University Hospitals Birmingham
NHS Foundation Trust

2008›2009
Annual Report & Accounts

This annual report covers the period
1 April 2008 to 31 March 2009

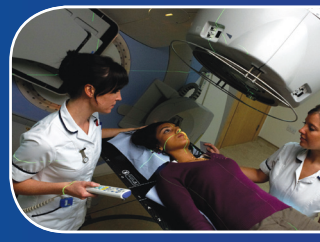
Presented to Parliament pursuant to Schedule 7, paragraph 25(4) of the National Health Service Act 2006

University Hospitals Birmingham NHS Foundation Trust
Annual Report & Accounts for the year ended 31 March 2009

Contents

University Hospitals Birmingham
NHS Foundation Trust

Section 1



2008 › 2009
Annual Report

This annual report covers the period
1 April 2008 to 31 March 2009

1.1 Names of persons who were Directors of the Trust

The Board is currently comprised as follows:

Chairman: Sir Albert Bore

Chief Executive: Julie Moore
Executive Director of Finance: Mike Sexton
Executive Medical Director: David Rosser
Executive Director of Delivery: Tim Jones
Executive Chief Nurse: Kay Fawcett
Chief Operating Officer (Acting): Kevin Bolger

Non-executive directors:
Professor David Bailey
Stewart Dobson
Tony Huq
David Ritchie
Clare Robinson
Professor Michael Sheppard
Gurjeet Bains

Caroline Wigley, Director of Organisation Development, left the Trust in August 2008. Tim Jones was appointed as Executive Director of Delivery and Kevin Bolger was appointed as Chief Operating Officer (Acting).

The Rt Revd Mark Santer retired as a Non-Executive Director on 30 November 2008. Ms Gurjeet Bains was appointed as a Non-Executive Director on 1 December 2008. Stewart Dobson, recently appointed Deputy Chair, and Clare Robinson, recently appointed Senior Independent Director, were each reappointed for a further term of three years as Non-Executive Directors on 25 September 2008.

1.2 Principal activities of the Trust

University Hospitals Birmingham NHS Foundation Trust is the leading university teaching hospital in the West Midlands. It provides traditional secondary care services to the South Birmingham catchment area. Specialist tertiary care is provided mainly across the West Midlands and a proportion of the Trust's activity is provided to patients who are referred from outside the region.
The Trust runs two hospitals, Queen Elizabeth Hospital and Selly Oak Hospital, which provide adult services to nearly 650,000 patients every year, from a single outpatient appointment to a heart transplant. The Trust is a regional centre for cancer, trauma, burns and plastics, and has the largest solid organ transplantation programme in Europe.

The Trust employs around 6,900 staff and is currently building Birmingham's first new acute hospital in 70 years. The £545 million hospital will open its doors to patients in the Summer of 2010.

The Trust's services are distributed across the two hospital sites as follows:

Queen Elizabeth Site	Selly Oak Site
General Surgery	Accident and Emergency
Breast Surgery	Medical Assessment Unit (MAU)
GI Surgery	General Medicine
GI Medicine	Elderly Care
Cardiology	Stroke Services
Cardiothoracic Surgery	Trauma
Renal Medicine	Vascular Surgery
Renal Surgery	Burns and Plastics
Urology	Hearing Assessment & Rehabilitation
Liver Surgery and Transplantation	Rheumatology
Liver Medicine	Diabetes
Ear, Nose, and Throat	Ophthalmology
Maxillofacial Surgery	Dermatology
Neurosciences	Ambulatory Care
Respiratory Medicine	Critical Care
Oncology	
Haematology	
Endocrinology	
Critical Care	

From July 2008, the Trust successfully re-organised its clinical management structure and created a fifth clinical division. The purpose of this was to create a transitional step between the existing structure and the models of care in the New Hospital. Each Division is led by a management team consisting of a Divisional Director, Director of Operations, and an Associate Director of Nursing. This triumvirate structure is mirrored through all the clinical specialties.

Royal Centre for Defence Medicine

The Trust is host to the Royal Centre for Defence Medicine (RCDM), the primary function of which is to provide medical support to military operational deployments. It provides secondary and specialist care for members of the armed forces and incorporates a facility for the treatment of service personnel who have been evacuated from an overseas deployment area after becoming ill or wounded/injured.
It is a dedicated training centre for defence personnel and a focus for medical research. The RCDM is a tri-service establishment, meaning that there are personnel from all three of the armed services. Although the RCDM is based at Selly Oak Hospital, defence personnel are fully integrated throughout both sites and treat both military and civilian patients. The Trust also holds the contract for providing medical services to military personnel evacuated from overseas via the "Aero med service".

Research and Development

The Trust has strong links with the University of Birmingham and Birmingham City University and takes a leading role in teaching and education. The Trust is also host to the Wellcome Trust Clinical Research Facility, which is Britain's largest biomedical charity and was established to strengthen clinical research in the NHS. This is a joint initiative between the Trust and the University of Birmingham Medical School, both of which are involved in the strategic planning of the service. See Birmingham Clinical Research Academy on page 5.

1.3 Trust Development and Performance during 2008/09

Strategic Planning

In 2008/09, the organisational vision and values were formalised and these define the focus and structure of strategic planning at the Trust. The vision is to deliver the best in care. The purpose that underpins this vision is to provide leading edge healthcare for the people and communities it serves locally, nationally, and internationally by delivering excellence in patient care through clinical expertise, research, innovation, teaching, training, and support services. The Trust has also established a set of values in conjunction with the vision and purpose; to treat all with respect, to take personal and team responsibility, to innovate and improve the way we do things, and to act with honesty in all we do.

Trust Performance

The Trust is one of the most consistently highest performing trusts in the NHS and has been rated "excellent" for financial management and "good" for quality of clinical and non-clinical services for the past three years by the Healthcare Commission.

The Trust has ended the financial year of 2008/09 in a strong position and has shown commendable performance against targets and standards. The main priorities for the Trust are detailed, along with a commentary providing an overview of work undertaken during the year and performance achievements.

Infection Prevention and Control

Infection prevention and control remained one of the Trust's key priorities in 2008/09. There have been significant reductions in MRSA (50% year on year) and Clostridium Difficile (40% year on year) rates which place the Trust below trajectory. Work has been undertaken with the Department of Health to implement the Saving Lives audit programme for infection prevention and control. The Trust also received an unannounced visit from the Healthcare Commission in August 2008 as part of the national Hygiene Code assessment programme. The results were positive and showed no breaches of the code.

Work continues with Chief Executive-led root cause analysis of infection cases, unannounced hand hygiene audits involving the Non-Executive and Executive Directors, deep cleaning programme, MRSA screening of elective and emergency admissions, isolation and co-horting arrangements and implementation of the Trust action plan.

Patient Experience and Quality

Quality and improving the patient experience continued to be priorities for the Trust in 200/09 and a number of steps were taken to further strengthen the arrangements in place for quality monitoring and improvement.

The Care Quality Group, led by the Executive Chief Nurse, is the formal Trust committee with responsibility for addressing patient

experience issues. The remit of this group is to develop a set of metrics to measure the care quality process, establish methods to capture patient feedback both Trustwide and locally, develop assurance processes around the progress with improvement of the patient experience by reviewing feedback from a variety of sources. It will also monitor progress against Divisional action plans to address issues raised within the national patient surveys to ensure that change is being delivered. The work of this group will continue in 2009/10.

A ward-based dashboard is in development as part of the Productive Ward project. This will allow ward staff to view a variety of care-related information including infection control, falls, complaints, length of stay, patient experience, and staffing. The impact of this will mean that specific issues can be quickly identified and provide an overall picture of performance by ward, therefore contributing to improved patient care. There is also a 'Back To The Floor' project in place for Senior Nurses which supports the dashboard work.

