

## Hazel Wyton, Director of Workforce and Organisational Development

Hazel was appointed to the Trust in November 2007. Hazel is a highly experienced HR and OD Director who has over 35 years' experience working within a professional HR function and over 20 years' experience of working within the highly regulated healthcare industry spanning voluntary, private and NHS sectors.

Hazel has a diverse background of experience spanning HR, leadership, education and organisational development. She has held wide workforce portfolios as well as leadership delivery of integrated healthcare strategies and has had national experience working with organisations such as The Kings Fund on national projects. Her key responsibilities are to develop and lead on workforce strategy, education, organisational development, human resources and occupational health.

## Julian Miller, Interim Director of Finance

Julian Miller joined the Board at HEFT as Interim Director of Finance in November 2015 on secondment from University Hospitals Birmingham NHS Foundation Trust (UHB). Julian is a Business Studies graduate and joined the NHS in 1995 before qualifying as a Chartered Management Accountant (ACMA, CGMA) in 1998. He has worked at UHB since 2000 in a variety of roles including Divisional Finance Manager, Head of Financial Management and Planning, Deputy Director of

Finance and most recently Director of Finance since 2012.

## Voting Non-executive Directors

### Andrew Edwards

Andrew Edwards started his career with West Midlands Regional Health Authority as a trainee engineer. He went on to complete a BEng Honours degree in environmental building services and became a chartered engineer and Fellow of the Institute of Healthcare Engineering & Estate Management. His career has spanned the public and private sectors and included time with a number of engineering design consultancies. Most recently he was a Director at the Couch Perry and Wilkes Partnership with responsibility for an engineering design business unit and general management. His key area of expertise is engineering design in healthcare. Andy joined the Board in October 2014.

### Professor Jon Glasby

A qualified social worker by background, Professor Jon Glasby is Head of the School of Social Policy at the University of Birmingham. Prior to this, he was Director of the University's Health Services Management Centre for seven years, where he specialised in joint work between health and social care and was involved in regular policy analysis and advice.

He has recently served as a Non-executive Director of the Birmingham Children's Hospital and, from 2003 to 2009, was the Secretary of State's representative on the board of the UK Social Care Institute for Excellence (SCIE). He is a Senior Fellow of the National Institute of Healthcare Research (NIHR) School for Social Care Research, and a Fellow of the Academy of Social Sciences and the Royal Society of Arts. Jon joined the Board in October 2015.

### Jackie Hendley

Jackie offers the Trust over 30 years of professional services experience, 11 as a KPMG partner for clients in plcs and private equity across a varied range of sectors both in the private and public sector. She has advised a wide range of Boards on tax, structuring, strategy, risk management and governance including operational restructuring and dispute mitigation.

Combining a commercial, accounting, auditing and tax background with Boardroom experience to offer constructive challenge and strategic advice, her experience includes challenging what business will look like in the future and how to maximise potential.

Jackie also advises clients and teams in many industries, including: retail, manufacturing, automotive, property, not for profit, public sector and transport. Jackie is passionate about supporting her local community and has been involved with a number of schools and charities in the area and is committed to bringing people together to build capacity and opportunity. Jackie joined the Board in June 2016.

### Dr Mike Kinski

Mike is a very experienced senior businessman who has worked in a range of business sectors in both the UK and overseas, which have been of considerable scale and complexity. He brings extensive Human Resources experience having led and operated in organisations both within the public and private sectors.

He has led major change programmes across the organisations he has worked in and has played a key role in transforming the workplace. Mike was Chair of the Advisory Group for the Government Task Force on Work Force Development, a member of the TUC Partnership Institute Advisory Board and is a Past President of the Chartered Institute of Personnel and Development. He brings strong commercial acumen and well developed experience of managing multiple stakeholders and agendas and has considerable experience as a NED and Chair. Mike joined the Board in June 2016.

### Karen Kneller

Karen is a practising barrister employed at the Criminal Cases Review Commission as Chief Executive. Before that she was a Senior Policy Adviser at the Crown Prosecution Service having been a prosecutor for a number of years.

Karen sits occasionally as a Judge of the Social Entitlement Chamber and is a member of the General Dental Council's Fitness to Practise panel. Karen is currently a trustee of BRAP, a national equalities think tank. She joined the Board in October 2014.

### Mehrunnisa Lalani

Mehrunnisa has a diverse background having worked for a range of public sector organisations from local Government to HM Prison Service. She started her career working with older people and Black & Minority Ethnic (BME) communities experiencing mental health difficulties. She has more recently been Director of Inclusion for the

Solicitors Regulation Authority (SRA) leading on consumer affairs, corporate complaints and equality, diversity and inclusion. At the SRA, Mehrunnisa transformed and improved the way complaints were being handled by establishing internal and external quality assurance leading to an improvement in customer satisfaction and reduction in complaints. She led the establishment of 'Legal Choices', an online interactive platform where consumers of legal services can access information about legal services, standards and regulation.

Mehrunnisa has also held a number of non-executive positions in the health and voluntary sector. She has served as a Lay member on the Leicestershire, Northampton and Rutland Strategic Health Authority and was a member of the East Midlands ACCEA.

She completed a four year term as an Independent Lay Member of the Leicester City Clinical Commissioning Group (CCG) where she chaired the Quality and Clinical Governance Committee and the Patient and Community Engagement Group. Mehrunnisa is currently a Lay Adjudicator on the British Association of Counselling and Psychotherapists (BACP) Fitness to Practice Panel and a member of the Pay Review Body for Doctors and Dentists (DDRB). She works as a consultant providing advisory and training services.

Mehrunnisa has a Postgraduate Diploma in Health Studies, an MA in Health and Community Development and a JNC Qualification in Youth and Community Work. Mehrunnisa joined the Board on 1 February 2017.

## Dr Jammi Rao

Dr Jammi Rao is a public health physician with many years' experience in the NHS. He has been a director of public health for the former North Birmingham Primary Care Trust, and worked for a time in the senior civil service.

He chaired the West Midlands Multi-Centre Research Ethics Committee for many years, served for a term as trustee of the British Medical Association (BMA), and of the Faculty of Public Health.

He currently holds a visiting chair in public health at Staffordshire University and is a judicial office holder as a medically qualified member of the Social Security and Child Support Tribunal.

Jammi joined the Board in July 2013 and left in June 2016.

## Professor Michael Sheppard

After an early career as a clinical academic in South Africa, Michael received MBChB (Honours) and PhD degrees from the University of Cape Town. He was elected Founder Fellow of the Academy of Medical Sciences in 1998.

Michael took up a lectureship at the University of Birmingham where he remained until 2013 becoming Professor of Medicine and then headed up the Division of Medical Sciences whilst also building his academic endocrine practice. Michael served most recently as Dean of Medicine and Provost and Vice Principal at the University of Birmingham.

Michael has been a member of, and chaired, a number of UK and international committees and endocrine societies as well as roles at The Royal College of Physicians, Medical Research Council and WHO.

Michael was previously a Non-executive Director (NED) at Birmingham Children's Hospital and UHB, and along with being a NED at Heart of England NHS Foundation Trust, he is also Chair of the West Midlands Academic Health Science Network Board. Michael joined the Board in June 2016.

## Directors' Register of Interests

The Trust's Constitution and Standing Orders of the Board of Directors require the Trust to maintain a Register of Interests for Directors. Directors are required to declare interests that are relevant and material to the Board. These details are kept up-to-date by an annual review of the Register, during which any changes to interests declared during the preceding 12 months are incorporated. The Register is available to the public on request to Interim Director of Corporate Affairs, Heart of England NHS Foundation Trust, Devon House, Bordesley Green East, Birmingham B9 5SS.

## Board Committees

The principal Board committees comprise:

- Audit Committee
- Nominations Committee
- Quality Committee
- Remuneration Committee

Their terms of reference are available from the Interim Director of Corporate Affairs on request.

## Directors' Attendance at Meetings

The table below shows the attendance of voting Directors at Board and key committee meetings during the year ended 31 March 2017.

| | Board | | Audit Committee | | Remuneration Committee | | Nominations Committee | |
|---|---|---|---|---|---|---|---|---|
| Meetings | 14 | | 6 | | 0 | | 0 | |
| Director | Attended | Relevant number | Attended | Relevant number | Attended | Relevant number | Attended | Relevant Number |
| J Brotherton | 13 | 14 | - | - | - | - | - | - |
| A Edwards | 14 | 14 | 5 | 6 | 0 | 0 | 0 | 0 |
| S Foster | 14 | 14 | - | - | - | - | - | - |
| J Glasby | 9 | 14 | 3 | 5 | - | - | 0 | 0 |
| J Hendley | 8 | 10 | 3 | 4 | 0 | 0 | 0 | 0 |
| M Kinski | 6 | 10 | 3 | 4 | 0 | 0 | 0 | 0 |
| K Kneller | 12 | 14 | 6 | 6 | 0 | 0 | 0 | 0 |
| M Lalani | 3 | 3 | 0 | 0 | 0 | 0 | 0 | 0 |
| J Miller | 14 | 14 | - | - | - | - | - | - |
| J Moore | 14 | 14 | - | - | - | - | 0 | 0 |
| J Rao | 3 | 4 | 2 | 2 | 0 | 0 | 0 | 0 |
| D Rosser | 12 | 14 | | | | | | |
| M Sheppard | 7 | 10 | 1 | 2 | 0 | 0 | 0 | 0 |
| J Smith | 14 | 14 | - | - | 0 | 0 | 0 | 0 |
| H Wyton | 14 | 14 | - | - | - | - | - | - |

Note: The key committees are those identified in the NHS Foundation Trust Code of Governance.

## Audit Committee

The work of the Audit Committee is to:

- Review the establishment and maintenance of an effective overall system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives
- Ensure there is an effective internal audit function that provides appropriate independent assurance to the Audit Committee, Quality Committee, Chief Executive and Board
- Ensure there are effective counter-fraud arrangements established by management that provide appropriate independent assurance to the Audit Committee, Quality Committee, Chief Executive and Board
- Consider and make recommendations to Audit Appointments Committee of the Council of Governors in relation to the appointment, re-appointment and removal of the external auditor and to oversee the relationship with the external auditor
- Monitor the integrity of the financial statements of the Trust, reviewing significant financial reporting issues and judgements which they contain and review significant returns to regulators and any financial information contained in other official documents including the Annual Governance Statement
- Review the Trust arrangements for its employees to raise concerns, in confidence, about possible wrongdoing in financial reporting or other matters and ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action

In 2016/17, the Committee met six times and discharged its responsibilities as set out in its terms of reference. It operates to a clearly defined annual business programme that the Committee sets for itself annually in advance. It has received comprehensive reports from the Interim Director of Finance and the Head of Corporate Risk and Compliance, as well as reports from both the internal and external auditors.

The reports from the Interim Director of Finance have highlighted the key issues for the Trust with regards to financial reporting in the year. There were no changes required by NHSI's Annual Reporting Manual (ARM) for 2015/16, so

the Committee agreed to the Trust's accounting policies remaining largely unchanged.

The Trust does not have its own internal audit function, so appoints another organisation to provide this service. Deloitte LLP provides this service to the Trust and the contract has been extended, pending the outcome of the Case for Change. 2016/17 was year three of this contract. An internal audit plan of work was agreed by the Committee in March 2016, following feedback from executive and Non-executive Directors and senior managers, and regular updates have been provided to the committee on the progress and findings of the planned reviews.

In addition to the regulatory requirements for core internal audit reviews (including financial systems, IT controls, budgetary controls risk management and compliance arrangements), two performance reviews were carried out, Medical Equipment Library; and Quality Indicators (follow up review). For both these reviews a report with actions to address risks is agreed with the management team for that area before being presented to Audit Committee. The Committee tracks progress against these action plans and also reviews the implementation of previously agreed actions.

The Trust has a Board Assurance Framework which is used to continually evaluate the risks the Trust is facing.

The Trust's external auditors are KPMG, who were awarded a four year contract commencing 1 April 2016 to 31 March 2020, following a tender process using a framework agreement. The Council of Governors Audit Appointments Committee agreed to appoint KPMG as external auditors for this period and the Council of Governors ratified this decision in March 2016. 2016/17 is the first year of their contract. KPMG presented its audit plan to the committee which set out its planned approach, an assessment of the risks and controls and proposed areas of focus. KPMG is working with internal audit to identify areas where they could reply on work performed already as part of the internal controls work.

The Trust places reliance on the external auditor's own internal processes and procedures to ensure auditor objectivity and independence are safeguarded. As a matter of best practice, the external auditors will hold discussions with the Audit Committee on the subject of auditor independence and have confirmed their independence in writing. There has been no non-audit work proposed by external audit in the 2016/17 year.

The Trust has a duty, under the Health and Safety at Work Act 1974 and the Human Rights Act 2000, to provide a safe and secure environment for staff, patients and visitors; and the Committee regularly reviewed the activities of the counter fraud team. There were no concerns raised around the provision of counter fraud services by the central NHS Protect assessment team.

The Committee consists solely of independent Non-executive Directors and at least one member has recent and relevant financial experience. Karen Kneller is the Chair. The attendance of committee members is shown in the table on page 40.

## Nominations Committee

The work of the Nominations Committee is to:

- Review the size, structure and composition of the Board and make recommendations with regard to any changes
- Give full consideration to succession planning
- Evaluate the balance of skills, knowledge and experience in relation to the appointment of both Executive and Non-executive Directors
- Identify and recommend suitable candidates to fill Executive Director vacancies.

In the case of Non-executive Director vacancies, including the Chair, the relevant information on skills, knowledge and experience is passed to the Council of Governors' Appointments Committee so that it can consider the information in its deliberations. The Council of Governors Appointments Committee is then responsible for the identification and recommendation of Non-executive Directors, including the Chair, to the Council of Governors. The Council of Governors Remuneration Committee is responsible for making recommendations as to their terms and conditions of employment.

In the case of Executive Director vacancies, the usual process involves the Nominations Committee reviewing the job description and person specification, undertaking the recruitment process and making a recommendation to the Board. It is for the Non-executive Directors to appoint and remove the Chief Executive although the appointment of the Chief Executive also requires the approval of the Council of Governors.

The Nominations Committee is chaired by the Chair of the Trust and also comprises the Non-executive Directors and the Chief Executive. It has not met during the year ended 31 March 2017, due to no appointments being required.

## Remuneration Committee

The Remuneration Committee did not meet during this financial year, as no changes to executive remuneration or the Trust's remuneration policy were proposed.

## Quality Committee

The Committee's duties include monitoring the performance of the Trust against the requirements of its clinical quality strategy, including:

- Reviewing, and monitoring action taken in relation to managing/exceptions
- Notifying the Board should any irregularities be identified
- Overseeing compliance with external and internal care standards
- Receiving quantitative and qualitative analyses reflecting all aspects of clinical governance, including complaints, claims, inquests and clinical incidents
- Ensuring that lessons are learned from complaints, litigation, adverse incident reports and trends, and service enquiries and review
- Overseeing the Trust's responses to all relevant external assessment reports and the progress of their implementation
- Assuring itself that participation in clinical audit and relevant R&D activity by individuals and multi-professional teams is encouraged and supported as integral to the provision of high quality clinical care
- Overseeing the development of the annual Quality Report and Quality Account
- Scrutinising assurance on the performance of the Trust's divisions against the Quality Framework that includes the relevant Strategic Objectives and the priorities set out in the Quality Account
- Initiating and monitoring investigation of areas of serious concern as necessary and ensuring resulting action plans are implemented and
- Monitoring the key performance indicators relevant to areas of clinical quality.

## Political Donations

The Trust made no political donations during the year ended 31 March 2017.

## Enhanced Quality Governance Reporting

The Performance Analysis, which can be found on pages 14 to 29, the Quality Account and Report, which can be found in Section 3 and the Annual Governance Statement, which can be found from page 68, discuss quality governance and quality in further detail, supplementing the information on quality governance found in this report.

The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to NHSI's Quality Governance Framework (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), it has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of health care provided to its patients.

## Cost Allocation and Charging Guidance

The Trust complies with all of the cost allocation and charging guidance issued by HM Treasury.

## Better Payment Practice Code

The Trust is obliged to report its performance against the Better Payment Practice Code which requires payment of undisputed invoices by the due date or within 30 days of receipt of goods or services or a valid invoice, whichever is later, for 90% of all invoices received by the Trust. The Trust's standard payment terms are 30 days.

However, cash management procedures introduced as part of the financial recovery programme, set out weekly payment allocations against which suppliers are prioritised, which can mean that invoices are paid after their due date. As a result the target has not been hit with 25% (68% 2015/16) of invoices by value being paid within the target timeframe in the full year.

# NHS Foundation Trust Code of Governance Disclosures

Heart of England NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance ("the Code") on a comply or explain basis. The Code, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Code is issued as best practice guidance, on a comply or explain basis; however, certain disclosure requirements apply in relation to the Code.

The Board considers that throughout the year it was fully compliant with the principles of the Code, save that:

- There were times during the year when less than half of the Board, excluding the Chair, comprised Non-executive Directors. This occurred due to timing differences in recruiting replacement Non-executive Directors but it continues to be the policy of the Board to comply with this requirement. The recruitment exercise for Non-executive Directors has now been completed.
- The Chair has not held any meetings with the Non-executive Directors without the executives present although the Chair has held individual meetings with the Non-executive Directors as part of the appraisal process.
- The Trust has not carried out an externally facilitated evaluation of the board against the "Well-led framework for governance reviews" this year, as per provision B6.2 of the Code of Governance, for the following reasons:
    - As referred to elsewhere within this report, as part of the Intervention, in November 2015, the Good Governance Institute were commissioned to deliver a governance evaluation and development programme, following which a programme of Board development was commenced. This has included a restructuring of the Board's committees and changes to the risk and control framework and is continuing.
    - The Trust is working with UHB to develop a business case for the two Trusts becoming a single legal entity, most probably through the merger by acquisition of the Trust by UHB. This will result in a new Board and governance structures and processes and it is considered that expenditure on an external review would be better spent following or in support of any such transaction.

The role of the Board is described on page 35 and 36. An outline of the role and responsibilities of the Council of Governors can be found on pages 44 to 47.

The identity of the Chair, the deputy Chair, the Senior Independent Director, the Chief Executive and members of the key committees of the Board can be found on page 35.

The identity of the members of the Council of Governors, their constituencies, details of their elections and appointments, the identity of the Lead and Deputy Lead Governor and the number of meetings and attendance are described in the Governors Report, which can be found on pages 44 to 47.

The Board regards all of the Non-executive Directors as independent in character and judgement.

The Governors have not exercised their power under paragraph 10C** of schedule 7 of the NHS Act 2006 to require one or more Directors to attend a Council of Governors meeting; however, both Non-executive and Executive Directors routinely attend meetings of the Council of Governors.

The performance of the Board and its committees is evaluated through the appraisal process for the Chair and the Non-executive Directors.

The Non-executive Directors serving during the current year have been appraised by the Chair, Jacqui Smith.

All Executive Directors are appraised annually by the Chief Executive (and the Chief Executive by the Chair), as part of the Trust's evaluation process and appraisal policy. The Senior Independent Director appraises the Chair, in consultation with and reporting to the Council of Governors via the Lead Governor.

The Directors fully explain their responsibility for preparing the Annual Report and Accounts on pages 67 to 75.

Information concerning the effectiveness of the Trust's system of internal controls can be found in the Annual Governance Statement from page 68.

The Trust has extended its contract for its Internal Audit function to Deloitte LLP. The Internal Audit function reports to the Audit Committee. Clinical governance matters are reviewed on behalf of the Board by the Quality Committee (previously by the Quality and Risk Committee) of the Board.

By attending meetings of the Council of Governors and its committees, both Executive Directors and Non-executive Directors develop an understanding of the views of Governors and members. In addition, the Governors have direct access to the Chair and the Interim Director of Corporate Affairs, both at meetings and informally, which enables them to channel their views to and receive feedback from the Directors.

A report on Membership Strategy and Engagement can be found on pages 47 to 48. This includes contact information, eligibility, membership numbers and a summary of the membership strategy.

The other significant commitments of the Chair were:

- Chair – The Precious Trust
- Chair – Public Affairs Practice for Westbourne Communications
- Associate – Cumberledge Eden & Partners
- Associate - Global Partners Governance
- Chair – University Hospitals Birmingham NHS Foundation Trust

A review of Directors' and Governors' material interests in organisations where those organisations or related parties likely to do business, or are possibly seeking to do business, with the Trust is carried out and there are no material interests to declare. To communicate with the directors or to obtain a copy of the Register of Directors' or Governors' Interests, contact: Interim Director of Corporate Affairs, Heart of England NHS Foundation Trust, Devon House, Bordesley Green East, Birmingham B9 5SS.

## Governors

The Trust's Council of Governors continues to make a significant contribution to the success of the Trust and its commitment, support and energy is greatly valued.

The Council of Governors comprises 34 Governor posts.

Governors are normally elected or appointed for a three-year period and are eligible for re-election or reappointment for a further two three-year terms. The Governors are elected or appointed as follows:

- 22 Public Governors, by ballot of public members
- 5 Staff Governors, by ballot of staff members
- 7 Stakeholder Governors, by appointment.

Elections were held in July 2016. The next Governor elections are due to be held in 2019.

The Council of Governors is responsible, amongst other things, for:

- Representing the interests of members as a whole and the public.
- Holding the Non-executive Directors individually and collectively to account for the performance of the Board as a whole.
- The appointment and, if appropriate, removal of the Chair, Non-executive Directors and the external auditor.
- Determining the remuneration of the Chair and the Non-executive Directors.

The Council of Governors met 11 times in the year ended 31 March 2017; the table below shows attendance levels:

| Meeting date | Number of Governors in attendance | Number of eligible Governors | Number of Directors in attendance |
|---|---|---|---|
| 4 April 2016 | 16 | 28 | 8 |
| 11 May 2016 | 18 | 28 | 13 |
| 6 June 2016 | 14 | 27 | 12 |
| 6 July 2016 | 18 | 26 | 13 |
| 27 July 2016 | 11 | 26 | 13 |
| 7 September 2016 AGM | 21 | 27 | 13 |
| 28 September 2016 | 11 | 27 | 13 |
| 24 October 2016 | 21 | 2 | 11 |
| 23 January 2017 | 19 | 28 | 14 |
| 2 February 2017 | 19 | 27 | 11 |
| 27 March 2017 | 19 | 27 | 15 |

During the year, no Governors were removed from office for persistent failure to attend meetings.

Elections for the Council of Governors were held in July 2016. Governors who resigned prior to year-end did not stand for re-election or who were not re-elected are shown in grey.

During the reporting year, the Governors of the Trust were:

| Constituency Type | Full Name of Constituency | Name of Governor | Origin | Note |
|---|---|---|---|---|
| Public | Erdington | Dr Olivia Craig | Elected (Contested) | Up to 13 August 2016 |
| Public | Erdington | Mr Albert Fletcher | Elected (Contested) | re-elected 13 August 2016 |
| Public | Erdington | Mr Thomas Webster | Elected (Contested) | elected 13 August 2016 |
| Public | Hall Green | Ms Sarah Edwards | Elected (Contested) | elected 13 August 2016 |
| Public | Hall Green | Mrs Susan Hutchings | Elected (Contested) | re-elected 13 August 2016 |
| Public | Hall Green | Mr Andrew Lydon | Elected (Uncontested) | Up to 13 August 2016 |
| Public | Hodge Hill | Ms Arshad Begum | Elected (Contested) | Up to 13 August 2016 |
| Public | Hodge Hill | Ms Attiqa Khan | Elected (Contested) | re-elected 13 August 2016 |
| Public | Hodge Hill | Mr Gerry Moynihan | Elected (Contested) | elected 13 August 2016 |
| Public | Rest of England & Wales | Mrs Kath Bell | Elected (Uncontested) | re-elected 13 August 2016 |
| Public | Rest of England & Wales | Mr Michael Kelly | Elected (Contested) | Re-elected 13 August 2016. Resigned [1 Nov 2016] |
| Public | Solihull | Ms Anne McGeever | Elected (Contested) | re-elected 13 August 2016 |
| Public | Solihull | Dr Mark Pearson | Elected (Contested) | Up to 13 August 2016 |
| Public | Solihull | Mr Stan Baldwin | Elected (Contested) | elected 13 August 2016 |
| Public | Solihull | Mr David Wallis | Elected (Contested) | re-elected 13 August 2016 |
| Public | Solihull | Mrs Jean Thomas | Elected (Contested) | re-elected 13 August 2016 |
| Public | South Staffordshire | Mr Barry Orriss | Elected (Contested) | re-elected 13 August 2016 |
| Public | South Staffordshire | Mr Phillip Johnson | Elected (Contested) | re-elected 13 August 2016 |
| Public | Sutton Coldfield | Mr Tony Cannon | Elected (Contested) | elected 13 August 2016 |
| Public | Sutton Coldfield | Mrs Louise E Passey | Elected (Contested) | elected 13 August 2016 |
| Public | Sutton Coldfield | Mrs Elaine Coulthard | Elected (Contested) | Up to 13 August 2016 |
| Public | Sutton Coldfield | Mr Ron Handsaker | Elected (Contested) | Up to 13 August 2016 |

| | | | | |
|---|---|---|---|---|
| Public | Tamworth | Mr Richard Hughes | Elected (Uncontested) | Up to 13 August 2016 |
| Public | Tamworth | Mr Derek Hoey | Elected (Uncontested) | elected 13 August 2016 |
| Public | Yardley | Mr Marek Kibilski | Reserve Governor (Uncontested) | Up to 13 August 2016 |
| Public | Yardley | Mr Keith Fielding | Elected (Contested) | elected 13 August 2016 |
| Public | Yardley | Mr David Treadwell | Elected (Contested) | re-elected 13 August 2016 |
| Staff | Clinical Support | Mr Michael Hutchby | Elected (Uncontested) | Up to 13 August 2016 |
| Staff | Medical & Dental | Mr Matthew Trotter | Elected (Uncontested) | re-elected 13 August 2016 |
| Staff | Non-Clinical Support | Mrs Emma Hale | Elected (Uncontested) | Up to 13 August 2016 |
| Staff | Non Clinical Support | Mr Lee Williams | Elected (contested) | elected 13 August 2016 |
| Staff | Clinical Support | Suzanne Nicholl | Elected (contested) | elected 13 August 2016 |
| Staff | Nursing & Midwifery | Mrs Veronica Morgan | Elected (Contested) | re-elected 13 August 2016 |
| Staff | Nursing & Midwifery | Mrs Jane Teall | Elected (contested) | elected 13 August 2016 |
| Staff | Nursing & Midwifery | Mrs Margaret Meixner | Elected (Contested) | Up to 13 August 2016 |
| Stakeholder | Birmingham City Council | Cllr Mohammed Aikhlaq | Appointed | Resigned May 2016 |
| Stakeholder | Birmingham City Council | Cllr John Cotton | Appointed | Appointed 28 June 2016 |
| Stakeholder | Solihull Metropolitan Borough Council | Cllr Jo Fairburn | Appointed | Appointed 17 May 2016 |
| Stakeholder | Birmingham City University | Carol Doyle | Appointed | Appointed 01 December 2012 |
| Stakeholder | University of Birmingham | Dr Catherine Needham | Appointed | Resigned 01 January 2017 |
| Stakeholder | University of Warwick | Dr Nicola Burgess | Appointed | Appointed 09 May 2014 |

As a result of lack of nominations at the 2016 election, Perry Barr constituency has two vacancies and Tamworth constituency has one vacancy.

Lichfield District Council and Tamworth Borough Council have not yet nominated anyone as their joint Stakeholder Governor. Aston University has not yet nominated anyone as a Stakeholder Governor. Following the resignation of Cllr Jim Ryan in May 2015, Solihull Metropolitan Borough Council nominated Cllr Jo Fairburn as Stakeholder Governor. Following the resignation of Cllr Mohammed Aikhlaq in May 2016, Birmingham City Council nominated Cllr John Cotton as Stakeholder Governor and, following the resignation of Dr Catherine Needham in January 2017, University of Birmingham has yet to nominate a replacement Stakeholder Governor.

Public constituencies are representative areas mainly around each of the main hospital sites. Stakeholders are organisations that the Trust works alongside in running its estate and training its workforce for example. Staff constituencies are groups of the workforce divided into classes, dependent on the type of work performed.

The Constitution describes the duties and responsibilities of the Governors and the processes intended to ensure a successful and constructive relationship between the Council of Governors and the Board. It confirms the formal arrangements for communication, an approach to informal communications and sets out the formal arrangements for resolving conflicts between the Council of Governors and the Board. The Constitution is available on the Trust's website. A statement of duties and responsibilities of Governors that includes the arrangements for resolving conflicts is also available on the Trust's website. Both documents are also available on request from the Interim Director of Corporate Affairs.

Following the governor elections held in July 2016, Mrs Jean Thomas was elected as Lead Governor and Mr Albert Fletcher as Deputy Lead Governor.

The role of the Lead Governor is to provide a communication channel for NHSI in the exceptional circumstances that NHSI finds it inappropriate to make contact with the Governors via the normal channels. Additionally, together with the Chair, the Lead Governor facilitates communications between the Governors and the Board and also contributes to the appraisal of the Chair.

### Governors' Register of Interests

The Trust's Constitution and Standing Orders of the Council of Governors requires the Trust to maintain a Register of Interests for Governors. Governors are required to declare interests that are relevant and material to the Board. These details are kept up-to-date by an annual review of the Register, during which any changes to interests declared during the preceding 12 months are incorporated. The Register is available to the public on request to Interim Director of Corporate Affairs, Heart of England NHS Foundation Trust, Devon House, Bordesley Green East, Birmingham B9 5SS.

## Membership

### Overview

The Trust has two membership constituencies as follows:

- Public constituency
- Staff constituency

The public constituency is divided into nine geographic areas that correspond to the Parliamentary constituencies of Birmingham and Solihull and a tenth that covers 'the Rest of England and Wales' (this allows individuals who live outside of the local area to become members of the public constituency).

Public members must:

- Be age 16 or over
- Live in a membership area
- Have made an application for membership
- Not be eligible to become members of the Staff constituency

A public member is a member of the Trust in a public constituency who could be either a patient or member of the public.

The Staff constituency is divided into four classes:

- Medical and dental
- Nursing and midwifery
- Clinical support
- Non-clinical support

A full listing of all the constituencies is available in Annex 1 to the Constitution, which is published on the Trust website and is available on request from the Interim Director of Corporate Affairs. This listing also shows the minimum number of members required and the number of Governors allocated for each constituency.

### Membership Overview by Constituency

| Constituency | 31/03/2017 | % | 31/03/16 | % |
|---|---|---|---|---|
| Public | 15,668 | 59.7% | 86,264 | 89% |
| Staff | 10,565 | 40.3% | 10,637 | 11% |
| Total Membership | 26,233 | 100% | 96,901 | 100% |

The significant reduction in the number of public members of the Trust is the result of an exercise to reduce the public membership to a smaller but more engaged public membership. Further details are on the following pages.

### Membership Strategy

In 2016, the Membership and Community Engagement Committee recognised that the Trust was an outlier compared to other foundation trusts in having a very high public membership and, further, that a considerable majority of its public members were not particularly engaged, possibly because a large number of them had been automatically enrolled.

The Committee formed a view that it would be better to have a smaller but more engaged public membership and, after consulting with the Chair,

Chief Executive and Council of Governors, the Committee was authorised to oversee a project that saw the total public membership reducing from 86,000 to around 16,000. This was achieved by writing to automatically enrolled members and inviting them to confirm their membership if they wished to; failing which, after a reminder, they were removed from the register of members.

A membership development plan is underway to enhance the engagement work already carried out. For 2017/18, the membership strategy will be to maintain the current membership numbers of no less than 26,000. It will include recruiting some new, fully representative and well engaged members to replace those that have died or moved away.

## Membership Profile

The Trust has updated the ACORN profiling and socio-economic grouping of its membership database and can confirm that the membership is broadly representative of the communities it serves.

## Membership Engagement

Membership movement and engagement is reported to the Membership and Community Engagement Committee of the Council of Governors, which in turn reports to the full Council of Governors meetings that are attended by Executive and Non-executive Directors.

During 2016/17, the emphasis has continued to be on member and community engagement, and achieved through:

- Publication of four issues of the Heart and Soul members' magazine
- Publication of the monthly members' newsletter to active members
- Monthly health seminars both on site and in the community
- Inclusion of members on the Community Patient Panels
- Inclusion of members on the Carer's Forum and Carer's Conference
- Inclusion of members on CRAG (Clinical Research Ambassador Group)
- Staff and patient publication News@
- GP surgeries
- Patient Participation Groups (PPG) - youth engagement through partnerships with local schools and colleges and the Trust youth forum, school health ambassadors and external youth specialists
- Further development of membership activities via social media and the Trust website.

## Community Engagement

The community engagement programme puts the Trust right at the heart of its community and this year has included "A Year On" events to keep our members and the public up to date with Trust news and developments.

Promoting health awareness at community events remains a key function in getting important health messages to the public, particularly to those harder to reach socio-economic groups. Trust Governors regularly attend membership community events to engage with their constituents.

Working with GP patient participation groups and their networks along with carer/support groups has played an important part in the community engagement programme this year.

Members and Governors continue to play a key role in developing and improving how HEFT engages with its communities and this will continue into 2017/18.

## Youth Engagement

The Trust's partnership with local schools and colleges continues to flourish and youth projects this year have included mental health, one of the main issues that impacts on young people. The project was in partnership with Birmingham Mind, Urban Heard and local schools and colleges and their health ambassadors.

HEFT has also worked closely with the Princes Trust on a youth project to provide young people the opportunity to experience working in a hospital environment and work on the skills needed to prepare them for life after college.

Developing links with local schools and colleges has been a real success for the Trust and the team will continue to build on this going forward into 2017/18. Work experience, placements and mentoring will play an integral part in the youth engagement programme.

# NHS Improvement's Single Oversight Framework

## Explanation of the foundation trust's risk ratings

NHS Improvement is the regulator and licensor of foundation trusts and has a duty to ensure that foundation trusts are effective, efficient and economic and maintain or improve the quality of their services. Since 1 April 2013, all foundation trusts were required to have a licence from Monitor to operate. Under Monitor's Risk Assessment Framework (RAF), it published two risk ratings for each NHS foundation trust: the Financial Sustainability Risk Rating (FSRR), and the Governance Risk Rating.

In October 2016, NHS Improvement introduced its Single Oversight Framework (SOF) that replaced Monitor's Risk Assessment Framework (RAF) as the system for overseeing NHS foundation trusts. Unlike the RAF, the new Framework is also applicable to NHS trusts that do not have foundation trust status.

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where 4 reflects providers receiving the most support, and 1 reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's Risk Assessment Framework (RAF) was in place. Information for the prior year and first two quarters relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

## Segmentation

The Heart of England NHS Foundation Trust has been segmented as level 3, in information published by NHSI, on their website, on 30 March 2017. The Trust remains under a series of enforcement actions from the NHSI (Monitor) issued between October 2014 and October 2015.

Information relating to these are available via the following link: https://www.gov.uk/government/groups/heart-of-england-nhs-foundation-trust

## Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above is not the same as the overall finance score here.

| Area | Metric | Explanation | 2016/17 Q3 score | 2016/17 Q4 score |
|---|---|---|---|---|
| Financial sustainability | Capital Service Cover | Can the Trust's income cover its longer term financial obligations | 3 | 3 |
| | Liquidity | Cash held to cover operating costs | 4 | 4 |
| Financial efficiency | I&E Margin | I&E surplus or (Deficit) as a proportion of total Income | 4 | 4 |
| Financial Controls | I&E Variance From Plan | Actual year to date surplus compared to plan | 1 | 1 |
| | Agency Spend | Distance of actual spend from the annual agency cap set by NHS Improvement | 2 | 1 |
| Overall scoring | | | 3 | 3 |

# Staff Report

## Analysis of Staff Costs

The Trust has throughout the year focussed its efforts on reducing agency staff costs and complies with new stringent NHSI requirements which relate to agency price caps and the use of approved agency frameworks.

## Staffing Breakdown

The table below shows the breakdown of staff heads in permanent positions and other staff types by staff group.

| Note 4.2 Average number of employees (WTE basis) | 2016/17 | 2016/17 | 2016/17 | 2015/16 | 2015/16 | 2015/16 |
|---|---|---|---|---|---|---|
| | Total | Permanent | Other | Total | Permanent | Other |
| | Number | Number | Number | Number | Number | Number |
| Medical and dental | 1,037 | 1,037 | | 1,050 | 1,050 | |
| Ambulance staff | 0 | | | 0 | | |
| Administration and estates | 2,124 | 2,009 | 115 | 2,211 | 2,066 | 145 |
| Healthcare assistants and other support staff | 2,184 | 1,578 | 606 | 1,993 | 1,515 | 478 |
| Nursing, midwifery and health visiting staff | 3,515 | 3,072 | 443 | 3,411 | 2,973 | 438 |
| Nursing, midwifery and health visiting learners | 0 | | | 0 | | |
| Scientific, therapeutic and technical staff | 1,090 | 1,041 | 49 | 1,065 | 995 | 70 |
| Healthcare science staff | 492 | 455 | 37 | 485 | 453 | 32 |
| Social care staff | 0 | | | 0 | | |
| Agency and contract staff | 0 | | | 0 | | |
| Bank staff | 0 | | | 0 | | |
| Other | 0 | | | 0 | | |
| Total average numbers | 10,442 | 9,191 | 1,251 | 10,215 | 9,052 | 1,163 |
| Of which | | | | | | |
| Number of employees (WTE) engaged on capital projects | 0 | | | | | |

| | 08WA | 08WB |
|---|---|---|
| Table 4A Staff sickness absence | 2016/17 | 2015/16 |
| | Number | Number |
| Total days lost | 130,616 | 129,362 |
| Total staff years | 9,180 | 9,261 |
| Average working days lost (per WTE) | 14.2 | 14 |

## Headcount by Gender

Senior managers are defined as per the Remuneration Report on page 57 and the following numbers are as at 31 March 2017.

| Workforce Groups | Female | Male | Grand Total |
|---|---|---|---|
| Senior Managers | 4 | 5 | 9 |
| Other Managers | 192 | 96 | 288 |
| Other Staff | 8,311 | 1,964 | 10,275 |
| Grand Total | 8,507 | 2,065 | 10,572 |

## Workforce Performance

The Trust closely monitors workforce key performance indicators as this provides an indication of the effectiveness of workforce performance. The following highlights some of the main workforce indicators that are captured:

- **Sickness Absence**

The Trust has seen a stable position in relation to sickness rates between April 2016 and March 2017, ending the year at 4.40% (moving annual average). During the year there has been a continued focus on staff wellbeing initiatives as well as active Operational HR management, contributing to attendance rates and overall well-being for staff.

Sickness absence data provided by Business Intelligence (based on the last financial year) show that 130,616 days were lost to sickness for 9,180 full-time equivalent staff.

- **Appraisal**

The Trust continues to emphasise the importance of staff appraisals, ensuring that staff receive clear objectives aligned to providing the highest quality of care to patients and service users. Appraisal rates have improved from 81.27% in April 2016 to 87.88% in March 2017, against a target of 85%.

- **Turnover**

The voluntary turnover rate has increased over the course of the year from 8.63% in April 2016 to 10.60% in March 2017, above the target of 8.5%. As a result of the increase in voluntary turnover, the Trust has established a Multidisciplinary Retention Group, chaired by the Deputy Chief Nurse, aimed at developing appropriate plans and actions to improve retention.

- **Mandatory Training**

Mandatory training compliance has remained stable across the year, remaining above the target of 85% between April 2016 (90.61%) and March 2017 (90.03%). During the year a revised mandatory training set was implemented. Compliance in areas such as Information Governance training has improved significantly since the introduction of revised e-learning and face to face training.

- **Time to Recruit**

The time taken to recruit has seen a significant reduction from an average of 9.34 weeks in April 2016 to 5.71 weeks as at March 2017. Input from the Recruitment Department and engagement from hiring managers has been instrumental in reducing the time taken to recruit.

## Workforce Planning

The Workforce Directorate facilitates divisional workforce plans, identifying the main workforce changes over a two to five-year period.

The plans are developed in conjunction with the Trust's operational and clinical management teams and are aligned to forecast changes within the service area and the financial remit of the Trust. The plans are designed to highlight any areas of risk and also areas of development, particularly around new roles.

In the last year, there has been further development of the Advanced Clinical Practitioner role and the commencement of recruitment for a Trainee Nursing Associate pilot. Both support future workforce sustainability.

## Ambitions for 2017/18

- In the next 12 months, the Trust will continue to make positive changes aimed at improving workforce performance at the same time taking into account the financial challenges.

- Workforce transformation and the continued development of new roles will provide different career opportunities, aimed at enhancing the Trust's clinical workforce and ultimately the patient experience.

## Staff survey

- **Staff engagement**

The Trust recognises and values its workforce, and regularly seeks staff feedback via quarterly and annual staff surveys. Staff survey results are published on the Trust intranet site and promoted through Trust-wide staff communications.

This year, the Trust introduced new staff inclusion networks (Disability, BaME and LGBT) to provide further opportunities for staff to share their experience of working for the organisation, to promote inclusion, and to identify areas for further improvement. These new networks exist alongside our established staff-side engagement and consultation forums (JNCC and JLNC).

- **Summary of performance – results from the NHS staff survey**

The National Staff Survey ran from October to December 2016 and included a full census of staff at the Trust. We achieved a 36% response rate (3,619 respondents), an increase from a 29% response rate to the 2015 survey.

The results show that, across the 32 key findings, the Trust improved on 23 findings, with no change on the remaining nine. We achieved a significant improvement in our staff engagement score from 3.63 in 2015 to 3.73 in 2016.

The details of the staff survey results for the Trust are:

| | 2015 | | 2016 | | Trust improvement/Deterioration |
|---|---|---|---|---|---|
| Response Rate | Trust | National Average | Trust | National Average | |
| | 29% | 42% | 36% | 41% | Improved |

| | 2015 | | 2016 | | Trust improvement/ Deterioration |
|---|---|---|---|---|---|
| Key findings (KF) - top 5 Ranking scores | Trust | National Average | Trust | National Average | |
| KF28. % of staff witnessing potentially harmful errors, near misses or incidents in last month | 29% | 31% | 26% | 31% | Improved (lower score the better) |
| KF 22. % of staff experiencing physical violence from patients, relatives or the public in last 12 months | 15% | 15% | 12% | 15% | Improved (lower score the better) |
| KF 25. % of staff experiencing harassment, bullying or abuse from Patients, relatives or the public in last 12 months | 28% | 28% | 25% | 27% | Improved (lower score the better) |
| KF 11. % of staff appraised in last 12 months | 85% | 86% | 90% | 87% | Improved |
| KF 26. % of staff experiencing harassment, bullying or abuse from staff in last 12 months | 27% | 26% | 24% | 25% | Improved (lower score the better) |
| | 2015 | | 2016 | | Trust improvement/ Deterioration |
| Bottom 5 Ranking scores | Trust | National Average | Trust | National Average | |
| KF 32. Effective use of patient / service user feedback | 3.50 | 3.70 | 3.57 | 3.72 | Improved |
| KF 30. Fairness & effectiveness of procedures for reporting errors, near misses & incidents | 3.54 | 3.92 | 3.63 | 3.72 | Improved |

| | | | | | |
|---|---|---|---|---|---|
| KF 1.<br>Staff recommendation of the organisation as a place to work or receive treatment | 3.47 | 3.76 | 3.59 | 3.76 | Improved |
| KF 21.<br>% believing the organisation provides<br>equal opportunities for career progression / promotion | 80% | 87% | 83% | 87% | Improved |
| KF 9.<br>Effective team working | 3.64 | 3.73 | 3.70 | 3.75 | Improved |

- **Future priorities and targets**

The 2016 results reflect the positive changes seen in the Trust during 2015/16. In the year ahead, the Trust will be focusing on two key corporate priorities: improving the resources staff have to do their jobs, and staff health and wellbeing. In addition, operational teams will also focus on key service specific issues.

Staff engagement through the quarterly Staff Friends & Family test (FFT) will continue to be monitored, with results and key themes reported to the Operational Workforce Committee for action.

## Equality diversity and fairness

The Trust has prioritised key areas of the equality and diversity agenda, including requirements covered within the national Equality Delivery System 2 (EDS2), Workforce Race Equality Standard (WRES) as well as working with external partners such as Stonewall to improve the Trust's standing as an employer of LGBT staff.

All of the HR policies set out the Trust's commitment to fairness and equality in the workplace and ensure continued promotion of non-discriminatory practices in relation to the 9 protected characteristics, including disability and race. The Trust has begun to implement a programme of unconscious bias training, for all staff, and it remains committed to employing people with a disability.

## Raising concerns

The Trust has strengthened its processes for staff to raise concerns at work and has appointed a Freedom to Speak up Guardian, in line with the national speaking up programme. In addition, it has a network of confidential contacts which our staff can access for advice and support.

## Staff involvement

The Trust has maintained positive relations with its staff side partners and continues to involve them in discussions about Trust performance, organisational change, and other key issues impacting the future of the organisation. These forums have also allowed the Trust to maintain a positive employee relations climate. In addition, enhanced Trust wide communication mechanisms have been implemented for all staff to improve communication. Key messages are delivered via weekly email briefings, monthly Chief Executive Team briefings, and a monthly newspaper for staff and visitors.

## Health and safety

In support of staff well-being, The Trust has continued to maintain a comprehensive occupational health and well-being service which includes fast-track physiotherapy provision and an externally hosted confidential staff counselling service. The Trust wide target to vaccinate 75% of our front-line staff against the flu was also met.

Maintaining the health and safety of Trust staff, patients and visitors is of paramount importance and is considered everyone's responsibility. A large proportion of accidents are preventable so teams are continually advised to familiarise themselves with Trust policies and procedures and to remain vigilant. Health and safety concerns are reported to the health and safety team and monitored by the Health and Safety Group through to resolution.

The Trust operates a zero tolerance policy with regards to staff being verbally, physically, racially or sexually assaulted whilst they are carrying out their work duties.