The Trust has established a Quality and Outcomes Research Unit that focuses on linking datasets from multiple information systems to monitor quality care delivery and care outcomes for patients. This capability will enable the Trust to closely monitor the outcomes of patients and assess clinical care delivery and the patient's experience.

The Clinical Quality Monitoring Group, led by the Executive Medical Director, is responsible for ensuring that the clinical services offered by the Trust are of the highest quality. The group assesses and monitors the quality of care provided and makes recommendations for actions to be taken. In 2009/10 the group will lead the Trust's process for the implementation of quality accounts reporting. See Quality Report in Section 3.

Operational Efficiency

Operational efficiency continues to be a priority for the organisation. Services review pathways to ensure that non-value added steps are removed and the patient experience is improved. This has supported the organisation to meet targets such as 18-week referral to treatment as well as reduce the number of appointment cancellations. The Trust has also made significant progress in implementing LEAN principles in Plastic Surgery theatres as a pilot area and has recently appointed a project manager to continue this work and roll it out across all theatres.

Through advances in information technology, the Trust will further develop the quality of service it provides to GPs such as reducing the turnaround times of clinical correspondence. The Trust is currently rolling out digital dictation across all specialties which will enable all clinic letters and discharge summaries to be available via the Trust's GP website in addition to patient results.

The Trust is currently streamlining its patient administration functions to continue to support improvements to the outpatient booking process; reducing cancellations; and delivering improvement to data quality. This will help ensure the pathway is efficient and patient-focussed.

Staff Survey

The Staff Survey results for 2008 were positive once again and the Trust performed in line with, or above, other acute providers in the majority of areas. Some 92% of staff felt their roles made a positive difference to patients.

Membership Strategy

2008/09 saw the Trust rationalise its membership to establish a robust database of 'quality' members which can be used to grow a more active, representative and value for money membership over the next 12 months and years to come. See Membership on page 45.

Birmingham Clinical Research Academy

The Birmingham Clinical Research Academy, launched to provide a high quality research support service, has already had significant successes, including a £10million Collaboration for Leadership in Applied Health Research and Care (CLAHRC) status and a £6.5 million National Institute for Healthcare Research (NIHR) Liver Unit. The Trust has also been designated as the first Cancer UK Research Centre. It continues to broaden its research activities as part of Birmingham Science City, with investment from Advantage West Midlands for development of a tissue biorepository and research bus. International links are being strengthened through partnerships with other research centres across Europe and the rest of the world.

In addition to its key research themes such as cancer, cardiovascular disease, metabolism and genetics, the research strategy focuses on translational research, speeding up the process of getting new scientific knowledge from the laboratory to the patient (from "bench to bedside"). The Trust is therefore integrating its research activities with education of staff, service improvement and quality measurement, and using the New Hospital development as a test-bed for new technologies and models of care. This will keep The Trust at the forefront of medical care.

A bid to become one of the UK's first Academic Healthcare Science Centres was jointly submitted with University of Birmingham and reached the shortlisting stage, though was not successful in its bid.

New Hospital and Clinical Service Redesign

Progress on the construction of the new hospital remains on time and on budget. All contractual obligations have, to date, been delivered and the Trust continues to monitor progress against them. A number of Clinical Service Redesign projects has been progressed to move existing practices and care models to those planned in the New Hospital.

The Trust has also commenced work on the operational commissioning programme which encompasses all of the planning and practical tasks associated with bringing the New Hospital into operational use.

Commissioning workstreams have been set up to undertake all of the planning associated with the physical transfer into the New Hospital. Each workstream broadly mirrors a New Hospital model of care. To underpin the process, a number of key personnel has been identified to provide expert advice and guidance on matters that will be relevant to all of the commissioning workstreams, e.g. communications, physical transfer, ICT, and workforce planning and staffing.

Social Responsibility

Over the last year the Trust has continued to place emphasis on its wider social responsibility and regeneration roles. Self assessment of Corporate Social Responsibility using the Sustainable Development Commission's toolkit continues to show that overall the Trust is

performing well with regard to increasing local employment, waste management and reducing energy consumption and furthering the use of less polluting products. The Trust is an active member of the Department of Health's regional Corporate Social Responsibility Group and has chaired the Waste Management sub-group.

The Trust also continues to play an active role in the wider life of Birmingham. The Trust aims to deliver the best in care and will do this in a way which reduces disadvantage and increases prosperity across Birmingham and the broader West Midlands. The Trust is a Champion of Marketing Birmingham and a Patron of the Birmingham Chamber of Commerce. The Trust plays a significant role in regional and sub-regional bodies such as Birmingham Science City, the Birmingham Employer Board, and Central Technology Belt.

Steps have also been taken to systematically identify key partners and stakeholders both in healthcare and in broader fields and as a result a programme has been put in place to strengthen key relationships.

The Learning Hub, key to broadening access to jobs and training in healthcare and construction activity related to the New Hospital, opened in August 2008. The ACTIVATE and Building Health vocational training projects now based at the Hub have enabled over 800 unemployed people to gain a job.

1.4 Principal Risks and Uncertainties Facing the Trust

The Trust has a robust system in place for the development and ongoing review of risk registers at a Trustwide, Divisional, and Departmental level. The key risks faced by the Trust can be summarised as follows:

- Risks to income
- Risks to costs
- Risks to activity
- Risks to clinical quality
- Risks to reputation
- Risks presented by the new hospital

The main uncertainties faced by the organisation relate to the external performance assessment framework and the standard NHS contract.

With regards to the external performance assessment framework, the expansion of the cancer targets presents a challenge, along with the 18 weeks referral to treatment target. The Trust receives as high a proportion of referrals from other trusts, which may refer patients late along the pathway, making these targets more challenging. Major progress has been made with reducing MRSA and C.diff rates, although bringing infection rates down further continues to be a challenge and will remain a top priority for the Trust.

As part of the standard NHS contract, commissioners are able to apply financial penalties to trusts for a range of performance issues. The main areas include significant activity variances that cannot be attributed to changes in demand, failure to achieve trajectories for MRSA and C-diff reductions, non-delivery of clinical quality indicators, CQUIN schemes and late submission of contract monitoring data. This remains a risk to the Trust and therefore a payment contingency has been built into the income plan.

1.5 Main trends and factors likely to affect the future development, performance, and position

It is expected that the external environment will continue to become more challenging, particularly as a result of:

- The impact of the 2009 budget and required efficiency savings
- The impact of the significant changes to the scope and structure of Payment by Results in 2009/10
- The inclusion of clinical quality indicators (CQUINS) as part of the standard NHS contract
- National plans for reducing mixed sex accommodation are significant for the Trust within the current facilities. From Summer 2010, the new hospital facilities will help address this challenge
- Commissioner service redesign plans will potentially have a significant impact on Trust plans
- The impact of the Darzi review and subsequent plans
- Full implementation of the European working time directive from August 2009
- The development of world-class commissioning and the impact on service provision
- The impact of the cancer reform strategy upon service planning and performance assessment
- Nationally-driven staff development and education and training initiatives
- Opportunities offered by Health Innovation and Education Cluster status to develop medical technology for the benefit of patients

The Trust's processes for assurance and performance management are continually revised to reflect national and local priorities. These processes also take account of requirements from the Care Quality Commission, Monitor, and other regulatory bodies. The Trust continues to place an increasing focus on quality, safety, and improving the patient experience. The internal performance framework is being further improved to reflect the Trust's vision and values.

The New Hospital is a significant factor that impacts on the Trust's development and performance. One of the key challenges is ensuring the project remains affordable and is delivered on time. There is rigorous monitoring and reporting mechanisms in place to ensure the New Hospital objectives are achieved. These are presented to the Board of Directors on a regular basis via detailed progress reports.

With regards to patient satisfaction, the Trust is developing its systems for obtaining patient feedback to enhance the existing methods. The mechanism for gathering real-time feedback is being implemented in all inpatient areas over the course of 2009/10. This will further improve the Trust's ability to listen and respond to patients.

Although the New Hospital will be opening in 2010, the Trust maintains environmental standards within the existing estate. There continues to be investment in the improvement of patient and public areas and steps taken to maximise privacy and dignity. However, the existing estate does present certain constraints around this matter. The organisation will be in a position to address these issues much more effectively in the New Hospital.

1.6 Finance and Performance

In line with recent years the Trust has again reported strong financial results for 2008/09. Total income has increased by 9.5% to £464.7 million ensuring that the Trust remains amongst the largest foundation trusts in the

country. Within this the Trust has achieved an income and expenditure surplus of £19.3 million which equates to 4.2% of turnover. This excellent financial performance is expected to result in the Trust achieving an overall Financial Risk Rating of 5 (the best rating available) from Monitor. Strengthening the underlying financial position has been a key objective for the Trust in advance of its move to a new PFI hospital from 2010/11 onwards. The achievement of significant surpluses ahead of the move has not been at the expense of healthcare provision to patients but has been part of the Trust's strategy to generate the cash required to fund a £25 million investment in new medical equipment in the New Hospital and will ensure the Trust is well-placed to manage the future increase in operating costs associated with the PFI.

Income and expenditure

The table below compares the original planned income and expenditure with the outturn position for 2008/09.

The largest component of the Trust's income is the provision of NHS healthcare, accounting for £375.0 million (80.7%) of the total. Non NHS clinical income contributes a further £12.5 million (2.7%) and this includes private patients, provision of healthcare to the military and costs recovered from insurers under the Injury Cost Recovery scheme.

The Trust has a number of other income streams which are not linked directly to patient care. These include levy funding for education which accounts for £28.9 million (6.2%) of the Trust's income in 2008/09 and income associated with Research and Development (R&D) activities which totals £10.8 million (2.3%). Education funding comprises the Service Increment for Teaching (SIFT), recognising the cost of training medical undergraduates from the University of Birmingham, the Medical and Dental Education Levy (MADEL) which supports the salary costs of post graduate doctors in training and support for Non-Medical Education and Training (NMET). R&D income includes grants from the National Institute of Health Research, support for the Wellcome Trust Clinical Research Facility, and funding for the Birmingham and Black Country Comprehensive Local Research Network, which is hosted by the Trust.

The Trust's Summarised Income and Expenditure (£M's)

	Plan 2008/09	Outturn Position 2008/09
Income	444.0	464.7
Expenditure	-411.6	-431.8
EBITDA	**32.4**	**32.9**
Depreciation	-11.1	-10.7
Dividend	-5.9	-5.9
Loss on asset disposal	0.0	-0.4
Interest	3.3	3.4
Net Surplus / (Deficit)	**18.7**	**19.3**

The balance of the Trust's income is attributable to services provided to other NHS bodies, trading activities and other miscellaneous items.

The main variances against plan in 2008/09 include additional healthcare income primarily for high cost drugs and devices paid for on a cost-per-case basis and additional R&D grant income. Both these sources carry corresponding expenditure commitments and therefore do not impact significantly on the Trust's bottom line surplus.

The largest item of expenditure is salaries and wages, accounting for £257.6 million, equivalent to 58.2% of total expenditure. Other significant components include £45.2 million on drugs (17.5%) and £62.3 million on Clinical Supplies and Services (24.2%).

Capital Expenditure Plan

In 2008/09 the Trust incurred £10.4 million of capital expenditure on new facilities and improving old environments. This is summarised below:

In addition to the above, during 2008/09 the Trust incurred £16.5 million of expenditure on enabling works relating to the New Hospital.

The Trust's planned capital expenditure over the next three financial years (2009/10 to 2011/12) totals £77 million. This plan runs alongside the development of the New Hospital. It is not anticipated that there will be any requirement to borrow against the Prudential Borrowing Limit during these years.

Of the £77 million capital programme, £25 million will be spent on protected buildings which are being retained for continuing use by the Trust.

The Selly Oak Hospital land is owned freehold and Queen Elizabeth Hospital is on a long-term lease from Birmingham City Council due to expire September 29, 2932.

Value for Money

The Trust's Financial Plan for 2008/09 included the delivery of cash- releasing efficiency savings of 4.5% against relevant budgets. In order to achieve this, a formal

Category	Capital Invested £ Million
Brought Forward Programmes from 2007/08	*2.6*
IT Replacement, Modernisation, Infrastructure and additional capacity	*0.9*
Retained Buildings	
• Development of West End building	*1.2*
• Relocation of RRPPS service offsite	*1.6*
• Other Works	*1.1*
Replacement of Equipment	*2.0*
Modernisation and Discretionary Spend:	
• New Equipment	*0.2*
• Other	*0.8*
Sub Total	***10.4***

cost improvement programme (CIP) totalling £11.5m was agreed for all Divisions and Corporate areas. This programme involved a combination of both cost reduction and income generation schemes.

In addition to the agreed annual cost improvement programme, further efficiency savings have been realised in the year through initiatives such as ongoing tendering and procurement rationalisation and a review of requests to recruit to both new and existing posts via the Workforce Approval Committee.

The Trust's use of resources is also assessed by the Healthcare Commission as part of the Annual Health Check based on the Financial Risk Ratings' assigned by Monitor. In the latest results published in October 2008 the Trust again achieved a rating of 'excellent' for the use of resources (based on 2007/08 outturn data).

Private Patient Income (PPI)

PPI was £3.5 million which is within the authorised limit of 1.23%.

University Hospital Birmingham Charities

The charitable funds for the Trust are administered by UHB Charities, a separate legal entity from the Trust. In 2008/09 the Trust received grants of £0.8 million from UHB Charities.

Audit Information

So far as the Directors are aware, there is no relevant audit information of which the auditors are unaware. The Directors have 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.

1.7 Policies in Relation to Disabled Employees and Equal Opportunities

The Trust's Single Equality Scheme was approved by the Board of Directors in July 2008. The scheme covers its responsibilities to employees with disabilities and all other diverse groups.

Disabled employees have regular access to the Trust's Occupational Health Services including ergonomic assessment of the workplace to ensure that access and working environment is appropriate to their needs. Staff who become disabled whilst in employment have access to these services and are also supported in moving posts with appropriate adjustments, should it become inappropriate for them to continue in their original post.

The Trust also ensures that staff with disabilities are able to access training opportunities. When booking onto training courses staff are asked if they have any special needs or requirements. If this is the case, arrangements are made. This includes the use of hearing loop facilities. A number of courses are also provided which focus on equality and diversity issues, and this includes equality and diversity workshops, disability awareness training, equality impact assessment training, cultural awareness workshops, recruitment and selection and deaf awareness programmes. All new staff receive information on equality and diversity issues during their induction. In addition a facility in partnership with Learn Direct is provided for staff who wish to improve upon their literacy and numeracy skills.
The Trust has achieved the 'two ticks' symbol which recognises employers as having appropriate approaches to people with disabilities. This requires employers to meet the following standards:

1. To interview all applicants with a disability who meet the minimum criteria for a job vacancy and consider them on their abilities.

2. To ensure there is a mechanism in place to discuss at any time, but at least once a year, with disabled employees what can be done to make sure they can develop and use their abilities.

3. To make every effort when employees become disabled to make sure they stay in employment.

4. To take action to ensure that all employees develop the appropriate level of disability awareness needed to make the commitments work.