In the past 12 months, the Health and Safety team has delivered a range of training interventions for staff including:

- Conflict Resolution Training and refresher course
- CoSHH Awareness Sessions
- Display Screen Equipment Workshops
- Managers' Health and Safety Roles and Responsibilities
- Risk Assessment Workshops
- Safety Champion Workshops
- Online Moodle courses

## Countering Fraud and Corruption

The Trust has a Counter Fraud and Corruption Policy which was reviewed in the last financial year. This can be found on the Trust's intranet together with the other policies for HEFT staff to access. The topic is also covered within staff mandatory training.

Regular counter fraud awareness messaging for staff via the Trust's regular communications channels, including the staff and patient newspaper, ensures staff remain vigilant to the risk of fraud and corruption within the NHS and know to report any concerns to their local NHS counter fraud specialist team.

## Off-payroll arrangements

These are detailed in the Remuneration Report on pages 60 and 61.

## Payments for Loss of Office

In 2016/17 the Trust had no compulsory redundancies or other departure agreements.

## Exit Packages: Non-compulsory Departure Payments

In March 2016, as part of the Financial Recovery Programme, the Trust launched a MARS scheme and all of the transactions related to this scheme have been competed in the 2016/17 year.

| | Agreements Number | Total Value of Agreements £000 |
|---|---|---|
| Voluntary redundancies including early retirement contractual costs | 0 | 0 |
| Mutually Agreed resignations (MARS) contractual costs | 40 | 1,016 |
| Early Retirement in the efficiency of the service contractual costs | 0 | 0 |
| Contractual payments in lieu of notice | 7 | 233 |
| Exit payments following Employment Tribunals or court orders | 0 | 0 |
| Non-Contractual payments requiring HMT approval | 0 | 0 |
| Total | 47 | 1,249 |

## Staff Experience

| Indicator | 2014 | 2015 | Trust performance Latest 2016 | National Average | Lowest reported Trust | Highest Reported Trust |
|---|---|---|---|---|---|---|
| Percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends | 48% | 55% | 62% | 70% | 49% | 85% |

The Trust considers that this data is as described for the following reasons:

This data reflects the improvements that have been seen across the organisation in the last 12 months:

- Stability provided by the new leadership team at Board level.
- Improved operational performance across the Trust, including HEFT becoming one of the best performing trusts in the country in relation to cancer targets.
- Introduction of Values Based Recruitment, ensuring staff are appointed based upon both technical and behavioural suitability.

The Trust intends to take the following actions to improve this score and so the quality of its services, by:

- Continuing with regular opportunities for staff to give their feedback via the quarterly Staff Friends & Family Test and full census of National Staff Survey, reviewing key themes and taking action in response.
- Focussing on supporting staff to improve their Health & Wellbeing and ensure staff have the resources they need to do their job.
- Continuing to embed the Trust's values and behaviours.

| Indicator | 2014 | 2015 | Trust performance Latest 2016 | National Average | Lowest reported Trust | Highest Reported Trust |
|---|---|---|---|---|---|---|
| Percentage of staff experiencing harassment, bullying or abuse form staff in the last 12 months (lower score is better) | 25% | 27% | 24% | 25% | 16% | 36% |

HEFT considers that this data is as described for the following reasons:

The Trust has seen an improvement in the above score and has taken action in the following areas:

- Introduction of a Freedom to Speak up Guardian and re-launch of the staff confidential contacts to support staff with concerns.
- Bullying & Harassment awareness campaign throughout January 2017 to encourage access to support and reporting of concerns.

HEFT intends to take the following actions to improve this score and so the quality of its services, by:

Continuing to raise awareness of the support that is available to staff experiencing bullying including:

- Executive team commitment to zero tolerance on Bullying & Harassment.
- Staff confidential contacts and the Trust's Freedom to Speak up Guardian.
- Staff counselling advice line (available 24 hours a day).

| Indicator | | 2014 | 2015 | Trust performance Latest 2016 | National Average | Lowest reported Trust | Highest Reported Trust |
|---|---|---|---|---|---|---|---|
| Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion for the workforce Race Equality Standard | White | 86% | 85% | 86% | 88% | 78% | 95% |
| | BME | 68% | 63% | 69% | 76% | 61% | 96% |

HEFT considers that this data is as described for the following reasons:

The Trust has seen an improvement in the above scores and has taken action in the following areas:

- Trust wide action plan in place to monitor progress against the Workplace Race Equality Scheme (WRES) to ensure employees from Black, Asian and minority ethnic (BAME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.
- Unconscious Bias training has been delivered to a group of managers.
- Revised Trust's Equal Opportunities policy to reinforce the commitment of all staff to workforce equality, diversity and inclusion.
- Staff Inclusion Steering Group with a focus on improving staff and patient experience.
- The establishment of employee networks to support under-represented groups across the workforce to promote inclusion.

HEFT intends to take the following actions to improve this score and so the quality of its services, by:

- Reviewing BAME staff access to non-mandatory training to ensure consistency and accuracy of reporting.
- Reviewing how staff should be reporting racial abuse, harassment and bullying.
- Interrogation of recruitment and selection data to ensure fairness in shortlisting and appointment processes.
- Full roll out of Unconscious Bias training.

## Modern Slavery

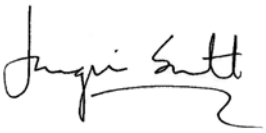
The Board has an approved annual statement on Modern Slavery which is published on the Trust website www.heartofengland.nhs.uk

# Remuneration Report

## Annual statement on remuneration from the chair of the Remuneration Committee of the Board:

No major decisions on senior managers' remuneration were made during the year ended 31 March 2017; therefore there were no substantial changes relating to senior managers' remuneration during the year.

**Signed**



**Rt Hon Jacqui Smith**
**Interim Chair**
**Date: 24 May 2017**

## Senior Managers' Remuneration Policy

For the purposes of this report, the Chief Executive has determined that 'senior managers' comprise the voting Executive and Non-executive Directors and three non-voting Interim Executive Directors (Fiona Alexander – Interim Director of Communications, Kevin Bolger – Interim Deputy Chief Executive – Improvement, David Burbridge – Interim Director of Corporate Affairs are providing services to the Trust under the UHB services agreement.

## Voting and non-voting Executive Directors

| Components of senior managers' remuneration | Commentary |
|---|---|
| Basic salary | The Committee normally determines senior managers' basic salaries with the aim of attracting, motivating and retaining high calibre employees who will deliver success for the Trust and high levels of patient care and customer service.<br><br>Basic salaries are not performance related, except to the extent that increases are dependent on satisfactory annual appraisals. They support the strategic objectives of the Trust by encouraging long term stability of employees. They do this by keeping pace with general increases in NHS salaries.<br><br>There are no provisions for recovery or withholding of basic salaries for senior managers or directors.<br><br>The Executive Directors providing services to the Trust under the UHB services agreement are remunerated by UHB and, as such, the Committee does not determine their basic salaries; rather the Trust is re-charged for their services by UHB on a time and cost basis. |
| Pension contributions | These relate to pension benefits accrued under the NHS Pension Scheme. Contributions are made by both the employer and employees in accordance with the rules of the scheme which apply to all NHS staff in the scheme. Further details are disclosed in Notes 5.1 and 5.6 to the Financial Statements.<br><br>Pension contributions are not performance related and therefore only support the strategic objectives of the Trust to the extent that they encourage long term stability of senior managers.<br><br>There are no provisions for recovery or withholding of pension contributions for senior managers or directors.<br><br>The Executive Directors providing services to the Trust under the UHB services agreement are remunerated by UHB and, as such, the Committee does not determine their pension arrangements. |

The Committee has adopted a policy of providing six months' notice in senior managers' service contracts. The principle applied to determination of payments for loss of office is to honour contractual entitlements only, which typically include pay in lieu of notice and pro rata pay for accrued but not taken holiday entitlement, if applicable.

Given the contractual nature of these elements, the circumstances of the loss of office are generally unlikely to be relevant to the exercise of any discretion. This does not apply to Executive Directors providing their services under the UHB services agreement.

In considering remuneration policy for senior managers', the Committee is cognisant of director pay levels in the NHS generally and in pay levels of other NHS staff, including its own employees. Given that no major decisions on senior managers' remuneration were made during the year end 31 March 2017, the Trust did not consult with employees, nor were comparisons used, when considering remuneration policy during the year.

As of 31 March 2017, there were two executive directors who were paid more than £142,500 for their services during the reporting year.

The individuals concerned are substantially employed by University Hospitals Birmingham NHS Trust and, thus, their salaries are determined by that Trust. HEFT has been informed that UHB has, through its Executive Appointments and Remuneration Committee, satisfied itself that this remuneration is reasonable for the reasons set out in its annual statement on remuneration in its annual report and taking into account that competition for suitably qualified and able individuals to serve as Senior Managers will come not only from within the NHS sector, but from other organisations, both public and private sector and in the UK and abroad.

## Non-executive Directors

Non-executive Directors' fees are determined by the Council of Governors having received recommendations from the Council of Governors Remuneration Committee which is chaired by the Lead Governor, Mrs Jean Thomas.

| Components of Non-executive Directors' fees | Commentary |
|---|---|
| Basic fee | The Trust pays a standard basic fee of £14,123 p.a. to all of its Non-executive Directors ("NEDs"), except the Chair, who is paid a basic fee of £50,000 p.a.<br><br>Basic fees are not performance related. They support the strategic objectives of the Trust by encouraging long term stability of the NEDs. They do this by keeping pace with NEDs' fees in the NHS.<br><br>There are no provisions for recovery or withholding of basic fees for NEDs. |
| Additional fee | The Trust has historically paid some NEDs a standard additional fee of £3,000 p.a. reflecting additional responsibilities over and above standard NEDs' duties; no NEDs remaining in post at 31 March 2017 were receiving such additional fees.<br><br>Additional fees are not performance related. They support the strategic objectives of the Trust by encouraging long term stability of the NEDs. They do this by keeping pace with NEDs fees in the NHS.<br><br>There are no provisions for recovery or withholding of additional fees for NEDs. |

## Annual Report on Remuneration

The Board's Remuneration Committee, which is chaired by the Chair and comprises the Non-executive Directors, determines the remuneration, allowances and other terms and conditions of the Executive Directors.

Details of the membership of the Committee, the number of meetings held in the year and attendance of individual members is given on pages 40 and 42.

Remuneration packages for Executive Directors, who are voting members of the Board, consist of basic salary and pension contributions. Salaries are reviewed with reference to director pay levels in the NHS and in the context of pay awards to other NHS staff. There are no performance related elements to their remuneration. This does not apply to the Executive Directors providing services under the UHB services agreement.

The Committee has access to the advice and views of the Chief Executive, the Director of Workforce and Organisational Development and the Interim Director of Corporate Affairs. No director or employee is involved in the determination of, or votes on, any matter relating to their own remuneration. Performance is judged and reviewed as part of the annual appraisal and personal development review process in line with Trust policies. The appraisal of all Executive Directors is carried out by the Chief Executive. Details of remuneration, including the salaries and pension entitlements of the Executive Directors, are published in Note 4.4 to the Financial Statements.

All of the employed Executive Directors have a rolling six month termination notice period included in their contracts. This does not apply to Executive Directors providing services under the UHB services agreement.

Except for the Executive Directors providing services under the UHB services agreement, there were no other amounts payable to third parties for the services of the Executive Directors and they received no benefits in kind (2014/15 £nil).

The only non-cash element of the remuneration of Executive Directors is a pension-related benefit accrued under the NHS Pension Scheme. Contributions are made by both the employer and employee in accordance with the rules of the scheme which apply to all NHS staff in the scheme.

The accounting policies for pensions and other retirement benefits are set out in Notes 1.13 and 5.6 to the Financial Statements.

The service contract details of the Executive Directors (except for the Executive Directors providing services under the UHB services agreement) in service at the end of the year are shown in the table below:

| Director | Date of contract | Notice period |
|---|---|---|
| Sam Foster | 01.09.2014 | 6 months |
| Jonathan Brotherton | 02.07.2014 | 6 months |
| Hazel Wyton | 01.03.2013 | 6 months |

During the year ended 31 March 2017 no senior manager received payments on loss of office.

Non-executive Directors, including the Chair, do not hold service contracts and are appointed for three years. Their appointment is terminable with one month's notice on either side. Non-executive Directors are appointed following interview by the Appointments Committee of the Council of Governors (save for Rt Hon Jacqui Smith, who was appointed in accordance with the written instruction of Monitor dated 22 October 2015).

The following table shows those Non-executive Directors in service at the end of the year and the date of their first appointment:

| Name | First Appointment date | Notice period | Unexpired term of contract as at 31 March 2017 |
|---|---|---|---|
| Andrew Edwards | 1 October 2014 | 1 month | 6 months |
| Jon Glasby | 1 October 2015 | 1 month | 1 years 6 months |
| Jackie Hendley | 13 June 2016 | 1 month | 2 years 4 months |
| Mike Kinski | 13 June 2016 | 1 month | 2 years 4 months |
| Karen Kneller | 1 October 2014 | 1 month | 6 months |
| Mehrunnisa Lalani | 2 February 2017 | 1 month | 2 years 11 months |
| Jammi Rao | 1 July 2013 | 1 month | resigned 30 June 2016 |
| Michael Sheppard | 13 June 2016 | 1 month | 2 years 4 months |
| Jacqui Smith | 1 December 2015 | 1 month | 1 year 8 months |

The Non-executive Directors do not receive pensionable remuneration. There were no amounts payable to third parties for the services of the Non-executive Directors and they received no benefits in kind (2016/17 £nil).

The Non-executive Directors were not awarded a general increase in remuneration during the year.

Expenses properly incurred in the course of the Trust's business by Directors and Governors are reimbursed in accordance with the Trust's policy on business expenses for employees and are published within the table on pages 61 and 62.

## Off Payroll Arrangements

Whilst the majority of the Trust's employees are paid via the payroll, there are occasionally situations where these arrangements are not suitable and the Trust pays for these services via an invoice. Following the guidance issued by Monitor in August 2013 relating to off payroll arrangements, all new suppliers that are anticipated to be paid more than £220 per day for more than 6 months are reviewed to ensure they have the appropriate arrangements in place and that the company is registered with HMRC for corporation tax purposes.

As per the following table, there are 46 (2016/17) companies where these arrangements existed at 31 March 2017.

| Duration of existence of arrangement | Number |
|---|---|
| Less than 1 year | 5 |
| 1-2 years | 9 |
| 2-3 years | 13 |
| 3-4 years | 6 |
| Over 4 years | 13 |
| Total | 46 |

There are two main staff groups where these arrangements have been used. Firstly, the Trust employs a number of individuals on an ad hoc basis to deliver training when Solihull Approach training courses have been booked. These arrangements have existed for several years and seven of these suppliers have been used for more than six months and have been paid more than £220 per day when the courses are delivered.

Secondly, the Trust uses a system for sourcing of locum and agency doctors using a third party IT system and agency suppliers to find a suitable resource to fill the placement in the most cost effective way. There are 26 of these suppliers in use as at 31 March 2017.

The remaining suppliers are where individual engagements have been agreed between the Trust and the supplier to provide services to the Trust which includes project support for specialist projects such as the urgent care centre and financial recovery programme.

As shown in the following table, in 2016/17 there have been five off payroll arrangements which are new or have reached six months duration in the year.

| | Number |
|---|---|
| New engagements, or those that reached six months in duration between 01 April 2016 and 31 March 2017 | 5 |
| Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and national insurance obligations | 5 |
| **Number for whom assurance has been requested** | 5 |
| Of which: | |
| Number for whom assurance has been received | 5 |
| Number for whom assurance has not been received | 0 |
| Number that have been terminated as a result of assurance not being received | 0 |

As shown in the following table, the Trust does not have any Board members or senior officials with significant financial responsibility that are off-payroll arrangements.

| **Off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 01 April 2016 and 31 March 2017** | **Number** |
|---|---|
| Board members | 0 |
| Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements. | 15 |

## Expenses

In addition, the Trust's governors and directors incur non-taxable expenses in association with activities that they undertake that support the objectives of the Trust. Listed as follows are the expenses paid directly to the individual via payroll. Any travel expenses, such as accommodation, are centrally paid via the Trust.

| | Year ended 31 March 2017 | | |
|---|---|---|---|
| | Number in office | Number receiving expenses | Total £00 |
| Directors | 15 | 2 | 50 |
| Governors | 28 | 16 | 29 |

| | Year ended 31 March 2016 | | |
|---|---|---|---|
| | Number in office | Number receiving expenses | Total £00 |
| Directors | 10 | 4 | 29 |
| Governors | 28 | 14 | 40 |

## Fair Pay Multiple

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.

| | Year ended 31 March 2017 | Year ended 31 March 2016 |
|---|---|---|
| Band of highest paid director's total (£'000) | 275-280 | 295-300 |
| Median Total (£'000) | 26 | 26 |
| Ratio | 10.6 | 11.4 |

Total salary includes salary, performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions, the cash equivalent transfer value of pension nor any other accrued pension benefits not yet taken. In March 2016 the highest paid director shown above included a severance payment of £173k, because in that year the guidance did not exclude severance payments from the calculation. In March 2017 the highest paid director shown above is based on the SLA value paid by the Trust.

## Senior Managers' Salaries and Entitlements

The following tables show the senior managers' pay and entitlement for 2016/17 and the prior year 2015/16.

| NAME AND TITLE | Year Ended 31 March 2017 | | | | | |
|---|---|---|---|---|---|---|
| | Salary | Expense Payments (Taxable) | Performance pay and bonuses | Long term performance pay and bonuses | All pension related benefits | Total |
| | Bands of £5,000 | Total to nearest £100 | Bands of £5,000 | Bands of £5,000 | Bands of £2,500 | Bands of £5,000 |
| | £'000 | | £'000 | £'000 | £'000 | £'000 |
| **SENIOR MANAGERS** | | | | | | |
| Andrew Foster (1)<br>Interim Chief Executive February 2015 to November 2015) | | | | | | |
| Dame Julie Moore (2)<br>Interim Chief Executive from October 2015 | 275-280 | | | | | 275-280 |
| Adrian Stokes<br>Director of Delivery and Deputy Chief Executive to November 2015 | | | | | | |
| Kevin Bolger (5)<br>Interim Director of Improvement and Deputy CEO from November 2015 | 85-90 | | | | 32.5-35 | 120-125 |
| Andrew Catto<br>Medical Director to February 2016 | | | | | | |
| David Rosser (5)<br>Interim Medical Director from March 2016 | 90-95 | | | | 36.5-37.5 | 125-130 |
| Sam Foster<br>Chief Nurse | 130-135 | | | | 90-92.5 | 225-230 |
| Darren Cattell (3)<br>Interim Director of Finance from January 2015 to January 2016 | | | | | | |
| Julian Miller (4)<br>Interim Director of Finance from February 2016 | 150-155 | | | | 152.5-155 | 300-305 |
| Jonathan Brotherton<br>Director of Operations | 120-125 | | | | 60-62.5 | 180-185 |
| Hazel Wyton (Nee Gunter) | 120-125 | | | | 32.5-35 | 155-160 |
| David Burbridge (5)<br>Interim Director of Corporate Affairs from November 2015 | 55-60 | | | | 17.5-20 | 75-80 |
| Fiona Alexander (5)<br>Interim Director of Communications from November 2016 | 20-25 | | | | 0-0.25 | 20-25 |
| Non-Executive Directors | | | | | | |
| Rt Hon Jacqui Smith<br>Chairman form December 2015 | 50-55 | | | | | 50-55 |
| Leslie Lawrence<br>Chairman to November 2015 | | | | | | |
| Alison Lord to January 2016 | | | | | | |
| Jammi Rao to June 2016 | 0-5 | | | | | 0-5 |
| David Lock to February 2016 | | | | | | |
| Patrick Cadigan to October 2015 | | | | | | |
| Laura Serrant-Green to September 2016 | | | | | | |
| Mike Kinski from June 2016 | 10-15 | 0.3 | | | | 10-15 |
| Jackie Hendley from June 2016 | 10-15 | 0.2 | | | | 10-15 |
| Michael Shepherd from June 2016 | 10-15 | | | | | 10-15 |
| Mahrunnisa Lalani from February 2017 | 0-5 | | | | | 0-5 |
| Karen Kellner | 10-15 | | | | | 10-15 |
| Andrew Edwards | 10-15 | | | | | 10-15 |
| Jon Glasby from October 2015 | 10-15 | | | | | 10-15 |

| NAME AND TITLE | Year Ended 31 March 2016 | | | | | |
|---|---|---|---|---|---|---|
| | Salary | Expense Payments (Taxable) | Performance pay and bonuses | Long term performance pay and bonuses | All pension related benefits | Total |
| | Bands of £5,000 | Total to nearest £100 | Bands of £5,000 | Bands of £5,000 | Bands of £5,500 | Bands of £5,000 |
| | £'000 | | £'000 | £'000 | £'000 | £'000 |
| **SENIOR MANAGERS** | | | | | | |
| Andrew Foster (1)<br>Interim Chief Executive February 2015 to November 2015) | 280-285 | | | | | 280-285 |
| Dame Julie Moore (2)<br>Interim Chief Executive from October 2015 | 120-125 | | | | | 120-125 |
| Adrian Stokes<br>Director of Delivery and Deputy Chief Executive to November 2015 | 270-275 | | | | 15-20 | 285-290 |
| Kevin Bolger (5)<br>Interim Director of Improvement and Deputy CEO from November 2015 | | | | | | |
| Andrew Catto<br>Medical Director to February 2016 | 160-165 | | | | 30-35 | 200-205 |
| David Rosser (5)<br>Interim Medical Director from March 2016 | 10-15 | | | | 10-15 | 20-25 |
| Sam Foster<br>Chief Nurse | 130-135 | | | | 30-35 | 165-170 |
| Darren Cattell (3)<br>Interim Director of Finance from January 2015 to January 2016 | 230-235 | | | | | 230-235 |
| Julian Miller (4)<br>Interim Director of Finance from February 2016 | 30-35 | | | | | 30-35 |
| Jonathan Brotherton<br>Director of Operations | 120-125 | | | | 60-65 | 180-185 |
| Hazel Wyton (Nee Gunter) | 120-125 | | | | 25-30 | 145-150 |
| David Burbridge (5)<br>Interim Director of Corporate Affairs from November 2015 | 55-60 | | | | 10-15 | 65-70 |
| Fiona Alexander (5)<br>Interim Director of Communications from November 2016 | | | | | | |

| Non-Executive Directors | | | | | | |
|---|---|---|---|---|---|---|
| Rt Hon Jacqui Smith<br>Chairman form December 2015 | 50-55 | 0.9 | | | | 50-55 |
| Leslie Lawrence<br>Chairman to November 2015 | 30-35 | | | | | 30-35 |
| Alison Lord<br>to January 2016 | 10-15 | 1.5 | | | | 10-15 |
| Jammi Rao<br>to June 2016 | 10-15 | | | | | 10-15 |
| David Lock<br>to February 2016 | 10-15 | 0.3 | | | | 10-15 |
| Patrick Cadigan<br>to October 2015 | 5-10 | | | | | 5-10 |
| Laura Serrant-Green<br>to September 2016 | 5-10 | | | | | 5-10 |
| Mike Kinski<br>from June 2016 | | | | | | |
| Jackie Hendley<br>from June 2016 | | | | | | |
| Michael Shepherd<br>from June 2016 | | | | | | |
| Mahrunnisa Lalani<br>from February 2017 | | | | | | |
| Karen Kellner | 10-15 | | | | | 10-15 |
| Andrew Edwards | 10-15 | | | | | 10-15 |
| Jon Glasby<br>From October 2015 | 5-10 | | | | | 5-10 |

## Notes

(1) Andrew Foster was paid by Wrightington Wigan & Leigh (WWL) Foundation Trust and his salary is recharged to the Trust. His full Pension benefit details are also recorded within the accounts of WWL Foundation Trust.

(2) Dame Julie Moore is paid by University Hospitals Birmingham NHS Foundation Trust. Her services are recharged to the Trust in line with an SLA between UHB and the Trust agreed in October 2015.This charge reflects the charge made by UHB and not the salary paid to Dame Julie Moore The salary paid to her is in the £250k-£255k banding. Her full pension details are also recorded within the accounts of University Hospitals Birmingham NHS Foundation Trust.

(3) Darren Cattell's salary was paid via a Consultancy company. There are no pension benefits.

(4) Julian Miller is paid by University Hospitals Birmingham NHS Foundation Trust (UHB) and his salary is recharged to the Trust. He is not a director of UHB and his pension costs in 2015/16 were not made available by the NHS pensions Authority.

(5) These directors are employed by UHB and share their time between HEFT and UHB. The costs included in the table above are for the portion of the time spent at HEFT which equates to approximately half of the time. Their full salary paid by UHB to these directors is:

| | Bands of £5'000 |
|---|---|
| Kevin Bolger | 150-155 |
| David Rosser | 215-220 |
| David Burbridge | 125-130 |
| Fiona Alexander | 125-130 |

receives remuneration in both his capacities of board director and medical consultant, the combined total is disclosed in the table above. The banding disclosure of the latter clinical role equates to 110-115 (2015/16: 120-125).

Pension details will be recorded in the accounts of UHB.

## Senior managers' pensions
## Pension Benefits

| Name and current title | Real increase in pension at age 60 | Real increase in lump sum at age 60 | Total accrued pension at age 60 at 31 March 2017 | Lump sum at age 60 related to accrued pension at 31 March 2017 | Cash Equivalent Transfer Value at 31 March 2017 | Cash Equivalent Transfer Value at 31 March 2016 | Real Increase in Cash Equivalent Transfer Value | Employers Contribution to Stakeholder Pension |
|---|---|---|---|---|---|---|---|---|
| | (bands of £2,500) £000 | (bands of £2,500) £000 | (bands of £5,000) £000 | (bands of £5000) £000 | £000 | £000 | £000 | To nearest £100 |
| Sam Foster (Chief Nurse) | 2.5-5 | 0-2.5 | 35-40 | 95-100 | 525 | 470 | 39 | 0 |
| Julian Miller (Interim Director of Finance from 03 Feb 2016) | 0-7.5 | 17.5-20 | 35-40 | 110-115 | 582 | 444 | 97 | 0 |
| David Rosser (Interim Medical Director from 01 March 2016) | 0-2.5 | 2.5-5 | 35-40 | 115-120 | 745 | 695 | 29 | 0 |
| David Burbridge (Interim Director Of Corporate Affairs from 25 Nov 15) | 0-2.5 | 2.5-5 | 10-15 | 40-45 | 267 | | 15 | 0 |
| Fiona Alexander (Interim Director Of Communications from 20 Nov 2016) | 0-2.5 | 0-2.5 | 0-5 | 5-10 | 45 | | 1 | 0 |
| Kevin Bolger (Interim Director Of Improvement & Deputy CEO from 09 Nov 2015) | 0-2.5 | 2.5-5 | 35-40 | 115-120 | 855 | | 32 | 0 |
| Jonathan Brotherton (Director of Operations) | 2.5-5 | (2.5)-(5) | 25-30 | 80-85 | 422 | 389 | 23 | 0 |
| Hazel Wyton (nee Gunter) (Director of Workforce & OD) | 0-2.5 | 2.5-5 | 10-15 | 40-45 | 290 | 252 | 27 | 0 |

As non-executive members do not receive pensionable remuneration, there are no entries in respect of pensions for non-executive members. The details above have been provided by the NHS Pensions Agency.

### Subject to Audit

The elements of the Remuneration Report designated as subject to audit are:

- Single total figure table of remuneration for each senior manager
- Pension entitlement table and other pension disclosures for each senior manager
- Fair pay disclosures
- Payments to past senior managers, if relevant
- Payments for loss of office, if relevant (see Staff Report)

**Dame Julie Moore**
**Interim Chief Executive Officer**
**Date: 24 May 2017**

## Statement of Accounting Officer's Responsibilities

### Statement of the Chief Executive's responsibilities as the accounting officer of Heart of England NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHSI.

NHSI, in exercise of powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Heart of England NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Heart of England NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *Department of Health Group Accountings Manual* and in particular to:

- Observe the Accounts Direction issued by NHSI, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual and the Department of Health Group Accounting Manual have been followed, and disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- Prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

**Signed**

**Dame Julie Moore**
**Interim Chief Executive Officer**
**Date: 24 May 2017**

# Annual Governance Statement

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Heart of England NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact, should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Heart of England NHS Foundation Trust for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts.

Heart of England NHS Foundation Trust has a Board approved Risk Management Policy & Procedure that provides explicit guidance for all staff concerning:

- Leadership and accountability
- Roles and responsibilities for managing risk
- Processes for risk management
- Risk management education and training.

The risk management policy sets out the Trust's approach to risk, defining the structures for the reporting, ownership, management and escalation of risk at all levels within the organisation. It includes everybody's responsibility for handling risk.

The risk management policy clearly details that it is the Chief Executive who has overall responsibility for the Trust's risk management programme. Operational responsibility is delegated to the Director of Corporate Affairs. Each Executive Director is responsible for overseeing risk management activities in their respective directorates.

The Board is responsible for overseeing the delivery of the risk management strategy and is supported by the work of its sub-committees. The Board gains independent assurance on the effectiveness of its risk management processes through the work of internal audit programme, which is reported to the Audit Committee.

The risk management policy provides further detailed guidance for staff regarding their role in the whole risk management lifecycle. Staff training for the identification and management of risk is available from the Safety and Governance Directorate. This training is also supported by a corporate induction and mandatory training programme for all staff which provides training in the management of specific clinical and non-clinical risks.

The Board of Directors is responsible for the strategic direction of the Trust in relation to Risk Management. The Trust has a risk management strategy which includes details of the key frameworks that the Trust uses to assess overall risk within the organisation. This includes Care Quality Commission (CQC) compliance; the Board Assurance Framework (BAF); external reviews and assessments; incidents, complaints, claims and lessons learned. The strategy aims to triangulate information from each of these sources to provide a detailed picture of its key risks and how they should be managed. The strategy documentation is currently being revised to reflect the changes made to committee structures referred to above.
Since January 2016, the Trust Executive and Non-executive Directors have carried out unannounced Board of Directors' Governance visits. These are reported to the Clinical Quality Committee by the Executive Medical Director.

The risk management policy focuses on the risk management lifecycle and how risks are identified through risk assessments, are recorded through risk registers and how they are controlled and managed – through the Board and relevant Committees. There is a standard risk matrix used across the Trust to ensure a standard scoring system is applied to all risks. The Trust has a Trust-wide electronic system for recording risks (Datix) allowing more transparency regarding what risk there is and also improvements to managing risk trends and themes. This policy forms the key control for defining the Trust's appetite for risk and it is used to manage and escalate risks. The policy contains clear processes for risk escalation.

The escalation of risks is from Directorate through the division quality and safety committee structure and ultimately to the Board Quality Committee and Chief Executive Group. Non-clinical risks (excluding financial risks) are escalated through

similar structures, though this is through corporate departmental meetings rather than site and division meetings.

The Trust has an internal compliance framework in respect of the Health and Social Care Act regulations – which are monitored by the Care Quality Commission (CQC).

The Trust has arrangements in place for recording and managing risks associated with data security. There is an Information Governance risk register. Information Governance issues and risks are managed by the Information Governance Group, which is chaired by the Trust's Senior Information Risk Officer, who reports to the Board and the Audit Committee.

The BAF identifies key risks to the Trust's corporate aims and objectives and is reviewed on a quarterly basis by Executive Directors and the Board of Directors. A recent internal audit review of the BAF and risk management systems gave moderate assurance.

There was one high priority recommendation identified which was the need for more robust and SMART action plans.

In the absence of an agreed strategy, the Board has identified the current strategic risks facing the Trust. These risks are formally reviewed on a quarterly basis, first by the Executive Management team - then the Board. There are currently 13 risks identified on the Board Assurance Framework and appropriate risk management and mitigation plans are in place for each. The strategic risk register for 2017/18 will be presented quarterly to the Chief Executive's Group and the Board of Directors.

Strategic risks at 31 March 2017 are:

SRR1 – Sustainable medical workforce model
SRR2 – Sustainable nursing workforce model
SRR3 – Delivery of clinical operational standards
SRR4 – The physical estate on all sites
SRR5 – IT infrastructure
SRR6 – Financial plan 2017/18
SRR7 – Cash position
SRR8 – Leadership skills and capacity
SRR9 – Regulatory intervention
SRR10 – Sustainability and Transformation plan
SRR11 – BREXIT
SRR12 – Case for Change
SRR13 – Social care funding and impact on DTOCS and LOS

The requirements of the Monitor condition FT4 (Foundation Trust governance) and the corporate governance statement were monitored through the committee structure outlined above, with the aim that the Trust is assured that the required elements are monitored appropriately. The Trust has completed a baseline assessment which was presented to the Audit Committee and Board. Regular compliance reviews will be completed and reported to the Board.

This Annual Governance Statement provides an outline of the structures and mechanisms that the Trust has in place to maintain a sound system of governance and internal control, amongst other things, to meet the requirement of the Monitor FT4 (Governance) requirement. It takes assurance from these structures and its various committees, as well as feedback from internal and external audit and other internal and external stakeholders regarding the robustness of these governance structures. These same mechanisms are used by the Board to ensure that the content of its Corporate Governance Statement is valid.

The Trust uses an online incident reporting system (Datix) for all clinical and non-clinical incidents. The Trust actively encourages the reporting of incidents. There is a supporting policy and procedure in place for incident reporting and the Trust's commitment to having an open culture ensures that the reporting of incidents is actively encouraged by all staff. This policy also supports a range of on-going initiatives to encourage learning and feedback from incidents. The Trust provides regular uploads of incident data to the National Reporting and Learning Service (NRLS). There is a separate Trust policy for the management and investigation of serious incidents (SIs). The Trust policy framework mandates the completion of an equality impact assessment for all Trust policies and procedures.

Performance data is reported through the Divisional structure and for assurance to the Chief Executive's group and the Board. For quality governance purposes, this is triangulated with patient experience information, nursing metrics and the quality dashboard and is reviewed at the Quality Committee.

Risk Management is embedded throughout the organisation. Risks are reported locally through the local risk registers or directorate meetings. This is reflected in the Risk Management policy and procedure. The Board of Directors establishes which risk tolerance is deemed to be acceptable to the Trust.

The Trust has an incident management policy and the Datix system allows for the robust reporting and management of those incidents. The Trust also uses the Datix system for the reporting and management of risks which allows triangulation and aggregation of risks and incidents for

reporting to Trust committees.

Any incidents which are considered to be 'severe' (as defined by the National Patient Safety Agency (NPSA) definition) are escalated by the Investigations team to an appropriate Executive Director who decides whether the incident should be treated as a Serious Incident (SI).

All SIs are investigated using the Root Cause Analysis (RCA) methodology. All SIs are reported and managed in accordance with the national framework.

Serious Incidents and RCAs are reviewed regularly via an Executive led forum. Clinical teams are invited to present the findings and lessons learned from these incidents.

The Trust has an executive led Policy Assurance group and all new and revised policies undergo an equality impact assessment as part of the approval process.

The Trust informs and, where appropriate consults with, relevant stakeholders, including staff, on the management of risks faced by the organisation, including:

- Council of Governors
- Patient Panels
- Overview and scrutiny committees
- Commissioners
- NHSI

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission. The Trust received an unannounced responsive inspection in October 2016 by the Care Quality Commission (CQC). The draft report from this visit is still to be received by the Trust.
The CQC has not taken enforcement action against Heart of England NHS Foundation Trust during 2016/17.

As an employer with staff entitled to membership of the NHS pension scheme, control measures are in place to ensure that all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. The Foundation Trust has undertaken risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust's financial recovery programme set out a requirement for enhanced and more rigorous financial reporting across the organisation. As a result, a new reporting structure was implemented from April 2016 to ensure that all significant financial matters were reported to the Board of Directors, underpinned by a detailed review and challenge at a divisional and directorate level. A comprehensive monthly paper highlighting the financial position, variances to Annual Plan and updating on savings plans, cash flow and capital issues is presented to the Board of Directors and the Chief Executives Group by the Interim Director of Finance. This is supported by discussions at the twice monthly Financial Recovery Programme Board which is chaired by the Interim Director of Finance and attended by executive directors together with divisional senior management teams including operational, nursing, medical and finance representatives to ensure that the Financial Recovery Plan (FRP) stays on track to deliver the agreed savings by 2019/20.

The monthly Cost improvement Plan (CIP) Steering Group, also chaired by the Interim Director of Finance, focusses primarily on the local efficiency targets specific to the divisions and corporate departments. During the early part of the year the group ensured that a robust set of schemes were in place to fully deliver the planned £12.0m of tactical efficiency savings in 2016/17 as identified in the Plan submitted to NHSI in May 2016. Once full plans had been agreed, and the Quality Impact Assessment completed, the focus has been on delivery against the plan and setting up a rigorous planning process for the 2017/18 year with the intention to start the year with fully developed plans. To assist this process, a new savings database has been developed that increases the visibility of performance against plans and includes an on-line quality impact assessment process and details of required actions and milestones in order to deliver the scheme.

At a lower level, there are divisional rectification meetings, held at least once a month in each Division to identify financial performance issues at a more granular level and ensure mitigating actions are taken against any risks identified. The financial discussions take place alongside discussions relating to activity and performance against NHSI access targets. The Director of Operations and Chief Nurse or their

representatives attend these meetings ensuring the balance between financial and operational risk is maintained. The Council of Governors are kept informed of the financial position by a monthly update from the Interim Director of Finance.

The Board of Directors approved an Annual Plan for 2016/17 which was submitted to NHSI in May 2016. The Trust submits financial, workforce and performance data to NHSI on a monthly basis comparing actual performance against this plan. The level of detail required by NHSI has increased over the year, including details on agency staff costs and efficiency metrics as recommended by Lord Carter. NHSI has held regular review meetings with the Trust throughout the year and has taken no further regulatory actions as the financial position remains on track against the Plan. There have also been significant improvements in operational performance with Referral to Treatment (RTT) times, diagnostic waits and Cancer targets all being met consistently throughout the year.

At the time that the Plan was approved, it was anticipated that the Trust would require cash support from the Department of Health in the year and the Board of Directors approved the terms for a revenue loan. However, careful cash planning and applying strict working capital controls, as well as the capital plan reducing, has resulted in the Trust not requiring interim revenue during 2016/17. This has avoided the Trust incurring the expected interest payments during the year.

NHSI required the Annual Plan for 2017/18 and 2018/19 to be submitted at the end of 2016 and a plan for a reduced deficit in 2017/18 and a small surplus in 2018/19 was agreed by the Board of Directors and the Council of Governors. Both of these years have stretching savings targets and include continued central support in the form of Sustainability and Transformation Funding from the Department of Health. Despite this, it is currently anticipated that there will be a requirement for cash support in 2017/18 from the Department of Health. The Board of Directors has also approved an initial capital loan application for the enabling works associated with the ACAD development and the costs of developing the Full Business Case. The cash will be drawn down as the costs are incurred during 2017 and repaid over 25 years.

For 2016/17 the Trust negotiated a contract with commissioners based on the Payment by Results mechanism and a two year contract on the same basis covering 2017/18 and 2018/19 was signed in December 2016. Monthly meetings are held between senior members of the Trust and commissioners to discuss and agree actions in relation to meeting performance targets and dealing with any contractual queries. The performance against activity targets are reviewed monthly by executives and senior managers at the monthly Chief Executives Group and the Demand and Capacity Group and issues, risks, mitigations and actions plans are reported to NHSI on a regular basis.

The Audit Committee, which includes representatives from the Trust's internal and external auditors, meets bi-monthly. It ensures that the recommendations contained in the reports from the annual internal and external audit programmes are being implemented. This committee provides additional scrutiny on behalf of the Board of Directors regarding the governance processes within the Trust and is also responsible for reviewing the Board Assurance Framework. Internal Audit has performed audits on the core financial systems and gave significant assurance ratings including in the area of budgetary control where a limited assurance rating was reported in the previous year. A moderate assurance rating was awarded for the CIP process (an improvement from the previous limited assurance). However, the majority of the recommendations have already been implemented as part of the 2017/18 planning process so a further improvement in the rating would be expected next year.

Despite the improvement in the financial performance, activity performance and governance processes and a reduced level of NHSI scrutiny on the organisation, the Trust remains in breach of its licence with a number of enforcement actions in place. The external auditors have considered the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. They have modified their conclusion on these arrangements because of the NHSI interventions remaining in place, the financial position of the Trust and because the Trust has not hit the A&E 4 hour wait improvement trajectory for the latter part of the year. The Trust has also had to perform a detailed going concern assessment to confirm that this is an appropriate basis on which to prepare the accounts.

The Trust's Information Governance Assessment Report score overall score for 2016/17 was 40% and was graded as not satisfactory. This is addressed further below, under Control weaknesses.

The following table includes details of information governance level 2 incidents:

| Summary of Serious Incidents requiring investigations involving personal data as reported to the Information Commissioners Office in 2016/17 | | | | | |
|---|---|---|---|---|---|
| **Nature of incident** | **Nature of data involved** | **Number of data subjects potentially affected** | **Notification steps** | | |
| Unauthorised access of patient information | Patient Medical Records | 2 | Patient was aware of access. Second access related to own child | | |
| Further action on information risk | | Written warning placed on staff member's personal file, ongoing audits of access to patient records. | | | |
| November 2016 | Patient handover document given to patient in error | Patient Information | 19 | Patients to be informed | |
| Further action on information risk | | Document returned | | | |
| January 2017 | Unauthorised access of patient information | Patient medical records | 7 | Patients to be informed | |
| Further action on information risk | | Disciplinary investigation | | | |

Incidents classified at lower severity level (Level 1):

| Summary of other personal data related incidents 2016-17 | | |
|---|---|---|
| | | |
| **Category** | **Breach Type** | **Total** |
| A | Corruption or inability to recover electronic data | 0 |
| B | Disclosed in Error | 19 |
| C | Lost in Transit | 1 |
| D | Lost or stolen hardware | 0 |
| E | Lost or stolen paperwork | 8 |
| F | Non-secure Disposal – hardware | 0 |
| G | Non-secure Disposal – paperwork | 0 |
| H | Uploaded to website in error | 0 |
| I | Technical security failing (including hacking) | 3 |
| J | Unauthorised access/disclosure | 10 |
| K | Other | 4 |

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

Operational responsibility for the development of the Quality Account & Report lies with the Director of Corporate Affairs. The process of development is managed through an Annual Report project group that meets regularly in the run up to publication, to review progress with the three main elements of the Annual Report: the Annual Report; Quality Account & Report and Financial Statements. This provides assurance that the quality account and report is being prepared in accordance with applicable national guidance and also that it provides a balanced account of the activities of the previous year. Future priorities are agreed by the Executive Directors who ratify the final list of priorities for the coming year.

The Trust has a number of policies in place that are regularly reviewed to ensure that quality care is provided to patients, including infection control, safeguarding, complaints and falls, for example. Information regarding the effectiveness of these policies is reflected in the Quality Account and Report and is used to develop plans to drive further improvement.

The Trust uses the same systems and processes to collect, validate, analyse and report on data for the annual Quality Reports as it does for other clinical quality and performance information. Information is subject to regular review and challenge. The Quality Account & Report is subject to extensive internal and external scrutiny to ensure that is provides a balanced view of the organisation's progress during the year. The scrutiny process includes the Trust members and Governors, commissioners, Health watch and the relevant Overview and Scrutiny Committees who are all invited to provide comments on the Report. These commentaries are included in the final document.

The Quality Account & Report is subject to audit by the Trust's external auditors. This includes data testing on specific indicators, as well as an audit of the content of the Report itself – in line with the requirements of Monitor's Annual Reporting Manual. Further detail on the data quality processes are outlined in the Quality Account & Report itself.

The performance data and reporting contained in the Quality Account & Report is scrutinised in year by Trust committees, external stakeholders and the Trust's internal auditors. This is to ensure that metrics are being recorded accurately and that the integrity of the data quality is maintained.

As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have the responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report, in the Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is informed in a number of ways. The head of internal audit provides an overall opinion of the arrangements for gaining assurance through the Board Assurance Framework and on the controls reviewed as part of the internal audit work. My review is also informed by:

- NHSI reporting
- CQC fundamental standards
- Health and Safety Executive
- Patient experience metrics
- Nursing metrics
- Dr Foster Intelligence information
- Staff surveys
- Internal Audit
- External Audit and
- Peer reviews.

Each level of management, including the Board, reviews the risks and controls for which it is responsible. This is monitored through a robust reporting structure, defined by the risk management strategy and Board Assurance Framework.

## Control Weaknesses

The Head of Internal Audit has provided an overall opinion that, with regard to the Core Internal Audit Programme, Substantial assurance can be given, meaning that, whilst there is a basically sound system of internal control, there are weaknesses, which put some of the system

objectives at risk. This opinion relates to:

- Cash management
- Income and debtors
- Payments and creditors
- Budgetary control
- Cost Improvement Programme (CIP)
- Payroll
- Computer based IT controls and
- Charitable Funds.

There is evidence that the level of non-compliance with some of the controls may put some of the system objectives at risk. The weaknesses identified which put some system objectives at risk relate to Cost Improvement Programmes and IT controls.

However, with regard to the Trust's Board Assurance Framework and Risk Management, the Head of Internal Audit Opinion is one of Moderate assurance, with recommendations being made regarding the development of actions to address identified risks, review and reporting. The Head of Internal Audit has acknowledged that the Trust's Board Assurance Framework processes have been revised during the year as a new organisational structure and governance processes were implemented by the Trust in response to Monitor/ NHSI enforcement actions.

The Interim Director of Corporate Affairs is continuing to lead the implementation of new processes following a restructuring of the Trust's governance and assurance framework. This work has included a review of the compliance framework for the Trust and the effectiveness of associated controls, a restructuring of the governance support teams and establishment of a clear chain of assurance from ward to Board.

Action plans to address the recommendations of the internal auditors have been developed and are being implemented.