5. Each year to review the commitments and achievements, to plan ways to improve on them and let employees and the Employment Services know about progress and future plans.

The Trust's commitment to candidates with disabilities is outlined in its Information for Applicants which is attached to all job advertisements.

Managers are required to promote the recruitment of all diverse groups and are required to complete Equality and Diversity training.

The Learning Hub provides employment placement programmes for a six-week period for members of the local community who are looking for work. During this period trainees will be able to experience first hand the huge amount of job roles available within the hospital. They will also receive advice and guidance on life coaching skills, career guidance and job preparation, practical support and mentoring. The Trust's Single Equality Scheme and associated information is available on our website www.uhb.nhs.uk

1.8 Consultation

The Trust believes that communication and consultation with staff and its representatives are an essential part of delivering the best in care. This is supported by its vision and values.

The Trust conducts an annual staff survey, publishes the results to staff and implements an action plan each year. In the 2008 survey 92% of staff indicated that the work they do makes a positive difference to patient care.

The Trust has a monthly newspaper, InsideOut which is widely circulated and a weekly e-newsletter, In the Loop, that contain a wide range of information to staff much of which encourages staff engagement in a wide range of service developments and activities. This includes training opportunities and services for staff.

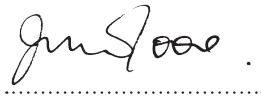
Each month the Chief Executive holds a Team Briefing for senior managers who are required to cascade the information given to their teams. This is supported by a written briefing which is circulated around the Trust.

The Trust has a formal structure for engaging with the recognised Trade Unions. This includes a Trust-wide group - The Trust Partnership Team - which comprises Directors, senior managers and representatives from the Trade Unions. Each Division has a Consultative Committee. These meet monthly. The Trust also has a Joint Local Negotiating Committee which deals with matters relating to medical staff. This meets quarterly.

The Trust is making significant progress in ensuring that the workforce is ready for the move to the New Hospital. Workforce plans are being developed to ensure it has the right staffing levels and skills for when it moves into the New Hospital. These are focused on a range of developments including new

services and new modes of care. There is significant engagement with staff and staff representatives in this work.

This an exciting time for University Hospitals Birmingham NHS Foundation Trust and the community it serves. We have a lot of hard work to look forward to but we believe that the foundations we are currently laying will give us the base for continuing to provide high quality health care to our patients and their carers for many years to come.



June 4 2009

Julie Moore
Chief Executive

Date

2. Background

The Trust runs two hospitals, the Queen Elizabeth and Selly Oak, which are situated 1.5 miles apart in South Birmingham.

On July 1, 2004 the Trust achieved Foundation Trust status under the Health and Social Care (Community Health and Standards) Act 2003, which brought with it not only a number of benefits and advantages for patients and the community as well as financial freedoms for the organisation, but also different operating and functioning requirements from those of a NHS trust.

The annual accounts have been prepared under a direction issued by Monitor.

2.1 Changes in accounting policies by The Trust in 2008/09

There has been no change in accounting policies in 2008/09.

2.2 External Auditors

The Trust's external auditors are KPMG LLP. The audit cost for the year is £99,000 of which £69,000 relates to statutory audit services, and £30,000 which relates to non-audit work.

The reappointment of external audit services from 2007/08 onwards was made by the Board of Governors, following a competitive tender exercise. In addition following a competitive tendering exercise from the April 1, 2006, KPMG has also provided taxation advice to the Trust.

2.3 Pensions

The accounting policy for pensions and other retirement benefits are set out in note 1.15 to the accounts and details of senior employees' remuneration can be found in the Remuneration Report in Section 2.

2.4 Going Concern

After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason the Trust has continued to adopt the Going Concern basis in preparing these accounts.

3.1 Trust Development and Performance during 2008/09

The Trust broadly met its objectives for 2008/09 and has successfully met or exceeded some very challenging targets, treating more patients than ever before.

Over 98% of patients were treated, admitted, or discharged from A&E in less than four hours over the course of the year.
The Trust has also met the national target for thrombolysis and sustained some of the lowest inpatient and outpatient waiting times in the NHS.

It has also achieved further reductions in diagnostic waiting times. It has met the December 2008 milestone for the 18-week referral to treatment target and continues to maintain this performance.

	2007/08	2008/09	% change
Inpatient Finished Consultant Episodes	65,407	67,515	3.22
Day-cases (excluding renal dialysis regular day attenders)	28,707	30,165	5.07
Outpatient attendances	375,010	461,080	22.84
A&E Attendances	81,770	82,838	1.30
Total treatments	550,894	641,201	16.3

3.2 Main Trends and Factors Underlying the Development, Performance, and Position of the Trust during 2008/09

Models of Care for the New Hospital

Modelling of ways of working in the New Hospital has commenced across a number of areas. The Trust is currently piloting the concept of multi-speciality medical wards on the Trust's Selly Oak site and has introduced pre-screening and ambulatory care for medical specialties on the Queen Elizabeth site. This work is allowing real-time testing of assumptions prior to the move to the New Hospital site.

The Trust is currently developing an outpatient clinical aggregation model. This will be used to track changes in outpatient capacity requirements and efficient use of outpatient facilities both within the organisation and within Trust community outreach services.

Community-Based Care

In line with national and local priorities, the Trust has successfully collaborated with partner organisations to move services into a community setting and closer to the patient. A number of specialities already have a significant community-based presence either through their partnerships with specific GP practices or through a long-standing strategy to deliver care in the community (e.g. satellite dialysis units). There are currently community-based clinics for Ophthalmology, Ear Nose and Throat, Plastics, Dermatology, Diabetes, Orthopaedics, and Renal Satellite Dialysis.

Detailed work has been undertaken to develop a community outreach services strategy for the Trust. During the next financial year, the Trust will move to implement increased provision of speciality services in the community.

3.3 The position of the Trust at the end of the year

The Trust has ended the year in a strong position from a financial and performance perspective. Significant progress has been made in moving towards the models of care in the New Hospital, delivering increased activity in a community setting, improving patient safety by significantly reducing infection rates, further increasing the emphasis on clinical quality and outcomes, and realising efficiency savings to remove non-value added steps and reduce wastage in the system.

Moving forwards into 2009/10, the Trust is well-placed to deliver another successful year. One of the greatest challenges in the coming 12 months is to ensure that the New Hospital remains affordable and is delivered on time. The Trust will start to commission the new building in a little over a year.

The Trust clearly recognises that it is the care and treatment that we give to patients that will make it an excellent hospital. Clinical redesign projects are progressing to ensure that the Trust really does focus all its work around the patient, combining excellence in clinical treatment with the most efficient pathway for the patient. It is also working on ways to measure and publicise the quality of the treatment and care it gives to its patients.

The key priorities for the Trust in the coming year will be to:

- Reduce infection rates still further
- Improve the experience and satisfaction of patients
- Ensure progress on all aspects of the New Hospital project
- Further develop the Birmingham Clinical Research Academy
- Continue to play a leading role in the wider Birmingham community

3.4 Performance against Key Patient Targets

In October 2008, the Healthcare Commission published the performance ratings for 2007/08. The Trust achieved ratings of "excellent" and "good", making it one of the most consistently highest performing healthcare organisations in the country. The organisation is also delivering the financial results needed to facilitate the move into the New Hospital building.

The Trust's primary focus for the past year has been on infection control and, thanks to the hard work and efforts of all, it has made significant reductions in healthcare acquired infections. However, there is still much to do in this area and the focus on infection control will remain a priority for the coming year. The Trust will also continue to improve the patient experience and their satisfaction with the services it provides by listening carefully to its patients and acting upon that feedback.

The Trust received its A&E and Inpatient survey results which highlighted many areas of good practice as well as some priority areas that required improvement. The Trust has in place a formal committee, the Care Quality Group, to enhance the patient experience and improve patient satisfaction.

The following table sets out performance against The Trust's main targets for 2008/09:

National Targets/Standards for 2008/09

Indicator	National Target	Data Period	YTD
Existing Commitments			
Data quality on ethnic group for patients	>=85%	Apr 08 - Mar 09	93.0%
Thrombolysis - call to needle within 60 minutes	>=68%	Apr 08 - Mar 09	75.0%
Thrombolysis data quality - completion of key fields	Completion in line with indicator construction		Full completion
Delayed transfers of care	<=3.5%	Apr 08 - Mar 09	2.9%
A&E 4 hour waits	>=98%	Apr 08 - Mar 09	98.06%
Inpatient waits longer than 26 weeks	<=0.03%	Apr 08 - Mar 09	0.0%
Outpatient waits longer than 13 weeks	<=0.03%	Apr 08 - Mar 09	0.0%
Revascularisation 13 week waits	<=0.1%	Apr 08 - Mar 09	0.0%
Rapid access chest pain clinic waits longer than 2 weeks	>=98%	Apr 08 - Mar 09	100%
% Operations cancelled on day or after admission	<=0.8%	Apr 08 - Mar 09	0.37%
No of cancelled operations not admitted within 28 days	<5%		0%
National Priorities			
Participation in heart disease audits	Participation in line with indicator construction	Apr 08 - Mar 09	Full participation
Engagement in clinical audits	Yes for 5 questions including question 1	Apr 08 - Mar 09	5 including Q1)
Stroke care: patients spending >90% of time on stroke unit	Thresholds not released by Care Quality Commission (CQC)	Apr 08 - Mar 09	40.0%
Stroke care: support services for stroke (composite)			68.8%
Number of MRSA bacteraemias	<=48	Apr 08 - Mar 09	35
Number of C. difficile cases >48 hours after admission	<=526	Apr 08 - Mar 09	357
18 week referral to treatment - admitted patients	>=90%	Jan - Mar 09	95.0%
18 week referral to treatment - non-admitted patients	>=95%		97.3%
18 weeks data quality and completeness - admitted patients	Between 90% and 110%		95.2%
18 weeks data quality and completeness - non-admitted patients			91.8%
18 weeks - direct access audiology	>=95%		98.3%
18 weeks - direct access audiology data quality	Between 90% and 110%		102.9%
Cancer - 31 days from decision to treat to treatment - existing target	>=98%	Apr - Dec 08	99.5%
Cancer - 31 days from decision to treat to treatment - new target	Thresholds not released by CQC	Jan - Mar 09	95.6%
Cancer - 62 days from urgent referral to treatment - existing target	>=95%	Apr - Dec 08	97.4%
Cancer - 62 days from urgent referral to treatment - new target	Thresholds not released by CQC	Jan - Mar 09	87.1%
Cancer 2 week waits - existing methodology	100%	Apr - Dec 08	100%
Cancer 2 week waits - new methodology	Thresholds not released by CQC	Jan - Mar 09	92.98%
Experience of patients	Target construction and thresholds not released by CQC	2008	N/A at time of publication
NHS staff satisfaction	Target thresholds not released by CQC	2008	3.42

3.5 Performance Monitoring and Improvement

The Trust has a robust performance monitoring system in place which contributes to driving improvements in the quality of care. On a monthly basis, the Board of Directors and Executive Director level groups receive a performance report detailing progress against national and local targets.

The reports act as an assurance mechanism that targets are being achieved and where there is underachievement, that action is being taken to improve performance.

The risk-based approach is taken to the performance management of national targets in particular. This approach aligns effectively with reporting target risks to Monitor. Findings from Healthcare Commission (now the Care Quality Commission) assessments are also reported to Board level with detailed action plans incorporating any recommendations made.

3.6 Standard NHS Contract

2008/09 was the first year of the standard NHS contract. Performance against the contract is monitored and discussed at a joint meeting with the Lead Commissioner on a monthly basis. Associate commissioners attend on a quarterly basis to contribute to these discussions. The Trust has been successful in complying with the terms of the contract and has recently signed off the 2009/10 contract with the host commissioner. The contract includes a greater emphasis on quality of care with the incorporation of clinical quality indicators (CQUINS).

3.7 Patient Care

How the Trust is using its foundation trust status to develop its services and improve patient care

The Trust is undertaking a number of initiatives to develop its services and improve patient care. This year a new Care Quality Group has been developed which has patient governors as part of its membership. This group has explored the issues that have been raised in patient advocacy and liaison contacts, complaints, and national and local surveys.

As a result of this the Trust has a focused campaign and the success of this is being measured through a new clinical dashboard which can be viewed both Trustwide and within each clinical area. The findings from this dashboard are informing the 'Back to the Floor' initiative which involves senior nursing staff visiting clinical areas weekly, gaining assurance of quality by observing and influencing care as well as sharing learning and good practice. Full roll-out is planned for April 2009.

This local project is supported by the implementation of the National Productive ward project. This work, aimed at releasing time to care empowers ward staff to make changes at ward level which increase efficiency and so release nurses' time to care for patients. Three wards have started the project and are already demonstrating changes in ways of working. The Trust plans that all wards will have completed the foundation elements of the project before moving into the New Hospital building.

Service improvements following staff or patient surveys or comments and Healthcare Commission reports

The Trust actively utilises the recommendations from patient and staff surveys to lead developments in care. 'Back to the Floor' uses the information gained by patients' comments to focus the observation of care in that area and as this is continued weekly, improvements can be monitored and used in other clinical areas to share good practice.

Developments from patient surveys include the availability of electronic questionnaires for patients to provide rapid feedback on their care and enable each ward to address issues raised and for the Trust to recognise where best practice is delivered ie. the acute pain team are looking to expand services in order to improve the speed of the provision of pain relief.

In response to the Healthcare Commission and Department of Health there have been increases in domestic hours to increase levels of cleanliness in high risk areas. Following a recent Trust-instigated audit significant changes are underway to provide the patients with single sex accommodation and to ensure that the highest levels of privacy and dignity are maintained during their care experience.

Other improvements include:

- All toilet facilities clearly marked for male or female use
- Reduction in noise at night time within wards
- Clutter removed from ward corridors and dayrooms to improve the environment for patients
- Expansion of the Welcomer Service to support patients in finding their destination within the hospital
- Hand wipes available for use by patients prior to eating
- Improved presentation and temperature of food and raised awareness of snack boxes
- Patient and public-friendly signage in the New Hospital
- Introduction of a bedside Hospital Information booklet for those patients that do not have access to the hospital information channel on the bedside TV
- Revision of the pricing system for the bedside patient entertainment system and introduction of a two-hour TV card

Arrangements for monitoring improvements in the quality of healthcare and progress towards meeting any national and local targets, incorporating Healthcare Commission assessments and reviews and The Trust's response to any recommendations made

The Trust has had an ongoing programme to address issues related to healthcare associated infections which focused upon the Saving Lives benchmarking programme developed by the Department of Health.

The main areas were those related to increasing awareness and ownership of the problem and a recognition that all staff have a part to play.

In order to support this, the hotel services team became part of the Chief Nurse's portfolio and their integration into the care team has had a significant impact on the environmental cleanliness within the Trust.

Electronic prescribing has been developed to improve the timeliness of provision of decolonisation therapy for MRSA. This is now an automatic process which triggers when a positive MRSA result is registered on the reporting system.

Extra effort has been made to improve access to isolation to patients who are identified as high risk or infectious. Extra training and education has been provided to all levels of staff on the basics of infection prevention and aseptic management of patient lines.