In addition, the Trust's self-assessment against the Information Governance Toolkit has confirmed a weakness in controls regarding Information Governance. Training has been reviewed and an improved level of compliance is already being achieved. A full action plan is being implemented to strengthen controls in this area.

## Monitor Undertakings

The Trust continues to operate under a number of section 106 enforcement undertakings and an additional licence condition imposed under section 111, as set out below.

The Trust signed the first Section 106 undertaking in December 2013 and at the beginning of the 2014/15 year was implementing the agreed plans to deliver against the A&E four hour target and was rated red in relation to governance. At this point the Trust anticipated that it would meet all other targets.

At the end Quarter 1 of 2014, the Trust remained red rated because it had not achieved the A&E target for more than three successive quarters, as well as not achieving the Referral to Treatment (RTT) (admitted) target, 2-week wait (all cancers) target, the 2-week wait (breast) target and the 62 day wait target.

For the remainder of the year, the Trust also failed to achieve these targets with the exception of the 62 day standard which has been achieved since Quarter 2 of 2014/15. These persistent target breaches were viewed by Monitor as a failure of governance arrangements.

As a result, in October 2014, the December 2013 section 106 undertaking was updated to reflect the latest plans to improve performance against the A&E four hour target. A new section 106 undertaking was agreed that recorded, amongst other things, the actions intended to address the RTT, and all cancer wait time targets.

Earlier in the year the Trust had commissioned Deloitte LLP to carry out a governance review and as part of the new undertaking, it was agreed that the Trust would share with Monitor the findings of this review and the resulting actions plans.

In January 2015, the Trust's license was varied pursuant to section 111, placing a requirement on the Trust to ensure it has in place stronger leadership capacity and capability and governance systems and processes to enable it to comply with the conditions of its license.

During the year, Monitor was satisfied that the Trust was in breach of the additional licence condition imposed in January 2015 and a further additional licence condition under section 111 was imposed on the Trust, requiring it to make certain appointments to the posts of Chair and Chief Executive. In addition, the Trust has given further enforcement undertakings under section 106, relating to the Trust's financial position. These are without prejudice to the previous undertakings.

Whilst much progress has been made in addressing the issues that led to the above enforcement action and additional licence conditions, the leadership arrangements currently in place remain on an interim basis and, as such, the above conditions and undertakings remain in place. Regular communication continues between the Trust and

Monitor to review progress on these issues.

With the exception of the internal control issues that have been outlined above, no further significant internal control issues have been identified. Steps are being taken to address those internal control issues, with the intent of driving rapid and effective improvement.

**Signed**

**Dame Julie Moore**
**Interim Chief Executive Officer**
**Date: 24 May 2017**

# Section 3 **Quality Account**

This report covers the period 1 April 2016 to 31 March 2017

# Contents

Section 2

# Quality Account

## Introduction

All providers of NHS Services in England are required to produce an Annual Quality Account. The purpose of a Quality Account is to inform the public about the quality of services delivered by the Trust. Quality Accounts enable NHS Trusts to demonstrate commitment to continuous, evidence based quality improvement and to explain progress to the public.

Heart of England NHS Foundation Trust will be referred to as HEFT or the Trust.

## Part 1

## Chief Executive's Statement

The Trust has continued to focus on delivering high quality care and treatment to patients during 2016/17 whilst working on improving our position in relation to finances and performance.

I have been Interim Chief Executive, with the Rt Hon Jacqui Smith as Chair, since December 2015. This is a dual role across HEFT and University Hospitals Birmingham NHS Foundation Trust (UHB). Since then there have been a number of interim changes to the HEFT Board with members of the Executive Board Directors from UHB in place for all positions except the Chief Nurse, Director of Operations and Director of Workforce. In the 18 months since we have joined the organisation our priorities have been to bring financial and operational stability to the organisation to ensure we are delivering the best possible quality of care to patients.

The most important task faced by the executive team was to reinvigorate the clinical and support staff to engage with addressing the challenges and to take a more proactive approach to resolve performance issues. This requires an on-going cultural change across the organisation and will take time to deliver, but appears to be progressing well.

During this time we have implemented a new operational structure to ensure clear roles, responsibilities and accountabilities across the organisation. In addition we have developed a number of joint working groups between the University of Birmingham Hospitals NHS Foundation Trust and HEFT. The aim being to encourage collaborative learning and sharing of best practice from both organisations; for example, reviewing serious incidents and taking a combined approach to safety projects such as identification and management of sepsis and the introduction National Safety Standards for Invasive Procedures.

HEFT has agreed their vision of "Building Healthier Lives" and the Trust's values of "Honest, Caring, Supportive and Accountable".

In line with national trends, the Trust has seen unprecedented demand for its services with large increases in Emergency Department attendances and admissions, which has put significant pressure on our ability to deliver planned treatments.

HEFT continues to be one of the best performing Trusts in the country in relation to meeting cancer operational standards.

Prior to NHS Improvement's intervention HEFT was concentrating on improving the basics and this continues with a focus on:

- Governance
- Urgent care
- Scheduled care
- Information management and technology
- Mortality
- Culture and engagement
- Financial stability

With regards to quality there has been some progress against the improvement priorities laid out in the Quality Report 2015/16 however, despite a number of initiatives, the Trust has not improved as much as planned in all of these. We will therefore be carrying over two of these priorities into 2017/18 priorities as outlined in Part 2.

An improvement priority carried over from last year was to improve the response rate and overall score in the Friends and Family Test in the Emergency Department. This has shown a

marked improvement with our response rate now consistently above the regional average and the positive responders very close to the regional average.

The project to reduce maternal harm through category 1 Caesarean section Quality Improvement Programme (QIP) pathway will continue, although not as an improvement priority for the Quality Account 2017/18. Accuracy of data has been identified as an issue to be addressed as some of the results presented were disappointing and may not reflect the improvement in practice. The quality of some of the data extracted was poor and therefore could not be included (see Part 2). This project has been presented at a number of national safety conferences. It is planned that a team from HEFT will present an update and the lessons learned when undertaking a quality improvement project at the CHFG (Clinical Human Factors Group) Open Seminar, Human Factors and Safer Births Event in Birmingham on 11th May 2017.

The Trust has therefore chosen to:

- Continue with 1 of the 4 priorities from 2016/17; 'Reduce avoidable harm to patients from omission and delay in receiving Parkinson's disease medication' for 2017/18.
- Amend 1 of the 4 priorities from 2016/17; 'Improve early recognition and management of sepsis and reduce hospital acquired sepsis'. The priority will now be to 'Improve early recognition and management of sepsis'.
- Add reducing surgical site infection after major surgery and improving Infection rates for C Difficile and/or MRSA.

The Trust signed up in 2015 to the National Sign-up to Safety Campaign which was launched in 2014. This campaign aims to make the NHS the safest healthcare system in the world. The ambition is to halve avoidable harm in the NHS over the next three years. Organisations were invited to join the Sign up to Safety campaign and make five key pledges to improve safety and reduce avoidable harm. HEFT joined the Sign up to Safety campaign in 2015 and made the following four Sign up to Safety pledges:

- Reducing harm from deterioration including sepsis;
- Reducing medication related harm;
- Reducing harm from pressure ulcers;
- Reducing harm in maternity services.

The Trust was last inspected in September/October 2016 by the Care Quality Commission (CQC) as part of the national inspection regime. The Trust is awaiting the first draft report from the CQC. During the inspection there was no enforcement action taken by the CQC.

The Trust will continue working with commissioners, healthcare providers and other organisations to influence future models of care delivery and deliver further improvements to quality during 2017/18.

On the basis of the processes the Trust has in place for the production of the Quality Report, I can confirm that to the best of my knowledge the information contained within this report is accurate.

**Dame Julie Moore**
**Interim Chief Executive Officer**
**Date: 24 May 2017**

# Part 2

## Priorities for improvement 2016/17:

This part of the report sets out progress made against the four priorities identified for improvement during 2016/17, which were:

**Priority 1:**
Reduce avoidable harm to patients from omission and delay in receiving Parkinson's disease medication;

**Priority 2:**
Improve early recognition and management of sepsis and reduce hospital acquired sepsis;

**Priority 3:**
Reduce maternal harm through the category Caesarean section 1 Quality Improvement Programme (QIP) pathway;

**Priority 4:**
Improve Friends and Family Test responses within the Emergency Department.

The Trust has made progress against two of the four priorities.

| No | Priorities for improvement | 2016/17 | 2017/18 | Comments |
|---|---|---|---|---|
| 1 | Reduce avoidable harm to patients from omission and delay in receiving Parkinson's disease medication. | Yes | Yes | Targets and methodology kept the same for 2017/18. |
| 2 | Improve early recognition and management of sepsis and reduce hospital acquired sepsis. | Yes | Yes | Targets and methodology amended for 2017/18. |
| 3 | Reduce maternal harm through the category Caesarean section 1 Quality Improvement Programme (QIP) pathway. | Yes | No | To be discontinued. |
| 4 | Improve Friends and Family Test responses within the Emergency Department (ED). | Yes | No | Consistent improvement in response rate and positive recommender score. To be discontinued. |

Based on these improvements the Trust has chosen to continue with 1 of the 4 priorities from 2016/17. **Priority 1:** 'Reduce avoidable harm to patients from omission and delay in receiving Parkinson's disease medication' for 2017/18. HEFT has not achieved the 90% compliance target for Parkinson's patients receiving their medication within 30 minutes of the prescribed time and so will continue with this priority for 2017/18.

**Priority 2** has been monitored via the national sepsis CQUIN for which the Trust has partially achieved in 2016/17 for both measures (inpatient screening and initiation of treatment and day 3 review). For this reason HEFT has decided to continue with the priority. The priority will be amended to ensure better alignment of the Trust's aim with national priorities. The priority will now be to 'Improve early recognition and management of sepsis and reduce hospital acquired sepsis'.

A further two local priorities have been agreed for 2017/18 in line with a priority identified by the Surgical Quality and Safety group and one as a result of concerns around the Trust-wide rise in MRSA and Clostridium Difficile cases. These priorities were agreed at Quality Committee following discussion at a multidisciplinary meeting.

**Priority 3:** Reducing surgical site infection after major surgery is a new priority. Surgical Site Infection (SSI) can lead to major morbidity and even mortality. The majority of these infections are considered preventable. A recent Quality Improvement Project at Heartlands Hospital demonstrated that the introduction of a 'bundle of interventions' (BOI) reduced readmissions after major abdominal surgery by >70%. In December 2016, the WHO and the American College of Surgeons produced best practice guidelines aimed at reducing SSI.

At the last visit CQC (2016) the Trust was unable to provide surgical site infection (SSI) rates by speciality and site. A multidisciplinary steering group has been established in order to align our

BOI to these global best practice guidelines and to roll-out the bundle across the Trust in all theatres that undertake major surgery where the risk of SSI is high (such as major vascular, abdominal or thoracic surgery) and where the consequences of SSI can be particularly devastating for patients (such as major joint replacement). The BOI will be based on NICE Quality Standard 49 and includes use of a 'social wash' prior to surgery, ChloraPrep® for skin preparation, antiseptic impregnated sutures, measures to reduce footfall in theatre flow and change of instruments and drapes for skin closure.

This priority demonstrates the Trust's ability to learn from patient outcomes. Embracing the BOI shows how HEFT is focused on developing its safety culture to embrace global recommendations for best practice that aim to minimise harm from surgical interventions. This investment in quality will improve the safety of surgery in HEFT and enhance our patients' experience.

**Priority 4:** Improve infection rates for Clostridium Difficile (C Diff) and MRSA. This is a new priority which reflects our ongoing commitment to reducing infection rates. Please refer to Part 3 for more 2016/17 performance data.

These two new priorities will be measured via quarterly reports to the Clinical Quality Monitoring Group, using established Trust systems and processes.

## Priority 1: Reduce avoidable harm to patients from omission and delay in receiving Parkinson's disease medication

### 1. Aim and rationale

Missed and delayed doses of Parkinson's disease medication is known to be harmful. Patients with Parkinson's disease can deteriorate rapidly in terms of their ability to move, speak and swallow. Complications can prolong length of stay in hospital, it is distressing for patients and delays and omissions in medication can be life-threatening. This problem is recognised nationally and is the reason why Parkinson's UK promotes their "Get it on time" campaign.

The initial Trust baseline data (2015) showed only 53% of inpatients were receiving their Parkinson's disease medication within 30 minutes of the prescribed time. The aim was to improve this from 53% to 90% across the whole Trust by December 2016.

### 2. Process for monitoring progress

Monitoring omissions and delays in Parkinson's disease medication is via the live medication dashboard. The electronic dashboard provides historical and 'live' data to ward areas, allowing the review of reasons for delays and non-administration.

The Parkinson's Quality Improvement project team meet monthly to monitor progress and report to the Safer Medicines Practice Group (SMPG), which is chaired by the Clinical Director of Pharmacy.

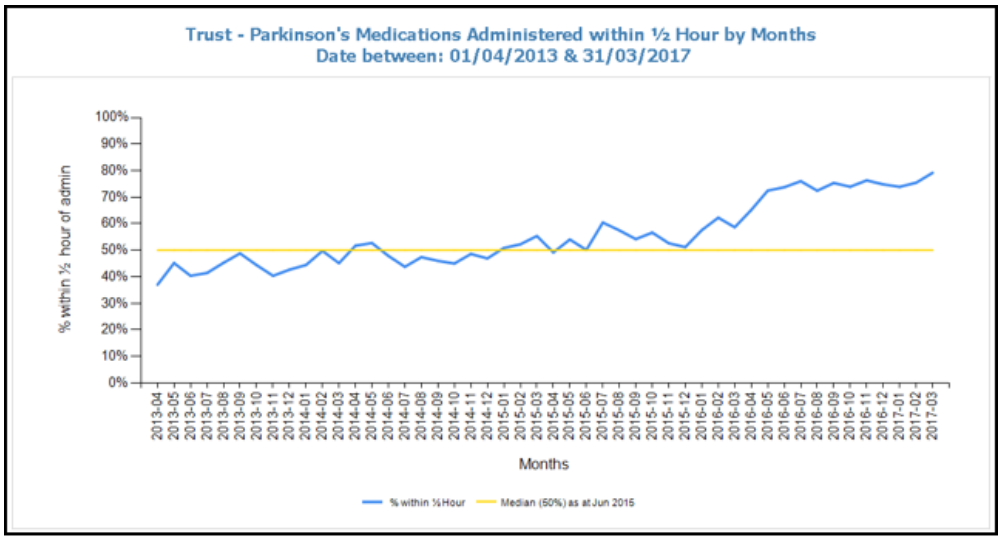
Parkinson's disease medication is now part of the Nursing and Midwifery Care Quality Dashboard. Progress on performance is reported monthly to the Chief Executive's Group (CEG) by the Chief Nurse.

### 3. Current performance

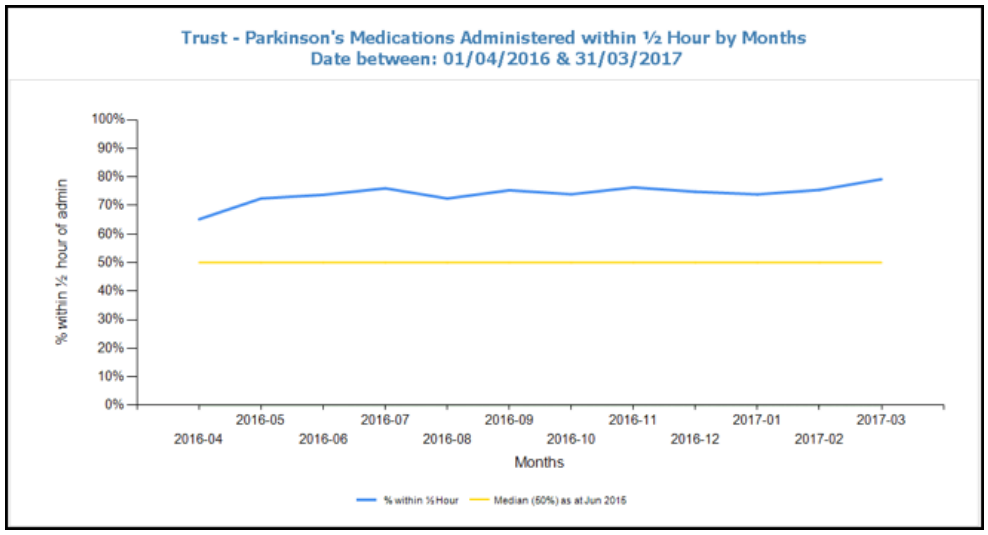
The percentage of patients who received their Parkinson's disease medication within 30 minutes of the prescribed time has improved across the three hospital sites from 53% to 75%; however, this is non-compliant with the 90% Trust target (Graph 1a and 1b).

It is expected that performance will continue to improve as the nurse responder bleep system is more widely utilised across all wards. In addition, the stocks of emergency Parkinson's disease medication have increased and also added to the pharmacy out of hours cupboard to support timely administration.

**Graph 1a:** Trust wide improvement since project commenced for the period April 2013 – March 2017*




**Graph 1b:** Trust wide improvement for the period April 2016 – March 2017*




*Data has been taken from the Trust Medication Dashboard.

Initial Trust wide data collected in January 2015 (31 days from 14th January to 13th February) showed that 12.48% of Parkinson's medications were omitted.

Following the improvement interventions below, data collected for the same period in 2016 and 2017 showed a significant decrease and currently sits at 4.70%.

As a Trust we prescribe approximately over 30,000 doses of Parkinson's disease medication per year. This improvement equates to thousands more time critical medications being received correctly by patients thereby reducing harm and medication error.

**Table 1:** Trust wide omissions in Parkinson's disease (31 days from 14th January to 13th February) medications for the last three years:

| 2015 | 2016 | 2017 |
|---|---|---|
| 12.48% | 9.67% | 4.70% |

## 4. Improvements and progress against 2016/17 initiatives:

### 4.1 Education

- Parkinson's disease educational film shared Trust wide and included in training and induction sessions for clinical staff.
- Delivery of focussed teaching to different groups of staff including visits to all adult wards.
- Parkinson's disease intranet website with resources and information shared Trust-wide, now included in training and induction sessions for clinical staff.
- Flow charts and safety cards developed for the management of Parkinson's disease patients who are "Nil by Mouth" or have swallowing difficulties. These are available to all staff on the Trust intranet and in the adult nursing safety manual.

### 4.2 Patient identification

- Development of Parkinson's disease medication dashboard providing historical and 'live' data to ward areas. This allows for the review of reasons for delays and non-administrations in Parkinson's disease medications.
- Parkinson's disease medications added to nursing 'safety huddles' and handovers.

### 4.3 Medication administration

- The availability / stock level of emergency Parkinson's disease medication has increased on all three sites.
- Automatic bleep system implemented alerting ward staff that a Parkinson's disease medication is due.

## 5. Initiatives to be implemented in 2017/18:

- Following feedback from the Patient Experience team about the in hospital experiences of patients with Parkinson's disease, the Trust's patient self-administration policy is under review.
- A review of Trust-wide reasons for omissions and delays in the administration of Parkinson's disease medication is currently underway to drive further improvements.
- Monthly monitoring via Care Quality Dashboard.

The project has received local and national recognition. Project information has been shared regionally and there has been national dissemination via Sign-up to Safety national newsletters and Parkinson's UK. The educational video has recently won an award at the Haelo film festival.

In March 2017, the Parkinson's Quality Improvement team were winners of Parkinson's Excellence Network Awards which recognises and celebrates outstanding services that make a difference to people in the UK affected by Parkinson's disease. The project has also recently been shortlisted for the HSJ Patient Safety Award.

# Priority 2: Improve early recognition and management of sepsis and reduce hospital acquired sepsis

## 1. Aim and rationale

Sepsis is a life threatening condition that arises when the body's response to an infection injures its own tissues and organs. Sepsis leads to shock, multiple organ failure and death, especially if not recognised early and promptly treated.

As part of the National Sign-up to Safety Campaign the Trust aims to reduce avoidable harm by 50% from failure to recognise sepsis by 2018. This will be achieved by:

- Reliable recognition and screening of sepsis;
- Timely and reliable escalation and sepsis treatment;
- Reducing hospital acquired sepsis and antimicrobial resistance;
- Improving sepsis education and awareness.

The definition of sepsis has recently been reviewed by the National Institute for Health and Care Excellence (NICE). Studies have shown that implementation of this new definition will significantly increase the number of patients labelled as septic, for example; within the intake of medical patients we would expect an increase of 50%. This will inevitably have an impact on the reported statistics into 2017/18.

## 2. Process for monitoring progress

The national sepsis CQUIN 2016/17 promotes timely identification and treatment for sepsis, both in emergency departments and inpatient areas. The national sepsis CQUIN is monitored by the Performance team.

The CQUIN has two key elements for audit:

- The percentage of patients who meet the criteria for sepsis screening and are screened for sepsis using a recognised screening tool.
- The percentage of patients who present with severe sepsis, Red Flag sepsis or septic shock and are administered intravenous antibiotics within the appropriate timeframe. In addition these patients must have an empiric review within three days of prescribing of antibiotics.

There was an initial delay in agreeing the final CQUIN contract requirements. This contributed to a delay in devising a framework for delivery of the CQUIN. Therefore, it was agreed that in Quarter 1 a pilot study could be undertaken with a smaller cohort of patients to test the proposed framework and systems and to identify errors and inefficiencies.

Following the pilot a robust framework was devised to support the successful transition to full delivery by the Trust divisions in Quarter 2. Alongside the basic data requirements of the CQUIN further audit data has been included to enable "deep dive" information to be sourced. This will better enable Trust wide learning and promote better outcomes for patients diagnosed with sepsis.

## 3. Current performance

| Table 2: Sepsis CQUIN Results 2016-17 | | | | | |
|---|---|---|---|---|---|
| **2A Part 1: Emergency - Sepsis Screening** | | | | | |
| | **2016-17** | | | | |
| | **Qtr 1** | **Qtr 2** | **Qtr 3** | **Qtr 4** | **Total** |
| Total number of patients eligible for screening | 150 | 107 | 67 | 57 | 381 |
| Total number of patients screened | 84 | 46 | 31 | 32 | 193 |
| % of eligible patients receiving screening | 56.00% | 42.99% | 46.27% | 56.14% | 50.66% |
| **2B Part 1: Inpatients - Sepsis Screening** | | | | | |
| | **2016-17** | | | | |
| | **Qtr 1** | **Qtr 2** | **Qtr 3** | **Qtr 4** | **Total** |
| Total number of patients eligible for screening | 27 | 66 | 62 | 150 | 305 |
| Total number of patients screened | 5 | 31 | 43 | 118 | 197 |
| % of eligible patients receiving screening | 18.5% | 47.0% | 69.4% | 78.7% | 64.6% |
| **2A Part 2: Emergency - Antibiotic Administration** | | | | | |
| | **2016-17** | | | | |
| | **Qtr 1** | **Qtr 2** | **Qtr 3** | **Qtr 4** | **Total** |
| Total number of patients requiring antibiotics | 30 | 90 | 200 | | 320 |
| Total number administered within 1 hour | No data | 28 | 134 | | 162 |
| % of patients receiving antibiotics within 1 hour | | 31.11% | 67.0% | No data | 50.63% |
| Total number also having an empiric review | 8 | 9 | | | |
| % of patients receiving antibiotics & empiric review | 26.67% | 10.00% | - | No Data | |
| **2B Part 2: Inpatients - Antibiotic Administration** | | | | | |
| | **2016-17** | | | | |
| | **Qtr 1** | **Qtr 2** | **Qtr 3** | **Qtr 4** | **Total** |
| Total number of patients requiring antibiotics | No data | 45 | 62 | | 107 |
| Total number administered within 1 hour | | 25 | | | 25 |
| % of patients receiving antibiotics within 90 mins | | 55.56% | - | *56.82% | - |
| Total number also having an empiric review | | 14 | | | |
| % of patients receiving antibiotics & empiric review | | 37.78% | | | |

* Combined performance for Antibiotic Administration and Empiric Review

## 4. Improvements and progress against 2016/17 initiatives

### 4.1 Adult Inpatient areas

- A sepsis training session is delivered to all new nurses at Trust induction.
- Sepsis education is delivered on the new Acute Illness Management (AIM) course.
- The on-going promotion of the sepsis screening pathway, for example, via the animated sepsis screening educational video.
- The Trust's "Lesson of the Month" programme has been utilised to raise awareness around sepsis and sepsis screening in September and October 2016.
- The Critical Care Out-reach Team (CCORT) database has been modified to include questions relating to sepsis.

### 4.2 Paediatrics

- Sepsis teaching sessions have been delivered to 81% of qualified nursing staff (88 out of 108) and plans are underway to train the remaining 20 nursing staff.
- Sepsis scenarios have been included in the paediatric emergency care study day.
- The paediatric sepsis Moodle package is on iSkills on the Trust intranet page.

### 4.3 Maternity

- A maternity specific sepsis screening tool and care pathway were launched in April 2016.
- Maternity sepsis training continues as part of the mandatory Obstetric Emergency Day and since 2016 this has included scenario based sepsis sessions.

### 5. Initiatives to be implemented in 2017/18:

A revised sepsis screening pathway that is based on the latest NICE guidance is being developed and piloted prior to Trust-wide launch.

### 5.1 Adult Inpatient areas

- Changes are currently being made to the Modified Early Warning Score (MEWS) charts to include a sepsis screening prompt, which is due to be launched in May 2017.
- The Adult Modified Early Warning (MEWS) Policy is being updated to reflect new guidance integrating the sepsis pathway, which will be launched in May 2017.
- Nursing metrics audits will include the sepsis screening element.

### 5.2 Paediatrics

- There will be a further pilot and implementation of the final paediatric sepsis screening tool.
- Paediatric Early Warning Score (PEWS) charts are currently under review and will include a sepsis prompt box.

### 5.3 Maternity

- The Obstetric Modified Early Warning Score (MEOWS) chart is currently under review and will include a sepsis screening prompt. This is due to be launched in May 2017.
- Twelve month on going audits of severe sepsis cases are currently in progress.

## Priority 3: Reduce maternal harm through the category Caesarean section 1 Quality Improvement Programme (QIP) pathway

### 1. Aim and rationale

This quality improvement project was identified as a priority by the multi-professional team at a staff engagement event in 2012. The team reported that, at times, when a category 1 CS (Caesarean Section) was required the team did not always perform effectively and/or efficiently and the ability to achieve the 30 minute DDI (Decision-Delivery Interval) was challenging. The priority has been monitored during 2016/17 at regular directorate governance meetings.

A CS is classified as a category 1 when there is immediate threat to the life of the woman or foetus and national guidance recommends that the procedure should be carried out as quickly as possible after making the decision.

The need to achieve a specified DDI is supported by quantitative data on various aspects of foetal and maternal outcomes rather than the interplay of factors that can affect this time period. Although some work has been conducted in the UK to examine where the systematic delays lie and how to avoid them (Tuffnell et al. 2001).

It has been identified that more work is needed to determine how to optimise the DDI interval and evaluation of these factors could be used to inform future NICE guidance, local service evaluation and training of the multidisciplinary team (MDT).

The improvement project aimed to streamline the decision to delivery pathway to ensure that delays are minimised and to focus on:

- Training
- Leadership

### 2. Process for monitoring progress

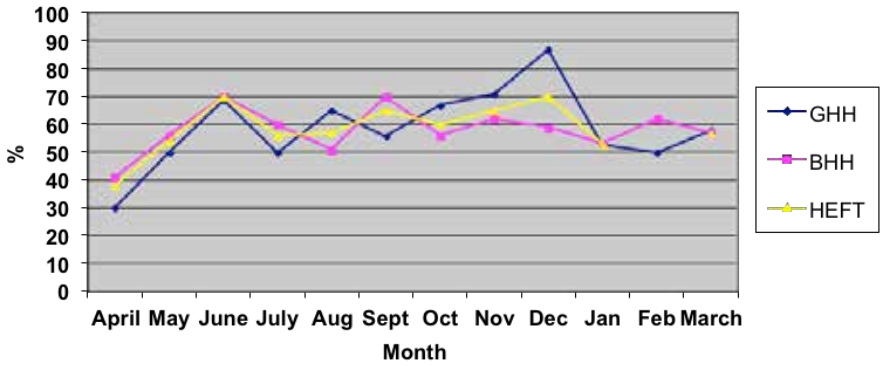
Historically the DDI compliance for Category 1 CS was measured annually as an identified core audit for maternity services. A retrospective audit of hospital records was undertaken and reported via the local clinical audit group. More recently following the implementation of a maternity information system (Badgernet) data can be accessed easily and enables the service use the data

more responsively to improve safety.

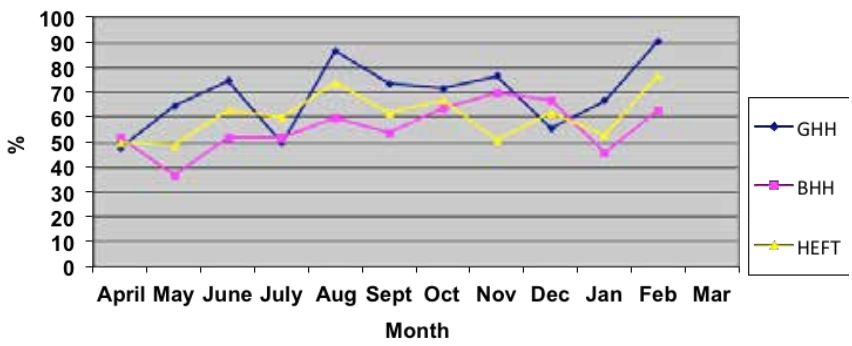
## 3. Current performance

The DDI compliance data demonstrates an inconsistent improvement throughout 2015-2017; this is presented in Graphs 2 and 3 on the next page. Some of the results presented are disappointing and may not reflect the improvement in practice; the quality of the data extracted was poor and therefore could not be included, for example, incomplete or missing fields.

**Graph 2:** DDI Compliance 2015/16




**Graph 3:** DDI Compliance 2016/17




## 4. Missing Data

There were a number of cases with missing data so the DDI could not be calculated. The results are presented in Table 3 below.

**Table 3:** Number of cases with missing data by hospital site and financial year.

| | Good Hope Hospital (GHH) | Birmingham Heartlands Hospital (BHH) |
|---|---|---|
| 2015/16 | 23% | 21% |
| 2016/17 | 12% | 17% |

## 5. Improvements and progress against 2016/17 initiatives

- Developed and redefined pathway for Category 1 CS with the MDT;
- Staff have attended MDT human factors based training;
- Procured equipment to reduce time to prepare for the procedure;
- Radio-controlled clocks placed in theatre.

## 6. Initiatives to be implemented in 2017/18

It is expected that compliance with the DDI will improve further following implementation of:

- Improved IT training for all team members to enable them to complete the maternity information system accurately;
- Engagement with the BHH team and re launch the pathway;
- Implementation of an anaesthetic decision tool;
- Monitoring 'live' compliance daily and reporting reasons for delays;
- Up scale human factor training supported by money awarded from HEE (Health Education England);
- Consider monitoring the DDI for Category 1 CS on the maternity dashboard.

This project was presented at a number of national safety conferences. A team from HEFT presented an update and the lessons learned at a quality improvement project at the CHFG (Clinical Human Factors Group) Open Seminar, Human Factors and Safer Births Event in Birmingham in May 2017.

# Priority 4: Improve Friends and Family Test responses within the Emergency Department

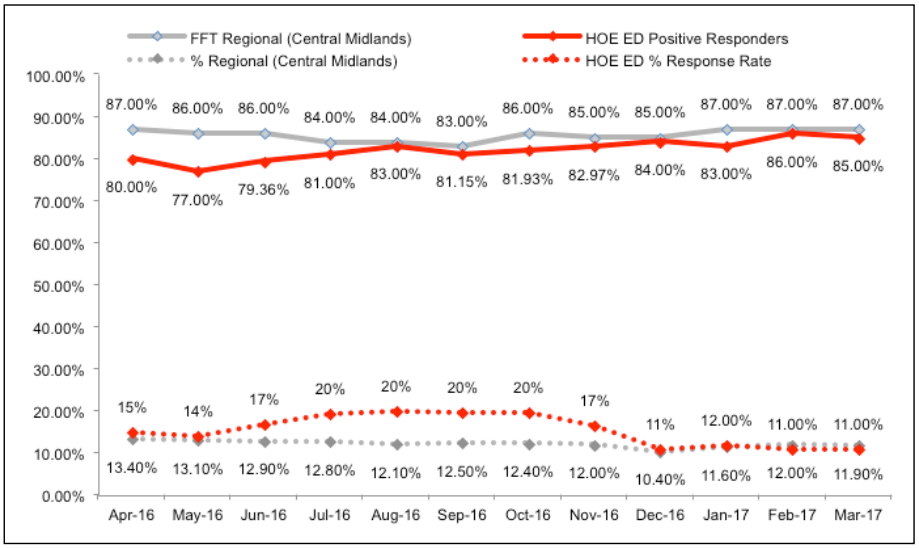
## 1. Aim and rationale

The Friends and Family Test (FFT) is seen as an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience.

Graph 5 below shows that the Trust achieved an average during the year of 82% positive recommendation. The average score during 2015/16 was 79%. The average score for the region was 85.6%.

The Trust has improved performance against the regional score progressively over the previous months. The gap in March 2016 was 12.7%. In December this gap was 1%. A score of 86% in February is the highest ever achieved FFT score in the HEFT ED.

**Graph 5:** HEFT FFT Emergency Department Response Rate and Positive Recommender Score Compared with the Region. The dotted lines relate to response rate and the complete lines relate to positive recommenders:



## 2. Process for monitoring

Process continues to be monitored via the patient experience dashboard and forms part of discussion at divisional quality and performance meetings.

FFT is collected by a member of the Patient Services team who visits every ward each week. The process for completion of the forms on the ward is that it is done without the guidance or input of staff, unless required as stipulated in the national FFT guidance. Staff ask patients or their relatives to complete the form on the patient's behalf and this is then placed in the locked ward collection box. Comments are collated and input via ward performance dashboard for staff to see and act upon.

Data from areas such as the Emergency Department and Outpatients is collected via SMS/ text message and automated voice calls to a land line number.

## 3. Current performance

The Trust's average positive recommender score over the period April – September 2016 for ED was 80.4%. Over the following 6 month period, October 2016 - March 2017, the Trust's average positive recommender score was 83.7%.

## 4. Improvements and progress against 2015/16 initiatives

- Implementation of the revised divisional structure has enabled closer monitoring and support for the ED department.
- Streaming nurses have been introduced in ED to initially assess the patients before they are formally triaged. This initiative has positively impacted on patient flow within the ED and enabled patients to be assessed in the right area dependant on their requirements.
- A patient information board has been created in ED at GHH which provides information on the patient journey in ED, for example, which staff are on duty and processes and procedures they may experience during their stay.
- Additional staff have been appointed to care for patients at busy times when waiting to be assessed in cubicles. This is to ensure patient safety and dignity is maintained throughout busy periods. Initial care plans are instigated during this time to ensure individualised patient care needs are identified and addressed. The assessment includes observations, tissue viability and pain.
- Additional volunteers have been recruited to ED. They provide valuable support for patients and their relatives providing update information and a point of contact. This has proved beneficial to patients, carers and ED staff.
- House keepers have been appointed to support ED and cater for the nutrition and hydration needs of patients and their relatives during their time in ED.
- In response to complaint and FFT themes there are now core trainers in ED for customer service training. This training addresses issues regarding staff attitude and behaviours, de-escalation of incidents and the early intervention and potential resolution of concerns and complaints through effective communication.
- Tissue viability risk assessment and reporting is an area of good practice in the ED. This is to ensure initial screening and recognition of patients potentially at risk and to implement preventative actions.
- 'You said we did' information is displayed for patients to see in ED. Positive feedback and areas for improvement are highlighted and initiatives to enhance patient experience are showcased.
- A HALO (hospital ambulance liaison officer) has been funded for BHH ED to oversee patients awaiting cubicles at busy times.
- Quiet 'safe' areas are available for patients who present with psychological issues where they can be reviewed in a quiet environment.
- Dedicated child friendly areas for children in ED to make their experience less stressful as possible.

## 5. Initiatives to be implemented

- The ED care quality metrics are currently being reviewed and revised to ensure they are appropriate for ED patients.
- The possibility of a funded HALO for GHH is currently being scoped.
- An "Always Event" focussing on pain assessment and management in ED is currently being scoped.
- The opportunity to enable 24/7 availability of paediatric ED at GHH is currently being scoped.
- A review of trolley mattresses is being undertaken to enhance patient comfort and to ensure maximum tissue viability. A pilot will be undertaken.

# Part 2: Review of Services/Statements of Assurance from the Board

The Trust is required to include statements of assurances from the Trust Board. These statements are common across all NHS Quality Accounts.

## 1. Service income

During 2016/17, HEFT provided and/or sub-contracted 124 relevant health services including Acute, Specialised, Public Health and Community Services.

HEFT has reviewed all the data available to them on the quality of care in 124 of these relevant health services.

The income generated by the relevant health services reviewed in 2016/17 represents 100% of the total income generated from the provision of relevant health services by the HEFT for 2016/17.

## 2. Clinical audit

During 2016/17, 43 national clinical audits and 9 national confidential enquiries covered NHS services that the Trust provides.

During that period, HEFT participated in 95% of the national clinical audits and 100% national confidential enquires of the national clinical audits and national confidential enquires which it was eligible to participate in.

The national clinical audits and national confidential enquiries that HEFT was eligible to participate in during 2016/17 are as follows. (Please see **Appendix 1**).

## 3. Participation in clinical audits and national confidential enquiries 2016/17

The national clinical audits and national confidential enquiries that HEFT participated in, and for which data collection was completed during 2016/17, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

## 3.1 Reviewing reports of national and local clinical audits

The reports of six national clinical audits were reviewed by the provider in 2016/17 and HEFT intends to take the following actions to improve the quality of healthcare provided:

| Table 4: Audit title | Improvements identified |
|---|---|
| Myocardial Ischaemia National Audit Project (MINAP) | 1. Continue to review the STEMI pathway on a monthly basis and further analyse all breaches/act accordingly if necessary.<br>2. Review the timeliness of NSTEMI patients receiving coronary angiography <72 hrs,<br>3. Analyse breaches.<br>4. Establish a working party to review NSTEMI pathway on a prospective basis in order to meet the BPT. |
| Falls and Fragility Fracture Audit Programme- National Hip Fracture Database 2016 | 1. Dedicated NOF list for trauma<br>2. Anaesthetist present at trauma meeting<br>3. Consolidate service to one site.<br>4. BPT achieved in 70% of cases |
| National Heart Failure Audit | 1. Establish mechanism for BPT reporting.<br>2. Develop a coding validation process<br>3. Implement heart failure database on Dendrite with handheld devices<br>4. Continue to fully participate in the national heart failure audit, submitting 70% of discharges. |
| Procedural Sedation National Audit | 1. Develop a new proforma for procedural sedation to include capnography as a vital signs. Proforma will include planned sedation level required and level achieved. |

| Table 4:<br>Audit title | Improvements identified |
|---|---|
| MBRRACE –UK Perinatal Mortality Report | 1. To improve data collection and aim for 100% completeness for:<br>• Ethnicity<br>• Smoking<br>• Body mass index<br>• Main cause of death<br>• Intended type of care at booking<br>• Birth weight<br>• Gestational age at birth. |
| National Audit of Percutaneous Coronary Interventional (PCI) | 1. Continue to review key performance indicators (STEMI and NSTEMI) pathways on a monthly basis and further analyse all breaches.<br>2. Review the NSTEMI pathway. Incorporate the recent IMS project reviewing cardiac pathways and service line reporting.<br>3. Review all PCI mortality patients. |

## 3.2 Local Clinical Audits

The reports of 177 local clinical audits were reviewed by the provider in 2016/17 and HEFT intends to take the following actions to improve the quality of healthcare provided (please see in the table on next page). Staff undertaking clinical audit are required to report any actions that should be implemented to improve service delivery and clinical quality to the Safety and Governance Department via an electronic reporting system.

| Table 6: Specialty | Audit Title | Actions |
|---|---|---|
| Acute Medicine - BHH | AMU clerking proforma | Highlighting the importance of the different parts of the clerking booklet to all junior doctors during induction.<br>Improvement in the quality of documentation by Medical staff - re-audit.<br>Removal of parts of nursing assessment as largely unused. |
| | AMU Clerking Proforma Audit | Improve the documentation by nursing and medical team.<br>Simplify and shorten nursing proforma.<br>Simplify the clerking proforma - less tick boxes |
| | Are we managing alcohol withdrawal appropriately? | Audit on the note keeping standards in AMU.<br>Improve the use of the AMU pro forma on alcohol withdrawal - Re audit.<br>Teaching session for junior doctors and nurses on management of Patients with alcohol withdrawal in A&E and AMU |
| | Documentation within AMU | AMU clerking booklets and continuation sheets to be coloured to clearly show any notes made on these sheets were written in AMU.<br><br>Distribution of audit results to all AMU health professionals. Dr to impress importance of accurate documentation at induction of new AMU doctors including need for;<br>a. Author name printed with each entry<br>b. Author signature with each entry. Re-audit to ensure improvement |
| | Recognition and early management of AKI (acute kidney injury) on AMUs across the West Midlands | AKI care bundle.<br>E-Alert system. Re-audit |
| Acute Medicine - GHH | AMU Documentation Audit | Feedback to nursing staff regarding audit results.<br>Include information on correct documentation on local induction. |
| | Discharge Summaries Audit | To present audit results in the departmental and hospital audit meeting. |
| | Do patients with a label of COPD have a formal diagnosis with spirometry according to NICE guidelines? | Re-audit in 6-12 months following presentation of results |
| | Quality of Post take ward round in AMU | The recommendation was given to ward managers to regularly audit consultant based disposition and escalation plan.A separate escalation treatment plan proforma was suggested only for DNACPR patients. |
| Acute Medicine - SH | Oxygen Prescribing on Medical Wards | Oxygen prescribing to be looked at by senior staff as an ongoing action from the Clinical Standards Group |
| | Single Centre Retrospective Analysis of Oral Anticoagulation for Atrial Fibrillation | Prescribing information poster to be developed |

| Table 6: Specialty | Audit Title | Actions |
|---|---|---|
| Elderly - SH | An Audit of Clinical Records in Ward 8, Solihull Hospital | Emphasise the need to use black ink and fully complete staff name, grade and title. |
| Therapies | Audit of Dietetic Documentation | Audit was fed back as a presentation to general team members.<br>Areas for improvement highlighted were:<br>Recording of biochemical markers.<br>Assessment of nutritional requirements, change in appetite, assessment of compliance.<br>Clinical markers documentation of whether diet sheets were provided or not.<br>Documentation of calculated requirements |
| | Audit of Dietetic documentation against departmental standards | Record an estimated weight/BMI when actual measurement is not available, and document that an actual measurement was not obtained<br><br>An additional compulsory field in dendrite may help dietitians to record the progress and compliance of their plan on review consultations. This would make communication between dietitians reviewing this patient clear. |
| | Audit of Dietetic in-patient management against nutritional support standards (NICE Guidelines). | Findings of audit to be disseminated to Dietetic general team. Areas for improvement:<br>Trust policy in concordance with NICE recommendations specify that all hospital inpatients should be screened for malnutrition (NICE 2006)<br><br>Screening for malnutrition should be carried out by HCP's with appropriate skills and training (NICE 2006) |
| | Audit of documentation in the Cystic Fibrosis and HIV Dietetic team compared against HEFT therapies documentation standards | Disseminate findings to Dietetic general team, report back areas for improvement are:<br><br>1. Have relevant clinical biomarkers been recorded?<br><br>2. Has whether meeting nutritional requirements been recorded?<br><br>3. Have correct medical abbreviations used?<br><br>4. Were relevant biochemical markers recorded?<br><br>5. Was the time recorded? |
| | Audit of documentation practices against standards in the Dietetic Elderly Care Team. | Make sure that the time of contact on dendrite matches the time on handover.<br>Record estimate or actual body weight.<br>Complete supplement codes.<br>Record biochemical markers.<br>Include diet history.<br>Include assessment of compliance to previous plan in the follow up entry. |
| | Electronic Case Notes Standards Audit | Provide SLT team with access to presentation and outcomes from the audit via SharePoint. |

| Table 6: Specialty | Audit Title | Actions |
|---|---|---|
| Gastroenterology - BHH | An audit of therapeutic paracentesis in hospital inpatients: correct human albumin solution prescribing and administration. | To develop new guidelines for trust on paracentesis |
| | An audit of therapeutic paracentesis in hospital inpatients: quality of documentation. | Add documentation advice to liver guidelines |
| | Assessment of junior doctors' understanding on management of decompensated chronic liver disease | New trust guidelines to be developed for CLD |
| | Biologic audit Heartlands and Solihull 2016 | To email clinical lead regarding resources for IBD nurse led clinic |
| | Management of decompensated liver disease within first 24 hours of admission | National bundle adapted for local use |
| Gastroenterology - SH | A review of IV vitamin B and C prescribing as part of assisted alcohol withdrawal in HEFT | Circulate this audit to BSMHFT in-patient units to encourage use of IM vitamin b/c for patients in alcohol withdrawal but also those who are malnourished.<br><br>Share with other BSMHFT RAID teams out with HEFT to encourage optimal IV vitamin b/c prescribing at Queen Elizabeth Hospital and City Hospital. |

| Table 6: Specialty | Audit Title | Actions |
|---|---|---|
| General Surgery | Management of acute large bowel obstruction: colonic stent / surgery within 48 hours | Present at clinical governance meeting-<br><br>Discussed possibility of increasing stent service.<br><br>Advise colleagues to obtain CT scan as soon as possible in acute large bowel obstruction cases.<br><br>Discuss the logistics of colorectal consultants to be available to perform emergency large bowel operations even if upper GI consultants are on-call. |
| | Re-audit of concurrent use of laxatives in patients on opiate analgesia | Poster put up in office and surgical ward following 1st audit. |
| | Retrospective analysis of laparoscopic practice for colorectal cancer between two sites. | BMI documentation should be compulsory when patients are referred to MDT. |
| | Clinical Variation in Practice of Cholecystectomy and Surgical Outcomes | Patients admitted as emergencies should be considered for cholecystectomy on same admission (though very dependent upon local resources) |
| | Appropriate maintenance fluid management for surgical patients | Increase awareness of guidelines with teaching sessions- ideally at the start of FY1.<br><br>Day team to prescribe fluid for patients requiring maintenance fluids overnight with a review of this requirement the next day. |
| | Trust wide Consent and Documentation audit | Consent: Ensure the white copy and trust information leaflet about the operation is given to the patient after consent and ensure this is ticked on the consent form. To email all of the consultants in the department with findings:<br><br>1. Need to give patients white copy, and document that it's been given<br><br>2. Consent confirmation section to be completed on relevant patients<br><br>3. Ensure key demographics details are entered in every consent form (e.g.: Name, DOB).<br><br>4. Training at induction for SHOs and SPRs on providing information leaflets using ICARE and correct consenting procedure at induction.<br><br>Documentation: Emphasis at induction for SHOs and SPRs on correct documentation. To email all of the consultants in the department with findings:<br><br>1. Always need to record patient location 2. Always need to print author's name 3. Always need to time entries. Re-audit. |

| Table 6: Specialty | Audit Title | Actions |
|---|---|---|
| Renal | Factors influencing success of CAPD. | A prospective multicentre study needs to be carried out to validate the results of this analysis. |
| | General Medicine Electronic Handover Audit against Royal College of Physician handover guidance | Planned DNAR box on concerto<br>Planned White Space Box – enter bleep numbers on concerto<br>Planned changes to the TTO Box on concerto |
| Respiratory Medicine | EBUS audit and service at Good Hope Hospital | Poster presented at the American Thoracic society conference |
| Thoracic Surgery | Antibiotic Prescribing in Thoracic Patients | Encourage daily EP review during ward round.<br><br>Inform all junior doctors in the Thoracic unit regarding the Trust Antibiotics guideline.<br><br>Present findings to the Thoracic team.<br><br>Speak to EP regarding making duration prescribing compulsory for antibiotics |
| | National Lung Cancer Audit (LUCADA) | Recommendations from published national audit reports will be reviewed and implemented by the directorate. Process for doing so being implemented currently. |
| | Patients experience of thoracic research | Since the development of a specialised thoracic surgery research team in 2010 the number of patient consented into clinical trials increased 7 fold.<br><br>From staff interviews a recurring theme was that a clear team structure and a specialist training aided them to be better patient advocate not only in research but in the clinical pathway. |
| | Quality of electronic discharge summaries in the Department of Thoracic Surgery at the Birmingham Heartlands Hospital | Actions not feasible as junior doctors cover multiple areas |
| Trauma & Orthopaedics - BHH | Adequacy and Accuracy of Total Joint Replacement consent | Remind consultants of the importance of them taking consent and the reasons why |
| | Coding for total knee replacement | Dissemination of the audit information to all doctors writing the operation notes for TKR. Re-audit. |
| | Re-Audit on the accuracy of outpatient clinic outcomes and coding. | Re-audit showed improved documentation and coding of outpatient outcome.<br><br>We will keep clinicians more involved. |

| Table 6: Specialty | Audit Title | Actions |
|---|---|---|
| Trauma & Orthopaedics - GHH | Audit on functional outcomes of distal radius fractures treated with open reduction and internal fixation | Open reduction and internal fixation of distal radius fracture with locking plate yields a good radiological and functional outcome |
| | Patellofemoral Joint Replacement in an independent centre-an intermediate outcome study | Exclude patients who have any degree of osteoarthritis in the weight bearing area of the knee from having this procedure, as the study shows higher revision rate in those patients from Patellofemoral joint replacement to Total knee replacement. |
| Dermatology | NICE clinical guidelines for the management of atopic eczema | 1) BAD (British Association of Dermatology) to develop a standardized atopic eczema proforma to capture audit points.<br><br>2) BAD to explore the possibility of online educational material to be sent to patients and their carers. |

An administrative error lead to incorrect figures published on pages 84 and 85 in the 2015/2016 Quality Account. In 2015/2016 the Trust reported participating in 34 national audits and 2 confidential enquiries which equates to participation in 97% of eligible audits and 100% of confidential enquiries. The correct figures are 45 national audits and 6 confidential enquiries with participation in 89% of eligible audits and 100% of confidential enquiries. The 2015/16 account also reported the Trust reviewed 15 national clinical audit reports and 86 local clinical audit reports; the correct figures are 18 and 166 respectively.