During the roll-out of this plan the Trust had its annual inspection against the Hygiene Code made by the Healthcare Commission in August 2008.

This was a very positive report which indicated that there were no material breaches of the code. Performance against, and monitoring of, improvements related to healthcare associated infections are monitored and the monthly Infection Prevention and Control Committee and the wider care quality issues identified are monitored as part of the Care Quality group chaired by the Executive Chief Nurse.

In November 2008 the Healthcare Commission was asked to investigate the provision of complex tertiary paediatric services at Birmingham Children's Hospital following concerns raised by clinicians at BCH and at the Trust, over quality of care, capacity, lack of training and availability of equipment.

The HCC undertook an investigation and the report was published in March 2009. It outlined 12 recommendations for BCH to implement. Where appropriate, the Trust is continuing to support BCH with its provision of paediatric care.

3.8 Patient and Public Involvement activities 2008/09

Patient and Carer Councils

Patient and Carer Councils were reorganised from four Divisional Councils to two hospital-based councils.

The purpose of the Councils is for patients, foundation members and the public to work in partnership with staff to improve the services provided to patients. All council members are also Foundation Trust members. Both councils have been active in seeking patients' views to influence the improvements in care. Councils have continued to use the 'Adopt-A-Ward' scheme to facilitate partnership working with ward staff.

The councils hosted a seminar in the Autumn to showcase and publicise their work and the improvements in the patient experience they have been able to influence. The seminar was attended by 100 people, including those from other neighbouring NHS organisations and the local Primary Care Trust.

The work programme included audit of food provision to inpatients, review of the provision of single sex accommodation, review of the bedside entertainment system, and review of patient information and the Trust internet site. Service improvements for patients, as outlined on page 25, have been implemented.

Clean Your Hands Campaign led by Patient and Carer Councils

For the third year running, the councils led and co-ordinated a campaign to raise awareness, amongst patients, visitors and staff, of the need to wash or clean their hands.

The campaign included displays of hand washing information, posters and a selection of promotional materials - e.g. mini hand gels and pens - to 'encourage' participation. Over 1,300 members of staff, patients and visitors completed a brief questionnaire to assess their awareness of hand cleaning.

Staff and Patient and Carer Council members also visited ward areas armed with ultraviolet light hand washing boxes, information leaflets and questionnaires. During these visits, patients, visitors and staff had the opportunity to use the light boxes to check their hand washing technique.

A report of the campaign, results from the questionnaire, and recommendations have been reported to the Infection Prevention and Control Committee.

Models of Care

A group of Foundation Trust Members and Patient and Carer Council representatives have continued to meet with representatives of the Business Continuity and Clinical Redesign department in the Models of Care Group. The group members have been able to provide a 'sense check' for the emerging models of care. They have had the opportunity to comment on, or suggest, improvements that the Trust may need to undertake to ensure that the patient has the best possible experience during their visit or stay in the hospital.

The group have had the opportunity to comment on the process for dealing with an acutely ill patient, the process for check-in at the outpatient department and the new ambulatory care facility.

The Models of Care were developed to help map out all of the different processes that patients will go through during their visit or stay in the New Hospital.

Information Group

The group was established three years ago and provides a forum for involving patients and the public in reviewing and influencing the way in which information is provided in all formats. This ensures that all information within the Trust is produced in a way that is useful to patients, carers and the public, has a consistent style, and is in a non-jargonised language that falls in line with national NHS guidelines. This year the group has specifically been involved with:

- **The format for patient questionnaires:** to gain feedback on the patient experience.

- **Development of a prototype 'Your Views' webpage:** to publicise positive comments and feedback from patients and carers and also to give them the opportunity to give feedback or vote on key issues or ideas. Further development is planned for the forthcoming year.

- **Plasma Screens:** the group undertook an audit of the paper notice boards across both hospitals. They have also been involved in consultation on the messages and information to be displayed on the new plasma screens/electronic notice boards.

Interim PPI Forum/Local Involvement Networks (LINks)

A good relationship has continued this year with the Interim PPI Forum following the disbanding of the PPI Forums and commencement of LINks. The Birmingham LINks is currently in a development phase and so support has continued to the group during this phase, as follows:

- **Interim PPI Forum** - the interim PPI Forum was supported up until it was

terminated in September 2008. The Trust hosted meetings and arranged fact-finding visits. Members were also invited to take part in various consultations.

- **Interim UHB LINks Forum** - the Trust has hosted the meetings of the Interim UHB LINKs forum since it started in December 2008. Meetings have taken place between the LINks host organisation, Gateway, and the Trust to discuss potential ways forward.

Consultations

- Patient and Carer Council members, Interim LINks members, and Foundation Members were consulted on the following during the year:

- NHS Constitution - consultation on the contents of the NHS Constitution.

- South Birmingham Primary Care Trust 'Making Experiences Count' - SBPCT invited the Trust's PCCs and Interim LINks Forum members to a consultation on the new complaints procedure.

- Research projects - PCCs were asked for their views on the following research projects:
  - Trauma Unit
  - Critical Care Unit

- Wayfinding and Signage in the New Hospital - Council members and members of the Interim LINks Forum were invited to take part in a consultation on the methods of wayfinding and the signage for the New Hospital.

- Foundation Membership Recruitment - Council members and members of the Interim LINks Forum were invited to take part in a consultation on the new membership recruitment packs.

Care Quality Commission – Statement of User Involvement.

Increase in volunteers from the local community

The Trust had 668 people registered as volunteers at the end of December 2008. An effort has been made to recruit from groups that would not traditionally be linked with hospital volunteering. The profile of volunteers is now:

- 24% male
- 34% black and Asian
- 39% under 30 years old
- 22% over 66 years old
- 12% employed

The Voluntary Services Team has received national recognition from the NHS Centre for Innovation and Improvement for the excellence in recruitment and organisation of the voluntary services at the Trust.

Good working relationships have continued with the Birmingham Voluntary Services Council, other voluntary organisations, Birmingham City Council, local universities and colleges and community groups. This has enhanced the development of the voluntary services at the Trust and added to the infrastructure that will ensure the continuation of the service for years to come. All volunteers have now become Foundation Trust members.

Foundation members' healthcare seminars

Each month the Trust holds healthcare seminars to which all members of the Foundation Trust are invited to attend. The seminars cover many different topics from healthcare issues such as healthy eating and exercise, infection prevention and control, diseases affecting the liver, to information

about hospital services, such as A&E, to new technology and developments in medical treatment.

The monthly events feature an hour-long presentation and a 30-minute question and answer session to enable members to air their views and ask the experts. The sessions are also a great opportunity for the governors to meet members.

Quarterly evening seminars were introduced in March 2009 to capture members who find it difficult to attend during the day due to work or child care commitments.

3.9 Complaints

The Trust received 609 formal complaints in 2008/09, which was 6.5% higher than the number received in 2007/08. It responded fully to 88% of complaints within the national standard of 25 working days. The main issues raised in complaints were:

- Perceptions of clinical treatment
- Communication and information
- Outpatient appointments
- Some of the actions taken as a result of feedback include:
- Inter-ward transfer document pilot introduced to improve inter-ward communication Session on headache management introduced into the A&E Department's Registrar teaching programme
- Importance of maintaining glaucoma care highlighted in Older People's Champions' Newsletter

The Trust also runs a Patient Advice and Liaison Service (PALS). There were 2,060 PALS contacts in 2008/09 of which 1,017 (49.5%) were related to issues/concerns raised. This compares with 1,545 PALS contacts the year before of which 818 (53%) were related to issues/concerns raised. This equates to a 33.3% increase in PALS contacts overall but a 3.5% reduction in issues/concerns raised. The main issues/ concerns raised were similar to complaints – communication and information, perceptions around clinical treatment and outpatient appointments being cancelled or delayed.

3.10 Social and community issues

The New Hospital Team and Communications Team have been actively promoting and publicising the New Hospital to a variety of community groups, religious groups and health centres.

3.11 Stakeholders, Partnerships, alliances and contractual arrangements

Significant progress has been made in developing stakeholder relations as set out in the table on page 24.

Local Health organisations	
South Birmingham PCT	• The Trust signed local health pledge with the PCT • Second Board to Board meeting held from which there was agreement to: - Use FT membership for public involvement - Work together on reducing coronary vascular disease mortality, identifying hypertension, improved stroke care and reducing hospital admission for alcohol-related harm • Primary secondary interface group continues • Community services strategy is being implemented
GPs	• During 2008/09, a GP satisfaction survey was undertaken • The overall conclusion of the survey was that there has been a significant improvement since the survey conducted in 2005, on a number of points • The level of GP satisfaction with the Trust has increased by 13% from 73% to 86% since 2005, with a significant shift towards being 'very satisfied' (8% in 2005, 30% in 2008) rather than just 'satisfied' • In South Birmingham nearly 60% of practices are now using the Trust's electronic communications system, GP Practice Page, which now has 687 individual users • GP open evenings for the New Hospital have been held
Heart of Birmingham PCT	• Community strategy being implemented
Birmingham East and North PCT and Specialised Commissioning Agency	• Chief Operating Officer continues to hold regular meetings with the head of the SCA • Agreement to fast track Neurosurgery performance • Exploring potential of improving rehabilitation facilities
West Midlands SHA	• The Trust Chair and Chief Executive Officer regularly meet their SHA counterparts • The Trust Medical Director chaired one of the SHA Darzi clinical groups • Trust developed an 18-week breach sharing protocol that has been adopted throughout the SHA
Heart of England Foundation Trust	• Meeting of Executive teams has been held and agreement reached to co-operate on a number of issues including medical staff training and management development

Local Health organisations	
Sandwell and West Birmingham Trust	• Continued co-operation with SWBH on the Pan Birmingham Decontamination project • Chief Operating Officer holds meetings with SWBH Director of Strategy
Birmingham Children's Foundation Trust	• The Trust is continuing to support BCH with its provision of tertiary paediatric care, where appropriate
West Midlands Ambulance Trust	• Meeting of Chairs and Executive Directors has taken place • Working together to improve turnaround times for patients • Support the WMAT with patient transport
National health bodies	
Monitor	• Chair and CEO have met Monitor Chair on a number of occasions • Trust hosted visit by Monitor Chief Operating Officer • Regular discussions take place with the Trust's Relationship Manager • The Trust Medical Director is a member of Monitor's working group developing Quality metrics
Healthcare Commission (Care Quality Commission	• Trust hosted visit by Head of Operations • Relationships are being developed with successor body
Department of Health	• The Trust has agreed two secondments to DH to influence policy and to continue to play an active role in developing Connecting for Health
Collaborative working	• Have working relationships with a number of trusts and the Department of Health to deliver a variety of services
Non NHS contractual Partners	
Consort/Balfour Beatty	• Relationships continue at all levels to ensure the delivery of the New Hospital on time and on budget
Xchanging	• The Trust resumed the management of 'HR Business Services' (payroll, HR and pensions services) from its commercial partner Xchanging from the end of November • All the relevant staff and Staff Side representatives in Birmingham and Stoke were consulted about the change • This change was driven by Xchanging's decision to focus its business on international and private sector customers

Non NHS contractual Partners	
B-Braun	• The Trust transferred its HSDU service to B Braun Sterilog in July 2008 as part of the Pan Birmingham Decontamination project. • The move provides the Trust with a compliant solution for the New Hospital and flexibility to expand as required to support growth in activity. Trust staff transferred to the new facility to ensure a smooth transfer and continuity of service provision
University of Birmingham	• Quarterly liaison meetings continue • The Birmingham Clinical Research Academy is successfully being developed and a Director has been appointed. A longer term shared translational research strategy is a key priority. • A bid for Academic Healthcare Science Centre status was jointly submitted and reached the shortlisting stage • Work on Health Education and Innovation Cluster status is being progressed
Ministry of Defence	• As well as hosting The Royal Centre for Defence Medicine (RCDM) as outlined on page 6, the Trust has established a close working relationship with the Ministry of Defence, including Joint Medical Command (JMC) and the Defence Medical Services Department (DMSD). • Under this arrangement the Trust also sub-contracts work to: - Birmingham City University - The University of Birmingham - The Royal Orthopaedic NHSFT - Heart of England NHSFT - Birmingham City and Sandwell NHST (inc. B'ham Eye Centre)
FMC Renal Services Limited	• The Trust has worked closely with FMC in the planning of new satellite haemodialysis facilities. A 16-station purpose built unit will open in Worcester in June 2009 and a further unit in Woodgate Valley by the end of 2009. • Both of the new satellite units have been designed with the flexibility to house community outpatient clinics which will be used by Renal Medicine and associated specialties.

Other relationships	
Advantage West Midlands/Central Technology Belt	• The Trust's Chair has regular contact with Chair/CEO of AWM • The Trust's Chief Executive has presented New Hospital and medical technology possibilities to Science City and Central Technology Belt Boards • The Trust's Head of Regeneration chairs Innovative Health group meetings of Birmingham Science City and represents the NHS on the Board of Central Technology Belt – both of which have a priority for medical technology, especially translational research • There is a good relationship with AWM and the West Midlands Office in Europe focusing on influencing the European Commission on health issues and maximising funding opportunities
Birmingham City Council	• There is generally constructive engagement on New Hospital and Selly Oak planning issues • The City Council continues to support The Trust's Learning Hub through grant aid from the Neighbourhood Renewal Fund and by secondment • The Trust plays an active role in the City Council's South West Birmingham Regeneration Group and the Edgbaston and Selly Oak Constituencies • Regular attendance at Overview and Scrutiny committee meetings
Learning and Skills Council	• The Trust is a member of the Birmingham Employer Board chaired by the Learning and Skills council and has presented on jobs and training issues to the Board and at a West Midlands CBI conference • The Trust is a member of the Improving Health Increasing Employment group chaired by the LSC which focuses on helping people move from disability benefit to employment
JobCentre Plus	• Close working relationships exist with JobCentre through the Learning Hub which, working across the whole of healthcare, aims to broaden access to jobs and training for unemployed people • The Learning Hub has recently gained awards for the most innovative Local Employment Partnership recruitment practices and the outstanding LEP in the West Midlands.
Government Office for the West Midlands (GOWM)	• The Trust has worked with GOWM through the Regional Health Partnership to write the Economy component of the Regional Health Strategy; and is an active member of the Good Corporate Citizenship group that GOWM chair

4.1 NHS Foundation Trust Code of Governance

In September 2006 Monitor, the independent regulator of Foundation Trusts, published the NHS Foundation Trust Code of Governance as best practice advice. The purpose of the Code is to assist NHS foundation trust boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance. The Code is issued as best practice advice, but imposes some disclosure requirements. These are met by the Trust's Annual Report for 2008/09.

In its Annual Report, the Trust is required to report on how it applies the main and supporting principles of the Code.

The Board of Directors recognises the importance of the principles of good corporate governance and is committed to improving the standards of corporate governance. The Code is implemented through key governance documents and policies, including:

- The Constitution
- Standing Orders
- Standing Financial Instructions
- Schedule Of Reserved Matters, Role Of Officers And Scheme Of Delegation
- The Annual Plan
- Committee Structure

4.1.1 Application of Principles of the Code

A. The Board of Directors

The Board of Directors' role is to exercise the powers of the Trust, set the Trust's strategic aims and to be responsible for the operational management of the Trust's facilities, ensuring compliance by the Trust with its terms of authorisation, its constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations.