## 4. Research

The number of patients receiving relevant health services provided or sub-contracted by HEFT in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee:

| | |
|---|---|
| NIHR (National Institute of Health Research) portfolio studies: | 5,350 |
| Non-NIHR portfolio studies: | 54 |
| **Total** | **5,404** |

In 2015/16 the total number of patients recruited was 6,086.

There are over 500 research projects being undertaken across the Trust in various stages of activity from actively recruiting patients into new studies to long-term follow-up. In 2016/17 over 150 new research studies were given approval to start within the Trust. There are 30 specialties across the Trust currently taking part in research, with between one and six research active consultants in each of these areas.

Clinical trials remain the largest research activity performed at the Trust in terms of project numbers. We have a mixed portfolio of commercial and academic studies, the majority of which are adopted onto the National Institute for Health Research (NIHR) portfolio; HEFT was the 15th highest recruiting Trust to NIHR studies in 2015/16, this being the latest data available comparing sites. Non-portfolio work is also undertaken and this comprises of commercial clinical trials, student based research or pilot studies for future grant proposals.

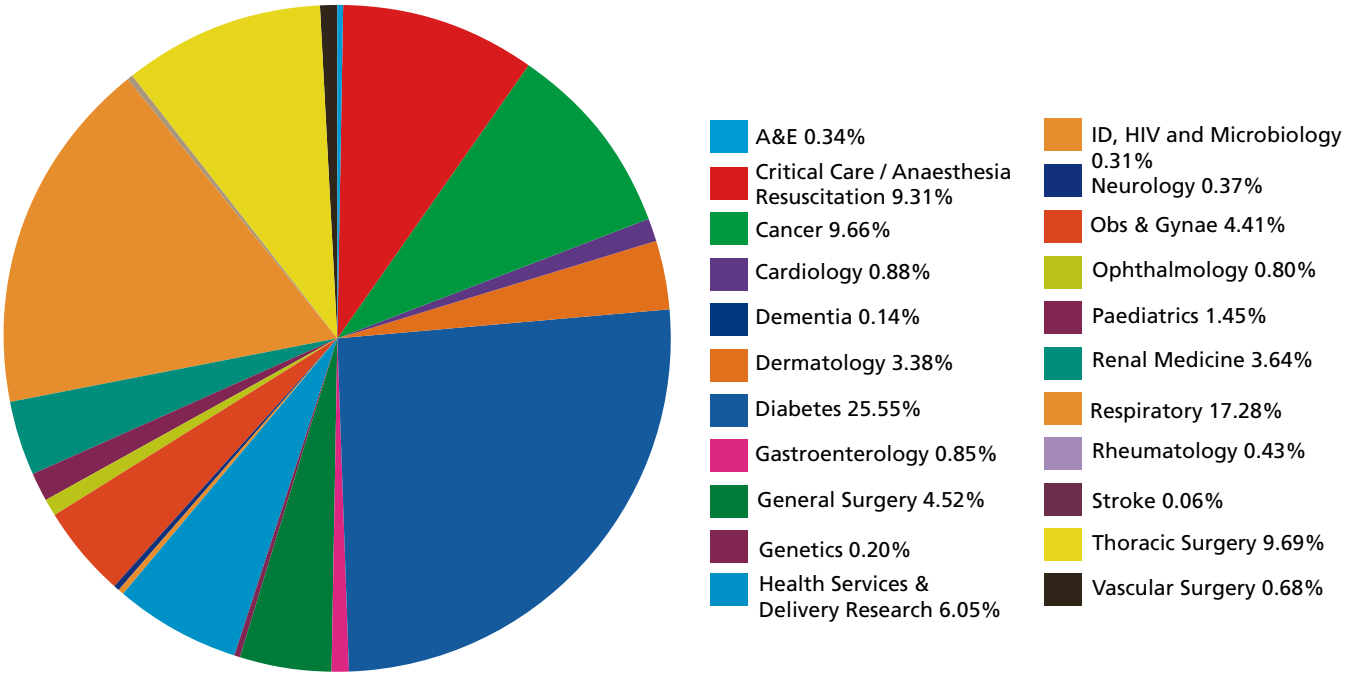
During 2016/17 patient recruitment was highest in Renal Medicine, Diabetes and Thoracic Surgery. Some of this success is due to a HEFT investigator, Dr Mark Thomas, whose Research for Patient Benefit (RfPB) funded study looking at the identification and management of acute kidney injury has now completed recruitment. In one of last year's growth areas (Mental Health) one of our consultants (Professor George Tadros) has recently obtained funds from the same stream, such that recruitment in this area is likely to rise sharply in 2017/18.

Areas to highlight research growth in 2016/17 are:

- Our highest recruiting specialties based on numbers of patients entered into research projects are Diabetes (899), Respiratory Medicine (608) and Thoracic Surgery (341).
- General surgery, in particular bariatric surgery and Obstetrics and Gynaecology have seen an increase in activity following a period of investment into research infrastructure. Both

areas have recruited over 150 patients and have each contributed 4.5% of the Trust's overall portfolio.

**Graph 6:** The Trust's Research Portfolio by Directorate:




2016/17 has seen the continuation of new researchers leading grant applications and development of new research collaborations, both within the Trust and with external partners. Academic appointments in recent years have also strengthened collaborations with the Trust and academic institutions. This has led to the development of new research collaborations and grants, some in a new direction for the Trust in the areas of public health and patient safety.

Applications for funding, either led by HEFT or with HEFT co-applicants, continues to be made predominantly to the NIHR funding streams, and for the year 2016/17 totalled in excess of £2 million. To date much of this is still awaiting the outcome; with many NIHR funding streams taking in excess of 8 months to inform the researchers of the outcome of their application. We have seen a continued increase in enquiries for advice in the development of local projects, which are part of further degrees, from junior doctors, nurses, midwives and allied health professionals.

The Research Fellows Forum and Clinical Internship Programme continue to deliver benefits in educational terms for researchers. This year has also seen the appointment of 5 Trust funded doctoral research fellows working in the areas of infectious disease, respiratory, geriatric, renal and diabetes medicine. There is a common theme to several of the projects as conditions that are prevalent in the HEFT patient population, and in which health service design or clinical pathways could be optimised. A similar programme in surgical and other specialties is an ambition for next year.

The Trust supported NHS Consultant Fellowship posts continue, with new appointments this year in Orthopaedic surgery (Mr Mark Dunbar), general surgery (Ms Olga Tucker), respiratory medicine (Dr Adel Mansur) and Immunology (Dr Thirumala Krishna). We anticipate a portfolio of projects from them in the area of post-operative recovery, oesophageal cancer, severe asthma, penicillin allergy and telemedicine over the years to come, in conjunction with university partners at Birmingham and Warwick.

This year has also seen the participation of the Trust in a key NIHR/CRN (Clinical Research Network) led patient experience survey, the results of which demonstrated the value HEFT patients place on participation in research. A grant submission is also planned to work on ways in which patient involvement can be enhanced in future.

## 5. Commissioning for Quality and Improvement (CQUIN)

A proportion of the HEFT income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between HEFT and any person or body they entered into a contract, agreement, or arrangement with for the provision of relevant health services through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2016/17 and for the following 12 month period are available electronically at http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html

The CQUIN values within the contract for the financial year ending March 2017 represents £12,282,898 of the Trust's income and span the Acute, Specialised Services, and Public Health Contracts.

The table below list each of the CQUINs included in the Framework and their status for 2016/17.

The CQUIN value within the contract was £12,664,928 of the Trust's income in 2015/16.

| Table 7a: Quarter 4 update Provider | Ref | Title | Achievements as at end of Q4, 2016/17 |
|---|---|---|---|
| Acute | 1a | **NHS Staff health and wellbeing**<br>Introduction of wellbeing initiatives | *Achieved |
| Acute | 1b | **NHS Staff Health and Wellbeing**<br>Healthy food for NHS staff, visitors and patients | Achieved |
| Acute | 1c | **NHS Staff Health and Wellbeing**<br>Improving the Uptake of Flu Vaccination for Front Line Clinical Staff | Achieved |
| Acute | 2a | **Timely identification and treatment of Sepsis in emergency departments**<br>Screening<br>Antibiotic Administration<br>Empiric antibiotic Review | Quarter four<br>Emergency Department screening<br>Partially achieved<br>Emergency Department Initiation of treatment and day 3 review<br>Not achieved. |
| Acute | 2b | **Timely identification and treatment of Sepsis in Acute Inpatients departments**<br>Screening<br>Antibiotic Administration<br>Empiric antibiotic Review | Inpatient Screening<br>Partially Achieved<br>Initiation of treatment and day 3 review<br>Partially achieved |
| Acute | 3a | **Reduction in antibiotic consumption per 1000 admissions** | 2016/17 performance (to be confirmed) |
| Acute | 3b | **Empiric review of antibiotic prescriptions** | Achieved |
| Acute | 4 | **Clinical Utilisation Review (CUR) Tool** | Achieved up to Q3<br>Q4 performance (to be confirmed) |
| Acute | 5 | **Effective Safe transfer and discharge of care** | *Achieved |
| Acute | 6 | **Monitor review and action plan all VTE occurrences up to 90 days post discharge** | Achieved |
| Acute | 7 | **MDT Review of perinatal Deaths** | *Achieved |

| Table 7b: Provider | Ref | Title | Achievements as at end Q4, 2016/17 |
|---|---|---|---|
| NHSE Public Health | 8 | **PAR scoring in Orthodontics** | Achieved up to Q3<br>Q4 performance (to be confirmed) |
| NHSE Public Health | 9 | **AAA Improving access and uptake** | Achieved |
| NHSE Specialised Services | 10 | **EGFR Monitoring system** | Achieved |
| NHSE Specialised Services | 11 | **Neonatal Term Admissions** | *Achieved |

*Achieved subject to confirmation from the Commissioner.
The Q4 Performance is not yet available for assessment for the peach coloured CQUINs

The following shows CQUIN Schemes for 2017-2019.

| Table 7c: Contract | Contract Ref | CQUIN Description |
|---|---|---|
| Acute | 1 | Health and Wellbeing |
| Acute | 2 | Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) |
| Acute | 4 | Improving services for people with mental health needs who present to A&E |
| Acute | 6 | Offering advice and guidance |
| Acute | 7 | E-Referrals one year CQUIN 2017-18 |
| Acute | 8 | Supporting Proactive and Safe discharge |
| Acute | 9a | Preventing ill health by risky behaviour tobacco and alcohol one year CQUIN 2018-19 |
| Specialised Services | GE3 | Hospital Medicines Optimisation |
| Specialised Services | CA2 | Nationally standardised Dose banding for Adult Intravenous Anticancer Therapy (SACT) |
| Specialised Services | IM2 | Cystic fibrosis patient adherence (adult) |
| Specialised Services | WC5 | Neonatal Community Outreach |
| Specialised Services | WC4 | Paediatric Networked Care |
| Specialised Services | GE1 | Clinical Utilisation Review |
| Specialised Services | CA3 | Optimising Palliative Chemotherapy Decision Making |
| Public Health | - | Bowel Screening |
| Public Health | - | Orthodontics |
| Community | 1 | Health and Wellbeing |
| Community | 10 | Improving the assessment of wounds |
| Community | 11 | Personalised Care and Planning |

## 6. Care Quality Commission

HEFT is required to register with the Care Quality Commission (CQC) and its current registration status is registered with requirement notices (see Tables 8). HEFT does not have any conditions on registration. The CQC has not taken enforcement action against HEFT during 2016/17. HEFT has not participated in special reviews or investigations by the CQC during 2016/17.

The Trust was last inspected in September/October 2016 by the CQC as part of the new national inspection regime. During this inspection there was no enforcement action taken by the CQC. The Trust is currently awaiting the first draft report from the 2016 CQC inspection. The CQC ratings grid provided below by site are from the previous inspection in December 2014 when there were some requirement notices registered. N.b. The CQC visit was unannounced and although surgical services were visited an internal technical difficulty prevented the CQC in being able to write a detailed report and therefore the CQC report states "not rated" for Surgery.

**Table 8a:** Birmingham Heartlands:

| | Safe | Responsive | Well-led |
|---|---|---|---|
| Emergency Care | Requires Improvement | Inadequate | Inadequate |
| Medicine | Requires Improvement | Requires Improvement | Requires Improvement |
| Surgery | Not rated | Not rated | Not rated |
| Maternity | Requires Improvement | Requires Improvement | Requires Improvement |
| Outpatients | Requires Improvement | Requires Improvement | Requires Improvement |
| Overall | Requires Improvement | Requires Improvement | Requires Improvement |

**Table 8b:** Good Hope:

| | Safe | Responsive | Well-led |
|---|---|---|---|
| Emergency Care | Requires Improvement | Requires Improvement | Requires Improvement |
| Medicine | Requires Improvement | Requires Improvement | Requires Improvement |
| Surgery | Not rated | Not rated | Not rated |
| Maternity | Requires Improvement | Good | Requires Improvement |
| Outpatients | Requires Improvement | Requires Improvement | Requires Improvement |
| Overall | Requires Improvement | Requires Improvement | Requires Improvement |

**Table 8c:** Solihull:

| | Safe | Responsive | Well-led |
|---|---|---|---|
| Emergency Care | Requires Improvement | Requires Improvement | Requires Improvement |
| Medicine | Requires Improvement | Requires Improvement | Requires Improvement |
| Surgery | Not rated | Not rated | Not rated |
| Maternity | Requires Improvement | Good | Requires Improvement |
| Outpatients | Good | Good | Requires Improvement |
| Overall | Requires Improvement | Requires Improvement | Requires Improvement |

**Table 9:** CQC Inspection Area Ratings for HEFT source (CQC website Latest report published on 1 June 2015):

| | Rating |
|---|---|
| Safe | Requires improvement |
| Effective | Good |
| Caring | Requires improvement |
| Responsive | Requires improvement |
| Well-led | Requires improvement |

## 7. Data Quality

HEFT submitted records during 2016/17 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

**Table 10:** Percentage of records in the published data which included the patient's valid NHS number is shown below:

| Valid NHS Number | % |
|---|---|
| Admitted patient Care | 99.69 |
| Outpatient Care | 99.83 |
| Accident and Emergency | 98.18 |

**Table 11:** The percentage of records in the published data which included the patient's valid General Medical Practice code:

| Valid GP Practice | % |
|---|---|
| Admitted Patient Care | 100% |
| Outpatient Care | 100% |
| Accident and Emergency | 100% |

## 8. Information Governance Toolkit

HEFT's Information Governance Assessment Report score overall score for 2016/17 was 40% and was graded Red (not satisfactory).

## 9. Clinical coding error rate

HEFT was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission (Note: the Audit Commission has now closed and responsibility now lies with NHS Improvement).

## 10. Improvement of data quality

HEFT will be taking the following actions to improve data quality (DQ):

- A suite of DQ indicators form part of monthly Directorate reports and will become a standing agenda item on the Data Quality Steering Group with action plans being put in place to improve on performance.
- Reports monitoring the timeliness against the new target of within two hours for Admissions, Discharges and Transfers (ADT) have been set up with links on the Data Quality SharePoint site for use by all operational inpatient areas. A monthly DQ ADT matrix report detailing the top three areas of concern across all divisions is reported monthly to Matrons and Lead Nurses and is monitored via the Care Quality Meeting.
- The Trust employs a team of DQ staff within the Finance Performance Directorate who raise the importance of good DQ, validate activity on a daily basis and also participate in the training of staff in regards to the impacts of inaccurate data as well as what good DQ looks like for the Trust's main systems.
- A Data Quality Strategy and Data Quality Policy are in place. The DQ team focuses on any areas of concern that require improvement and ensures actions are put in place to enable the accurate reporting of data in a timely fashion using the six dimensions of data quality model.

## 11. National quality indicators

A national core set of quality indicators has been jointly proposed by the Department of Health and Monitor (now NHS Improvement) for inclusion in Trust Quality Reports from 2012/13. The data source for all the indicators is the NHS Digital (Note: formerly the Health and Social Care Information Centre HSCIC) which has only published data for part of 2016/17 for some of the indicators. The Trust's performance for the applicable quality indicators is shown in **Appendix 3** for the latest time periods available.

Further information about these indicators can be found on the NHS Digital website:

http://content.digital.nhs.uk/

# Part 3: Other information

The selected indicators below relate to patient safety, clinical effectiveness and patient experience and present the Trust's latest performance for 2016/17. Where applicable, these are governed by standard national definitions.

Two of the patient safety initiatives for medication safety and deteriorating patients are now part of the Sign up to Safety campaign. There is further information regarding this national programme later in this report.

## 1. Patient Safety

### 1.1 Medication safety

Medication safety continues to be a high priority for HEFT. The medication safety work stream, aligned to Sign Up to Safety has been over-seeing and leading on a number of improvement projects to reduce avoidable harm from medication.

Reducing harm from missed and delayed doses has been the focus for promoting timely administration of antibiotics stat doses and treatment for Parkinson's disease. A medication bleep has been introduced to alert staff across all three hospital sites when doses are due and a 'live' dashboard has been developed for both initiatives. The following improvements have been seen with the antibiotics:

- Antibiotics stat doses, from April 2016 to March 2017 – from 75.0 % to 79.8% given within one hour. This supports the timely management of sepsis.
- The appropriateness of the use of piperacillin-tazobactam, i.e., prescribed in accordance with guidelines or following microbiology approval has improved from 71% at the end of 2015/16 to 83% at the end of 2016/17.

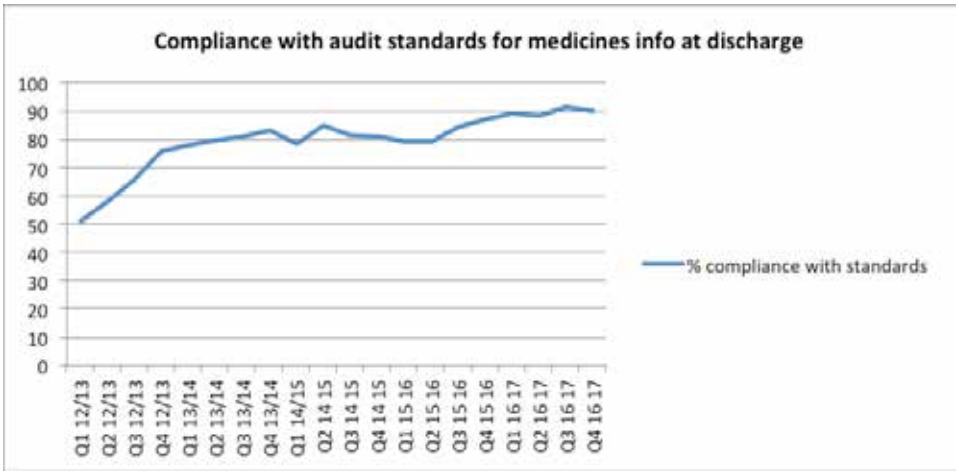
Antibiotic stat doses are now part of the Quality Dashboard metrics. Continuing with the aim to reduce harm from missed and delayed doses, reports have been generated using enhanced electronic prescribing functionality for a new pilot. The enhanced electronic prescribing functionality provides information to nurses about which medicines are due to be administered later that day and allows them to order the medicines electronically if required. The key aim is to reduce the number of medicines reported as unavailable.

A similar report for pharmacists and medicines management technicians will enable them to prioritise their clinical pharmacy activity so that patients admitted on or prescribed new high risk or time critical medicines receive a timely review.

The next patient safety initiative for the medication safety work stream will be to focus on reducing avoidable harm from high risk or time critical medicines including injectable medicines.

It is very important that information about any changes to a patient's medicines whilst they have been in hospital is conveyed to the GP or receiving healthcare setting at discharge. Improving the quality of medicines information at discharge has been a medication safety project. A key performance indicator has been in place to measure the proportion of discharge letters containing information about whether a medicine has started, been changed or stopped together with the reasons why and to explicitly state where there have been no intentional changes to pre-admission medication. Using quality improvement methodology the proportion of discharge letters meeting the audit standards has improved over the last few years from 51% in 2012/13 to 90.1% in 2016/17.

**Graph 7:**



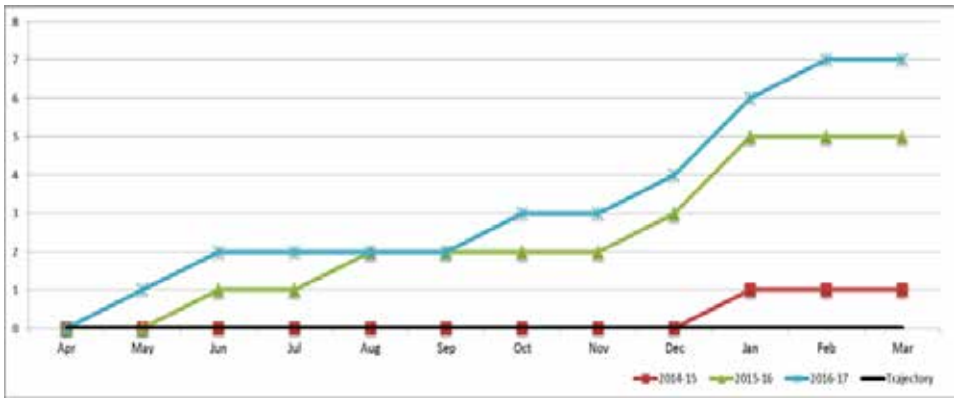

## 1.2 Deteriorating patients (sepsis)

Please see Priority 2 Improving early recognition and management of sepsis and reduce hospital acquired sepsis.

## 1.3 Infection control MRSA bacteraemia

There is a national zero tolerance for MRSA bacteraemia. Nine post 48-hour MRSA bacteraemia have been reported for 2016/17. Seven of these cases were attributed to the Trust although one of the seven was deemed to be a contaminant. A MRSA reduction plan is being developed for implementation throughout 2017/18.

**Graph 8:** MRSA bacteraemia cases for April 2014 to March 2017, with the annual threshold shown:




The trajectory for post 48 hour Clostridium difficile cases was set at 64 for the year. The Trust has exceeded this with a total of 76 cases of Clostridium difficile reported. Each of these underwent an in-depth post infection review to determine whether the Clostridium difficile could have been avoided. 58 of the 76 cases were deemed to be unavoidable.

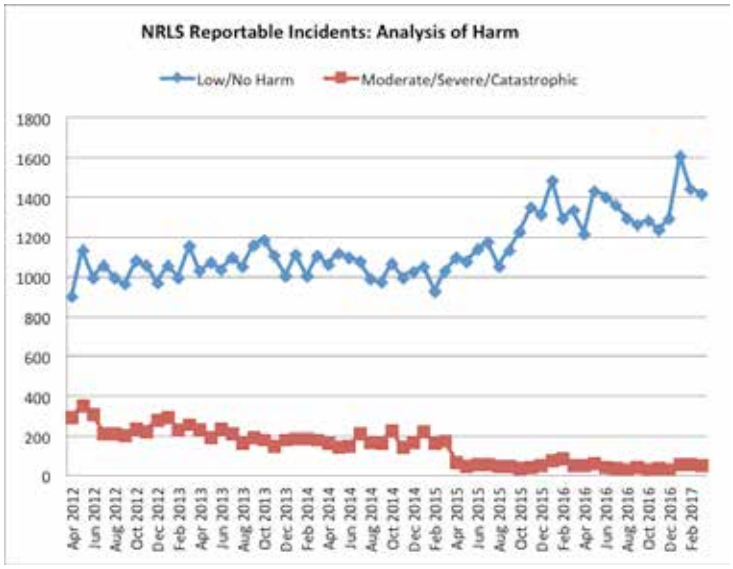
**Graph 9:** C. difficile toxin-positive post-48 hour cases from April 2014 to March 2017 with the annual threshold shown:


## 1.4 Incident reporting

The Trust actively encourages the reporting of all types of incidents[1] to ensure lessons can be learned from such occurrences. A high level of incident reporting is considered, by the Trust, as an indication of a good safety culture.

Patient Safety Incidents (PSI) are broadly defined as any incident causing or having the potential to cause harm to a patient in receipt of care or accessing Trust services. These incidents are reported to the National Reporting and Learning System (NRLS) in support of national data analysis, comparison and learning.

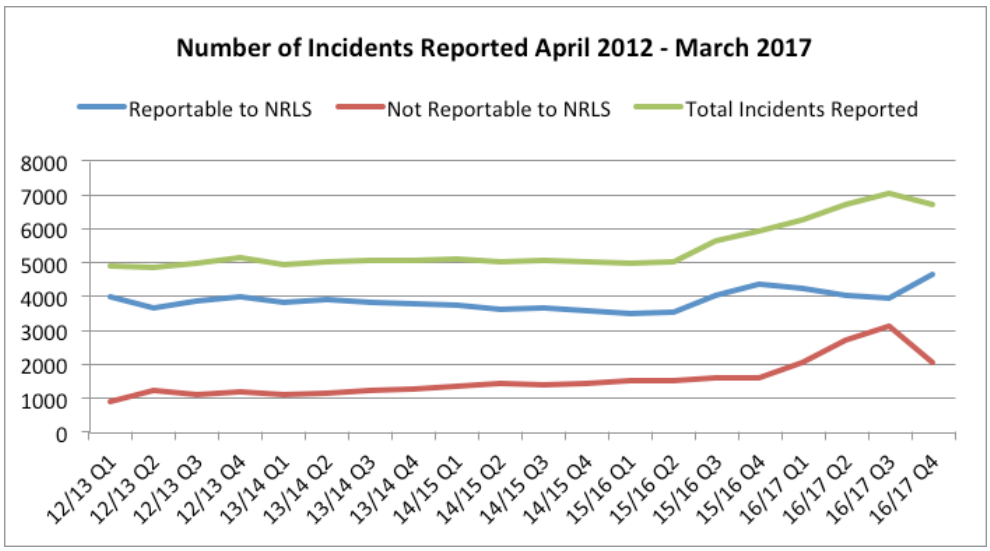
**Graph 10:** Number of incidents reported to NRLS April 2012 – March 2017:




[1] The definition of an incident is very broad and can be considered as any event which causes or has the potential to cause any of the following;

- Harm to an individual
- Financial loss to an individual or the Trust
- Damage to the property of an individual of the Trust
- Disruption to services provided by the Trust
- Damage to the reputation of the Trust

**Graph 11:** Number of NRLS reportable incidents April 2012 – March 2017:



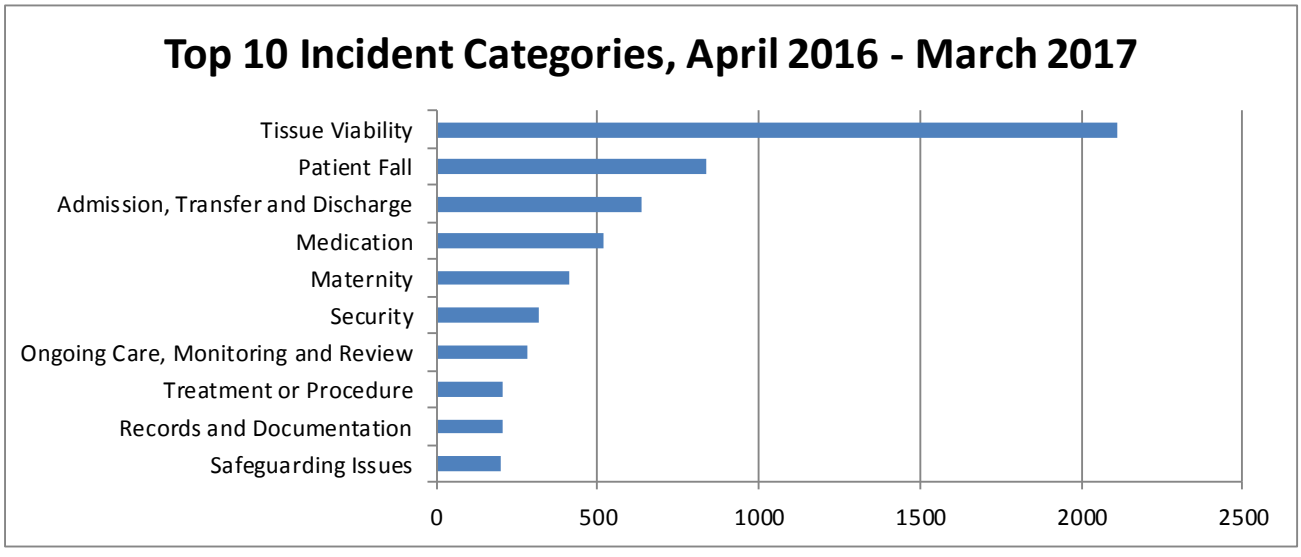

The incident reporting profile indicates that for 2016/17 the number of incidents reported has increased over the financial year, with an overall increase in low/no harm incidents and a decrease in moderate/severe or catastrophic incidents. This is an indication of a mature safety culture within an organisation.

To date the Trust has reported 26,773 incidents for this financial year. Of those 16,905 are patient safety incidents reportable to the NRLS. This demonstrates an increase in reporting compared to the last financial year.

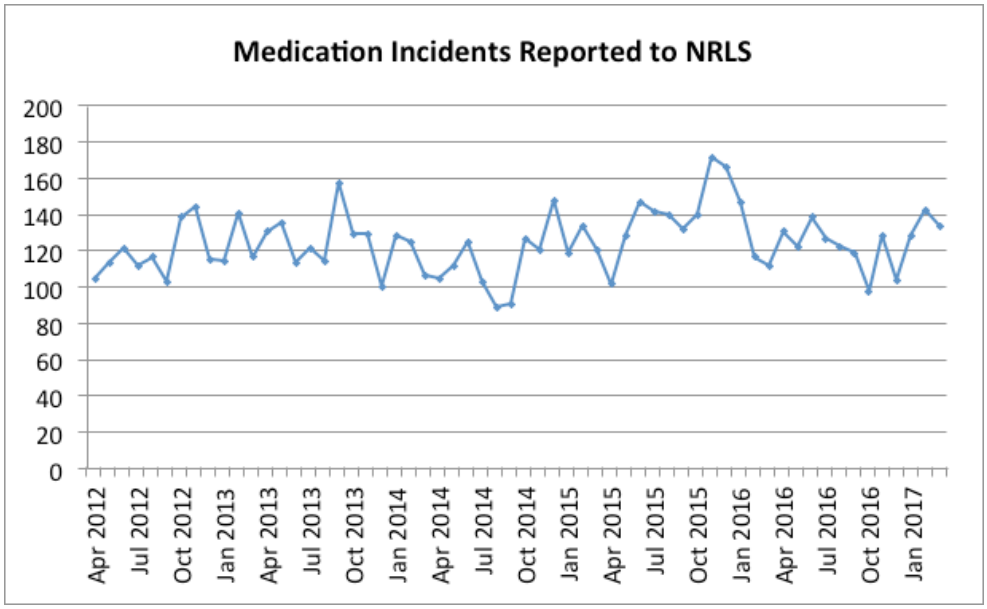
The incidents are reported from all locations where Trust services are provided including primary care settings. The profile of where incidents are reported from remains broadly similar to last year, with the majority of incidents reported from Heartlands Hospital, Good Hope Hospital and Solihull Hospital, which is a reflection of where the Trust provides the majority of its services.

The top 10 categories of reported incidents present little change in reporting patterns over this financial year.

**Graph 12:** Top 10 Trust Incident Categories April 2016 - March 2017 (Note: Tissue Viability relates to pressure ulcers):



**Graph 13:** Medication Incidents Reported to NRLS:




## 1.5 Serious Incidents (SI) and Never Events (NE) [2]

The Trust uses incident risk rating and severity of harm as one way to identify the most serious incidents and decides how an incident should be investigated.

In 2016/17 over 162 reported severe harm incidents have been 'scoped' using the internal Initial Incident Review proforma. The Trust has adopted the approach to Serious Incident Investigation that is in place at University Hospitals Birmingham. There are now 2 categories of serious incidents; STEIS reportable SI's and Internal SI's (SI reporting criteria not met but deemed a safety concern or opportunity for learning), which are both investigated by the Investigation team with clinical experts assisting. This has resulted in the following data for 2016/17:

- 32 Serious Incident investigations in line with the Trust Incident Management Policy and the National Serious Incident Framework.
- 23 Internal Serious Incident investigations led by the Trust Investigations Team.
- 30 local level RCA's led by the Directorate Team with oversight from the investigation/ governance teams.

**Table 12:** Trust Serious Incident Investigations from 2011/12 – 2016/17 (Note: NE is Never Event, PNE is a potential Never Event):

| Site | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 |
|---|---|---|---|---|---|---|
| BHH | 11 | 7 (2xNE) | 7 (1x NE) | 17 (1xPNE) | 19 (5xNE) | 30 (1xNE) |
| GHH | 1 | 3 (1xNE) | 4 (2xNE, 1xPNE) | 6 | 5 | 21 (1xNE) |
| SH | 5 | 1 | 3 (2xNE) | 2 (1xNE) | 4 (1xNE) | 4 |
| Other | - | - | 1 | - | - | - |
| Total | 17 | 11 | 15 | 25 | 28 | 55 |

[2] Never Events are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'.

**Table 13:** Trust Serious Incident investigations 2016/17 by Division:

| | Total number Serious Incident Investigations |
|---|---|
| Division 1 – Clinical Support Services | 3 |
| Division 2 – Women & Children's Services | 17 |
| Division 3 – Emergency Care | 17 |
| Division 4 – Medical Specialities | 1 |
| Division 5 – Surgery | 17 |

This year the Trust has had two Never Events:

- Wrong eye injection – Ophthalmology (Division 5)
- Misplaced naso-gastric tube – Stroke (Division 3)

The Trust has continued to actively share and disseminate learning from serious incident investigations with 'Safety Lessons of the Month', doctors' 'Risky Business Forum' and 'SI at a Glance' reports. It is also continuing to work with the commissioners to share learning from incidents and best practice incident management across the local healthcare economy.

## 1.6 Duty of Candour

As of November 2014, NHS England required a contractual duty of openness to be included in all commissioning contracts, called 'duty of candour' (DOC). This meant that NHS organisations were contractually required to tell patients about adverse events where moderate, severe or catastrophic harm has occurred, and ensure that lessons are learned to prevent them from being repeated. The essence of 'being open' is that patients, relatives and carers should receive the information required to understand what has happened, receive an apology, details of the investigation and assurance that lessons will be learned to help prevent the incident reoccurring.

These principles are not new, and are outlined in the Trust's 'Being Open' policy. This year the Trust has taken the opportunity to review the process, by which DOC is implemented.

Compliance within the Trust is monitored monthly and data also provided to the Clinical Commissioning Group (CCG).

Moderate and above harm incidents reported to Datix (incident reporting software) are reviewed by the handler as soon as is reasonably practicable following the incident occurrence. The level of harm is confirmed by the handler and if necessary an initial incident review will be requested to confirm the level of harm. Once it has been confirmed that the DOC is required the patient or patient's representative is informed of the incident by a nurse or doctor with appropriate seniority, and where possible, the member of staff should be known to the patient/patient representative.

Verbal DOC is applied within 24-48 hours, the Duty of Candour Conversation: Verbal Notification Proforma is completed and filed in the healthcare records. The verbal DOC is followed up with written DOC, if further investigation is going to be undertaken; details are included in the written DOC.

Following any investigation the report is made available to patient/patient representative.

DOC compliance is reported to the Clinical Commissioning Group (via the Trust's Performance Team) on a monthly basis. Compliance is assessed on the tenth working day of each month for incidents reported two months previously, i.e., two months in arrears.

## 1.7 Morbidity and mortality

The Trust monitors monthly mortality rates using crude number of deaths, the Hospital Standardised Mortality Rate (HSMR), and the Summary Hospital Level Mortality Indicator (SHMI) available from the Hospital Evaluation Data tool (HED) and quarterly from NHS Digital. It also monitors monthly surgical mortality and complications outcomes provided by the CRAB tool. (Copeland Risk Adjusted Barometer).

The outcomes of the National Audits and surgeon specific data are also reviewed. A regular report on mortality indicators and review of alerts is reported to Trust Board, Quality Committee and the Clinical Quality Monitoring Group (CQMG).

The Trust has been trialling sending daily emails detailing mortality information to senior managers and this will be rolled out over the next month. Any anomalies or unexpected deaths are investigated with thorough clinical engagement.

## 1.7.1 Summary Hospital-level Mortality Indicator (SHMI)

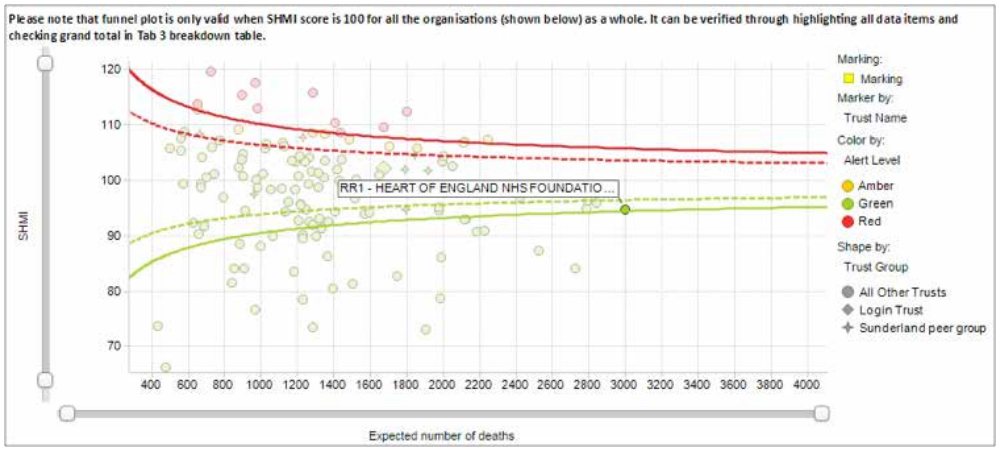
The Health and Social Care Information Centre (HSCIC) first published data for the Summary Hospital-level Mortality Indicator (SHMI) in October 2011. This is the national hospital mortality indicator which replaced previous measures such as the Hospital Standardised Mortality Ratio (HSMR). The SHMI is a ratio of observed deaths in a trust over a period time divided by the expected number based on the characteristics of the patients treated by the trust. A key difference between the SHMI and previous measures is that it includes deaths which occur within 30 days of discharge, including those which occur outside hospital.

The Summary Hospital-level Mortality Indicator should be interpreted with caution as no single measure can be used to identify whether hospitals are providing good or poor quality care[1]. An average hospital will have a SHMI around 100; a SHMI greater than 100 implies more deaths occurred than predicted by the model but may still be within the control limits. A SHMI above the control limits should be used as a trigger for further investigation.

The Trust's latest HSCIC published SHMI is 97 for the period July 2015 to June 2016 which is within tolerance band 2 and published on the HSCIC website.

SHMI for April 2016 to November 2016 was 94 due to 2,835 observed mortalities and 3027 expected.

**Graph 14:** Information taken from HED (Healthcare Evaluation Data) tool:



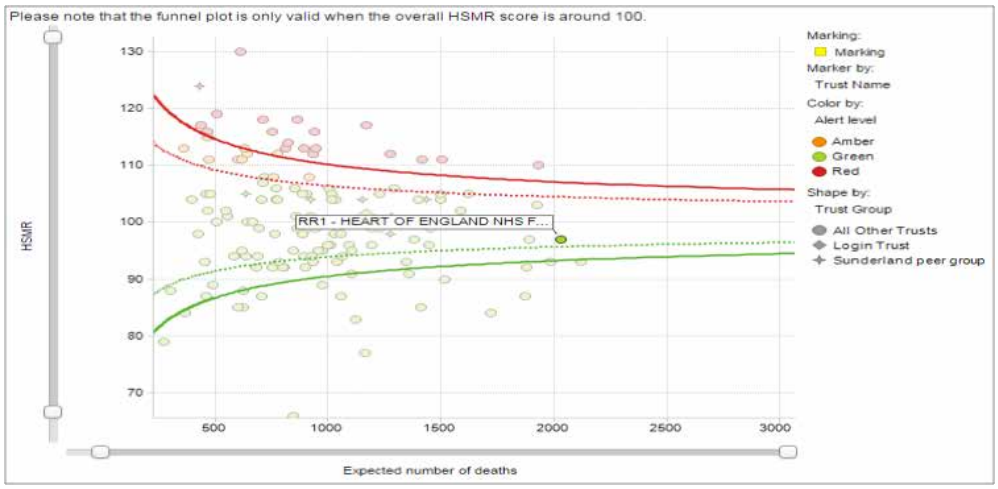

## 1.7.2 Hospital Standardised Mortality Ratio (HSMR)

The Trust has concerns about the validity of the Hospital Standardised Mortality Ratio (HSMR) which was superseded by the SHMI but it is included here for completeness. The validity and appropriateness of the HSMR methodology used to calculate the expected range has however been the subject of much national debate and is largely discredited. The Trust is continuing to robustly monitor mortality in a variety of ways as detailed above.

HEFT HSMR in 2016/17 (April- December) was 97: 1970 observed mortalities out of 2020 expected, calculated using the HED tool.

[1] Freemantle N, Richardson M, Wood J, Ray D, Khosla S, Sun P, Pagano, D. Can we update the Summary Hospital Mortality Index (SHMI) to make a useful measure of the quality of hospital care? An observational study. BMJ Open. 31 January 2013.

**Graph 15:** Information taken from HED tool:

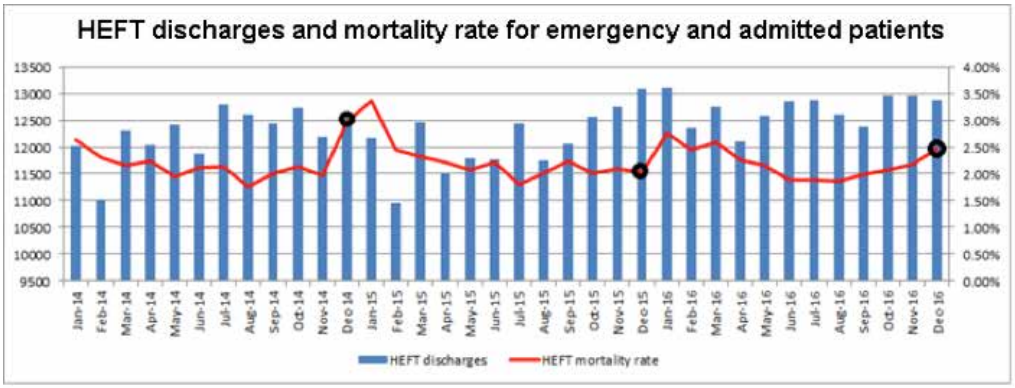



The Trust has seen a steady decline in its monthly HSMR over the last three years since a peak during 2013. It should be noted that following the move to a new patient administration system in July 2014 it was identified that there was a period of inaccurate inputting of the type of admission with more patients being coded as emergency rather than elective admissions. As a result the HSMR and SHMI may have been affected for the periods covering data July 2014-end of March 2015 and was not reliable for mortality measurement. The current data provided is based on reliable data.

## 1.7.3 Crude mortality

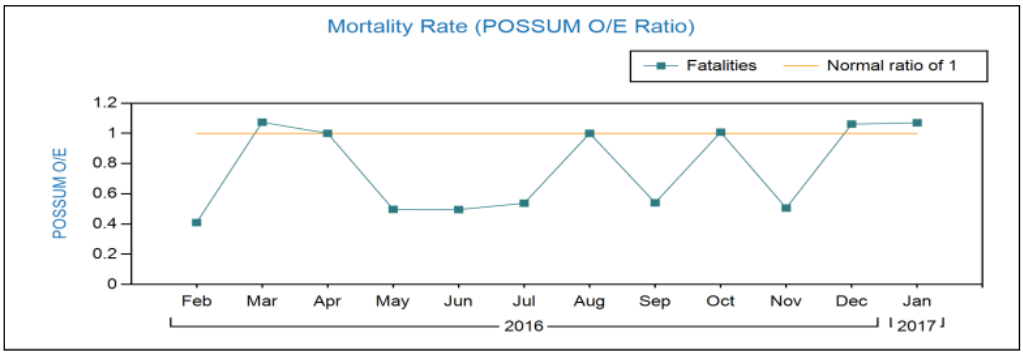
The graph below shows the Trust's crude mortality rates for emergency patients. The crude mortality rate is calculated by dividing the total number of deaths by the total number of patients discharged from hospital in any given time period. The crude mortality rate does not take into account complexity, case mix (types of patients) or seasonal variation.

**Graph 16:**




## 1.7.4 CRAB surgical mortality

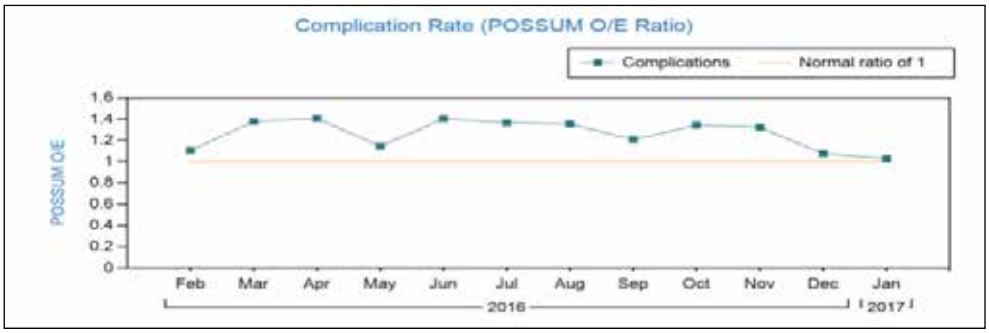
**Graph 17:** The CRAB 30 day surgical mortality observed/expected (O/E) ratio continues to show a level at or significantly below the normal ratio of 1, which means HEFT is within accepted limits.




*The final data point may be subject to change due to late reported data

**Graph 18:** Overall risk adjusted surgical complication rate.

The overall morbidity rate for the surgical specialties has dropped to within the normal expected ratio.




## 1.8 Patient experience

The Trust measures patient experience feedback received in a variety of ways, including local and national patient surveys, the NHS Friends and Family Test, complaints, concerns and compliments. This vital feedback is used to make improvements to our services and we are monitoring how these improvements are embedded throughout the Trust.

### 1.8.1 Inpatient satisfaction

On all inpatient wards patients are asked to comment on their experience with us. During 2016-17, 36,000 inpatients provided feedback. Patients are asked to rate their satisfaction with the care they received during the daytime and at night. Patients' experiences of services and care at the weekend are also monitored.

As an overall measure over the year patients reported 86% satisfaction (average data April 2016 – March 2017) with their care as a whole.

The Trust has an online dashboard which all ward areas use to monitor patient, carer and relative's feedback about care provided. This includes both the statistical ratings of their ward and also the specific written comments that are also provided by patients, carers and relatives. Whilst ward areas look at these comments to identify themes to assist in their continuous improvement, in the main these comments are very positive and motivational for staff in clinical areas, in understanding what they have done well.

The Divisional triumvirates are asked to report their patient experience data monthly via ward to Board reporting mechanisms and account for any exceptions in performance.

### 1.8.2 Friends and Family Test (FFT)

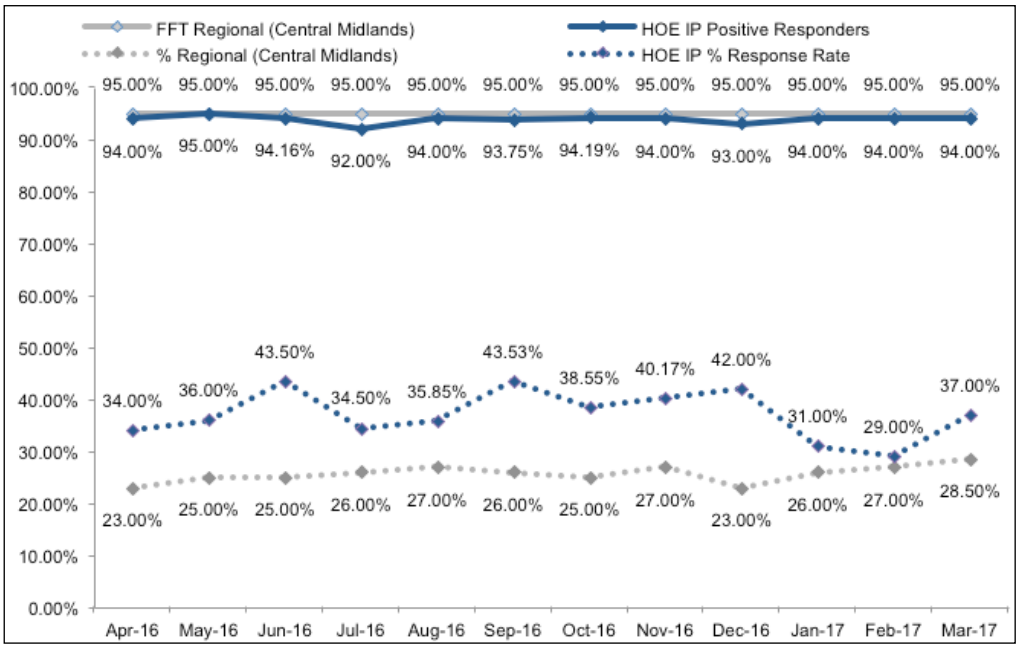
The FFT is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family if they were in need of similar treatment or care. In line with national practice driven by NHS England, the Trust presents results as a percentage of respondents who would recommend the service (either likely or extremely likely to recommend the Trust's care) to their friends and family.

The Trust undertakes this feedback work across inpatient care, the emergency department, maternity services, outpatients, day case surgery and community services.

In the graphs below the solid lines represent proportion of patients who responded positively about their care. The dotted lines represent the proportion of patients who participated. The grey lines represent the regional picture; the coloured lines represent the Trust's performance.

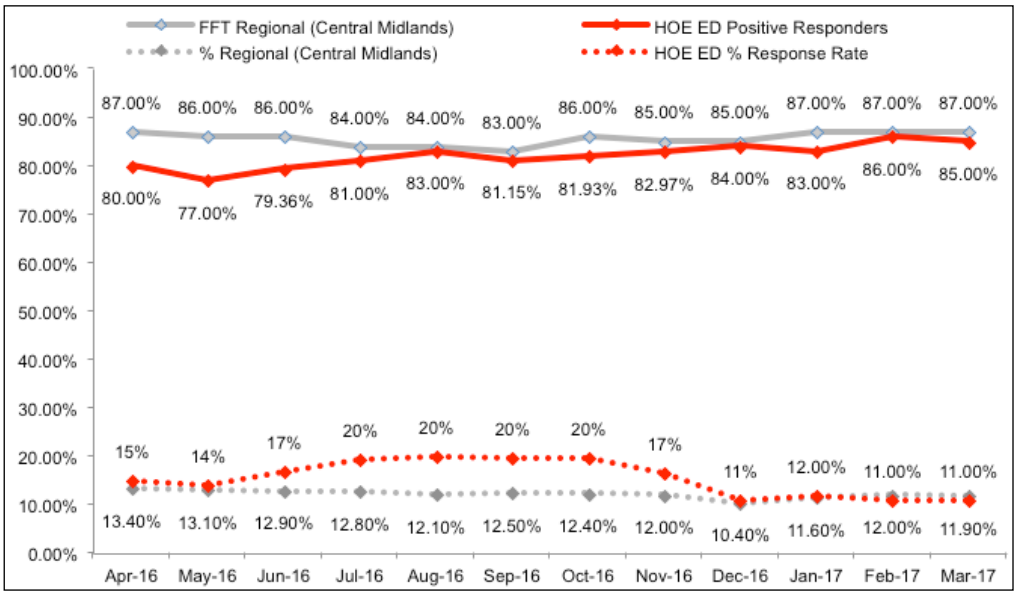
The data below shows that the Trust achieved an average during the year of 94% positive recommendation. The average score during 2015 – 16 was 93.4%. The average score for the region was 95%.

**Graph 19:** FFT Inpatients (Note: HOE is HEFT):




The graph below shows that the Trust achieved an average during the year of 82% positive recommendation. The average score during 2015 – 16 was 79%. The average score for the region was 85.6%.

**Graph 20:** FFT Emergency Department:




Further information can be found in Priority 4.

## 1.8.3 Patient comments (FFT)

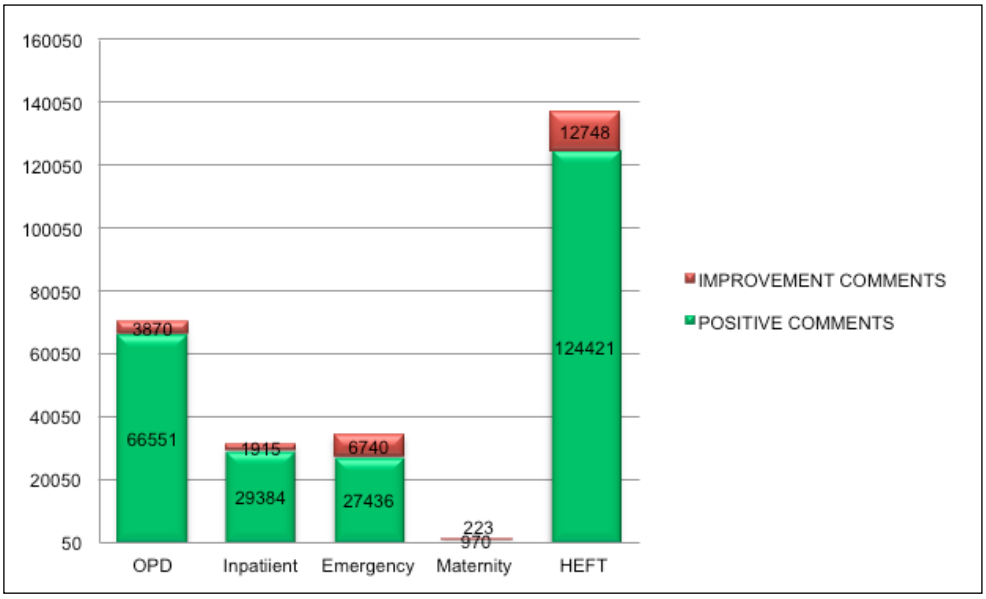
Through its FFT work, the Trust received over 135,000 comments from patients, carers and relatives about their experiences of care during 2016 – 17. The vast majority of these comments, 91%, have been positive reflections of care and treatment and these comments are used at service level to reinforce these positive examples to follow with staff.

The online dashboard where these comments can be accessed is embedded in practice across the organisation. The graphs and tables below show the proportion of positive versus requires improvement comments by location.

The comments provided by patients are used locally to understand why patients have provided a particular rating though the FFT. The positive nature of most of the comments are also used to assist in staff morale and motivation in understanding what it is that patients have appreciated most about their care and treatment. In conjunction with other feedback such as the complaints and concerns, the suggestions for improvement provide local areas with some narrative about what patients would like to see improved.

A Patient Expertise Steering Group is being established with matrons from Divisions and specialties to review patient feedback and develop work streams to improve patient experience across the Trust.

**Graph 21:**




| Table 14: HEFT Service | Top 3 Improvement Themes |
|---|---|
| Outpatient | Attitude |
| | Care |
| | Communication |
| Emergency | Attitude |
| | Care |
| | Waiting times |
| Inpatient | Attitude |
| | Care |
| | Environment |
| Maternity | Attitude |
| | Environment |
| | Care |

Some specific examples are shown below.

### 1.8.4 Positive feedback

- Whilst compliments are not yet routinely collated across the Trust, 115 compliments have been recorded during 2016 – 17 via the Trust's Patient Services Team. These compliments have either been made within a letter of complaint e.g. 'the nurses on ward 21 were angels' or as a letters of thanks sent directly to the Patient Services Team.
- It should be noted that compliments are received in a variety of ways across the Trust from a thank you card, a verbal thank you, boxes of chocolates for the ward staff through to letters to the Chief Executive. At present there is no overall collation of these, however the comments received via the FFT referred to above, do provide a useful indicator of what drives compliments. Some examples of these are provided below:
- GHH Ward 2 – 'Very professional, they explained things to me and they are all very friendly'.
- SH AMU – 'The nurse explained to us everything that was happening, she was very friendly and made me feel at ease'.
- BHH 19 – 'Communication very good, support when needed and treatment explained when asked about details.'
- Community – 'Staff were knowledgeable, caring and great at providing strategies for my daughter to help improve her condition. We are grateful for the help we have received'. (Children's Nursing Services – Bishop Wilson Clinic).

### 1.8.5 Learning from Excellence launched in Maternity and Critical Care

- Safety in healthcare has traditionally focused on avoiding harm by learning from error. This approach may miss opportunities to learn from excellent practice. Learning from Excellence (LfE) will provide a way of identifying, capturing, celebrating and learning from episodes of excellence.

### 1.8.6 How the Trust is using this feedback

Our feedback, including complaints, tells us that a large proportion of patient experience improvements centre around how well we communicate with patients, relatives and carers and how we build our systems and provide care and treatment with the patient in mind.

The continued development of the nursing quality dashboard and the ward to Board assurance framework will assist the Divisions by highlighting feedback received and themes for action.

Over the year we have continued to work closely with the Patient Community Panels (PCP) members who have kindly contributed to the work-streams described below:

| Table 15: Date | Task | Details |
|---|---|---|
| January to June 2016 | PLACE (Patient Led Assessments of the Care Environments) | Members assisted with PLACE inspections on all 3 sites in the role as patient inspectors. |
| April 2016 | Quality Review | A quality review took place at Good Hope on Ward 17 in April 2016 and results fedback to ward and Division management. |
| May 2016 | Maternity Surveys | Surveying of maternity patients. These were undertaken at Good Hope and Heartlands hospitals and fedback to the Heads of Division. |
| September and October 2016 | Open visiting surveys | Patient, visitor and staff surveys were undertaken to obtain views on the Open Visiting policy, which was introduced in 2015, on behalf of the Deputy Chief Nurse. |
| September / October 2016 | Telephone calls to wards | PCP members contacted inpatient wards/areas to survey staff attitude, responsiveness (Kate Grainger – 'Hello my name is . . .' campaign)and understanding of open visiting. |
| October 2016 | Mock CQC inspections | 2 PCP members/Governors from each panel attended Mock CQC inspections. |

| | | |
|---|---|---|
| October 2016 | Improving the experience of patients in pain | PCP participated in a task and finish group focussing on improving the experience for patients in pain. |
| January 2017 | Observing hand washing | Members assisted the Infection Control department with observing of hand washing of staff and relatives. |
| February 2017 to June 2017 | PLACE | Members assisted with PLACE inspections. |

### 1.8.7 National survey programme

The Trust participated in the national inpatient patient experience survey on behalf of the Care Quality Commission (CQC).

### 1.8.8 National Inpatient Survey

Areas highlighted for improvement included:

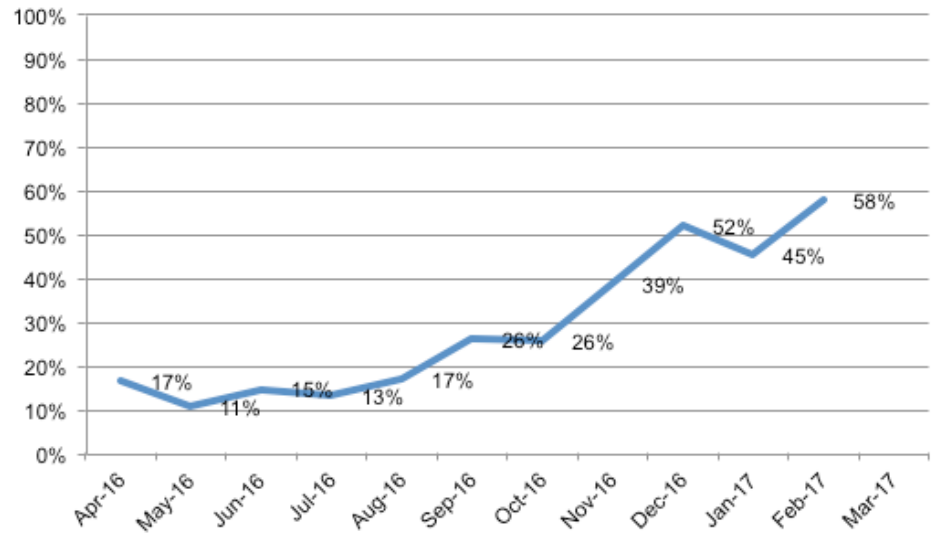
- Planned admission: Not offered a choice of hospitals
- Admission: Had to wait a long time to get a bed on a ward
- Discharge: Did not feel involved about decisions about discharge from hospital

A series of sessions will be held in 2017 with senior clinical staff, in conjunction with the Picker Institute, to understand the reason for the scores report and to develop action plans for each of the areas mentioned above.

## 1.9 Complaints

A rigorous quality assurance process was implemented for complaint responses and embedded at the beginning of 2016. Following this the Trust sought to reduce the number of open complaints and improve the timeliness of complaint handling. The Trust has focussed on how complaint responses are managed and the improvements required, building on the work of the previous year. The graphs below demonstrate progress with this over the year.

**Graph 22:** %Compliance with complaint closures within 30 working days:

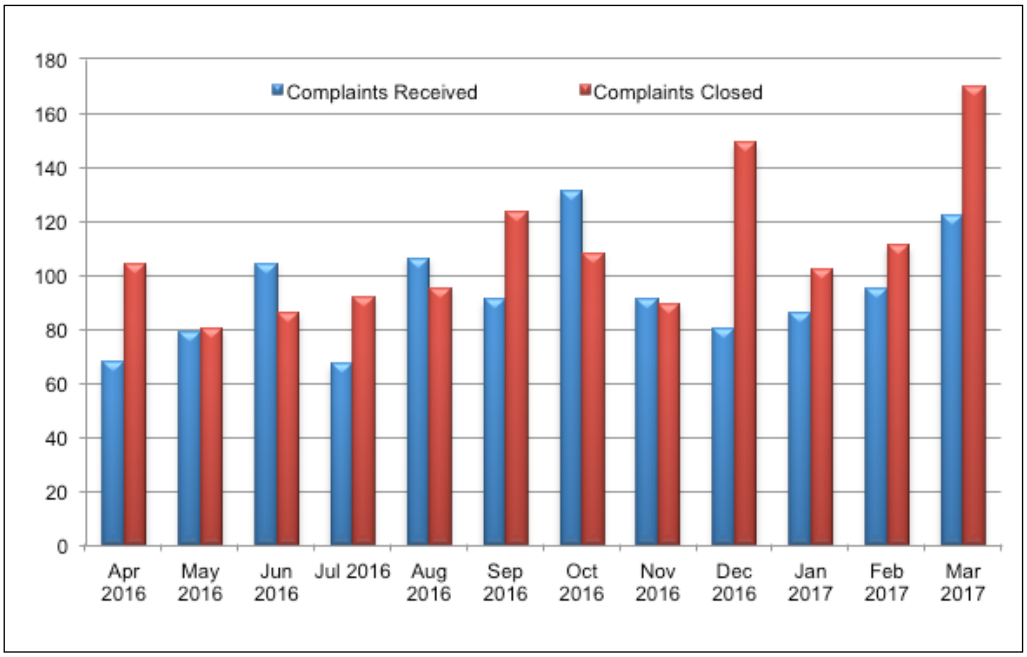



* Data for March will be finalised mid May 2017 (30 working days from the end of March 2017).

The Trust has a trajectory to reach 85% of complaints closed within 30 working days by the end of quarter 4 2018. This will be monitored routinely throughout the year.

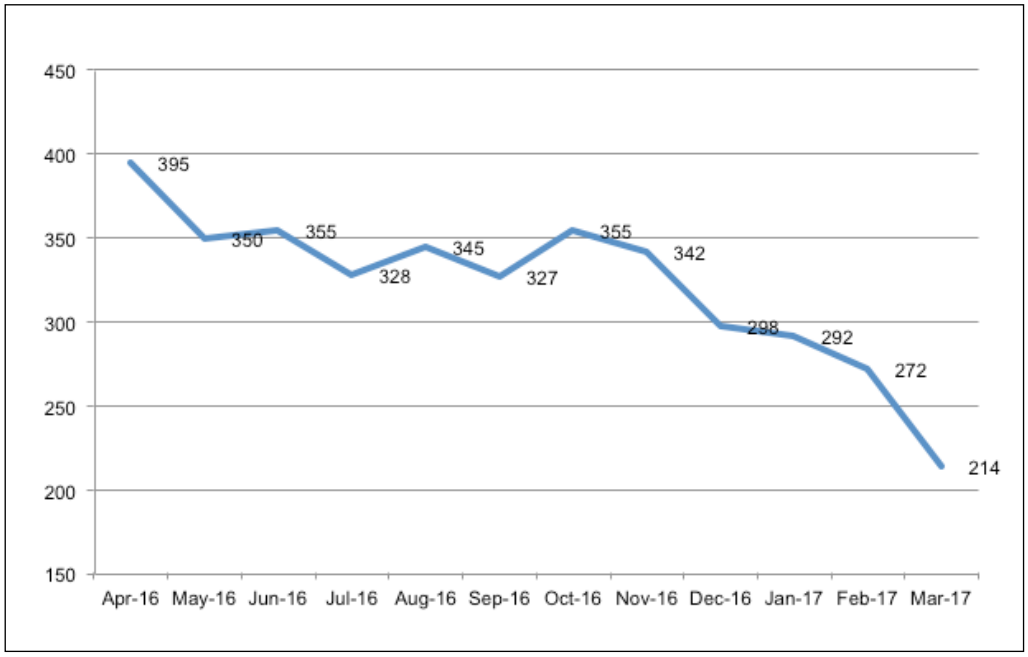
During the year 1,120 complaints were received and 1309 complaints were closed. The bars in the graph below represent the numbers by month.

**Graph 23:** Number of complaints received and closed by month:




The graph below demonstrates progress against the reduction in the numbers of complaints live in the system at a point in time.

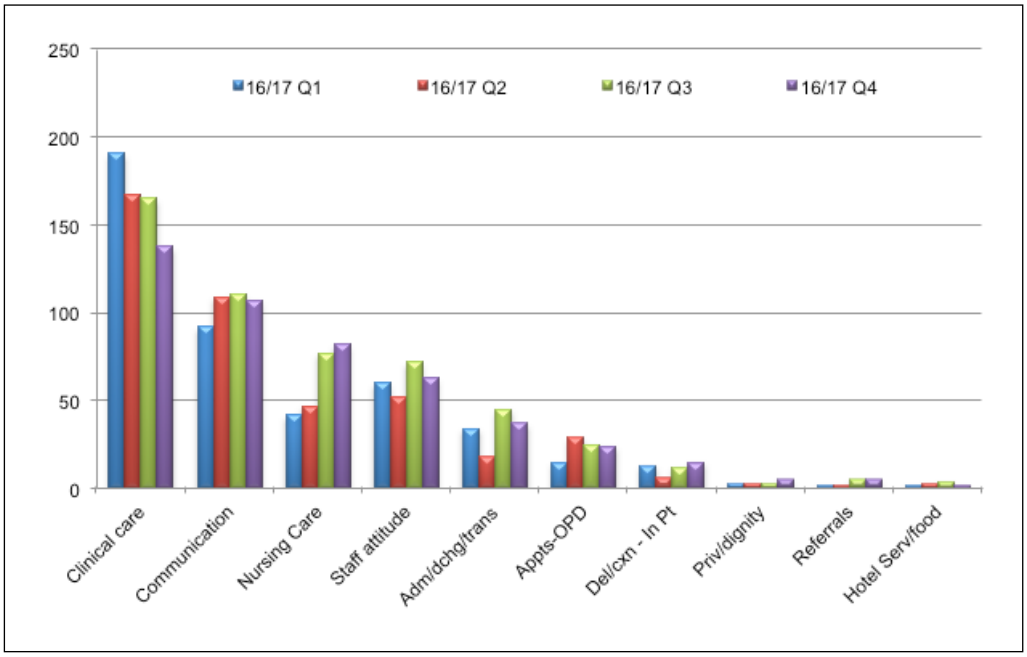
**Graph 24:** Numbers of all current complaints by month:



Complaint handling training has been provided across the Trust to senior managers, heads of nursing, matrons, and ward sisters/charge nurses. This training has been interactive using live (anonymised) examples of complaints received.

A thematic analysis of all complaints received is undertaken. From the 1120 complaints received, 1936 themes were identified. The top ten of these are shown in the graph below.

**Graph 25:** Themes evident in complaints:




Part of the quality review of each complaint, prior to a final response being sent to the complainant, focuses on the rigour of any actions to be implemented as a result of each complaint and whether actions are sufficient in order to address the complaint. Divisional leads are working with the complaints team to compile details of all actions pledged as a result of complaint investigations to allow them to monitor and ensure lessons are learnt from complaints and provide assurance that improvement to enhance patient experience is taking place.

Where failings in care and service are identified through a complaint investigation, the Division will provide an action plan detailing the measures being taken to minimise the likelihood of a recurrence. These actions are feedback to the complainant either through the complaint response or through a meeting with key senior staff.

Assurance of action plan implementation is delivered locally through divisional governance structures and examples of action plans are provided through contractual reporting to the CCG. During the coming year Divisions will be provided with a quarterly log of all actions, which have been pledged through compliant investigations. They will be asked to provide assurance of the implementation of these actions.

Examples of this learning are customer care study days facilitated by NHS Elect and the education team, complaints training provided Trust wide on an ongoing basis by the Heads of Patient Experience.

Some examples of improvements made as a result of patient complaints include: tissue viability training; information notice boards in place; changes in practice to improve patient hygiene; auditing buzzer proximity to patients; and a broad range of training and refresher activities.

## 1.10 Parliamentary Health Service Ombudsman (PHSO)

The PHSO provides a service to the public by

undertaking independent investigations into complaints that government departments, a range of other public bodies in the UK, and the NHS in England, have not acted properly or fairly or have provided a poor service. The aim of the PHSO is to provide an independent high quality complaint handling service that rights individual wrongs, drives improvement in public services and informs public policy.

During 2016/17, the PHSO requested information regarding twenty-seven complaints, an increase of one compared with previous year 2015-2016.

Five complaints were upheld by the PHSO and six were partially upheld. 14 complaints were not upheld. The Trust was notified originally of these referrals during 2016/17 or previously. A total of 16 complaints remain on-going or are in the process of being scoped by the PHSO. The Trust has action plans in place to address these issues or have acted in accordance with PHSO advice.

The Complaints Department is currently in the process of mapping the correlation between re-opened complaints and those referred to the PHSO to gain a more in-depth understanding of why complainants may remain dissatisfied with the initial responses to their complaints.

## 1.11 Single Oversight Framework

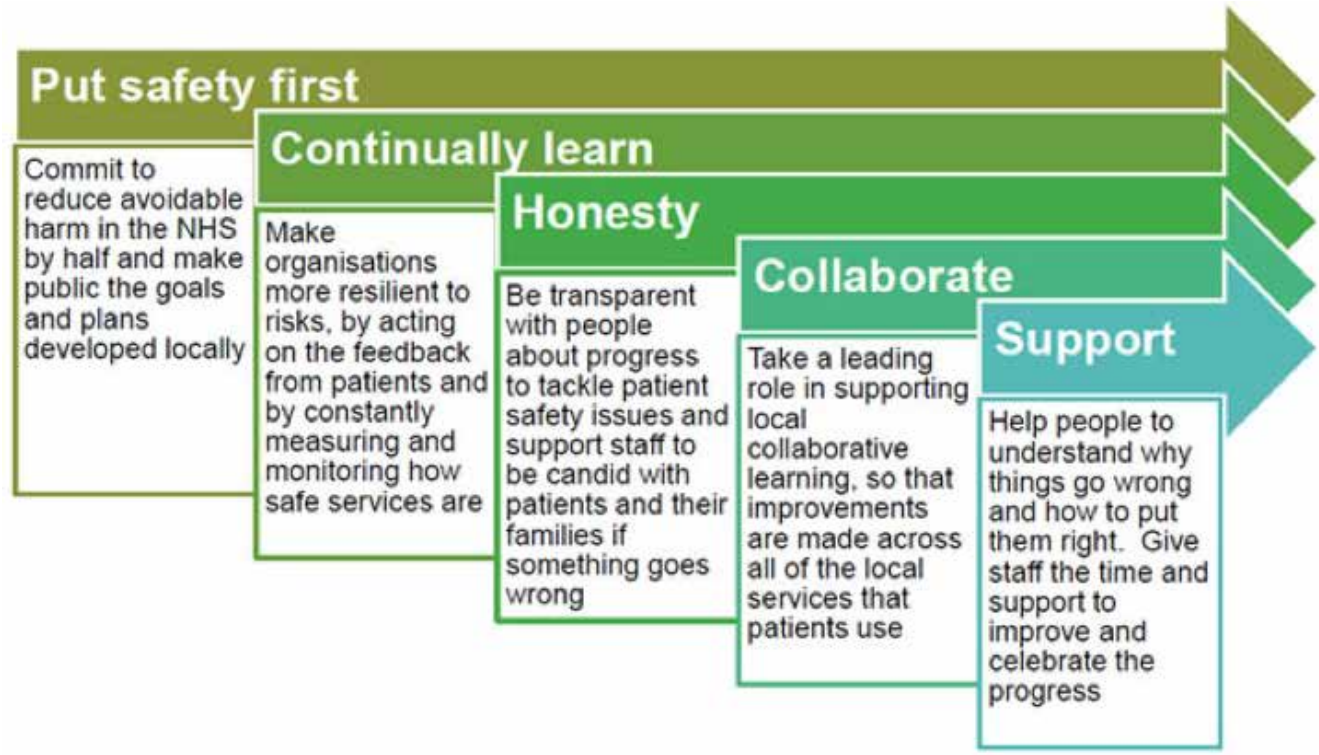
Please see Appendix 2.

## 1.12 Sign up to Safety

The national Sign-up to Safety Campaign was launched in 2014 and aims to make the NHS the safest healthcare system in the world. The ambition is to reduce avoidable harm by 50% in the NHS over the next three years and save 6000 lives.

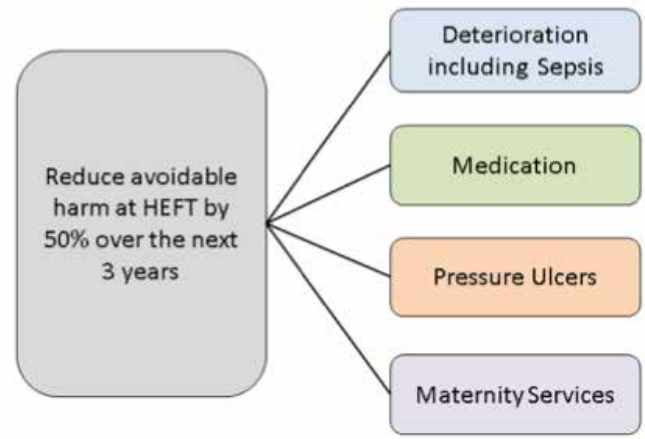
The Trust joined the Sign-up to Safety Campaign in December 2015. The Trust has committed to the actions it will undertake in response to the five National Sign-up to Safety pledges (table 16).

**Table 16 –** National Sign-up to Safety Pledges:




Prior to the formal sign up process staff were consulted with to identify safety priorities. In the interest of openness and transparency initial priorities were drafted and then refined through collaborative consultation with key teams and individuals. Following this four safety priorities were identified to reduce avoidable harm (table 2).

**Table 16 –** HEFT Sign-up to Safety priorities:




Improvement work concerning each of the safety priorities is led by a designated Safety Improvement Lead supported by a multi-disciplinary Safety Improvement Team. The teams work with relevant clinical areas to involve patients and the public. Each safety priority has additional work-streams which will focus on areas for improvement.

## Safety Priority 1 – reducing harm from deterioration including sepsis

- To improve early recognition and management of sepsis and reduce hospital acquired sepsis.
- To improve early recognition, appropriate monitoring and management of patients at risk of deterioration.

## Safety Priority 2 – reducing medication related harm

- To reduce avoidable harm from omissions and delays in medication.
- To reduce avoidable harm from medication errors.
- To reduce avoidable harm from high risk medicines (HRM's).

## Safety Priority 3 – reducing harm from pressure ulcers

- To reduce the number of avoidable grade 2, and grade 3 device related pressure ulcers.
- To reduce non-hospital grade 2 pressure ulcers deteriorating to avoidable grade 3 pressure ulcers.

## Safety Priority 4 – reducing harm in maternity services

- To reduce avoidable harm to mothers and babies resulting from suboptimal telephone advice and triage of women within the community.
- To reduce avoidable harm to mothers and babies from delays of access to theatre for emergency caesarean section.

The Sign-up to Safety Steering Group meet quarterly to monitoring the progress of the safety priorities. Quarterly progress reports are submitted to the Chief Nurse.

**Table 16:** Glossary of Terms:

| Term | Definition |
|---|---|
| A&E | Accident & Emergency – also known as the Emergency Department |
| Acute Trust | An NHS hospital trust that provides secondary health services within the English National Health Service |
| Administration | When relating to medication, this is when the patient is given the tablet, infusion or injection. It can also mean when anti-embolism stockings are put on a patient. |
| Bacteraemia | Presence of bacteria in the blood |
| Bed days | Unit used to calculate the availability and use of beds over time |
| Benchmark | A method for comparing (e.g.) different hospitals |
| Care Quality Meeting | a HEFT meeting chaired by the Chief Nurse, which assesses the quality of care, mainly nursing |
| CCG | Clinical Commissioning Group |
| Clinical Audit | A process for assessing the quality of care against agreed standards |
| Clinical Coding | A system for collecting information on patients' diagnoses and procedures |
| Clinical Dashboard | An internal website used by staff to measure various aspects of clinical quality |
| Commissioners | See CCG |
| Concerto | Patient administration system |
| Congenital | Condition present at birth |
| CQC | Care Quality Commission |
| CQMG | Clinical Quality Monitoring Group; a HEFT group chaired by the Executive Medical Director, which reviews the quality of care, mainly medical |
| CQUIN | Commissioning for Quality and Innovation payment framework |
| Datix | Database used to record incident reporting data |
| Day case | Admission to hospital for a planned procedure where the patient does not stay overnight |
| Division | Specialties at HEFT are grouped into Divisions |
| ED | Emergency Department (previously called Accident and Emergency Department) |

| Term | Definition |
|---|---|
| Elective | A planned admission, usually for a procedure or drug treatment |
| Episode | The time period during which a patient is under a particular consultant and specialty. There can be several episodes in a spell |
| Foundation Trust | Not-for-profit, public benefit corporations which are part of the NHS and were created to devolve more decision-making from central government to local organisations and communities. |
| GI | Gastro-intestinal |
| GP | General Practitioner |
| HCS | Healthcare Commissioning Services |
| Healthwatch Birmingham | An independent group who represent the interests of patients and the public. |
| HEFT | Heart of England NHS Foundation Trust |
| HES | Hospital Episode Statistics |
| HSCIC | Health and Social Care Information Centre |
| HSMR | Hospital Standardised Mortality Ratio |
| IT | Information Technology |
| ITU | Intensive Treatment Unit (also known as Intensive Care Unit, or Critical Care Unit) |
| MEWS | Modified Early Warning System |
| MINAP | Myocardial Ischaemia National Audit Project |
| Monitor | See NHS Improvement |
| Mortality | A measure of the number of deaths compared to the number of admissions |
| MRSA | Meticillin-resistant Staphylococcus aureus |
| Myocardial Infarction | Heart attack |
| NaDIA | National Diabetes Inpatient Audit |
| NBOCAP | National Bowel Cancer Audit Programme |
| NCAA | National Cardiac Arrest Audit |
| NHS | National Health Service |
| NHS Improvement | Independent regulator of NHS Foundation Trusts |
| NIHR | National Institute for Health Research |

| Term | Definition |
|---|---|
| NRLS | National Reporting and Learning System |
| Observations | Measurements used to monitor a patient's condition e.g. pulse rate, blood pressure, temperature |
| Peri-operative | Period of time prior to, during, and immediately after surgery |
| NHSE Public Health | Public Health England |
| PROMs | Patient Reported Outcome Measures |
| Prophylactic / prophylaxis | A treatment to prevent a given condition from occurring |
| RCA | Root cause analysis |
| Readmissions | Patients who are readmitted after being discharged from hospital within a short period of time e.g., 28 days |
| Safeguarding | The process of protecting vulnerable adults or children from abuse, harm or neglect, preventing impairment of their health and development |
| SHMI | Summary Hospital Mortality Indicator |
| SSNAP | Sentinel Stroke National Audit Programme |
| Trajectory | In infection control, the maximum number of cases expected in a given time period |
| UHB | University Hospitals Birmingham NHS Foundation Trust |
| VTE | Venous thromboembolism – a blood clot |

# Part 4: Statements from Stakeholders

## Birmingham Cross City CCG

### Heart of England NHS Foundation Trust
### Quality Account 2016/17
### Statement of Assurance from Birmingham CrossCity CCG May 2017

1.1 Birmingham CrossCity Clinical Commissioning Group (BCC CCG), as coordinating commissioner for Heart of England NHS Foundation Trust (HEFT), welcomes the opportunity to provide this statement for inclusion in the Trust's 2016/17 Quality Account.

1.2 A draft copy of the Quality Account was received by BCC CCG on the 25th April and the review has been undertaken in accordance with the Department of Health Guidance. This statement of assurance has been developed in consultation with neighbouring CCGs.

1.3 In the version of the Quality Account we viewed some full year data was not yet available and so we have not been able to validate those areas; we assume, however, that the Trust will be populating these gaps in the final published edition of this document.

1.4 The Trust's 2016/17 quality priority of 'Reducing avoidable harm to patients from omission and delay in receiving Parkinson's disease medication' target of 90% was not achieved; however, there have been significant improvements across the three hospital sites, moving from 53% to 75%. It is of note that the Trust has received local and national recognition for this work and in particular the team winning the Parkinson's excellence in network award. The CCG supports the Trust's decision to maintain this as a priority for 2017/18.

1.5 The CCG is pleased to note that the Trust is to continue focusing on the issue of sepsis in the coming year, revising the scope to 'improve early recognition and management of sepsis'. The information provided in the Quality Account does not clearly state what the target was for 2016/17, how the Trust performed nor does it identify what the target will be in 2017/18.

1.6 Despite an inconsistent performance on the quality improvement target of 'reduce maternal harm through the category caesarean section1' the Trust has taken a decision to discontinue with this priority. No explanation or rationale has been provided, though some initiatives are listed for acting upon in 2017/18.

1.7 Positive work has been undertaken by the Trust in improving the Friends and Family Test (FFT) responses within the Emergency Department (ED). It is pleasing to see that through the hard work and commitment of staff the Trust has improved the experience of patients, families and carers. It was good to read that the Trust has responded to complaints and FFT themes to provide customer service training in ED – this is clearly having an impact.

1.8 Two new priorities are to be introduced for 2017/18 – reducing surgical site infection (SSI) after major surgery and improve infection rates for Clostridium difficile and/or MRSA. Though the reader is provided with little detail on the rationale for choosing these new priorities; for example information on the baseline and proposed targets for SSI and details of the initiatives that will be undertaken to support delivery against these targets.

1.9 The Quality Account lacks information on reduction in pressure ulcers; it would have been good to have included this as it is a priority identified in the Trust's 'sign-up to Safety' Pledge. Improvements were made last year (2016/17) though the Trust failed the year end KPI target for reduction of Grade 3 pressure ulcers. There has been much work undertaken in addressing this issue and it would be helpful for this to remain a focus, particularly as tissue viability is the greatest reported reason for incidents.

1.10 It was positive to read about the greater psychological input being provided as a response to the Sentinel Stroke National Audit Programme data results together with the improved admission pathway for Stroke patients.

1.11 It was pleasing to read that the Trust actively shares learning from Serious Incident investigations through a variety of forums and mechanisms across the organisation.

1.12 The section on National Quality Indicators is well presented and clearly provides the reader with details of the Trust's

performance, comparative national data and information on actions to be taken to improve results.

1.13 The CCG would have liked the account to have contained more information on infection control and the neonatal unit.

1.14 We have made some specific comments to the Trust directly in relation to the Quality Account which we hope will be considered as part of the final document. These include: gaps in data (sepsis); completion of the 'actions' area of the audit table; revision of the wording around MRSA; and comments on the complicated and technical aspects of the mortality section.

1.15 As commissioners, we have worked closely with HEFT over the course of 2016/17, meeting with the Trust regularly to review the organisations' progress in implementing its quality improvement initiatives. We are committed to engaging with the Trust in an inclusive and innovative manner and are pleased with the level of engagement from the Trust. We hope to continue to build on these relationships as we move forward into 2017/18

**Barbara King**
**Clinical Accountable Officer**
**Birmingham CrossCity CCG**

# Healthwatch Birmingham

## Statement from Healthwatch Birmingham on Heart of England NHS Foundation Trust Quality Account 2016/2017

Healthwatch Birmingham welcomes the opportunity to provide our statement on the Quality Account for Heart of England NHS Foundation Trust 2016/17. In line with our role, we have focused on the following:

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

### Patient experience and feedback

Healthwatch Birmingham recognises the Trust's use of different methods to measure patient feedback including surveys, Friends and Family Test, complaints, concerns, and compliments. Equally, the use of these to make improvements to services. What we would also like to see in next year's report is:

- A demonstration of how patient feedback and experiences have been used to develop priorities for the 2018/19 Quality Account in the 2017/18 Quality Account;
- Changes in practice or improvement to services that have been made as a result of patient feedback and experience in the 2017/18 Quality Account.

We commend the Trust on the improvement made in the Friends and Family Test (FFT) scores although unfortunately the positive responder rate is still below the regional score for 2016/17. We note that the response rate is above the regional score but Graph 5 shows that whilst there was a significant increase in the response rate between May and December 2016, the response rate decreased between December 2016 and February 2017 by at least 6%. A comparison of the FFT scores indicates that the positive responder rate is higher for inpatients than for the emergency department. Conversely, the Friends and Family Test scores on patients having a positive experience of care after being discharged from A & E has continued to decrease (From 88.71 in 2013/14 to 79.50% in 2015/2016) and is lower than the national average (84.39%).

Healthwatch Birmingham recognises the changes and plans that have been made to improve patient experience in the Emergency Department. We believe that plans to institute an 'always event' and review the care quality metrics in ED will provide the foundation for partnering with patients and their families; and demonstrate the Trusts commitment to person-centred care. This will require the Trust to understand what is important to patients and families. Therefore co-production will be key to ensuring the Trust meets the patients' needs. In order to achieve this, there is a need to further improve the FFT response rate.

### Learning from patient feedback and experiences:

We note that the Trust is using 'excellent practice' as a tool for learning in addition to learning from feedback and complaints. We agree that this is beneficial. The report states that concerns raised through learning were on:

- communication with patients, relatives and carers;
- how the Trust builds its systems and provide care; and
- treatment that is patient centred.

The Trust should indicate how it intends to address these issues, for instance giving more detail in the report on how the Trust will improve communication with patients, relatives and carers.

We welcome the National Inpatient Experience Survey conducted by the Trust on behalf of Care Quality Commission. We ask the Trust to further involve patients in review sessions to be held in 2017. This will help the Trust to better understand the reasons for the scores received (in particular on lack of choice and not feeling involved in decision-making around discharge) and develop plans that will capture the needs of patients. We welcome the Trust's work to gain an in-depth understanding of why people may remain dissatisfied with their initial response for complaints cases that are re-opened or referred to the Parliamentary and Health Service Ombudsman (PHSO). This will help the Trust to identify where changes are needed including the complaints process. The Trust should consider involving service users to deepen this understanding.

Healthwatch Birmingham asks the Trust to consider developing a strategic plan for involving patients and the public. This would demonstrate commitment across the Trust to using patient and

public insight, experience and involvement in order to understand barriers to improving health outcomes. It will also make clear, arrangements for collating feedback and experience.

## Variability in healthcare

## Parkinson's disease

The Trust has not met its target of 90% of inpatients receiving their Parkinson's disease medication within 30 minutes. For the 2016/17 period, the percentage increased to 75% and we therefore welcome this priority being carried over to 2017/18. The way data (Graph 1a and 1b) has been presented does not give insight into how each of the three hospital sites are performing individually. Aggregating data based on Hospital would make clear the change each hospital needs to make to achieve this priority.

We welcome the inclusion of patient experiences in the review being carried out by the Trust to identify reasons for omissions and delays in the administration of Parkinson's disease medication. We would like to see examples in the 2017/18 Quality Account on how patient experiences have informed any changes you make following these reviews.

## Sepsis

Following the implementation of the framework for delivering the CQUINN in Quarter 1 and 2, improvement in the percentage of eligible patients receiving screening in the Emergency Department, has been inconsistent. The percentage of eligible patients receiving screening has decreased in Quarter 2 and 3 from 56% in Quarter 1 to 42.99% in Quarter 2 and 46.27% in Quarter 3. We do acknowledge the improvement for inpatients from 18.5% in Q1 and 68.4% in Quarter 3.

The report also indicates that in Quarter 2 only 31% of patients (emergency) requiring antibiotics received antibiotics which increased to 67% in Quarter 3. In addition, only 10% of the 31% in emergency received antibiotics and an empirical review compared to 37.78% for inpatients. We are concerned that there appears to be a variation in the quality of care received depending on how individuals access the service. For instance, inpatients are more likely to receive antibiotics and a review in contrast to patients in the Emergency Department.

## Care Quality Commission rating

Based on a 2014 inspection, HEFT is rated 'requires improvement' in all domains. It is also rated inadequate in the 'responsive and well-led' domain for emergency care (Birmingham Heartlands). Good Hope rated 'good' under maternity for the 'responsive' domain. We note that the Trust is awaiting results of a 2016 CQC inspection. We hope to see improvement in these ratings based on the action plans set out following the 2014 inspection.

Regarding the National Quality Indicators on the Patient Reported Outcome Measures Scores (PROMS), Re-admission, and patient experience indicator, the Trust has not provided up to date data. The Trust should also consider indicating the national data to enable comparison. Considering that the issue of readmissions and patient experience were points of concern in the CQC inspection of 2014, we would have liked to see a clearer approach to addressing these issues. If there is a plan in place, the Trust should consider referring to this in the actions they intend to take.

## Mortality

The report shows that the percentage of patient's deaths with palliative care coded at diagnosis or speciality level has increased. When contrasted with National performance, HEFT is 25.9% above the best performing Trust (0.6%) on the mortality indicator. We note that one of the initiatives taken to address this indicator is the development of a Patient Safety Group. We look forward to hearing how the patient safety group has helped the trust to make improvement and will continue to do so through 2017/18.

## Patient safety

The number of reported incidents continued to increase over the years and there are 2,944 more patient safety incidents reported by the Trust (April 2016 and September 2016) compared to the national average. More concerning is that the number of reported incidents is 8267 with 57 resulting in serious harm for 2016/17. We agree that higher reporting numbers are a sign of a safety culture within the Trust but they could also be a sign of variability in the quality of care.

We note that the Trust uses 'Safety Lessons of the month', doctors 'Risky Business Forum' and 'Serious Incident at a Glance' reports to share learning from serious incident investigations. The Trust should consider including examples of learning and the impact on service delivery, access or quality.

**To conclude -** we commend the Trust for being one of the best performing trusts in the country in relation to meeting cancer operational standards. Equally, for winning the Parkinson's Excellence Network Awards which recognise and celebrate outstanding services that make a difference to people in the UK affected by Parkinson's disease.

**Andy Cave**

**CEO**
**Healthwatch Birmingham**

# Joint Health Overview and Scrutiny Committee comments

The Scrutiny Committee were disappointed with the late submission of this year's Quality Account statement for discussion at their Scrutiny Board meeting on Wednesday 26 April. Many of the Councillors had not had the time to digest the comprehensive information in the report. Some of the Councillors commented on the nature of the incomplete information and highlighted that they felt unable to provide a coherent commentary as there was incomplete data and a lot of the data provided within the report had not been accurately verified.

However, a number of comments were made about the account at the joint meeting and this is reflected below:

- There was a need for greater numbers of staff to have training in managing change and problem-solving as a means of dealing with challenges of working within the health service.
- There were still significant challenges in respect of discharge that needed to be addressed, particularly with managing the availability and accessibility of appropriate medication. It was hoped that the electronic prescribing system would help improve efficiency and effectiveness.
- It was helpful to see more patient experience data within the report but there was scope to further improve this. It would be useful to see more evidence of how patients / service users have shaped changes in policy and practise, the lessons learnt from Serious Incidents and how the Trust ensures that there is no bias with engagement and feedback activities.

The Scrutiny Committee will want to take a strong oversight of the proposed merger between Heart of England Foundation Trust and University Hospitals Birmingham and the implementation of the Birmingham and Solihull Sustainability and Transformation Plan over the next 12 months.

**Councillor Mrs G Sleigh, Chairman of Health and Adult Social Care Scrutiny Board.**

# Directors' Statement of Responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

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

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2016 to May 2017
    - papers relating to quality reported to the board over the period April 2016 to May 2017
    - feedback from the commissioners dated 18/05/2017
    - feedback from governors dated 23/01/2017 / 24/04/2017
    - feedback from local Healthwatch organisations dated 17/05/2017
    - feedback from Overview and Scrutiny Committee dated 18/05/2017
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 26/04/2017 (this is the date the Trust's complaints data was made available to the HSCIC)
    - 2015 National Patient Survey (published in June 2016; this is the latest available survey. The 2016 survey has been delayed and is unlikely to be published before June 2017)
    - 2016 national staff survey March 2017
    - Head of Internal Audit's annual opinion over the Trust's control environment dated 19/05/2017
    - CQC inspection report dated 01/06/2015
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, 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 Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

Rt Hon Jacqui Smith,
Interim Chair

Date: 24 May 2017

Dame Julie Moore,
Interim Chief Executive Officer

Date: 24 May 2017

# Appendix 1: Clinical Audit

The national clinical audits (Table 1) and national confidential enquiries (Table 2) that HEFT participated in, and for which data collection was completed during 2016/2017, 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.

**Table 1:** HEFT National Clinical Audit Participation:

| National audit HEFT eligible to participate in | HEFT participation 2016/17 | Percentage of required number of cases submitted |
|---|---|---|
| Adult Asthma | Yes | 2016/17 Data unavailable at time of report. |
| BAUS Urology Audits - Radical Prostatectomy Audit | Yes | 100% |
| BAUS Urology Audits - Nephrectomy audit | Yes | 100% |
| BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL) | Yes | 2016/17 Data unavailable at time of report. |
| Bowel Cancer (NBOCAP) | Yes | 100% (Latest data from 2016 NBOCAP Report) |
| Cardiac Rhythm Management (CRM) | Yes | 100% |
| Case Mix Programme (CMP) - Intensive Care Audit | Yes | 100% |
| Diabetes (Paediatric) (NPDA) | Yes | |
| Elective Surgery (National PROMs Programme) | Yes | 100% patients receive surveys. 6.69% patient response rate (Apr-Sep 2016/17) |
| Endocrine and Thyroid National Audit | Yes | |
| Falls and Fragility Fractures Audit programme (FFFAP) - Inpatient Falls | Audit did not proceed | n/a |
| Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database | Yes | 100% |
| Head and Neck Cancer Audit | Yes | 100% data collected locally but unable to submit to the national audit |
| Inflammatory Bowel Disease (IBD) programme / IBD Registry | No | Did not participate due to resource implications. |
| Major Trauma Audit | Yes | 94% |
| Moderate & Acute Severe Asthma - adult and paediatric (care in emergency departments) | Yes | 100% |
| Myocardial Ischaemia National Audit Project (MINAP) | Yes | 100% |
| National Audit of Dementia - Dementia care in general hospitals | Yes | 66% |
| National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty) | Yes | 100% |

| | | |
|---|---|---|
| National Cardiac Arrest Audit (NCAA) | Yes | 100% |
| National Chronic Obstructive Pulmonary Disease (COPD) Audit programme - Pulmonary rehabilitation | Yes | Data collection on-going. |
| National Chronic Obstructive Pulmonary Disease (COPD) Audit programme - Secondary Care | Yes | Data collection on-going. |
| National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA) - Clinician/Patient Follow-up | Audit did not proceed | n/a |
| National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA) - Clinician/Patient Baseline | Audit did not proceed | n/a |
| National Comparative Audit of Blood Transfusion programme - Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients | Yes | 100% |
| National Comparative Audit of Blood Transfusion programme - 2017 National Comparative Audit of Transfusion Associated Circulatory Overload (TACO) | Yes | 50% |
| National Comparative Audit of Blood Transfusion programme - Audit of Patient Blood Management in Scheduled Surgery - Re-audit | No | Did not participate due to resource implications. |
| National Comparative Audit of Blood Transfusion programme - Audit of the use of blood in Lower GI bleeding | Audit did not proceed | n/a |
| National Diabetes Audit – Adults - National Diabetes Foot Care Audit | Yes | Data collection ongoing – all patients who consented are to be submitted. |
| National Diabetes Audit – Adults - National Diabetes Inpatient Audit (NaDia) | Yes | |
| National Diabetes Audit – Adults - National Pregnancy in Diabetes Audit | Yes | |
| National Diabetes Audit – Adults - National Diabetes Transition | Yes | 100% |
| National Diabetes Audit – Adults - National Core Diabetes Audit | Audit did not proceed Data collection for 16/17 does not begin until June | n/a |
| National Emergency Laparotomy Audit (NELA) | Yes | >90% |
| National Heart Failure Audit | Yes | 70% |
| National Joint Registry (NJR) - Knee replacement | Yes | 94% |
| National Joint Registry (NJR) - Hip replacement | Yes | 80% |
| National Lung Cancer Audit (NLCA) - Lung Cancer Clinical Outcomes Publication | Yes | 65% |
| National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP) | Yes | 100% |
| National Ophthalmology Audit - Adult Cataract surgery | Yes | |
| National Prostate Cancer Audit | Yes | 81% |
| National Vascular Registry | Yes | 100% |

| | | |
|---|---|---|
| Oesophago-gastric Cancer (NOGCA) | Yes | 95% |
| Paediatric Pneumonia | Yes | Data collection was ongoing to 30/04/2017. |
| Renal Replacement Therapy (Renal Registry) | Yes | 100% |
| Sentinel Stroke National Audit programme (SSNAP) | Yes | 100% |
| Severe Sepsis and Septic Shock (care in emergency departments) | Yes | 100% |
| UK Cystic Fibrosis Registry - Paediatric | Yes | 100% |
| UK Cystic Fibrosis Registry - Adult | Yes | 100% |

**Table 2:** HEFT Clinical Outcome Review Programme Participation:

| Audit Title | Participation in 2016/17 | % of cases submitted |
|---|---|---|
| Child Health Clinical Outcome Review Programme - Chronic Neurodisability | Yes | 100% |
| Child Health Clinical Outcome Review Programme - Young People's Mental Health | Yes | 100% |
| Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality Surveillance | Yes | 100% |
| Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality and Morbidity confidential enquiries | Yes | 100% |
| Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal mortality surveillance and mortality confidential enquiries | Yes | 100% |
| Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal morbidity confidential enquiries | Yes | 100% |
| Medical and Surgical Clinical Outcome Review Programme - Acute Pancreatitis | CORP performed 15/16 | 100% |
| Medical and Surgical Clinical Outcome Review Programme - Physical and mental health care of mental health patients in acute hospitals | Yes | 100% |
| Medical and Surgical Clinical Outcome Review Programme - Non-invasive ventilation | Yes | 100% |

# Appendix 2: Performance against indicators included in the NHS Improvement Single Oversight Framework

In the 2015/16 Quality Account, trusts were required to report performance for the Monitor Risk Assessment Framework. This changed to the NHS Improvement Single Oversight Framework on 1 October 2016, and for the 2016/17 Quality Account trusts are required to report only on indicators common to both frameworks. Therefore there are fewer indicators in the 2016/17 Quality Account than the previous 2015/16 report.

| Description of Target | Target 2016/17 | 2013-14 | 2014-15 | 2015-16 | 2016/17 |
|---|---|---|---|---|---|
| Minimise rates of Clostridium difficile | ≤64 | 82 | 75 | 61 | 76 |
| Reduction of incidence of MRSA bacteraemia (attributable cases) | 0 | 8 | 1 | 5 | 7 |
| Patients urgently referred with suspected cancer by their GP or dentist waiting no more than 2 weeks for first appointment | ≥93% | 92.86% | 84.42% | 91.44% | 95.61% |
| Patients urgently referred with breast symptoms (where cancer was not initially suspected) by their GP waiting no more than 2 weeks for first outpatient appointment | ≥93% | 93.20% | 79.18% | 91.28% | 95.49% |
| Patients waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers | ≥96% | 97.92% | 97.99% | 98.75% | 99.31% |
| Patients waiting no more than 31 days for subsequent treatment where that treatment is surgery - Surgery Modality | ≥94% | 98.44% | 98.79% | 98.20% | 99.15% |
| Patients waiting no more than 31 days for subsequent treatment where that treatment is an anti-cancer drug regimen - Anti Cancer Drug Modality | ≥98% | 100% | 100% | 99% | 99.89% |
| Patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer (including Rare Cancer) | ≥85% | 86.33% | 85.12% | 82.91% | 97.08% |
| Patients waiting no more than 62 days from referral from an NHS Screening service to first definitive treatment for all cancers - National Screening Service | ≥85% | 97.00% | 90.65% | 95.93% | 87.61% |
| 18 week incomplete RTT pathways | ≥92% | 96.29% | 92.54% | 90.53% | 92.45% |
| Maximum waiting time of 4 hours in A&E from arrival, to admission, transfer or discharge | ≥95% | 93.02% | 90.38% | 88.13% | 85.52% |

## 18 week incomplete pathways

The reported indicator performance has been calculated based on all patients recorded as having been referred to the FT for consultant led services and who are on incomplete pathways at the end of the period. Completeness of this information is therefore dependent on the complete and accurate entry of data at source (referrals received for consultant led services) and the complete recording of all those on incomplete pathways at period end; it is not possible to check completeness to source because referrals may be received through different routes, for example, by letter, fax or via the live 'Choose and Book' system or may have been received in a prior period. Patients who have not been identified within the population will therefore not be included in the indictor calculation. To the best of the knowledge of the Trust, the information is complete.

## Maximum waiting time of 4 hours in A&E from arrival, to admission, transfer or discharge

The reported indicator performance has been calculated based on all patients recorded as having attended A&E. Completeness of this information is therefore dependent on the complete and accurate entry of data at source by the clinician who carries out initial assessment or by A&E reception. Patients who have not been correctly registered in A&E will therefore not be included in the indictor calculation. To the best of the knowledge of the Trust, it is complete.

| Target | Definition | Criteria |
|---|---|---|
| Maximum waiting time of 4 hours in A&E from arrival, to admission, transfer or discharge | Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge. | The indicator is defined within the technical definitions that accompany Everyone counts: planning for patients 2014/15 - 2018/19 and can be found at www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf Detailed rules and guidance for measuring A&E attendances and emergency admissions can be found at https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/03/AE-Attendances-Emergency- Definitions-v2.0-Final.pdf |
| 18 week complete pathways | Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period | The indicator is expressed as a percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period;<br>The indicator is calculated as the arithmetic average for the monthly reported performance indicators for April 2015 to March 2016;<br>The clock start date is defined as the date that the referral is received by the Foundation Trust, meeting the criteria set out by the Department of Health guidance; and<br>The indicator includes only referrals for consultant-led service, and meeting the definition of the service whereby a consultant retains overall clinical responsibility for the service, team or treatment. |

# Appendix 3: National Quality Indicators

The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period.

## 1. Mortality

| | Previous Period (July 2014 - June 2015 ) | Current Period (July 2015 - June 2016) | | | | Comments |
|---|---|---|---|---|---|---|
| | | | National Performance | | | |
| | HEFT | HEFT | Overall | Best | Worst | |
| (a) Summary Hospital -level Mortality Indicator (SHMI) value | 1.09 | 0.97 | - | 0.69 | 1.17 | |
| (a) SHMI banding | 2 | 2 | - | 3 | 1 | |
| (b) Percentage of patients deaths with palliative care coded at diagnosis or speciality level | 20.9 | 26.5 | | 0.6 | 54.8 | |

The Trust considers that this data is as described for the following reasons as this is the latest available on the NHS Digital website.

It should be noted that during July 2014 - April 2015, following the implementation of a new patient administration system PMS2, there were some issues with data quality. There were issues with the recording of the type of admission (emergency rather than elective) which will have had an effect on the risk adjustment for our indicator. This will potentially have lowered our SHMI level during that earlier time period but this is now reliable data.

The Trust intends to take the following actions to improve this indicator, and so the quality of its services. The Trust will be adopting the technical approach that University Hospitals Birmingham NHS Foundation Trust (UHB) takes to improving quality.

The Trust has also been reviewing and improving our mortality framework and processes over the last year taking into account the newly published national guidance and further development of our medical examiner's role.

The list below includes some of the current quality care initiatives that are being undertaken:

- Improving coding and data quality within the clinical record to help capture data along with local quality improvement projects;
- Trust wide quality improvement projects;
- Improving timeliness of administration of STAT dose antibiotics;
- Developed a Patient Safety Group;
- Increased focus on sepsis and deteriorating patient along with the launch of new MEWS policy;
- Focus on diabetes management;
- Collaborative working with colleagues at University Hospitals Birmingham on sepsis management.

### Palliative care

The Trust considers that this data is as described for the following reasons:

- An internal process flaw which resulted in a significantly lower number of Trust palliative

care episodes being recorded was discovered in April 2013 and addressed.

The Trust has taken the following actions to improve this score, and so the quality of its services, by continuing to monitor this data and validate on a monthly basis.

## 2. PROMs

| Patient Reported Outcome Measures Scores (PROMS) | Trust Performance Latest | | | National Average | Lowest reported Trust | Highest Reported Trust |
|---|---|---|---|---|---|---|
| | Apr 14 - Mar 15 | Apr 15 - Dec 15 | Apr 16 - Sep 16 | | | |
| (i) groin hernia surgery | 0.094 | 0.084 | 0.082 | 0.089 | 0.016 | 0.162 |
| (ii) varicose vein surgery | 0.12 | 0.135 | 0.152 | 0.099 | 0.016 | 0.152 |
| (iii) hip replacement surgery | 0.397 | 0.425 | 0.411 | 0.449 | 0.330 | 0.525 |
| (iv) knee replacement surgery | 0.299 | 0.288 | 0.320 | 0.337 | 0.261 | 0.430 |

The Trust considers that this data is as described for the following reasons:

- The Trust has focused on Trauma & Orthopaedic (T&O) PROMS as they continue to be an outlier in the CQC Intelligent Monitoring Report.

The Trust intends to take the following actions to improve this score, and so the quality of its services, by:

- All activity is now undertaken within the Trust and work is now focussed on the Solihull site to reduce length for elective hip surgery. The work within T&O also feeds into the Trust overall LOS programme which is one of the four key work streams 2016/17.
- Continue work on the enhanced scheme piloted at Solihull Hospital.
- The enhanced recovery scheme and the focus on the knee pathways are now starting to show improvement and this approach will now be applied to the hip pathway.
- Improving the understanding of the data and undertake a detailed piece of work on capacity and demand across the T&O Directorate.
- Continuing our work on improving both Groin Hernia Surgery and Varicose Vein Surgery which have both shown consistent improvement month on month.

## 3. Readmissions

| Percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period. | 2010/11 | 2011/12 | Trust performance Latest 2012/13 | National Average | Lowest reported Trust* | Highest Reported Trust* |
|---|---|---|---|---|---|---|
| (i) 0 to 15 | 11.87% | 11.85% | 11.72% | 9.57% | 0.00% | 50.00% |
| (ii) 16 or over | 8.07% | 7.63% | 7.87% | 7.26% | 0.00% | 22.58% |

The Trust considers that this data is as described for the following reasons:

- The data is produced by the health and social care information centre but it should be noted that it is 4 years old.

The Trust intends to take the following actions to improve this score and, so the quality of its services, by:

- Learning from recent multi-disciplinary audits across the health and social economy in relation to readmission rates, variance and causative factors. This will also incorporate any data quality improvement issues.
- Further improving discharge practice via a locally agreed CQUIN in line with best practice guidance from NICE National Guidance 27 and the West Midlands Quality Review Service Quality Standards on Transfer of Care from Acute and Intermediate Care.
- Evaluating results from the Solihull Discharge Surveillance Pilot aimed at reducing Readmissions and agreeing next steps through the Trust workstream on reducing occupied bed days.
- Benchmarking specialties or care providers that appear to be outliers to address any clinical concerns or process factors and agreeing plans with partners where necessary i.e. GPs, care homes, community services, mental health and social care.

## 4. Patient experience

| Indicator | 2013/14 | 2014/15 | Trust performance Latest 2015/16 | National Average | Lowest reported Trust | Highest Reported Trust |
|---|---|---|---|---|---|---|
| Trust's responsiveness to the personal needs of its patients during the reporting period | 63.6 | 66.1 | 64.2 | 69.6 | 58.9 | 86.2 |

| Indicator | 2013/14 | 2014/15 | Trust performance Latest 2015/16 | National Average | Lowest reported Trust | Highest Reported Trust |
|---|---|---|---|---|---|---|
| Friends and Family Test – Patient having a positive experience of care after being discharged from A&E | 88.71% | 85.96% | 79.50% | 84.39% | 46.33% | 100.00% |

The Trust considers that this data is as described for the following reasons:

The data reflects that the organisation has worked to make improvements to inpatient experience. Whilst the decrease in the ED FFT score is not a large one, this reflects that increasing demand and the challenges associated with being one of the largest and most diverse providers of acute healthcare in the country means that ED patient experience remains a priority for the Trust.

The Trust intends to take the following actions to improve this score, and so the quality of its services, by:

- Using the expertise and experience of Community Patient Panel members to support monthly ward quality reviews
- Dedicated action plan and work to support patient experience improvements in the ED, including volunteers to support vulnerable

people receiving treatment in the department.
- The increased use at ward level patient comments made via the FFT. A quality dashboard has been developed to facilitate the use of these comments by supervisory ward sisters.
- Undertaking thematic analysis of patient comments in conjunction with complaints feedback.
- Providing training for Trust staff in managing and prevention of complaints.
- Patient experience monitoring to understand the differences in experience across weekdays, weekends and during the night.

## 5. Staff experience

| Indicator | 2014 | 2015 | Trust performance Latest 2016 | National Average | Lowest reported Trust | Highest Reported Trust |
|---|---|---|---|---|---|---|
| Percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends | 48% | 55% | 62% | 70% | 49% | 85% |

The Trust considers that this data is as described for the following reasons:

This data reflects the improvements that have been seen across the organisation in the last 12 months:

- Stability of leadership at Board level and in the Trust's finances.
- Introduction of Values Based Recruitment to six areas, ensuring staff are appointed based upon both technical and behavioural suitability.
- Improving performance targets, leading HEFT to be one of the best performing Trusts in the country in relation to cancer.

The Trust intends to take the following actions:

improve this score and so the quality of its services:

- Continue with regular opportunities for staff to give their feedback via the quarterly Staff Friends and Family Test and full census of National Staff Survey, reviewing key themes and taking action in response.
- Continue to embed the Trust's values, with values and behaviours incorporated into: recruitment; induction; policies and procedures
- Schwartz rounds will continue to be held, giving staff time to reflect and to share experience across staff groups.

| Indicator | 2014 | 2015 | Trust performance Latest 2016 | National Average | Lowest reported Trust | Highest Reported Trust |
|---|---|---|---|---|---|---|
| Percentage of staff experiencing harassment, bullying or abuse form staff in the last 12 months<br><br>(lower score is better)<br><br>KF26 | 25% | 27% | 24% | 25% | 16% | 36% |

The Trust considers that this data is as described for the following reasons:

The Trust has seen an improvement in the above score and has taken action in the following areas:

- Introduction of a Freedom to Speak up Guardian and re-launch of the staff Confidential Contacts to support staff with concerns.
- Bullying and Harassment Awareness Campaign throughout January 2017 to encourage access to support and reporting of concerns.

The Trust intends to take the following actions to improve this score and so the quality of its services, by continuing to raise awareness of the support that is available to staff experiencing bullying including:

- Staff Confidential Contacts and the Trust's Freedom to Speak up Guardian.
- Staff counselling advice line (available 24 hours a day).

| Indicator | | 2014 | 2015 | Trust performance Latest 2016 | National Average | Lowest reported Trust | Highest Reported Trust |
|---|---|---|---|---|---|---|---|
| Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion for the workforce Race Equality Standard KF21 | White | 86% | 85% | 86% | 88% | 78% | 95% |
| | BME | 68% | 63% | 69% | 76% | 61% | 96% |

The Trust considers that this data is as described for the following reasons:

The Trust has seen an improvement in the above scores and has taken action in the following areas:

- Trust wide action plan in place to monitor progress against the Workplace Race Equality Scheme (WRES) to ensure employees from Black, Asian and minority ethnic (BAME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.
- Pilot of Unconscious Bias training has been delivered to a group of managers.
- Revised Trust's Equal Opportunities policy to reinforce the commitment of all staff to workforce equality, diversity and inclusion.
- Staff Inclusion Steering Group with a focus on improving staff and patient experience.
- The establishment of employee networks to support underrepresented groups across the workforce.

The Trust intends to take the following actions to improve this score and so the quality of its services:

- Review of BAME staff access to non-mandatory training to ensure consistency and accuracy of reporting.
- Review of how staff should be reporting racial abuse, harassment and bullying.
- Interrogation of recruitment and selection data to ensure fairness in shortlisting and appointment processes.
- Roll Out of Unconscious Bias training.

## 6. Venous Thromboembolism (VTE)

| Indicator | Q1 | Q2 | Q3 | Q4 | Total FY 2016/17 | National Average | Lowest reported Trust | Highest reported Trust |
|---|---|---|---|---|---|---|---|---|
| Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period | 98.35% | 97.70% | 96.74% | 97.47% | 97.37% | 95.67% | 79.93% | 100.00% |

The Trust considers that this data is as described for the following reasons:

Total 2016/17 VTE assessment was 97.37% against a target of greater than 95% of inpatients risk assessed.

The current system remains highly dependent on the completion of the Venous Thromboembolism Risk Assessment (VTE RA) via the Trusts electronic prescribing (EP) system. An 'ignore' option allows for rapid prescribing and administration of urgent medicines without having to complete the VTE risk assessment. Clinicians are reminded of any outstanding VTE risk assessments to be made when accessing either the prescribing option or pathology results option of the electronic patient record. A monitoring system of users selecting the 'ignore' option has been introduced with feedback to individual doctors and team leaders overusing this option.

A major improvement on the Trusts performance has been the application of a revised 'cohort' list. This provides an exclusion list of pre-agreed diagnostic criteria that do not require a VTE risk assessment; this is based on length of inpatient stay and type of procedure undertaken. In addition, the Trust has introduced a smart interconnected VTE RA algorithm to promote better thromboprophylaxis decision making with automated 'preferred' thromboprophylaxis.

There is a persistence of non-completion of VTE RA in about 500-600 admissions per month. These are monitored daily and fed back to respective Clinical Divisions via Divisional Directors and the Clinical Quality Management Group chaired by the Executive Medical Director.

The Trust intends to take the following actions to further improve the proportion of patients undergoing VTE risk assessment and the quality of the assessment:

- Raise awareness of the need to perform a VTE RA in those areas who admit patients for more than 12 hours but do not routinely use the Trust's electronic prescribing system.
- Feedback to poorly performing areas on a monthly basis.
- Investigate the extension of the use of the Trust's electronic prescribing system to all clinical inpatient areas.
- Work with the IT department to automate e-mail reminders that VTE RA's have not been completed on specific inpatients. Specific consultant based performance metrics are now being released on a monthly basis to improve compliance with this screening programme.
- Remind all clinical staff to complete the VTE RA in those areas reliant on paper prescribing (ED, AMU, SAU, ITU, and Ward 19).

All of the above actions are aimed to further improve the numbers of VTE RA completed as well as improve the quality of the thromboprophylaxis prescribed.

## 7. Clostridium Difficile (C. Difficile)

| Indicator | 2013/14 | 2014/15 | Trust Performance Latest 2015/16 | National Average | Lowest reported Trust | Highest reported Trust |
|---|---|---|---|---|---|---|
| Rate per 100,000 bed days of cases of C. difficile infection reported within the trust amongst patients aged 2 or over during the reporting period | 16.7 | 16.9 | 13.5 | 14.9 | 0.0 | 66.0 |

The Trust considers that this data is as described for the following reasons:

It is the latest available data on the NHS Digital (formerly HSCIC) website.

The Trust intends to take the following actions to improve this score and so the quality of its services, by:

- Post infection review of all post-48-hour toxin positive cases of C. Difficile carried out jointly with CCG and includes an audit of antibiotic therapy.
- Detailed Period of Increased Incidence (PII) reviews with feedback for wards with two or more cases of post 48 hours C. Difficile in any 28-day period.
- Typing of individual strains of C. Difficile to identify transmission incidents and outbreaks thus facilitating timely and effective management.
- Implementation of a RAG rated monitoring system for inpatients with C.Difficile to ensure timely and effective management.
- The use of Fidaxomycin in the treatment of C.Difficile.
- Faecal transplants for patients with protracted or relapsing C. Difficile infection.

## 8. Patient Safety

| Indicator | Apr 14 – Sep 15 | Oct 15 - Mar 16 | Trust performance Latest Apr 16 – Sep 16 | National Average (Apr 16 – Sept 16) | Lowest reported Trust (Apr 16 – Sept 16) | Highest Reported Trust (Apr 16 – Sept 16) |
|---|---|---|---|---|---|---|
| Number of patient safety incidents reported within the trust during the reporting period | 7,383 | 8394 | 7899 | 4955 | 1485 | 13485 |
| Rate of patient safety incidents reported within the trust during the reporting period | 34.0 | 36.76 | 33.75 | - | 21.15 | 71.81 |

| | | | | | | |
|---|---|---|---|---|---|---|
| The number of such patient safety incidents that resulted in severe harm or death. | 95 | 44 | 47 | - | 1 | 98 |
| Percentage of such patient safety incidents that resulted in severe harm or death. | 1.29% | 0.52% | 0.59% | 0.40% | - | - |

The Trust considers this data is as described for the following reasons:

The data is the latest available on the NRLS website. Whilst there are some minor discrepancies, due to the way that the information is collected and updated, analysis of our local incident reporting system provides similar data. The number of patient safety incidents reported within the Trust for the reporting period was 8267, and the number of patient safety incidents resulting in severe harm or death as 57 (0.68%).

The Trust considers a high level of incident reporting as a sign of a good safety culture and actively encourages staff to report both clinical and non-clinical incidents. The Trust reporting profile is shown in part 3 of this report. The patient safety incidents are uploaded to the NRLS. The remaining incidents are those that affect staff or property, or where patients involved were not in the care of the Trust at the time of the incident occurring; for example, non-hospital acquired pressure ulcers.

The Trust intends to continue with the following actions to increase the total rate of patient safety incidents reported within the Trust, and so the quality of its services. The Trust will continue to maintain an on-going review of the incident reporting procedures and management systems including:

- Review and adaptation of incident reporting forms and codes.
- Training needs analysis and production of training programmes for staff.
- Review and development of reporting and dashboard facilities within Datix.
- Review and update incident reporting and management policies and procedures.
- Continue to routinely monitor the Trust incident reporting profile.

# Section 4 **Auditor's Opinion**

This Annual Report covers the period 1 April 2016 to 31 March 2017

KPMG

## INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF HEART OF ENGLAND NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Heart of England NHS Foundation Trust to perform an independent assurance engagement in respect of Heart of England NHS Foundation Trust's Quality Report for the year ended 31 March 2017 (the 'Quality Report') and certain performance indicators contained therein.

### Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge.

We refer to these national priority indicators collectively as the 'indicators'.

### Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2016/17* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the *Detailed Requirements for external assurance for quality reports for foundation trusts 2016/17*.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes and papers for the period April 2016 to May 2017;
- papers relating to quality reported to the board over the period April 2016 to May 2017;
- feedback from commissioners, dated 18 May 2017;
- feedback from local Healthwatch organisations, dated 17 May 2017;
- feedback from Overview and Scrutiny Committee, dated 18 May 2017;
- the Council of Governors minutes and papers for the period May 2016 to April 2017;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the 2015 national patient survey, published June 2016;
- the latest national staff survey, March 2017;

- Care Quality Commission inspection report, dated 01 June 2015; and
- the 2016/17 Head of Internal Audit's annual opinion over the trust's control environment, dated 19 May 2017.

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

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Heart of England NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Heart of England NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

**Assurance work performed**

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

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

**Limitations**

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Heart of England NHS Foundation Trust.

**Basis for qualified conclusion**

In understanding the design of the processes in place to capture the data for the A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge indicator, we identified that in regards to ambulance arrivals and consistent with the prior year, the Trust starts the clock when the ambulance arrival is registered. The Trust does not refer to the ambulance arrival time.

Our sample testing confirmed this practice. The Trust Board has agreed that this practice is in the best interests of patients. The guidance states that 'arrival time is when handover occurs or 15 minutes after the ambulance arrives at A&E whichever is earlier.'

**Qualified conclusion**

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

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

KPMG LLP.

KPMG LLP
Chartered Accountants
One Snowhill
Snowhill Queensway
Birmingham
B4 6GH

30 May 2017

# Section 5 **Annual Accounts**


This Annual Report covers the period 1 April 2016 to 31 March 2017

Section 5

# Annual Accounts 31 March 2017

These Accounts for the year ended 31 March 2017 have been prepared by Heart of England NHS Foundation Trust (the Trust), to be presented to Parliament pursuant to Schedule 7, paragraph 25(4) (a) of the National Health Service Act 2006.

Dame Julie Moore
Interim Chief Executive

Date: 24 May 2017

# Independent auditor's report

## to the Council of Governors of Heart of England NHS Foundation Trust only

## Opinions and conclusions arising from our audit

### 1. Our opinion on the financial statements is unmodified

We have audited the financial statements of Heart of England NHS Foundation Trust for the year ended 31 March 2017 set out on pages 159 to 207 of the Annual Report. In our opinion:

— the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2017 and of the Trust's income and expenditure for the year then ended; and

— the Trust's financial statements have been properly prepared in accordance with the Department of Health's Group Accounting Manual 2016/17.

| Overview | |
|---|---|
| **Materiality:** Financial statements as a whole | £10m<br>1.4% of total income from operations |
| **Risks of material misstatement** | |
| | Recognition of NHS and non-NHS income |
| | Valuation of land and buildings |

## 2. Our assessment of risks of material misstatement

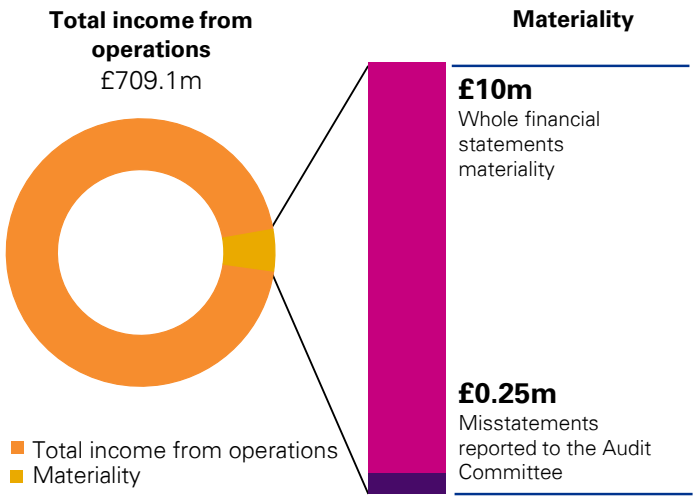
In arriving at our audit opinion above on the financial statements, the risks of material misstatement that had the greatest effect on our audit, in decreasing order of audit significance, were as follows:

| | The risk | Our response |
|---|---|---|
| **Operating income**<br>(£709.1 million; 2015-16: £672.4 million)<br><br>*Refer to page 163 of the Annual Report (accounting policy) and pages 174 to 176 of the Annual Report (financial disclosures).* | **Recognition of NHS and non-NHS income**<br><br>Of the Trust's reported total income, £617.4 million (2015/16, £586.1 million) came from Clinical Commissioning Groups (CCG) and NHS England.<br><br>Four CCGs and NHS England make up 89% of the Trust's income. The majority of this income is contracted on an annual basis, however actual achievement is based on completing the planned level of activity and achieving key performance indicators (KPIs). If the Trust does not meet its contracted KPIs then commissioners are able to impose fines, reducing the level of income achievement.<br><br>In 2016/17 the Trust has received transformation funding from NHS Improvement. This is received subject to achieving defined financial and operational targets on a quarterly basis. The Trust was allocated £23.3m of transformation funding. The year-end amount was £25.2m, made up of £0.5m incentive STF, and £1.4m bonus payment, following the Trust delivering its controls target of the year.<br><br>An agreement of balances exercise is undertaken between NHS bodies to agree the value of transactions during the year and the amounts owed at the year end. 'Mismatch' reports are available setting out discrepancies between the submitted balances from each party in transactions and variances over £250,000 are required to be reported to the National Audit Office to inform the audit of the Department of Health consolidated accounts.<br><br>The Trust reported total other operating income of £84.5 million (2015/16: £58.6 million) from other activities, primarily education and training, research and development, or other activities. Much of this income is contracted from NHS and non-NHS bodies under contracts that indicate when income will be received; on delivery, milestones, or periodically. There is a greater risk that the income has not been recognised under the accruals basis, and instead on a cash basis. Some sources of income require independent confirmations which can impact the amount of the income the Trust will actually receive. | Our procedures included:<br><br>— **Agreement of balances:** We assessed the outcome of the agreement of balances exercise with other NHS bodies. Where there were mismatches over £250,000 we obtained evidence to support the Trust's reported income figure;<br><br>— **Contract agreement:** For the five largest commissioners of the Trust's activity we agreed that signed contracts were in place;.<br><br>— **Contract variations:** We investigated a sample of contract variations for commissioners and sought explanations from management;<br><br>— **Contract disputes:** We discussed with Trust staff and reviewed income variances resulting from the agreement of balances exercise and confirmed whether the Trust is in formal dispute or arbitration in relation to any material income balances and examined the supporting correspondence, including if appropriate any legal advice given, in relation to the expected outcome as recorded within the financial statements;<br><br>— **Provision for impairment of receivables:** We confirmed the basis upon which any provisions for debt have been made, including the completeness and accuracy of the aged receivables analysis. We tested the assumptions taking into account both past performance and any circumstances specific to the year ended 31 March 2017;<br><br>— **Year-end sales invoice testing:** We tested a sample of sales invoices raised in March and April 2017 to support the completeness of both NHS and non-NHS income balances. We tested the sample to ensure that they were recorded within the correct financial year; and<br><br>— **Sustainability and Transformation Fund (STF) income:** Assessing the Trust's reporting and accounting for STF income received from the Department of Health and agreeing the amounts recognised to supporting documentation. |

| | The risk | Our response |
|---|---|---|
| **Property, plant and equipment**<br>(£251.8 million; 2015/16: £256.1 million)<br><br>*Refer to page 164 of the Annual Report (accounting policy) and page 184 of the Annual Report (financial disclosures).* | **Valuation of land and buildings**<br><br>Land and buildings are required to be held at fair value. As hospital buildings are specialised assets and there is not an active market for them they are usually valued on the basis of the cost to replace them with an equivalent asset.<br><br>When considering the cost to build a replacement asset the Trust may consider whether the asset would be built to the same specification or in the same location. Assumptions about changes to the asset must be realistic.<br><br>Assets may also lose value if they are no longer able to derive as much future benefit from their use as anticipated.<br><br>Valuation is completed by an external expert engaged by the Trust using construction indices and so accurate records of the current estate are required to inform the valuation. Full valuations are completed every five years, with interim desktop valuations completed in interim periods. During 2016/17 a desktop valuation was completed. | Our procedures included:<br><br>— **Opening balances:** We agreed the 2015/16 opening land and building balances to the 2015/16 valuation report and critically considered the use of the Alternative Site Valuation methodology applied to the Trust's Solihull and Good Hope sites;<br><br>— **Review of valuation:** We assessed the Trust's valuation report and considered the revaluation basis used and its appropriateness (including the continued use of Alternative Site Methodology). We engaged our property team experts to undertake an assessment of the revaluation;<br><br>— **Assessment of external valuer:** We carried out an assessment of the expertise of the valuer commissioned by the Trust to perform the revaluation exercise by ensuring that the valuer was appropriately qualified. We obtained the instructions provided to the valuer and assessed the independence and objectivity of the valuer and the terms under which they were engaged by management;<br><br>— **Asset data used by the valuer:** We considered the source of the information provided to, and used by, the valuer, and undertook testing to ensure both its completeness and accuracy, including the existence of assets and floor area measurements;<br><br>— **Management adjustments:** We confirmed the appropriateness of any amendments made by management to the information received from the valuer before being incorporated into the financial statements; and<br><br>— **Impairment review:** We considered management assessment of any need for an impairment across its asset base either due to loss of value or reduction in future benefits that would be achieved. |

## 3. Our application of materiality and an overview of the scope of our audit

The materiality for the financial statements was set at £10 million, determined with reference to a benchmark of income from operations (of which it represents approximately 1.4%). We consider income from operations to be more stable than a surplus-related benchmark. We report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £250,000, in addition to other identified misstatements that warrant reporting on qualitative grounds.




## 4. Our opinion on other matters prescribed by the Code of Audit Practice is unmodified

In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2016/17; and
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

## 5. We have nothing to report in respect of the matters on which we are required to report by exception

We are required to report to you if, based on the knowledge we acquired during our audit, we have identified information in the Annual Report that contains a material inconsistency with either that knowledge or the financial statements, a material misstatement of fact, or that is otherwise misleading.

In particular, we are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our audit and the directors' statement that they consider that the Annual Report and financial statements taken as a whole is fair, balanced and understandable; or
- the Audit Committee's commentary on page 40- 41 of the Annual Report does not appropriately address matters communicated by us to the Audit Committee.

Under the Code of Audit Practice we are required to report to you if, in our opinion:

- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

In addition we are required to report to you if:

- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.
- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

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

## 6. Other matters on which we report by exception - adequacy of arrangements to secure value for money

Under the Code of Audit Practice we are required to report by exception if we are not satisfied that the Trust has put in place proper arrangements to secure value for money in its use of resources for the relevant period.

During 2016/17, the Trust was operating under a number of section 106 enforcement undertakings and an additional licence condition imposed under section 111 by NHS Improvement which were still in place as at 31 March 2017. Specifically:

- December 2013 (updated October 2014) – Enforcement Undertaking issued for non-compliance with 4 Hour A&E wait, RTT, and cancer waiting targets.
- October 2014 – Enforcement Undertaking issued under Section 111 in regards to the Trust's Board, management and leadership capacity and capability, and governance systems and processes arrangements.
- January 2015 – Enforcement Undertaking issued under Section 106 following an external 'Well-Led' governance review which highlighted governance and leadership weaknesses.
- 22 October 2015 –Enforcement Undertaking issued under Section 111 which reflected the deterioration in the Trust's financial position with no recovery plan in place;

(continued overleaf)

## 6. Other matters on which we report by exception - adequacy of arrangements to secure value for money (cont.)

— 27 October 2015 –Enforcement Undertaking issued under Section 106 reflecting weaknesses in the Trust's governance and financial systems. At the time it was considered that the Trust did not ensure that its deteriorating financial position was identified or reported to the Board or Monitor in a timely manner.

In addition, the Trust was inspected by the Care Quality Commission during 2014/15. The overall rating of the Trust is "requires improvement". The Trust was re-inspected in October 2016 and is awaiting the results of this inspection. As at 31 March 2017, the 'requires improvement' rating stands.

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Despite making financial and operational improvements in year, most notably the achievement of the Trust's financial control target agreed with NHS Improvement at the start of the year, the Trust remains in breach of its licence with the above enforcement actions remaining in place at 31 March 2017.

With exception of the matters reported above, we are satisfied that in all other material respects the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2017.

## 7. We have completed our audit

We certify that we have completed the audit of the accounts of Heart of England NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

# Scope and responsibilities

As described more fully in the Statement of Accounting Officer's Responsibilities on page 67 of the Annual Report the accounting officer is responsible for the preparation of financial statements that give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the UK Ethical Standards for Auditors. A description of the scope of an audit of financial statements is provided on our website at www.kpmg.com/uk/auditscopeother2014. This report is made subject to important explanations regarding our responsibilities, as published on that website, which are incorporated into this report as if set out in full and should be read to provide an understanding of the purpose of this report, the work we have undertaken and the basis of our opinions.

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General, as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

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This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust as a body, for our audit work, for this report or for the opinions we have formed.

**Andrew Bostock** **for and on behalf of KPMG LLP**
*Chartered Accountants and Statutory Auditor*
One Snowhill, Snowhill Queensway, Birmingham, B4 6GH

30 May 2017

KPMG

## PRIMARY STATEMENTS
## Statement of Comprehensive Income for the year ended 31 March 2017

| | Note | 2016/17 £000 | 2015/16 £000 |
|---|---|---|---|
| Operating income from patient care activities | 4.1 | 624,611 | 613,818 |
| Other operating income | 4.6 | 84,526 | 58,593 |
| Total operating income from continuing operations | | 709,137 | 672,411 |
| Operating expenses | 5.1 | (725,638) | (711,731) |
| **OPERATING DEFICIT FROM CONTINUING OPERATIONS** | | **(16,501)** | **(39,320)** |
| Finance income | 7 | 69 | 188 |
| Finance costs - financial liabilities | 8.1 | (220) | (242) |
| Finance costs - unwinding of discount on provisions | | (3) | (3) |
| PDC dividends payable | | (5,983) | (6,593) |
| **NET FINANCE COSTS** | | **(6,137)** | **(6,650)** |
| Gains/(losses) of disposal of non-current assets | | (134) | (138) |
| Movement in fair value of investments | | 0 | 0 |
| **DEFICIT FOR THE YEAR FROM CONTINUING OPERATIONS** | | **(22,772)** | **(46,108)** |
| **Other comprehensive income** | | | |
| Impairments (1) | | (1,774) | 10,496 |
| Revaluations (1) | | 0 | 0 |
| Gain from transfer from demising bodies (1) | | 0 | 0 |
| Fair value (losses)/gains on available-for-sale financial investments (1) | | 0 | 0 |
| Other reserve movements | | 0 | 0 |
| **Total other comprehensive income** | | (1,774) | 10,496 |
| **TOTAL COMPREHENSIVE EXPENSE FOR THE YEAR** | | (24,546) | (35,612) |
| Prior year adjustments | | 0 | 0 |
| **TOTAL COMPREHENSIVE EXPENSE FOR THE YEAR** | | **(24,546)** | **(35,612)** |

(1) None of these items will be subsequently reclassified to income and expenditure.

## PRIMARY STATEMENTS
## Statement of Financial Position as at 31 March 2017

| | Note | 31 Mar 17 £000 | 31 Mar 16 £000 |
|---|---|---|---|
| **Non-current assets** | | | |
| Intangible assets | 9 | 2,005 | 10,695 |
| Property, plant and equipment | 10 | 251,824 | 256,150 |
| Investments | 12 | 0 | 0 |
| Trade and other receivables | 14 | 973 | 1,310 |
| Other financial assets | 29 | 0 | 0 |
| **Total non-current assets** | | **254,802** | **268,155** |
| **Current assets** | | | |
| Inventories | 13 | 10,749 | 9,144 |
| Trade and other receivables | 14 | 40,312 | 28,679 |
| Other financial assets | 29 | 0 | 0 |
| Cash and cash equivalents | 22 | 19,206 | 31,473 |
| **Total current assets** | | **70,267** | **69,296** |
| **Current liabilities** | | | |
| Trade and other payables | 15 | (102,115) | (86,878) |
| Borrowings | 17 | (480) | (480) |
| Other financial liabilities | | 0 | 0 |
| Provisions for liabilities and charges | 20 | (3,189) | (6,007) |
| Other liabilities | 16 | (6,296) | (6,471) |
| **Total current liabilities** | | **(112,080)** | **(99,836)** |
| **Total assets less current liabilities** | | **212,989** | **237,615** |
| **Non-current liabilities** | | | |
| Trade and other payables | 15 | 0 | 0 |
| Borrowings | 17 | (3,301) | (3,650) |
| Other financial liabilities | | 0 | 0 |
| Provisions for liabilities and charges | 20 | (6,172) | (5,903) |
| Other liabilities | 16 | 0 | 0 |
| **Total non-current liabilities** | | **(9,473)** | **(9,553)** |
| **Total assets employed** | | **203,516** | **228,062** |
| **Financed by** | | | |
| **Taxpayers' equity** | | | |
| Public Dividend Capital | | 196,709 | 196,709 |
| Revaluation reserve | 21 | 52,928 | 55,957 |
| Other reserves | | (169) | (169) |
| Income and expenditure reserve | | (45,952) | (24,435) |
| **Total taxpayers' and others' equity** | | **203,516** | **228,062** |

The annual accounts on pages 159 to 207 were approved by the Board of Directors on 24th May and signed on its behalf by:

Dame Julie Moore, Interim Chief Executive

## PRIMARY STATEMENTS

## Statement of Changes In Taxpayers' and Others' Equity for the year ended 31 March 2017

| | Note | Total taxpayers' and others' equity | Public Dividend Capital | Revaluation Reserve | Other Reserves | Income and Expenditure Reserve |
|---|---|---|---|---|---|---|
| **2016/17** | | £000 | £000 | £000 | £000 | £000 |
| **Taxpayers' and Others' Equity at 1 April 2016** | | **228,062** | **196,709** | **55,957** | **(169)** | **(24,435)** |
| Deficit for the year | | **(22,772)** | | | | (22,772) |
| Transfers between reserves | 21 | **0** | 0 | (1,255) | 0 | 1,255 |
| Impairments | 21 | **(1,774)** | | (1,774) | | 0 |
| Revaluation gains | 21 | **0** | | 0 | | |
| Other recognised gains and losses | | **0** | | 0 | 0 | 0 |
| Public Dividend Capital received | | **0** | 0 | | | |
| Public Dividend Capital repaid | | **0** | 0 | | | |
| Public Dividend Capital written off | | **0** | 0 | | | |
| Fair Value result on Available-for-sale financial investments | | **0** | | | | |
| Other reserve movements | 21 | **0** | 0 | 0 | 0 | 0 |
| **Taxpayers' and Others' Equity at 31 March 2017** | | **203,516** | **196,709** | **52,928** | **(169)** | **(45,952)** |

| | | Total taxpayers' and others' equity | Public Dividend Capital | Revaluation Reserve | Other Reserves | Income and Expenditure Reserve |
|---|---|---|---|---|---|---|
| **2015/16** | | £000 | £000 | £000 | £000 | £000 |
| **Taxpayers' and Others' Equity at 1 April 2015** | | **282,274** | **215,309** | **47,707** | **(169)** | **19,427** |
| Deficit for the year | | **(46,108)** | | | | (46,108) |
| Transfers between reserves | | **0** | 0 | (2,246) | 0 | 2,246 |
| Impairments | 21 | **10,496** | | 10,496 | | 0 |
| Revaluation gains | 21 | **0** | | 0 | | |
| Other recognised gains and losses | | **0** | | 0 | 0 | 0 |
| Public Dividend Capital received | | **0** | 0 | | | |
| Public Dividend Capital repaid | | **(18,600)** | (18,600) | | | |
| Public Dividend Capital written off | | **0** | 0 | | | |
| Fair Value result on Available-for-sale financial investments | | **0** | | | | |
| Other reserve movements | 21 | **0** | 0 | 0 | 0 | 0 |
| **Taxpayers' and Others' Equity at 31 March 2016** | | **228,062** | **196,709** | **55,957** | **(169)** | **(24,435)** |

## PRIMARY STATEMENTS
## Statement Of Cash Flows
## for the year ended 31 March 2017

| | Note | 2016/17 £000 | 2015/16 £000 |
|---|---|---|---|
| **Cash flows from operating activities** | | | |
| Operating deficit | | (16,501) | (39,320) |
| Depreciation and amortisation | | 14,192 | 17,326 |
| Impairments | | 11,466 | (867) |
| Income recognised in respect of capital donations | | (715) | (682) |
| Amortisation of PFI credit | | 0 | 0 |
| Increase in Trade and Other Receivables | 14 | (10,233) | 2,481 |
| Movement in Other Assets | | 0 | 0 |
| Increase in Inventories | 13 | (1,605) | (653) |
| Increase in Trade and Other Payables | 15 | 12,437 | 14,374 |
| Decrease in Other Liabilities | 16 | (175) | (30) |
| Decrease in Provisions | 20 | (2,552) | (3,193) |
| Tax (paid)/received | | 0 | 0 |
| Other movements in operating cash flows | | 0 | 0 |
| **Net cash (used in)/generated from operating activities** | | **6,314** | **(10,564)** |
| **Cash flows from investing activities** | | | |
| Interest received | | 74 | 185 |
| Purchase of financial assets | | 0 | 0 |
| Sales of financial assets | | 0 | 0 |
| Purchase of intangible assets | | (181) | (3,556) |
| Purchase of Property, Plant and Equipment | | (11,069) | (17,951) |
| Sales of Property, Plant and Equipment | | 0 | 0 |
| Receipt of cash donations to purchase capital assets | | 0 | 682 |
| **Net cash used in investing activities** | | **(11,176)** | **(20,640)** |
| **Cash flows from financing activities** | | | |
| Public dividend capital received | | 0 | 0 |
| Public dividend capital repaid | | 0 | (18,600) |
| Loans received | | 0 | 0 |
| Loans repaid | | 0 | 0 |
| Capital element of finance lease rental payments | 18 | (152) | (139) |
| Capital element of Private Finance Initiative Obligations | 19 | (206) | (197) |
| Interest paid | | 0 | 0 |
| Interest element of finance lease | 8 | (105) | (118) |
| Interest element of Private Finance Initiative obligations | 8 | (115) | (124) |
| PDC Dividend paid | | (6,838) | (5,816) |
| Cash flows from other financing activities | | 11 | 0 |
| **Net cash generated from/ (used in) financing activities** | | **(7,405)** | **(24,994)** |
| **(Decrease)/increase in cash and cash equivalents** | | **(12,267)** | **(56,198)** |
| **Cash and Cash equivalents at 1 April** | | **31,473** | **87,671** |
| **Cash and Cash equivalents at 31 March** | 22 | **19,206** | **31,473** |

## NOTES TO THE ACCOUNTS
## ACCOUNTING POLICIES

### 1.1 Basis of Preparation of Accounts

NHS Improvement has directed that the financial statements of NHS Foundation Trusts should meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the HM Treasury. Consequently, the following financial statements for Heart of England NHS Foundation Trust (the Trust) have been prepared in accordance with the DH GAM 2016/17 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to the Trust. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

### 1.2 Consolidation

The Trust is the Corporate Trustee to Heart of England NHS Foundation Trust Charitable Fund (Charity Number 1052330). The Trust has assessed that due to the materiality of the charity the application of IAS 27 (consolidated and separate Financial statements) will not be applied so consolidated accounts have not been prepared.

### 1.3 Income

Income 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 income for the Trust is contracts with commissioners in respect of healthcare services. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

The Trust makes an accrual in the statement of financial position at the year-end to account for the value of partially completed patient spells. The year on year movement in the value of this accrual is recorded within income from activities.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

### 1.4 Expenditure on goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

### 1.5 Intangible assets

**Recognition**

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

*Internally generated intangible assets*

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the trust intends to complete the asset and sell or use it;
- the trust has the ability to sell or use it;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

*Software*

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

**Measurement**

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

**Amortisation**

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. The amortisation periods for intangible assets are, in general, 5-10 years for software licences.

## 1.6 Property, Plant and Equipment

**Recognition**

Property, Plant and Equipment is capitalised where:

- 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 be provided to, the Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably. The cost must be where;
    - individually items have a cost of at least £5,000; or
    - collectively they 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
    - 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 e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

**Measurement**

*Valuation*

All property and plant assets are measured initially at cost, representing the costs 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.

For freehold and leasehold properties fair value is based on periodic, but at least quinquennial, rolling valuations performed by external independent valuers less subsequent depreciation and impairment losses. The valuations are performed with sufficient regularity to ensure that the carrying value does not differ significantly from fair value at the reporting date.

Short life equipment is valued at Depreciated Historic Cost due to the individually short life and low value of each asset. Non Short life equipment is assessed for fair value using depreciated replacement cost as a proxy. The Trust has concluded that there is no material difference between depreciated replacement cost and fair value for this class of assets.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

*Subsequent expenditure*

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

## NOTES TO THE ACCOUNTS
## ACCOUNTING POLICIES (continued)

*Revaluation and impairment*

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised as a reduction in operating expenses. This is a divergence from IFRS where this reversal would have been recognised in operating income but is in accordance with the GAM. Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. Impairments relating to a loss of economic benefits or a loss of service potential are recognised in operating expenses.

On an annual basis the Trust will transfer an amount from the revaluation reserve to the Income and Expenditure reserve to transfer the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve.

*Depreciation*

Items of Property, Plant and Equipment are depreciated on a straight line basis over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated. Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Depreciation is applied in the quarter after the asset is brought into use.

Assets in the course of construction and residual interests in off-statement of financial position sheet Private Finance Initiative contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively. Assets held under finance leases are depreciated over their estimated useful lives or, where shorter, the lease term.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as advised by the Trust's valuer, currently GVA. Leaseholds are depreciated over the primary lease term.

Equipment is depreciated evenly over the estimated life of the asset.

In assessing estimated useful economic lives, consideration is given to any contractual arrangements and operational requirements relating to particular assets. Unless otherwise determined by operational requirements, the depreciation periods for the principal categories of property, plant and equipment are, in general, as follows:

| | |
|---|---|
| plant & machinery | 5-15 years |
| transport equipment | 7 years |
| information technology | 5-8 years |
| furniture & fittings | 5-10 years |
| dwellings | up to 60 years |
| other buildings | up to 60 years |

**De-recognition of Property, Plant & Equipment**

Assets planned to be scrapped or demolished are held as operational assets with revised lives to reflect the period over which the assets economic life has been shortened. Once the asset has been disposed of it ceases to be recognised and is removed from the Trust's Fixed Asset Register.

Assets planned for sale on disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- there is documented management intent and approval in line with the Trust's Standing Financial Instructions to sell the asset;
- an active programme has begun to find a buyer and complete the sale;
- the asset is being actively marketed at a reasonable price;
- the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
- it is highly unlikely that the plan to sell the asset will be cancelled or materially changed so as to delay or impair the process such that the sale will take longer than 12 months or cease completely.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

## NOTES TO THE ACCOUNTS
## ACCOUNTING POLICIES (continued)

**Donated assets**

Donated non-current assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

**Private Finance Initiative (PFI) transactions**

PFI transactions which meet the International Financial Reporting Interpretations Committee 12 (IFRIC 12 - Service Concession Arrangements) definition of a service concession, as interpreted in HM Treasury's Financial Reporting Manual, are accounted for as 'on-Statement of Financial Position' by the Trust. The underlying assets are recognised as Property, Plant and Equipment at their fair value which is periodically assessed in line with the Trust's valuation policy. An equivalent financial liability is recognised in accordance with International Accounting Standard 17 (IAS 17 - Leases). The annual contract payments are split into the repayment of the liability, a finance cost and the charges for services. The finance cost is calculated using the effective interest rate for the scheme. The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

For PFI transactions which do not meet the IFRIC12 definition of a service concession, as interpreted in HM Treasury's Financial Reporting Manual, the PFI payments are recorded as an operating expense. Where the Trust has contributed to land and buildings, a prepayment for their fair value is recognised and amortised over the life of the PFI contract by charge to the Statement of Comprehensive Income. Where, at the end of the PFI contract, a property reverts to the Trust, the difference between the expected fair value of the residual on reversion and any agreed payment on reversion is built up over the life of the contract by capitalising part of the unitary charge each year, as property, plant and equipment.

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 (Leases). 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 (Property, Plant and Equipment).

PFI liability

The PFI liability is measured initially at the same amount as the fair value of the PFI asset and is subsequently measured as a finance lease liability in accordance with IAS 17 (Leases).

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.

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 cost and depreciated over the shorter of either remaining life of the contract or the life of the individual asset.

Assets contributed by the 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 Trust's Statement of Financial Position.

## 1.7 Transfers of functions (to /from) other NHS bodies/Local government bodies

For functions that have been transferred to the Trust from another NHS/Local government body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain/loss corresponding to the net assets/liabilities transferred is recognised within income/expenses but not within operating activities.

For property plant and equipment assets and intangible assets, the Cost and Accumulated Depreciation/Amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts.

For functions that the Trust has transferred to another NHS / Local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets/ liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. Adjustments to align the acquired function to the Foundation Trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers' equity.

## 1.8 Inventories

Inventories are valued at the lower of cost and net realisable value, on a first in first out basis. Each year end stock is assessed for slow moving, obsolete and defective stock and a provision made for this.

## 1.9 Research and Development

Expenditure on research is not capitalised, it is charged as an expense through the Statement of Comprehensive Income. Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

## 1.10 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 are short-term (3 months or less from date of acquisition) and are readily convertible to known amounts of cash with insignificant risk of change in value.

## 1.11 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

*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. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at Note 20 but is not recognised in the Trust's accounts.

*Non-clinical risk pooling*

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the 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 when the liability arises.

## 1.12 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 25 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are instead disclosed in Note 25.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

## 1.13 Expenditure on 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 annual leave entitlement earned but not taken by employees at the end of the period is recognised in the annual report and accounts to the extent that employees are permitted to carry-forward leave into the following period.

**Pension costs**

*NHS Pension Scheme*

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 Secretary of State, in England and Wales. It is not possible for the Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme. All eligible Trust employees are automatically registered to this qualifying workplace pension scheme without them needing to make an active decision to join.

*NEST scheme*

NEST (National Employment Savings Trust) is an automatic enrolment pension scheme available for Trust employees not eligible to join the NHS Pension scheme, They automatically become a member of this qualifying workplace pension scheme without them needing to make an active decision to join. It is a defined contribution pension scheme which enables the Trust to comply with it's legal duties from the Pensions Act 2008 regarding all staff having access to a workplace pension scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

## 1.14 Critical accounting judgements and key sources of estimation uncertainty

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

## 1.15 Critical judgements in applying accounting policies

The Trust is required under IAS1 (Presentation of Financial Statements) to disclose the critical judgements, apart from those involving estimations (see note 1.14) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the annual report and accounts. The following areas are where the application of the Trust's accounting polices involved significant judgements;

(a) The assumption within the Research and Development business unit is that it breaks even in any financial year. The head of the business unit regularly reviews the income and costs and flexes resource and obtains sources of income depending on the activity of the department.

(b) The Trust's policy on stock valuation is based on a first in first out basis. Some of the stock is valued manually and in some cases it has been necessary to value this stock on an average cost basis of stock purchased during the year. This has no material impact on the year end stock valuation.

## 1.16 Key sources of estimation uncertainty

The Trust is required under IAS1 (Presentation of Financial Statements), to disclose key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year. The Trust has reviewed the areas where there are sources of estimation uncertainty, including provision balances, PFI transactions, NHS injury scheme income and balances, income and debtor balances relating to contracted NHS income, debtor balances and asset valuations.

Within Provisions is an estimate of the value of the Kennedy review costs, the costs of putting right an environmental issue and the costs of putting right a clinical issue. The Kennedy review costs and the clinical issue costs are the estimated costs associated with the corrective action required as a result of the review, which included both clinical and non-clinical costs. The environmental provision is based on a specialist report and an assessment of the areas where the issue is required to be rectified over the next five years. In all of these cases, the actual cost could be different to the estimated values.

With the exception of the point above, the Trust has not made any further estimations or judgements that could have a significant risk of materially adjusting the carrying values of any other assets or liabilities within the next financial year.

## 1.17 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 non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

## 1.18 Foreign exchange

The functional and presentational currencies of the Trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. There are minimal foreign currency transactions.

## 1.19 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. However, they are disclosed in a separate note to the accounts (Note 22.1) in accordance with the requirements of the GAM.

## 1.20 Leases

**Finance leases**

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires.

The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

**Operating leases**

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received (e.g. reduced rentals or rent free periods) are added to the actual lease rentals invoiced and charged to operating expenses over the life of the lease to give a similar rental charge per year across each

year of the lease.

**Leases of land and buildings**

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

**Lessor**

Where the Trust acts as the lessor, the income due to the Trust is accounted for on an accruals basis.

## 1.21 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32 (Financial Instruments: Presentation). A charge, reflecting the forecast cost of capital utilised by the Trust, is paid over as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the actual average relevant net assets of the Trust during the financial year as set out in the "pre-audit" version of the annual accounts.

Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:

- donated assets;
- average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits with the exception of cash balances held in GBS accounts that relate to a short-term working capital facility;
- net assets and liabilities transferred from bodies which ceased to exist on 1 April 2015; and
- any PDC dividend balance receivable or payable.

The calculated dividend is not revised if any adjustments to net relevant assets are identified during the final audit process.

## 1.22 Other reserves

Other reserves were created to account for any differences between the value of fixed assets taken over by the Trust at inception and the corresponding figure in the opening capital debt.

## 1.23 Losses and Special Payments

Losses and special payments are incurred when there is an excess to pay on claims made through the NHS Litigation Authority for non-clinical claims or where the amount is below the excess in which case it is paid directly to the individual or organisation. This would be the case for small monetary value items such as spectacles, cash and clothing.

Losses and special payments are reported on an accruals basis, but exclude provisions for future losses.

## 1.24 Corporation Tax

NHS Foundation Trusts are potentially liable to corporation tax in certain circumstances. A review of other operating income is performed annually to assess any potential liability in conjunction with guidance on the HMRC website. As a result of this review it is concluded that the Trust did not have a corporation tax liability in 2015/16 or 2016/17.

## 1.25 Financial instruments and financial liabilities

*Recognition*

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made. Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described above. All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

*De-recognition*

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

*Classification and Measurement*

Financial assets are categorised as 'Fair Value through Income and Expenditure', 'Loans and

receivables', 'Available-for-sale' assets or assets 'Held to maturity'. Financial liabilities are classified as 'Fair value through Income and Expenditure' or as 'Other Financial liabilities'.

*Financial assets and financial liabilities at 'Fair Value through Income and Expenditure'*

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A

financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities. These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

*Loans and receivables*

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS debtors, accrued income and 'other debtors'. Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset. Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

*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 which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive income as an item of 'Other comprehensive income'. When items classified as 'available-for-sale' are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in Finance Costs in the Statement of Comprehensive Income.

*Other financial liabilities*

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities. Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

*Impairment of financial assets*

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only 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 the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

## 1.26 Going concern

The financial statements have been prepared on a going concern basis (see Note 2).

## a) IASB standard and IFRIC interpretations

The accounting standards listed below have been issued by the International Accounting Standards Board (IASB) but have not yet been adopted in the NHS in 2016/17. NHS bodies cannot adopt new standards unless they have been adopted in the HM Treasury FReM. The HM Treasury FReM generally does not adopt an international standard until it has been endorsed by the European Union for use by listed companies.

In some cases, the standards may be interpreted in the HM Treasury FReM and therefore may not be adopted in their original form. The following table lists changes issued by the IASB which have not yet been adopted:

| Change published | Financial year in which the change first applies |
|---|---|
| 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 11 (amendment) – acquisition of an interest in a joint operation | Not yet EU adopted. Expected to be effective from 2016/17. |
| IFRS 14 Regulatory Deferral Accounts | Not yet EU Endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DH group bodies. |
| IFRS 15 Revenue from contracts with customers | Application required for accounting periods beginning on or after 1 January 2018 but not yet adopted by the FReM: early adoption is not therefore permitted. |
| Annual improvements to IFRS: 2012-15 cycle | 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. |

The Trust has not adopted any of these policies early.

## NOTES TO THE ACCOUNTS

### Note 2 Going Concern

AS 1 requires management to assess, as part of the accounts preparation process, the NHS foundation trust's ability to continue as a going concern. The financial statements should be prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of the NHS foundation trust without the transfer of the services to another entity, or has no realistic alternative but to do so.

Table 6.2 of the FReM states that:

"The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern."

An assessment of the Trust's position under the HM Treasury's Financial Reporting Guidelines (FReM), issued for the Interpretation of paragraphs 25 to 26 of IAS 1 for the public sector context, has been undertaken. It is the Trust's view under this guidance that these accounts can be prepared on a going concern basis.

The Directors have performed their own internal review of the situation and all of the pertinent factors that need to be considered and have concluded that preparing the accounts on a going concern basis is reasonable.

The Trust has prepared its financial plans and cash flow forecasts on the continuing assumption that adequate funding will be received through the Department of Health and NHSI through the distressed funding facility and public dividend capital (PDC) support funding, which has been discussed with the NHSI team reviewing the financial position at the Trust, although this funding has not yet been finalised.

These funds are expected to be sufficient to prevent the Trust from failing to meet its obligations as they fall due and to continue until adequate plans are in place to achieve financial sustainability for the Trust.

The current economic environment for all NHS and NHS Foundation Trusts is challenging with ongoing internal efficiency gains necessary due to annual tariff (price) reductions, cost pressures in respect of national pay structures, non-pay and drug cost inflation, as well as nationally set contract penalties for contract performance deviations, combined with commissioner (CCG) expectations to reduce activity through ensuring care can be better provided within the community, i.e. managed outside the Hospital. The Trust has a plan to reduce the deficit in 2017/18 and return to surplus in 2018/19 but at the same time recognises there are challenges in managing the cash position. As a consequence the Trust may require external funding to ensure the levels of its services are maintained in 2017/18. This has been discussed by the Board of Directors and NHSI and the Trust anticipates that support may be required over the next three years while the financial recovery plan is completed.

The Board of Directors approved an funding application to NHSI in 2016/17 but due to effective cash management the funding was not required so the application was not submitted to NHSI. The Board of Directors had agreed the terms set out in the Department of Health funding agreement. The cash position of the Trust is monitored weekly and a monthly assessment is made in advance of the cash support draw down deadlines. The Trust stays in regular contact with the NHSI cash support team and the potential requirement for support has been discussed. There has been no indication that the Trust would be refused funding at the time an application is made.

Whilst the Board of Directors is aware of the cash pressures the Trust is facing, a funding application has not yet been approved. The need for additional funding can be delayed until the latter part of the financial year giving time to assess the case for becoming a single legal entity with UHB, as set out in section 1 of the Performance Report. The need for additional funding may be avoided completely dependent on the result of this assessment and the timelines should the initiative move forward.

## NOTES TO THE ACCOUNTS

### Note 3 Operating Segments

IFRS 8 Operating Segments requires the Trust to set out the segments included in these acocunts. The Trust is reporting one segment, Operational Healthcare which contains the core activities of the Trust that fall under the remit of the Clinical Sites and Divisions ('Divisions'). This activity is primarily the provision of NHS healthcare, either to patients and charged to the Clinical Commissioning Groups (CCGs) via the local delivery plan (LDP), or where healthcare related services are provided to other Trusts, Foundations Trusts, NHS England, CCGs and Local Councils and charged at service level agreement (SLA) prices.

The Operational Healthcare segment comprises the five clinical Divisions which in 2016/17 were CSS, Womens and Children's,Emergency Care, Medicine and Surgery. These Divisions existed from April 2016, and were a reallocation of directorates from the five clinical divisions that in 2015/16 were known as Good Hope, Solihull, Heartlands, Clinical Support Services and Women's and Children's Services. These Divisions have similar economic characteristics, the nature of the services they offer are the same (free NHS care), they have similar customers (the general public from the surrounding geographical areas) and have the same regulators (NHSI, Care Quality Commission and the Department of Health). The Divisions are managed by the Director of Operations who works closely with the Medical Director and Chief Nurse. This group of individuals make decisions alongside the Director of Finance and the Deputy Chief Executive about the allocations of budgets, capital funding and other financial decisions and the Chief Operating Decision maker for the Operational Healthcare segment is the Board of Directors.

All of the Trust's activities are based in the UK and its principal activity is healthcare. The Trust's registered address is Devon House, Heartlands Hospital, Bordesley Green East, Birmingham, B9 5SS.

### Note 4.1 Income from patient care activities

| | 2016/17 Total £000 | 2015/16 Total £000 |
|---|---|---|
| NHS Foundation Trusts | **0** | 0 |
| NHS Trusts | **0** | 0 |
| CCGs and NHS England | **617,390** | 586,141 |
| Local Authorities | **3,573** | 5,449 |
| Additional income for delivery of healthcare services | **0** | 18,600 |
| NHS Other | **5** | 0 |
| Non NHS: Private patients | **706** | 676 |
| Non-NHS: Overseas patients (non-reciprocal) | **404** | 251 |
| NHS injury scheme (was RTA) | **2,533** | 2,701 |
| **TOTAL** | **624,611** | **613,818** |

In 2015/16 the Trust received £18.6m from the Department of Health as one-off additional funding for delivery of healthcare services. The value was calculated as the difference between the Trust's planned capital expenditure for the year and the forecast as at month 7.

NHS Injury Scheme income is subject to a provision for doubtful debts of 22.94% (21.99% in 2015/16) to reflect expected rates of collection.

## NOTES TO THE ACCOUNTS

### Note 4.2 Income from patient care activities by type

| | 2016/17 Total £000 | 2015/16 Total £000 |
|---|---|---|
| Elective income | **95,003** | 90,893 |
| Non elective income | **191,088** | 180,253 |
| Outpatient income | **97,500** | 90,700 |
| A & E income | **27,219** | 27,250 |
| Other NHS clinical income | **191,497** | 183,852 |
| Community services income from CCGs and NHS England | **18,661** | 18,642 |
| Additional income for delivery of healthcare services | **0** | 18,600 |
| Private patient income | **706** | 676 |
| Other clinical income | **2,937** | 2,952 |
| **TOTAL** | **624,611** | **613,818** |

### Note 4.3 Split of income from activities arising from Commissioner Requested Services

Of the total income from activities, £620,963k (2015/16 £591,590k) is commissioner requested services income. Commissioner requested services are defined in the provider licence and are services that the commissioners believe would need to be protected in the event of provider failure.

### Note 4.4 Overseas Visitor's Patient's Income

| | 2016/17 Total £000 | 2015/16 Total £000 |
|---|---|---|
| Income recognised this year (1) | 404 | 251 |
| Cash payments received in-year (relating to invoices raised in current and previous years) | 340 | 261 |
| Amounts added to provision for impairment of receivables (relating to invoices raised in current and prior years) | 444 | 363 |
| Amounts written off in-year (relating to invoices raised in current and previous years) | 0 | 0 |

(1) This income £404k (2015/16 £251k) is charged by the Trust directly to patients who are not entitled to free NHS care under the Department of Health 'Guidance on implementing overseas visitor hospital charging regulations 2015'.

## NOTES TO THE ACCOUNTS

### Note 4.5 Operating Lease Income

| | 2016/17 Total £000 | 2015/16 Total £000 |
|---|---|---|
| **Operating Lease Income** | | |
| Rents recognised as income in the year | 0 | 62 |
| Contingent rents recognised as income in the year | 0 | 0 |
| **TOTAL** | **0** | **62** |
| | | |
| **Future minimum lease receipts due** | | |
| not later than one year; | 0 | 0 |
| later than one year and not later than five years; | 0 | 0 |
| later than five years. | 0 | 0 |
| **TOTAL** | **0** | **0** |

The Trust leased the Clinical Waste Facility based at the Yardley Green Road site to Tradebe Healthcare Limited (formerly Britcare Limited) until March 2016.

### Note 4.6 Other Operating Income

| | 2016/17 Total £000 | 2015/16 Total £000 |
|---|---|---|
| Sustainability and transformation fund income | 25,192 | 0 |
| Research and development | 4,589 | 4,611 |
| Education and training | 22,607 | 21,535 |
| Charitable and other contributions to expenditure | 715 | 682 |
| Non-patient care services to other bodies | 7,038 | 8,613 |
| Support from Dept of Health for mergers | 0 | 0 |
| Car parking income | 4,865 | 4,814 |
| Staff accommodation rentals | 290 | 257 |
| Clinical excellence awards | 580 | 720 |
| Catering income | 1,259 | 1,206 |
| Property rentals | 1,986 | 922 |
| Rental revenue from operating leases | 0 | 62 |
| Amortisation of PFI deferred credits | 0 | 0 |
| Other | 15,405 | 15,171 |
| **TOTAL** | **84,526** | **58,593** |

In 2016/17 the Department of Health provided £25,192k (2015/16 £nil) in Sustainability and Transformation Fund (STF) income. The STF scheme was introduced in an attempt to bring the provider sector back into financial sustainability and is linked to individual trusts hitting specific financial targets and performance targets. The Trust received its full allocation for 2016/17 following successful delivery of required targets as well as incentive and bonus allocations.

Car Parking includes £1,296k (2015/16 £1,352k) of income from charging staff who park on Trust Premises. Car parking income covers the cost of the car park and security staff, ground maintenance, services and utility and capital charges.

Other income for 2016/17 of £15,405k (2015/16 £15,171k) includes £0.5m (2015/16 £1.3m) of Community Services income. Maternity pathways income is £3.6m (2015/16 £3.9m) for services provided to other Trusts relating to maternity pathways registered at that Trust. The remaining income is for many smaller income stream services that are not individually material.

Property rentals of £1,986k (2015/16 £922k) comprises a number of agreements with third party organisations of both a formal and informal nature for the rental of Trust space.

## NOTES TO THE ACCOUNTS
## Note 5.1 Operating Expenses

| | 2016/17 Total £000 | 2015/16 Total £000 |
|---|---|---|
| Employee Expenses (1) | 443,267 | 436,848 |
| Drug costs | 72,883 | 68,307 |
| Supplies and services - clinical (excluding drug costs) | 77,001 | 77,341 |
| Supplies and services - general | 18,988 | 18,860 |
| Establishment | 7,360 | 5,972 |
| Research and development | 2,937 | 3,281 |
| Transport (Business travel only) | 1,154 | 1,223 |
| Transport (Other) | 1,265 | 1,235 |
| Premises | 28,912 | 28,467 |
| Increase/(decrease) in bad debt provision | 2,766 | 10,148 |
| Rentals under operating leases | 1,343 | 1,337 |
| Change in provisions discount rate | 261 | (2) |
| Inventories written down (net, including inventory drugs) | 451 | 155 |
| Inventories consumed (excluding drugs) | 0 | 0 |
| Depreciation on property, plant and equipment | 13,269 | 16,254 |
| Amortisation on intangible assets | 923 | 1,072 |
| Impairments of property, plant and equipment (2) | 3,672 | (867) |
| Net Impairments of intangible assets | 7,794 | 0 |
| Audit fees (3) | | |
| audit services - statutory audit | 96 | 101 |
| audit services - regulatory reporting | 18 | 39 |
| audit services - charity accounts | 0 | 0 |
| Clinical negligence | 21,913 | 15,353 |
| Loss on disposal of investments | 0 | 0 |
| Loss on disposal of intangible fixed assets | 0 | 0 |
| Loss on disposal of land and buildings | 0 | 0 |
| Loss on disposal of other property, plant and equipment | 0 | 0 |
| Legal fees | (254) | (5) |
| Consultancy costs (4) | 1,565 | 5,673 |
| Internal audit costs (5) | 445 | 1,215 |
| Training, courses and conferences | 3,642 | 2,529 |
| Patient travel | 3,061 | 3,089 |
| Car parking and Security | 1,602 | 1,404 |
| Restructuring | 74 | 365 |
| Early retirements | 102 | 43 |
| Hospitality | 5 | 83 |
| Publishing | 21 | 79 |
| Insurance | 416 | 805 |
| Other services | 6,259 | 9,805 |
| Losses, ex gratia and special payments | 21 | 61 |
| Other | 2,406 | 1,461 |
| **TOTAL** | **725,638** | **711,731** |

(1) Employee Expenses is broken down as follows:

| | £000 | £000 |
|---|---|---|
| Executive Directors | 1,018 | 1,619 |
| Non Executive Directors | 151 | 161 |
| Staff | 442,098 | 435,068 |
| | 443,267 | 436,848 |

(2) Relates to the revaluation of assets. These impairments are due to a change in market price. Further details can be found in note 11

(3) The audit fee of £96k (2015/16 £101k) relates to statutory audit work, including the fees for additional work on revaluation and includes VAT of £16k. Regulatory reporting fees are for Quality Accounts and includes £3k of VAT. There has been £0k (2015/16 £0k) of Other Audit work. The Trust's contract with its auditors provides for a limitation on the auditor's liability of £2m (2015/16 £5m).

(4) In 2015/16 Ernst and Young were paid £1.2m to provide support to the financial recovery programme, appointed by the Trust with support from Monitor. The costs in 2016/17 were £593k for work done up to July 2016.

(5) In 2015/16 Deloittes were paid £778k to provide part of the governance improvement programme that started in December 2015. In 2016/17 Deloitte provided internal audit and counterfraud work.

## Note 5.2 Operating lease expenditure

| | **2016/17 Total £000** | 2015/16 Total £000 |
|---|---|---|
| Hire of plant and machinery | **827** | 770 |
| Expenditure on other operating leases | **516** | 567 |
| **TOTAL** | **1,343** | **1,337** |

## Note 5.3 Analysis of Operating leases

| | **2016/17 Total £000** | 2015/16 Total £000 |
|---|---|---|
| Minimum lease payments | **1,343** | 1,337 |
| Contingent rents | **0** | 0 |
| Less sublease payments received | **0** | 0 |
| **TOTAL** | **1,343** | **1,337** |

| | **31 Mar 17 £000** | 31 Mar 16 £000 |
|---|---|---|
| Future minimum lease payments due: | | |
| not later than one year; | **1,425** | 934 |
| later than one year and not later than five years; | **1,927** | 1,551 |
| later than five years. | **0** | 0 |
| **TOTAL** | **3,352** | **2,485** |

The Trust holds various non-cancellable operating lease agreements within a lease portfolio which covers assets including medical equipment, vehicles, several short term leasehold buildings and land.

At the end of the 2016/17 year there were 23 (2015/16 18) lease agreements in place for various items of medical equipment (ranging from mattresses to CT scanners). The length of these leases ranges between five to fifteen years. There are 7 leases for motor vehicles for Community health workers. In addition, there are 8 operating contracts in place for the lease of land and buildings which includes Renal dialysis units. The lease agreements range from 10 to 15 years in duration.

The Trust utilises Leaseguard to support the renewal of the majority of the lease portfolio. The Trust does not have pre-determined purchase options written into the current lease agreements, but the right to purchase the leased assets is assessed at the decision point within each lease.

## NOTES TO THE ACCOUNTS
## Note 6.1 Employee Expenses

| | 2016/17 Total £000 | 2015/16 Total £000 |
|---|---|---|
| Wages and salaries | **348,828** | 341,022 |
| Social security costs | **32,210** | 25,667 |
| Pension costs - defined contribution plans Employers contributions to NHS Pensions | **40,117** | 38,641 |
| Pension Cost - other contributions | **0** | 0 |
| Termination benefits | **0** | 0 |
| Agency/contract staff | **22,542** | 31,357 |
| **TOTAL** | **443,697** | **436,687** |

In addition to the costs above, the Trust has incurred capitalised staff costs of £581k (£698k, 2015/16).

Total employee expenses do not include non executive director costs but include restructuring and early retirement costs as disclosed in Note 5.1.

## Note 6.2 Staff sickness absence

| | 2016/17 Number | 2015/16 Number |
|---|---|---|
| Days lost (long term) | **90,814** | 90,466 |
| Days lost (short term) | **39,802** | 38,896 |
| **Total days lost** | **130,616** | **129,362** |
| | | |
| **Total staff years** | **9,180** | 9,261 |
| Average working days lost | **14.2** | 14.0 |
| Total staff employed in the year (headcount) | **10,565** | 10,637 |
| Total staff employed in the year with no absence (headcount) | **3,791** | 4,039 |
| **Percentage staff with no sick leave** | **35.9%** | **38.0%** |

## Note 6.3 Monthly average number of employees (whole time equivalent)

| | 2016/17 Total Number | 2015/16 Total Number |
|---|---|---|
| Medical and dental | 1,037 | 1,050 |
| Ambulance staff | 0 | 0 |
| Administration and estates | 2,009 | 2,066 |
| Healthcare assistants and other support staff | 1,578 | 1,515 |
| Nursing, midwifery and health visiting staff | 3,072 | 2,973 |
| Nursing, midwifery and health visiting learners | 0 | 0 |
| Scientific, therapeutic and technical staff | 1,041 | 995 |
| Healthcare science staff | 455 | 453 |
| Social care staff | 0 | 0 |
| Bank and agency staff | 1,250 | 1,163 |
| Other | 0 | 0 |
| **TOTAL** | **10,442** | **10,215** |

Included in the above, there were 12 employees engaged on capital projects (12, 2015/16) and 3 staff engaged on the administration of the Charity (2, 2015/16).

## NOTES TO THE ACCOUNTS

### Note 6.4 Employee Benefits in kind

Other than Trust contributions to the NHS Pension Scheme, there were no employee benefits in kind in 2016/17 or 2015/16.

### Note 6.5 Early retirements due to ill health

| | 2016/17 Total | 2015/16 Total |
|---|---|---|
| Number of early retirements on the grounds of ill-health | 3 | 9 |
| Value of early retirements on the grounds of ill-health (£'000) | 354 | 493 |

The cost of these ill health retirements will be borne by the NHS Business Services Authority (Pensions Division).

### Note 6.6 Pension costs

Past and present employees are covered by the provisions of the two NHS Pensions 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 the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that ''the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these is as follows:

a) Accounting valuation

A valuation of the 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 the scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (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 representatives as deemed appropriate.

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

## NOTES TO THE ACCOUNTS

### Note 7 Finance income

| | 2016/17 | 2015/16 |
|---|---|---|
| | £000 | £000 |
| Interest on bank accounts | 69 | 188 |
| Interest on loans and receivables | 0 | 0 |
| Interest on available for sale financial assets | 0 | 0 |
| Interest on held-to-maturity financial assets | 0 | 0 |
| **TOTAL** | **69** | **188** |

### Note 8.1 Finance costs- financial liabilities

| | 2016/17 | 2015/16 |
|---|---|---|
| | £000 | £000 |
| Finance leases | **105** | 118 |
| Finance Costs in PFI obligations: | | |
| Main Finance Costs | **115** | 124 |
| Contingent Finance Costs | **0** | 0 |
| Other | **0** | 0 |
| **TOTAL** | **220** | **242** |

The Trust holds three Finance lease contracts all of which relate to building assets and in duration range from 25 years to 99 years. The buildings held under finance lease are the Birmingham Chest Clinic, The Glaxo Renal Unit and the Heartlands Education Centre Limited. Within these agreements the Trust does not have a contingent rent liability and does not have any outstanding sublease payments to be received.

The finance lease contracts held by the Trust do not contain any potential for the Trust to be exposed to contingent rent liabilities. The Birmingham Chest Clinic lease does not contain an option to purchase the building due to the part occupancy nature of the tenancy. Heartlands Education Centre Limited reverts to Trust ownership at the end of the lease term.

The finance leases held by the Trust do not restrict the Trust in any way due to relatively small size and structure of the borrowing.

## NOTES TO THE ACCOUNTS
## Note 9 Intangible assets
## Note 9.1 Intangible assets 2016/17

| | Total | Software licences (purchased) | Licences & trademarks (purchased) | Other (purchased) | Intangible Assets Under Construction |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| **Gross cost at 1 April 2016** | **21,268** | 13,282 | 0 | 0 | 7,986 |
| Additions - purchased | **27** | 27 | 0 | 0 | 0 |
| Additions - donated | **0** | 0 | 0 | 0 | 0 |
| Transfers by Normal absorption | **0** | 0 | 0 | 0 | 0 |
| Impairments | **(7,794)** | 0 | 0 | 0 | (7,794) |
| Reclassifications | **0** | 0 | 0 | 0 | 0 |
| Disposals | **0** | 0 | 0 | 0 | 0 |
| **Gross cost at 31 March 2017** | **13,501** | 13,309 | 0 | 0 | 192 |
| **Accumulated Amortisation at 1 April 2016** | **10,573** | 10,573 | 0 | 0 | 0 |
| Provided during the year | **923** | 923 | 0 | 0 | 0 |
| Impairments | **0** | 0 | 0 | 0 | 0 |
| Reclassifications | **0** | 0 | 0 | 0 | 0 |
| Revaluation surpluses | **0** | 0 | 0 | 0 | 0 |
| Disposals | **0** | 0 | 0 | 0 | 0 |
| **Accumulated Amortisation at 31 March 2017** | **11,496** | 11,496 | 0 | 0 | 0 |
| **Net book value** | | | | | |
| NBV - Purchased at 1 April 2016 | **10,674** | 2,688 | 0 | 0 | 7,986 |
| NBV - Donated at 1 April 2016 | **21** | 21 | 0 | 0 | 0 |
| **NBV total at 1 April 2016** | **10,695** | 2,709 | 0 | 0 | 7,986 |
| **Net book value** | | | | | |
| NBV - Purchased at 31 March 2017 | **2,005** | 1,813 | 0 | 0 | 192 |
| NBV - Donated at 31 March 2017 | **0** | | | | |
| **NBV total at 31 March 2017** | **2,005** | 1,813 | 0 | 0 | 192 |

The intangible asset base held by the Trust is currently valued using a depreciated cost model due to the individually low value of the assets and also due to the lack of evidence to suggest a fall in value. An active market does not exist and, as the Trust's intangibles are not income generating, the depreciated replacement cost model has been applied. The asset under construction relates to the electronic scanning of medical records which will be an asset that is internally generated, which has been impaired to a nominal value in the 2016/17 year due to the anticipation that this scheme will be aborted as alternative patient administration systems are investigated.

The Trust's intangible asset base has a finite life ranging from five to ten years and each asset is being amortised over this period. The Trust does not hold intangible assets funded by government grants.

## Note 9.2 Intangible assets 2015/16

| | Total | Software licences (purchased) | Licences & trademarks (purchased) | Other (purchased) | Intangible Assets Under Construction |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| **Gross cost at 1 April 2015** | **20,186** | 12,939 | 0 | 0 | 7,247 |
| Additions - purchased | **1,067** | 328 | 0 | 0 | 739 |
| Additions - donated | **15** | 15 | 0 | 0 | 0 |
| Transfers by Normal absorption | **0** | 0 | 0 | 0 | 0 |
| Revaluations | **0** | 0 | 0 | 0 | 0 |
| Reclassifications | **0** | 0 | 0 | 0 | 0 |
| Disposals | **0** | 0 | 0 | 0 | 0 |
| **Gross cost at 31 March 2016** | **21,268** | 13,282 | 0 | 0 | 7,986 |
| **Accumulated Amortisation at 1 April 2015** | **9,501** | 9,501 | 0 | 0 | 0 |
| Provided during the year | **1,072** | 1,072 | 0 | 0 | 0 |
| Impairments | **0** | 0 | 0 | 0 | 0 |
| Reclassifications | **0** | 0 | 0 | 0 | 0 |
| Revaluation surpluses | **0** | 0 | 0 | 0 | 0 |
| Disposals | **0** | 0 | 0 | 0 | 0 |
| **Accumulated Amortisation at 31 March 2016** | **10,573** | 10,573 | 0 | 0 | 0 |
| **Net book value** | | | | | |
| NBV - Purchased at 1 April 2015 | **10,674** | 3,427 | 0 | 0 | 7,247 |
| NBV - Donated at 1 April 2015 | **11** | 11 | 0 | 0 | 0 |
| **NBV total at 1 April 2015** | **10,685** | 3,438 | 0 | 0 | 7,247 |
| **Net book value** | | | | | |
| NBV - Purchased at 31 March 2016 | **10,674** | 2,688 | 0 | 0 | 7,986 |
| NBV - Donated at 31 March 2016 | **21** | 21 | 0 | 0 | 0 |
| **NBV total at 31 March 2016** | **10,695** | 2,709 | 0 | 0 | 7,986 |

## Note 10 Property, plant and equipment
## Note 10.1 Property, plant and equipment 2016/17

| | Total | Land | Buildings excluding dwellings |
|---|---|---|---|
| | £000 | £000 | £000 |
| **Cost or valuation at 1 April 2016** | **368,086** | 24,654 | 225,169 |
| Additions - purchased | **14,556** | 0 | 1,959 |
| Additions - leased | **0** | 0 | 0 |
| Additions - donated | **715** | 0 | 17 |
| Transfers by Modified absorption | **0** | 0 | 0 |
| Impairments charged to operating expenses | **(5,931)** | 0 | (5,931) |
| Impairments charged to revaluation reserve | **(8,189)** | (227) | (7,962) |
| Reversal of impairments | **8,674** | 0 | 8,674 |
| Reclassifications | **0** | 0 | 0 |
| Revaluation surpluses | **0** | 0 | 0 |
| Disposals | **(3,235)** | 0 | 0 |
| **Cost or valuation at 31 March 2017** | **374,676** | 24,427 | 221,926 |
| | | | |
| **Accumulated depreciation at 1 April 2016** | **111,936** | | 31,413 |
| Provided during the year | **13,269** | | 7,506 |
| Impairments recognised in operating expenses | **0** | | 0 |
| Reversal of impairments | **0** | | 0 |
| Reclassifications | **0** | | 0 |
| Revaluation surpluses | **0** | | 0 |
| Disposals | **(2,353)** | | 0 |
| **Accumulated depreciation at 31 March 2017** | **122,852** | 0 | 38,919 |
| | | | |
| **Net book value** | | | |
| NBV - Owned at 1 April 2016 | **239,267** | 24,654 | 178,737 |
| NBV - Finance lease & PFI Assets at 1 April 2016 | **11,024** | 0 | 11,024 |
| NBV - Donated at 1 April 2016 | **5,859** | 0 | 3,995 |
| **NBV total at 1 April 2016** | **256,150** | 24,654 | 193,756 |
| | | | |
| **Net book value** | | | |
| NBV - Owned at 31 March 2017 | **231,899** | 24,427 | 165,388 |
| NBV - Finance lease & PFI Assets at 31 March 2017 | **13,691** | 0 | 13,691 |
| NBV - Donated at 31 March 2017 | **6,234** | 0 | 3,928 |
| **NBV total at 31 March 2017** | **251,824** | 24,427 | 183,007 |

| Dwellings | Assets under Construction & POA | Plant & Machinery | Transport Equipment | Information Technology | Furniture & Fittings |
|---|---|---|---|---|---|
| £000 | £000 | £000 | £000 | £000 | £000 |
| 992 | 5,661 | 29,059 | (3) | 8,350 | 331 |
| 0 | 0 | 0 | 0 | 0 | 0 |
| 0 | 0 | 0 | 0 | 0 | 0 |
| 992 | 5,661 | 29,059 | (3) | 8,350 | 331 |

## NOTES TO THE ACCOUNTS
## Note 10.3 Property, plant and equipment 2015/16

| | Total | Land | Buildings excluding dwellings |
|---|---|---|---|
| | £000 | £000 | £000 |
| **Cost or valuation at 1 April 2015** | **338,815** | 26,447 | 194,929 |
| Additions - purchased | **18,123** | 680 | 4,595 |
| Additions - leased | **0** | 0 | 0 |
| 42,891 | **667** | 0 | 0 |
| Transfers by Modified absorption | **0** | 0 | 0 |
| Impairments charged to operating expenses | **(9,599)** | 0 | (7,059) |
| Impairments charged to revaluation reserve | **(9,893)** | (5,773) | (4,120) |
| Reversal of impairments | **30,855** | 0 | 30,855 |
| Reclassifications | **0** | 3,300 | 5,969 |
| Revaluation surpluses | **0** | 0 | 0 |
| Disposals | **(882)** | 0 | 0 |
| **Cost or valuation at 31 March 2016** | **368,086** | 24,654 | 225,169 |
| | | | |
| **Accumulated depreciation at 1 April 2015** | **96,426** | | 21,809 |
| Provided during the year | **16,254** | | 9,604 |
| Impairments recognised in operating expenses | **0** | | 0 |
| Reversal of impairments | **0** | | 0 |
| Reclassifications | **0** | | 0 |
| Revaluation surpluses | **0** | | 0 |
| Disposals | **(744)** | | 0 |
| **Accumulated depreciation at 31 March 2016** | **111,936** | 0 | 31,413 |
| | | | |
| **Net book value** | | | |
| NBV - Owned at 1 April 2015 | **228,237** | 26,447 | 158,968 |
| NBV - Finance lease & PFI Assets at 1 April 2015 | **4,144** | 0 | 4,144 |
| NBV - Donated at 1 April 2015 | **10,008** | 0 | 10,008 |
| **NBV total at 1 April 2015** | **242,389** | 26,447 | 173,120 |
| | | | |
| **Net book value** | | | |
| NBV - Owned at 31 March 2016 | **239,267** | 24,654 | 178,737 |
| NBV - Finance lease & PFI Assets at 31 March 2016 | **11,024** | 0 | 11,024 |
| NBV - Donated at 31 March 2016 | **5,859** | 0 | 3,995 |
| **NBV total at 31 March 2016** | **256,150** | 24,654 | 193,756 |

## Note 10.4 Additional Analysis of asset ownership

| | Total | Land | Buildings excluding dwellings |
|---|---|---|---|
| **At 31 March 2016** | **£000** | **£000** | **£000** |
| | | | |
| Freehold | **242,382** | 24,654 | 179,988 |
| Long Leasehold | **3,843** | 0 | 3,843 |
| Short Leasehold | **9,925** | 0 | 9,925 |
| **NBV total at 31 March 2016** | **256,150** | 24,654 | 193,756 |

## NOTES TO THE ACCOUNTS

## Note 11 Property Plant Equipment Revaluations in 2016/17

The Trust's revaluation policy requires a full revaluation every five years with an interim valuation required in-between. The last full valuation was completed as at 31 March 2013 and an interim valuation has been completed at 31 March 2016 and 31 March 2017. The Trust's valuers GVA, carried out this work in accordance with the terms of the Royal Institution of Chartered Surveyors' Valuation - Professional Standards, incorporating the International Valuation Standards (March 2012), the requirements of HM Treasury Financial Reporting Manual Guidelines and IAS 16 (Property Plant and Equipment). Public sector bodies, including the NHS, are required to apply the Revaluation Model set out in IAS 16 and value their capital assets to fair value.

Fair value is defined in IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction.

The assessment of fair value has been made on the assumption that the property is sold as part of the continuing enterprise in occupation (Existing Use Value).

**Non-Specialised Operational Assets**

The basis used for the valuation of non-specialised operational Trust-occupied property for accounting purposes under IAS 16 is fair value, which is the market value, subject to the assumption that the property is sold as part of the continuing enterprise in occupation.

**Specialised Operational Property**

Depreciated Replacement Cost (DRC) is the valuation approach adopted for reporting the value of specialised operational property for financial accounting purposes. The Royal Institute Of Chartered Surveyors Standards at Appendix 4.1,restating International Valuation Application (IVA 1) defines this as "the current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all relevant forms of obsolescence and optimisation".

**Revaluation Gains In 2016/17**

The revaluation that took place as at 31 March 2017 showed an decrease of £5,446k. Of this a net increase to the revaluation reserve of £1,174k is shown in the other comprehensive income section of the statement of comprehensive income. There is also a net charge to the statement of comprehensive income of £3,672k as a result of new impairement charges of £5,931k offset by reversal of previous impairments of £2,259k This would previously have been shown as income but now nets off cost as required in the GAM.

## Note 12 Investments

The Trust had no investments as 31 March 2016 or 31 March 2017.

## NOTES TO THE ACCOUNTS

### Note 13 Inventories
### Note 13.1 Inventories (by type)

| | 31 Mar 17 | 31 Mar 16 |
|---|---|---|
| | £000 | £000 |
| Drugs | 3,036 | 2,850 |
| Work in progress | 72 | 62 |
| Consumables | 7,452 | 6,120 |
| Energy | 189 | 112 |
| Other | 0 | 0 |
| **TOTAL** | **10,749** | **9,144** |

### Note 13.2 Analysis of inventories

| | 31 Mar 17 | 31 Mar 16 |
|---|---|---|
| | £000 | £000 |
| Opening carrying value | 9,144 | 8,491 |
| Add: Additions | 134,982 | 136,284 |
| Less: Inventories recognised in expenses | (132,926) | (135,476) |
| Less: Write-down of inventories recognised as an expense | (491) | (237) |
| Add: Reversal of any write down of inventories resulting in a reduction of recognised expenses | 40 | 82 |
| Other | 0 | 0 |
| **Carrying value at 31 March** | **10,749** | **9,144** |

## NOTES TO THE ACCOUNTS

### Note 14 Trade and other receivables
### Note 14.1 Trade and other receivables (by type)

| | 31 Mar 2017 £000 | 31 Mar 2016 £000 |
|---|---|---|
| **Current** | | |
| NHS Receivables -Revenue | 33,390 | 30,339 |
| NHS Receivables -Capital | 0 | 0 |
| Receivables due from NHS charities -Revenue | 0 | 0 |
| Other receivables with related parties -Revenue | 1,886 | 1,886 |
| Other receivables with related parties -Capital | 0 | 0 |
| Provision for impaired receivables | (9,241) | (16,509) |
| Prepayments | 6,137 | 5,542 |
| Accrued income | 504 | 749 |
| Interest receivable | 4 | 9 |
| PDC dividend receivable | 322 | 0 |
| VAT receivable | 1,005 | 630 |
| Other receivables -Revenue | 5,559 | 6,033 |
| Other receivables -Capital | 746 | 0 |
| **TOTAL** | **40,312** | **28,679** |
| | | |
| **Non-Current** | | |
| NHS Receivables -Revenue | 0 | 0 |
| NHS Receivables -Capital | 0 | 0 |
| Other receivables with related parties -Revenue | 3,114 | 2,675 |
| Provision for impaired receivables | (2,141) | (1,365) |
| Prepayments | 0 | 0 |
| Accrued income | 0 | 0 |
| Other receivables -Revenue | 0 | 0 |
| **TOTAL** | **973** | **1,310** |

## NOTES TO THE ACCOUNTS

### Note 14.2 Provision for impairment of receivables

| | 2016/17 | 2015/16 |
|---|---|---|
| | £000 | £000 |
| As at 1 April | 17,874 | 9,857 |
| Increase in provision | 7,370 | 10,148 |
| Amounts utilised | (9,258) | (2,131) |
| Unused amounts reversed | (4,604) | 0 |
| **At 31 March** | **11,382** | **17,874** |

### Note 14.3 Analysis of impaired receivables

| | 31 Mar 2017 | 31 Mar 2016 |
|---|---|---|
| | £000 | £000 |
| **Ageing of impaired receivables** | | |
| 0-30 days | 4,629 | 10,382 |
| 30-60 Days | 427 | 261 |
| 60-90 days | 329 | 239 |
| 90-180 days | 475 | 755 |
| Over 180 days | 5,522 | 6,237 |
| **TOTAL** | **11,382** | **17,874** |
| | | |
| **Ageing of non-impaired receivables past their due date** | | |
| 0-30 days | 0 | 0 |
| 30-60 Days | 948 | 875 |
| 60-90 days | 394 | 564 |
| 90-180 days | 1,687 | 1,215 |
| Over 180 days | 2,442 | 2,267 |
| **TOTAL** | **5,471** | **4,921** |

## NOTES TO THE ACCOUNTS

### Note 15 Trade and other payables

| | 31 Mar 2017 £000 | 31 Mar 2016 £000 |
|---|---|---|
| **Current** | | |
| Receipts in advance | 0 | 0 |
| NHS payables -Revenue | 6,675 | 2,091 |
| NHS payables -Capital | 0 | 0 |
| Amounts due to other related parties -Revenue | 0 | 0 |
| Amounts due to other related parties -Capital | 0 | 0 |
| Trade payables -Revenue | 25,447 | 14,862 |
| Trade payables -Capital | 7,880 | 4,547 |
| Social Security costs | 4,852 | 4,058 |
| PDC dividend payable | 0 | 533 |
| Other taxes payable | 4,187 | 4,133 |
| Other payables | 7,307 | 7,176 |
| Accruals | 45,767 | 49,478 |
| **TOTAL** | **102,115** | **86,878** |

### Note 16 Other liabilities

| | 31 Mar 2017 £000 | 31 Mar 2016 £000 |
|---|---|---|
| **Current** | | |
| Deferred Income | 6,296 | 6,471 |
| Deferred PFI credits | 0 | 0 |
| **TOTAL** | **6,296** | **6,471** |

There are no non-current other liabilities in 2016/17 (or 2015/16).

### Note 17 Borrowings

| | 31 Mar 2017 £000 | 31 Mar 2016 £000 |
|---|---|---|
| **Current** | | |
| Bank overdrafts | 0 | 0 |
| Drawdown in committed facility | 0 | 0 |
| Loans from Department of Health | 0 | 0 |
| Other Loans | 0 | 0 |
| Obligations under finance leases | 256 | 256 |
| Obligations under Private Finance Initiative contracts | 224 | 224 |
| **TOTAL** | **480** | **480** |
| | | |
| **Non-current** | | |
| Bank overdrafts | 0 | 0 |
| Drawdown in committed facility | 0 | 0 |
| Loans from Department of Health | 0 | 0 |
| Other Loans | 0 | 0 |
| Obligations under finance leases | 1,318 | 1,470 |
| Obligations under Private Finance Initiative contracts | 1,983 | 2,180 |
| **TOTAL** | **3,301** | **3,650** |

## NOTES TO THE ACCOUNTS

### Note 18 Finance lease obligations

| | Minimum Lease Payments 31 Mar 2017 £000 | Minimum Lease Payments 31 Mar 2016 £000 |
|---|---|---|
| **Gross lease liabilities** | **2,018** | **2,275** |
| **of which liabilities are due** | | |
| not later than one year; | **256** | 256 |
| later than one year and not later than five years; | **919** | 919 |
| later than five years. | **843** | 1,100 |
| Finance charges allocated to future periods | **(444)** | (549) |
| **Net lease liabilities** | **1,574** | **1,726** |
| not later than one year; | **256** | **256** |
| later than one year and not later than five years; | **628** | 628 |
| later than five years. | **690** | 842 |
| | **1,574** | **1,726** |

| | Present Value of Minimum Lease Payments 31 Mar 2017 £000 | Present Value of Minimum Lease Payments 31 Mar 2016 £000 |
|---|---|---|
| **Gross lease liabilities** | **1,648** | **1,903** |
| **of which liabilities are due** | | |
| not later than one year; | **255** | 255 |
| later than one year and not later than five years; | **846** | 846 |
| later than five years. | **547** | 802 |
| Finance charges allocated to future periods | **(489)** | (489) |
| **Net lease liabilities** | **1,159** | **1,414** |
| not later than one year; | **150** | 150 |
| later than one year and not later than five years; | **573** | 573 |
| later than five years. | **436** | 691 |
| | **1,159** | **1,414** |

## NOTES TO THE ACCOUNTS

### Note 19.1 PFI obligations (on SoFP)

| | 31 Mar 2017 | 31 Mar 2016 |
|---|---|---|
| | £000 | £000 |
| **Gross PFI liabilities** | **2,492** | **2,689** |
| **of which liabilities are due** | | |
| not later than one year; | 224 | 224 |
| later than one year and not later than five years; | 1,468 | 896 |
| later than five years. | 800 | 1,569 |
| Finance charges allocated to future periods | (285) | (285) |
| **Net PFI liabilities** | **2,207** | **2,404** |
| not later than one year; | 224 | 224 |
| later than one year and not later than five years; | 425 | 425 |
| later than five years. | 1,558 | 1,755 |
| | **2,207** | **2,404** |

### Note 19.2 On-SoFP PFI Commitments

The Trust is committed to make the following payments for on-SoFP PFIs obligations during the next year in which the commitment expires:

| | 31 Mar 2017 | 31 Mar 2017 | 31 Mar 2017 | 31 Mar 2016 |
|---|---|---|---|---|
| | Total | PFI 1 | PFI 2 | Total |
| | £000 | £000 | £000 | £000 |
| Within one year | **0** | 0 | 0 | 0 |
| 2nd to 5th years (inclusive) | **996** | 0 | 996 | 0 |
| 6th to 10th years (inclusive) | **0** | 0 | 0 | 904 |
| 11th to 15th years (inclusive) | **66** | 66 | 0 | 63 |
| 16th to 20th years (inclusive) | **0** | 0 | 0 | 0 |
| 21st to 25th years (inclusive) | **0** | 0 | 0 | 0 |
| 26th to 30th years (inclusive) | **0** | 0 | 0 | 0 |
| 31st to 35th years (inclusive) | **0** | 0 | 0 | 0 |
| 36th year and beyond | **0** | 0 | 0 | 0 |

### Note 19.3 On-SoFP PFI Service Charge Commitments

| | 31 Mar 2017 | 31 Mar 2017 | 31 Mar 2017 | 31 Mar 2016 |
|---|---|---|---|---|
| | Total | PFI 1 | PFI 2 | Total |
| | £000 | £000 | £000 | £000 |
| Within one year | **1,062** | 66 | 996 | 967 |
| 2nd to 5th years (inclusive) | **4,575** | 283 | 4,292 | 3,868 |
| Later than five years | **806** | 806 | 0 | 1,856 |
| Total | **6,443** | **1,155** | **5,288** | **6,691** |

## NOTES TO THE ACCOUNTS

## Note 19.4 PFI Contract Details

The Trust has entered into two PFI contracts:

**PFI 1 - Main Entrance and Retail Facility at Heartlands Hospital**

This is 25 year contract with BHE (Heartlands) Limited which commenced in August 2005. This contract has been treated as being on-statement of financial position by the Trust following a review of the contracts based on Treasury Taskforce Technical Note 1 "How to account for PFI transactions" which interprets IAS 16 (Property, Plant and Equipment) and IFRIC 12 (Service Concession Arrangements).

The contract states that the service provision must be made available for users of the Heartlands Hospital including patients, visitors and staff. The contract contains a range of measures upon which deficiency points are allocated if pre-agreed levels are not achieved. The deficiency points are valued and deducted retrospectively from the Trust unitary payment at the end of the following quarter. At the end of the contract, ownership of the Main Entrance structure transfers to the Trust, at this point the Trust is not liable to provide any compensation payment and the contract is deemed to have reached its natural termination. The Trust is entitled to terminate the contract voluntarily with 12 months written notice and there are specific circumstances such as hospital closure or significant reconfiguration.

**PFI 2 - Provision of Energy Management Services at Heartlands Hospital**

This is 15 year contract with Ener-G Combined Power Limited which commenced in August 2007. This contract has been treated as being on-statement of financial position by the Trust following a review of the contracts based on Treasury Taskforce Technical Note 1 (How to account for PFI transaction) which interprets IAS 16 (Property, Plant and Equipment) and IFRIC 12 (Service Concession Arrangements).

The contract is for the provision of combined heat and power facilities at the Heartlands Hospital. If either party terminates the contract before the end of the agreement, there is provision for either party to be liable to pay compensation as detailed within the contract. The assets are transferred at the end of the agreement and become assets of the Trust. The service provision is implicitly for the patients, visitors and staff of Heartlands Hospital.

The annual unitary payments of £63k (PFI1) and £966k (PFI2) made by the operator are included in the Statement of Comprehensive income on an accruals basis. There is a payment mechanism that allows for deductions to be made to the unitary payment where the quality standards set out in the contract are not met. The total charge made in 2016/17 was £1,029k (2015/16 £967k).

## NOTES TO THE ACCOUNTS
## Note 20 Provisions for liabilities and charges

| | Current 31 Mar 2017 £000 | Current 31 Mar 2016 £000 | Non-current 31 Mar 2017 £000 | Non-current 31 Mar 2016 £000 |
|---|---|---|---|---|
| Pensions relating to former directors | 0 | 0 | 0 | 0 |
| Pensions relating to other staff | 195 | 197 | 2,644 | 2,521 |
| Other legal claims | 257 | 348 | 0 | 0 |
| Agenda for Change | 0 | 0 | 0 | 0 |
| Redundancy | 0 | 0 | 0 | 0 |
| Kennedy Review | 1,064 | 2,114 | 0 | 0 |
| Other | 1,673 | 3,348 | 3,528 | 3,382 |
| **TOTAL** | **3,189** | **6,007** | **6,172** | **5,903** |

| | Total £000 | Pensions - other staff £000 | Other legal claims £000 | Agenda for Change £000 | Kennedy Review £000 | Redundancy £000 | Other £000 |
|---|---|---|---|---|---|---|---|
| **At 1 April 2016** | **11,910** | 2,718 | 348 | 0 | 2,114 | 0 | 6,730 |
| Change in the discount rate | **261** | 261 | 0 | 0 | 244 | 0 | (244) |
| Arising during the year | **876** | 156 | 231 | 0 | 0 | 0 | 489 |
| Utilised during the year | **(1,793)** | (195) | (244) | 0 | (513) | 0 | (841) |
| Reversed unused | **(1,896)** | (104) | (78) | 0 | (781) | 0 | (933) |
| Unwinding of discount | **3** | 3 | 0 | 0 | 0 | 0 | 0 |
| **At 31 March 2017** | **9,361** | **2,839** | **257** | **0** | **1,064** | **0** | **5,201** |
| Expected timing of cash flows: | | | | | | | |
| not later than one year; | **3,189** | 195 | 257 | 0 | 1,064 | 0 | 1,673 |
| later than one year and not later than five years; | **4,302** | 774 | 0 | 0 | 0 | 0 | 3,528 |
| later than five years. | **1,870** | 1,870 | 0 | 0 | 0 | 0 | 0 |
| **TOTAL** | **9,361** | **2,839** | **257** | **0** | **1,064** | **0** | **5,201** |

The 'Pensions- other staff' provision is made up of permanent injury and early retirement provisions. The calculations for these provisions are based on agreed annual payments, age, gender and estimated life expectancy. The final amount of payment that will be made is not known as this will depend on actual life expectancy which may differ from the estimated number of years. The estimated life expectancy is provided from Interim Life Tables provided by the Office for National Statistics. To the extent that some of these liabilities will not be settled for several years the provision is discounted using a nominal discount rate of 0.24% (2015/16 1.37%).

'Other legal claims' relate to personal legal claims that have been lodged against the Trust with the NHS Litigation Authority (NHSLA) but not yet agreed. The exact timing or amount of any payment will only be known once the case is heard, although it is expected that all cases will be resolved within the 2016/17 year.

Included in 'Other' is a provision for environmental corrections required in some sections of the Trust, provision for legal claims costs for cases being bought by members of staff, and provision for costs being pursued by commercial organisations.

No reimbursement is anticipated from any of these provisions, other than in some 'Other legal claims' when the Trust receives reimbursement for any sums paid out which exceed the Trust's excess level with the NHSLA.

## NOTES TO THE ACCOUNTS
## Note 21 Revaluation reserve

| | Revaluation Reserve -property, plant and equipment £000 |
|---|---|
| **Revaluation reserve at 1 April 2016** | **55,957** |
| Impairments | (1,774) |
| Revaluations | 0 |
| Transfers to other reserves | (1,255) |
| Other recognised gains and losses | 0 |
| Other reserve movements | 0 |
| **Revaluation reserve at 31 March 2017** | **52,928** |

| | |
|---|---|
| **Revaluation reserve at 1 April 2015** | **47,707** |
| Impairments | 10,496 |
| Revaluations | 0 |
| Transfers to other reserves | (2,246) |
| Other recognised gains and losses | 0 |
| Other reserve movements | 0 |
| **Revaluation reserve at 31 March 2016** | **55,957** |

All revaluation reserve movements relate to property, plant and equipment.

The transfers to other reserves is the amortisation of the revaluation reserve over the life the asset it relates to and is transferred to the I&E reserve.

In 2016/17 the Trust performed an interim revaluation exercise as required by the accounting policies. This resulted in an overall decrease in the asset value of £5,446k. Of this a gain of £6,415k increased the revaluation reserve and impairements of £8,189k were charged to the revaluation reserve.

## Note 22 Cash and cash equivalents

| | 31 March 2017 £000 | 31 March 2016 £000 |
|---|---|---|
| **At 1 April (as previously stated)** | 31,473 | 87,671 |
| Net change in year | (12,267) | (56,198) |
| **At 31 March** | **19,206** | **31,473** |
| | | |
| Broken down into: | | |
| Cash at commercial banks and in hand | 912 | 402 |
| Cash with the Government Banking Service | 18,294 | 31,071 |
| Other current investments | 0 | 0 |
| **Cash and cash equivalents as in SoFP** | **19,206** | **31,473** |
| | | |
| Bank overdrafts | **0** | **0** |
| **Cash and cash equivalents as in SoCF** | **19,206** | **31,473** |

## Note 22.1 Third party assets held by the NHS Foundation Trust

The Trust held £33k (£4k 31 March 2016) of cash at bank and in hand at 31 March 2017 which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

## NOTES TO THE ACCOUNTS

### Note 23 Contractual Capital Commitments

Commitments under contracts at the Statement of Financial Position date were:

| | 31 March 2017 | 31 March 2016 |
|---|---|---|
| | £000 | £000 |
| Property, Plant and Equipment | 2,127 | 1,445 |
| Intangible assets | 14 | 59 |
| **TOTAL** | **2,141** | **1,504** |

The majority of these commitments at 31 March 2017 relate to ICT asset schemes and radiology schemes.

### Note 24 Events after the reporting year

There have been no events after the reporting year.

### Note 25 Contingent Assets/Liabilities

| | 31 March 2017 | 31 March 2016 |
|---|---|---|
| | £000 | £000 |
| Gross value of contingent liabilities | (206) | (161) |
| Amounts recoverable against liabilities | 0 | 0 |
| **Net value of contingent liabilities** | **(206)** | **(161)** |
| Net value of contingent assets | 0 | 0 |

The contingent liabilities in 2016/17 (and 2015/16) were identified by the NHS Litigation Authority. It relates to non-clinical Liabilities to Third Parties (LTPS) claims, which are public and employer liability legal claims.

These liabilities are expected to be settled within a year, and no reimbursement is expected.

## NOTES TO THE ACCOUNTS
## Note 26.1 Related Party Transactions

During the year none of the Board members or parties related to them have undertaken any material transactions with the Trust.

All significant related party transactions are in relation to the primary activities of the Trust i.e. Provision of Healthcare.

The Trust has entered into a significant number of material transactions with the following organisations for which there are no guarantees given or received:

| | Income 31 March 2017 >£0.1m £000 | Income 31 March 2016 >£0.1m £000 |
|---|---|---|
| NHS Birmingham Crosscity CCG | 235,359 | 230,789 |
| NHS Solihull CCG | 142,969 | 139,699 |
| NHS England | 167,750 | 127,687 |
| NHS South East Staffs And Seisdon Peninsular CCG | 38,972 | 39,596 |
| Health Education England | 21,752 | 22,333 |
| NHS Birmingham South And Central CCG | 25,680 | 20,116 |
| Department of Health | 1,000 | 19,677 |
| NHS Sandwell And West Birmingham CCG | 9,305 | 8,571 |
| NHS Warwickshire North CCG | 7,267 | 6,880 |
| NHS Walsall CCG | 6,484 | 6,086 |
| Solihull Metropolitan Borough Council | 4,086 | 3,300 |
| Birmingham City Council | 38 | 2,364 |
| Burton Hospitals NHS Foundation Trust | 1,550 | 2,127 |
| NHS South Warwickshire CCG | 1,985 | 2,041 |
| The Royal Wolverhampton NHS Trust | 2,339 | 2,013 |
| NHS Redditch and Bromsgrove CCG | 1,881 | 1,623 |
| Sandwell and West Birmingham Hospitals NHS Trust | 1,688 | 1,425 |
| Public Health England (PHE) | 1,176 | 1,309 |
| NHS Coventry and Rugby CCG | 1,166 | 1,166 |
| NHS Cannock Chase CCG | 815 | 985 |
| Birmingham Children's Hospital NHS Foundation Trust | 1,031 | 881 |
| University Hospitals Birmingham NHS Foundation Trust | 729 | 846 |
| Birmingham Women's NHS Foundation Trust | 590 | 804 |
| Birmingham and Solihull Mental Health NHS Foundation Trust | 484 | 634 |
| Birmingham Community Healthcare NHS Trust | 480 | 534 |
| NHS Dudley CCG | 403 | 483 |
| NHS Wolverhampton CCG | 358 | 475 |
| NHS South Worcestershire CCG | 499 | 401 |
| NHS East Staffordshire CCG | 323 | 349 |
| University Hospitals Coventry and Warwickshire NHS Trust | 407 | 307 |
| Walsall Healthcare NHS Trust | 381 | 304 |
| Worcestershire Acute Hospitals NHS Trust | 321 | 297 |
| Sraffordshire and Stoke on Trent Partnership NHS Trust | 247 | 279 |
| NHS West Leicestershire CCG | 211 | 276 |
| NHS Stafford and Surrounds CCG | 167 | 243 |
| George Eliot Hospital NHS Trust | 89 | 221 |
| NHS Shropshire CCG | 304 | 213 |
| NHS Southern Derbyshire CCG | 298 | 185 |
| NHS Wyre Forest CCG | 243 | 175 |
| NHS Telford and Wrekin CCG | 195 | 169 |
| NHS Herefordshire CCG | 136 | 132 |
| NHS Nene CCG | 143 | 125 |
| NHS Gloucestershire CCG | 161 | 120 |
| **TOTAL** | **681,462** | **648,240** |

| | Expenditure 31 March 2017 >£0.1m £000 | Expenditure 31 March 2016 >£0.1m £000 |
|---|---|---|
| HM Revenue & Customs | 32,210 | 25,667 |
| NHS Litigation Authority | 21,913 | 15,782 |
| NHS Pension Scheme | 40,117 | 38,641 |
| Public Health England | 4,353 | 4,315 |
| NHS Blood and Transplant | 2,841 | 3,862 |
| West Midlands Ambulance Service NHS Foundation Trust | 2,878 | 2,648 |
| Birmingham Women's NHS Foundation Trust | 1,792 | 2,049 |
| Sandwell and West Birmingham Hospitals NHS Trust | 1,645 | 1,948 |
| University Hospitals Birmingham NHS Foundation Trust (1) | 3,198 | 1,698 |
| NHS Property Services | 1,272 | 652 |
| Community Health Partnerships | 0 | 554 |
| Birmingham City Council | 506 | 503 |
| Birmingham Community Healthcare NHS Trust | 184 | 400 |
| Birmingham and Solihull Mental Health NHS Foundation Trust | 1,429 | 330 |
| Birmingham Children's Hospital NHS Foundation Trust | 680 | 262 |
| The Royal Wolverhampton NHS Trust | 166 | 250 |
| Solihull Metropolitan Borough Council | 281 | 246 |
| Oxford Health NHS Foundation Trust | 253 | 240 |
| Wrightington, Wigan and Leigh NHS Foundation Trust (2) | 60 | 229 |
| NHS England | 159 | 176 |
| Care Quality Commission | 225 | 128 |
| **TOTAL** | **116,162** | **100,580** |

(1) In 2015/16 the Trust entered an agreement with University Hospitals Birmingham NHS Foundation Trust for management support. There is a charge for the Chief Executive and other salaries are recharged on a pro-rated cost basis. This arrangement has continued throughout 2016/17.

(2) In 2015/16 Wrightington, Wigan and Leigh NHS Foundation Trust recharged the Trust for the cost of the Chief Executive.

## NOTES TO THE ACCOUNTS
## Note 26.2 Related Party Balances

All significant related party balances are in relation to the primary activities of the Trust i.e. Provision of Healthcare.

The Trust has entered into a significant number of material transactions with the following organisations for which there are no guarantees given or received:

| | Receivables 31 March 2017 >£0.1m £000 | Receivables 31 March 2016 >£0.1m £000 |
|---|---|---|
| NHS England | 14,812 | 4,167 |
| Birmingham Women's NHS Foundation Trust | 410 | 294 |
| Burton Hospitals NHS Foundation Trust | 1,679 | 2,586 |
| Sandwell and West Birmingham Hospitals NHS Trust | 839 | 639 |
| Public Health England | 263 | 287 |
| Department of Works & Pensions | 5,000 | 2,248 |
| HM Revenue & Customs | 1,005 | 630 |
| NHS Birmingham Crosscity CCG | 3,738 | 8,017 |
| NHS Solihull CCG | 4,551 | 5,764 |
| NHS South East Staffs And Seisdon Peninsular CCG | 297 | 2,125 |
| University Hospital Birmingham NHS FT | 805 | 1,454 |
| Birmingham Community Healthcare NHS Trust | 396 | 507 |
| NHS Walsall CCG | 193 | 500 |
| Solihull Metropolitan Borough Council | 157 | 488 |
| NHS Birmingham South and Central CCG | 952 | 384 |
| Birmingham and Solihull Mental Health NHS Foundation Trust | 120 | 305 |
| George Eliot Hospital NHS Trust | 77 | 295 |
| The Royal Wolverhampton NHS Trust | 99 | 287 |
| NHS Wolverhampton CCG | 8 | 226 |
| NHS South Warwickshire CCG | 13 | 222 |
| Walsall Healthcare NHS Trust | 298 | 163 |
| Birmingham Children's Hospital NHS Foundation Trust | 410 | 156 |
| Walsall Metropolitan Borough Council | 37 | 134 |
| NHS Coventry and Rugby CCG | 33 | 119 |
| Health Education England | 177 | 104 |
| University Hospitals Coventry and Warwickshire NHS Trust | 115 | 101 |
| **TOTAL** | **36,484** | **32,202** |

## NOTES TO THE ACCOUNTS
## Note 26.2 Related Party Balances continued

| | Payables 31 March 2017 >£0.1m £000 | Payables 31 March 2016 >£0.1m £000 |
|---|---|---|
| HM Revenue & Customs | 9,039 | 8,191 |
| NHS Pension Scheme | 5,573 | 5,407 |
| NHS England | 348 | 1,406 |
| Sandwell and West Birmingham Hospitals NHS Trust | 1,204 | 1,348 |
| Public Health England | 1,582 | 1,184 |
| University Hospitals Birmingham NHS Foundation Trust | 1,441 | 1,153 |
| Birmingham Women's NHS Foundation Trust | 0 | 802 |
| Birmingham City Council | 85 | 316 |
| Northumbria Healthcare NHS Foundation Trust | 329 | 299 |
| Solihull Metropolitan Borough Council | 128 | 237 |
| Birmingham Community Healthcare NHS Trust | 180 | 208 |
| Birmingham Children's Hospital NHS Foundation Trust | 622 | 166 |
| NHS Solihull CCG | 331 | 166 |
| The Royal Wolverhampton NHS Trust | 11 | 145 |
| Birmingham and Solihull Mental Health NHS Foundation Trust | 335 | 119 |
| NHS Blood & Transplant | 735 | 106 |
| NHS Property Services | 1,021 | 8 |
| West Midlands Ambulance Service NHS Foundation Trust | 858 | 531 |
| **TOTAL** | **23,822** | **21,792** |

## NOTES TO THE ACCOUNTS
## Note 27 Key management personnel compensation

Under IAS 24 (Related Party Disclosures) there are additional disclosure requirements in respect key management personnel compensation. Note 4.4 discloses directors' remuneration as required under the Companies Act 2006. This note discloses compensation as defined under IAS 24.

Key management includes voting directors, both executive and non-executive. The compensation paid or payable in aggregate to key management for employment services is shown below:

| | 2016/17 | 2015/16 |
|---|---|---|
| | £'000 | £'000 |
| Short term employee benefits | **1,354** | **2,122** |
| Pension contributions | **52** | **111** |
| Other long term benefits | **0** | **0** |
| Post employment benefits | **0** | **0** |
| Termination benefits | **0** | **84** |
| Total | **1,406** | **2,317** |

There were no amounts owing to Key Management Personnel at the beginning or end of the financial year.

## Note 28 For PFI schemes deemed to be off-SoFP

**PFI 3 - Provision of Energy Management Services at Solihull Hospital**

The Trust holds a third PFI agreement with EnerG Combined Power Limited for the provision of energy services at Solihull Hospital. The scheme commenced in April 2010 and a unitary payment of £684k was paid in 2016/17 (801k in 2015/16). This is a 15 year agreement.

The Trust is accounting for this scheme as an off Statement of Financial Position PFI contract using the NHS Finance, Performance and Operations Guidance on "Accounting for PFI under IFRS" and also has been classified as a non finance lease under IAS 17.

In accordance with SIC 29 (Service Concession Arrangements), the Trust is committed to make the following payments for the service charge element of off-SoFP service concessions:

An estimated increase of 3% per annum has been added to reflect higher RPI and Inflation. Previous annual reports have not included this increase. The increase is in line with real amendments to prior years.

| | 31 Mar 2017 | 31 Mar 2016 |
|---|---|---|
| | Total | Total |
| | £000 | £000 |
| Within one year | 704 | 825 |
| 2nd to 5th years (inclusive) | 3,035 | 3,553 |
| Later than five years | 2,524 | 3,999 |
| Total | **6,263** | **8,377** |

## NOTES TO THE ACCOUNTS

## Note 29.1 Financial Risk Management

IFRS7 (Financial Instruments: Disclosures) requires disclosure of the role that financial instruments have had during the year in creating or changing the risks an entity faces in undertaking its activities.

The Trust is not exposed to significant financial risk factors arising from financial instruments. The continuing service provider relationship that the Trust has with local Clinical Commissioning (CCG) and the way those CCGs are financed, means that the Trust is not exposed to the degree of financial risk faced by business entities. In the current financial environment where affordability by CCG's has re-emerged as a theme, the Trust regularly reviews the level of actual and contracted activity with the CCG's to ensure that any income at risk is discussed and resolved at a high level at the earliest opportunity available. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

**Market Risk**

Market risk is the possibility that financial loss might arise as a result of changes in such measures as interest rates and stock market movements. The vast majority of the Trust's transactions are undertaken in sterling and so it is not exposed to foreign exchange risk and the Trust does not have any direct dealings with the stock market. Other than cash balances, the Trust's financial assets and liabilities carry nil or fixed rates of interest and the Trust's income and operating cash flows are substantially independent of changes in market interest rates. The Trust has not held cash on deposit in 2016/17 and the last deposit with National Loans Fund made in 2015/16 ended in September 2015.

**Credit Risk**

Credit risk is the possibility that other parties might fail to pay amounts due to the Trust. Credit risk arises from deposits with banks and financial institutions as well as credit exposures to the Trust's commissioners and other debtors. The Trust did not invest with banks and financial institutions in 2015/16. In the first half of 2015/16 the Trust placed money on the HM Treasury National Loans Fund and these investments were reported to the monthly Finance and Performance Committee but no investments have been made since September 2015. The Trust's net operating costs are incurred largely under annual service agreements with local CCGs, who are financed from resources voted annually by Parliament.

A regular review of large, old or problematic debt is performed and any issues escalated up to director level.

**Liquidity Risk**

Liquidity risk is the possibility that the Trust might not have funds available to meet its commitments to make payments. Prudent liquidity risk management includes maintaining sufficient cash and the availability of funding from an adequate amount of committed credit facilities. The Trust also seeks to minimise risk relating to prepayments made to suppliers, by keeping them to a minimum. Material prepayments are only made under contractual arrangements for periods not exceeding 12 months. The Trust has apopted tighter liquidity management policies in the year and performs monthly formal cash flow forecasts which are reproted to the Board as part of the finance report. The Trust ahs discussed arrangements with the Department of Health around short term finanncing facilities.

**Capital risk**

The Trust does not hold cash on deposit or any deposits so capital risk to the Trust is minimal.

## NOTES TO THE ACCOUNTS
## Note 29.2 Financial assets by category

| | Total | Loans and receivables | Available-for-sale |
|---|---|---|---|
| | £000 | £000 | £000 |
| **Assets as per SoFP** | | | |
| Trade and other receivables excluding non financial assets | **31,929** | 31,929 | 0 |
| Other Investments | **0** | 0 | 0 |
| Other Financial Assets | **0** | 0 | 0 |
| Cash and cash equivalents (at bank and in hand) | **19,206** | 19,206 | 0 |
| **Total at 31 March 2017** | **51,135** | 51,135 | 0 |
| Trade and other receivables excluding non financial assets | **23,456** | 23,456 | 0 |
| Other Investments | **0** | 0 | 0 |
| Other Financial Assets | **0** | 0 | 0 |
| Cash and cash equivalents (at bank and in hand) | **31,473** | 31,473 | 0 |
| **Total at 31 March 2016** | **54,929** | **54,929** | **0** |

The Financial Assets included above do not include Prepayments, PDC Receivable, amounts owing in respect of VAT from HMRC or amounts owing from the NHS Injury scheme. These are all included in Note 14.1 Trade receivables and other receivables.

## Note 29.3 Financial liabilities by category

| | Total | Other financial liabilities | Liabilities at fair value through I&E |
|---|---|---|---|
| | £000 | £000 | £000 |
| **Liabilities as per SoFP** | | | |
| Borrowings excluding Finance lease and PFI liabilities | **0** | 0 | 0 |
| Obligations under finance leases | **1,574** | 1,574 | 0 |
| Obligations under Private Finance Initiative contracts | **2,207** | 2,207 | 0 |
| Trade and other payables excluding non financial assets | **101,101** | 101,101 | 0 |
| Other financial liabilities | **0** | 0 | 0 |
| Provisions under contract | **9,361** | 9,361 | 0 |
| **Total at 31 March 2017** | **114,243** | **114,243** | **0** |
| Borrowings excluding Finance lease and PFI liabilities | **0** | 0 | 0 |
| Obligations under finance leases | **1,726** | 1,726 | 0 |
| Obligations under Private Finance Initiative contracts | **2,404** | 2,404 | 0 |
| Trade and other payables excluding non financial assets | **86,345** | 86,345 | 0 |
| Other financial liabilities | **0** | 0 | 0 |
| Provisions under contract | **9,191** | 9,191 | 0 |
| **Total at 31 March 2016** | **99,666** | **99,666** | **0** |

## NOTES TO THE ACCOUNTS
## Note 29.4 Fair values of financial assets

There is no difference between the book value and fair value of the financial assets at 31 March 2017.

## Note 29.5 Fair values of financial liabilities

There is no difference between the book value and fair value of the financial liabilities at 31 March 2017.

## Note 29.6 Foreign Currency Risk

The Trust has no foreign currency income and negligible foreign currency expenditure.

## Note 30 Losses and Special Payments

| | 2016/17 | 2016/17 | 2015/16 | 2015/16 |
|---|---|---|---|---|
| | Total number of cases | Total value of cases | Total number of cases | Total value of cases |
| | Number | Value £000's | Number | Value £000's |
| **LOSSES:** | | | | |
| 1. Losses of cash due to: | | | | |
| a. theft, fraud etc | 2 | 1 | 5 | 1 |
| b. overpayment of salaries etc. | | | 2 | 7 |
| c. other causes | 3 | 8 | 0 | 0 |
| 2. Fruitless payments and constructive losses | | | 0 | 0 |
| 3. Bad debts and claims abandoned in relation to: | | | | |
| a. private patients | | | 0 | 0 |
| b. overseas visitors | | | 0 | 0 |
| c. other | | | 0 | 0 |
| 4. Damage to buildings, property etc. (including stores losses) due to: | | | | |
| a. theft, fraud etc | | | 0 | 0 |
| b. stores losses | 10 | 97 | 3 | 180 |
| c. other | | | 0 | 0 |
| **TOTAL LOSSES** | **15** | **106** | **10** | **188** |
| **SPECIAL PAYMENTS:** | | | | |
| 5. Compensation under legal obligation | | | 0 | 0 |
| 6. Extra contractual to contractors | | | 0 | 0 |
| 7. Ex gratia payments in respect of: | | | | |
| a. loss of personal effects | 32 | 10 | 57 | 25 |
| b. clinical negligence with advice | | | 0 | 0 |
| c. personal injury with advice | 75 | 232 | 45 | 194 |
| d. other employment payments (excluding include special severance payments which are disclosed below) | | | 0 | 0 |
| e. other | | | 0 | 0 |
| 8. Special severance payments | | | 0 | 0 |
| 9. Extra statutory and regulatory | | | 0 | 0 |
| **TOTAL SPECIAL PAYMENTS** | **107** | **242** | **102** | **219** |
| **TOTAL LOSSES AND SPECIAL PAYMENTS** | **122** | **348** | **112** | **407** |

These losses (which are for approved cases only) are reported on an accruals basis excluding provision for future losses.

Legal claims totalling £231k (£194k, 2015/16) are included within these figures, but they are classified under 'Legal fees' rather than 'Losses, ex gratia and special payments' in Note 4.1 Operating Expenses.

There were no losses or claims exceeding £300,000 in 2016/17 or 2015/16.

## Note 31 Prior Year Adjustments

No prior year adjustments were applicable in 2016/17 or 2015/16 except for the restatement of income due to impairment reversals of £10,466k being offset against impairment cost in note 4.1 in line with the GAM.