The Trust has a formal scheme of delegation which reserves certain matters to the Board of Governors or the Board of Directors and delegates certain types of decision to individual executive directors.

The Board of Directors has reserved to itself matters concerning Constitution, Regulation and Control; Values and Standards; Strategy, Business Plans and Budgets; Statutory Reporting Requirements; Policy Determination; Major Operational Decisions; Performance Management; Capital Expenditure and Major Contracts; Finance and Activity; Risk Management Oversight; Audit Arrangements; and External Relationships.
The Board of Directors remains accountable for all of its functions; even those delegated to the Chairman, individual directors or officers, and therefore it expects to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.
All powers which are neither reserved to the Board of Directors or the Board of Governors nor directly delegated to an Executive Director, a committee or sub-committee, are exercisable by the Chief Executive or as delegated by her under the Scheme of Delegation or otherwise.

Details of the composition of the Board of Directors and the experience of individual Directors are set out in Board of Directors, page 37, of the Annual Report, together with information about the Committees of the Board, their membership and attendance by individual directors.

B. The Board of Governors

The Board of Governors is responsible for representing the interests of members, and

partner organisations in the local health economy as well as in the governance of the Trust. It regularly feeds back information about the Trust, its vision and its performance to the constituencies and the stakeholder organisations.

The Board of Governors appoints and determines the remuneration and terms of office of the Chairman and Non-Executive Directors and the external auditors.
The Board of Governors approves any appointment of a Chief Executive made by the Non-Executive Directors. The Chairman carries out annual appraisals for NEDs, but the Board of Governors has the responsibility for terminating individuals ie as a result of poor performance, misconduct etc.

Details of the composition of the Board of Governors are set out in Governors, page 33, of the Annual Report, together with information about the activities of the Board of Governors and its committees.

C. Appointments and terms of office

The balance, completeness and appropriateness of the membership of the Board of Directors were reviewed during the year by the Executive Appointments and Remuneration Committee. Following the confirmation by the Rt Revd Mark Santer of his intention to retire on 30 November 2008, it was decided to seek a replacement candidate with financial or commercial experience at a senior level within a commercial organisation. This appointment was made by the Board of Governors, on a recommendation from the Board of Governors' Nomination Committee for Non-Executive Directors. Additionally, two Non-Executive Directors were reappointed for second terms. Details of the composition of that Committee and its activities are set out on page 36 of the Annual Report. Details of terms of office of the Directors are set out in Board of Directors, page 37, of the Annual Report.

D. Information, development and evaluation

The Boards of Directors and Governors are supplied in a timely manner with information in an appropriate form and of a quality to enable them to discharge their respective duties. The information needs of both Boards are agreed in the form of an annual cycle and are subject to periodic review.

All directors and governors receive induction on joining their Board and their skills and knowledge are regularly updated and refreshed through seminars and individual development opportunities.

Both Boards regularly review their performance and that of their committees and individual members. Appraisals for all Executive and Non-Executive Directors (including the Chairman) have been undertaken and the outcomes of these have been reported to the Board of Governors or the Board of Directors as appropriate. The Board of Directors and the Audit Committee have each evaluated their performance.

E. Director Remuneration

Details of the Trust's processes for determining the levels of remuneration of its Directors and the levels and make-up of such remuneration are set out in the Remuneration Report in Section 2.

F. Accountability and Audit

KPMG LLP has been appointed by the Board of Governors as the Trust's External Auditor. The Board of Directors has appointed RSM Bentley Jennison as internal auditors. The Board of Directors presents a balanced and understandable assessment of the Trust's

position and prospects, maintains a sound system of internal control and ensures effective scrutiny through regular reporting directly to the Board of Directors and through the Audit Committee.

G. Relations with Stakeholders

The Board of Directors recognises the importance of effective communication with a wide range of stakeholders, including members of the Trust. Details of interactions with Stakeholders are set out from page 30 of the Annual Report and in Membership, page 45.

4.1.2 Compliance with the Code

The Trust is compliant with the Code, save for the following exceptions:

C.2.1 The Chief Executive and other Executive Directors should be subject to re-appointment at intervals of no more than five years.

Executive Directors are employed on substantive contracts and are not subject to re-appointment at intervals of no more than five years. The contracts may be terminated on six months' notice.

C.2.2 Non-Executive Directors, including the Chairman, should be appointed by the Board of Governors for specified terms subject to re-appointment thereafter at intervals of no more than three years.

Prior to December 2008, the Board of Governors approved four-year terms of office for Non-Executive appointments. Since then, Non-Executive Directors have been appointed or re-appointed for terms of three years, in accordance with the Code.

5. Board of Governors

The Trust's Board of Governors was established in July 2004, with 24 representatives (increased to 25 on 13 March 2007 due to Parliamentary constituency boundary changes) each elected for an initial term of three years. Elections for all sets were held in the previous financial year, whereby Governors appointed to public and patient seats at these elections were appointed for terms of either two or three years.

Three by-elections were held this year to fill seats that were vacant. Governors appointed to public and patient seats at these by-elections were appointed for terms of either two or three years.

The Trust opted to have elected Governors representing patients, staff and the wider public, in order to capture the views of those who have direct experience of our services, those who work for us, and those that have no direct relationship with the Trust, but have an interest in contributing their skills and experience to help shape our future.

In September 2008, the Board of Governors voted to amend the Constitution of the Trust so that the Board of Governors would be comprised as follows:

12 Public Governors elected by Public members

4 patient Governors elected by Patient members

5 staff governors elected by Staff members (no change)

6 stakeholder Governors appointed by 6 of its key stakeholders

The change to the number of stakeholder governors came into effect on 12 January 2009. The changes to public and patient governors will come into effect on 1 July 2009. Although, in 2007, patient and public governors were appointed with terms of two or three years from 1 July 2007, elections for all patient and public governor seats will be held in June 2009.

At present, the Board of Governors consists of:

- 14 public Governors elected from the Parliamentary Constituencies in Birmingham
- 6 patient Governors elected by Patient members, who are members of The Trust's two Patient and Carer Councils
- 5 staff Governors elected by the following staff groups:
  - o Medical
  - o Nursing (2)
  - o Clinical Scientist/Allied Health Professional
  - o Ancillary, Administrative and Other Staff
- 6 stakeholder Governors

During this year, the Governors have been:

Patient

Rita Bayley
Rosanna Penn
Valerie Jones
Paul Darby
Bridget Pearce
Alan Bailey

Public (by Parliamentary Constituency)

Northfield
Margaret Burdett
Vacant

Selly Oak
Brian Hanson
Gwyneth Harbun

Hall Green
David Spilsbury
Martin Straker-Welds

Edgbaston
Geoffrey Oates
Caroline Badley

Ladywood
Shazad Zaman

Perry Barr
Hazel Flinn

Yardley
Kadeer Arif

Hodge Hill
Anne Griffin*

Erdington
David Ward

Sutton Coldfield
Joan Walker

*Appointment terminated on 17 March 2009 by resolution of the Board of Governors in accordance with section 7.14.3(a) of the Constitution

Staff
(All elected for terms of three years from 1 July 2007)

Professor John Buckels (Medical Class)
Paul Brettle (Clinical Scientist/Allied Health Professional)
Erica Perkins (Nursing Class)
Barbara Tassa (Nursing Class)
Anne Waller (Ancillary, Administrative and Other Staff)

Stakeholder

The Most Revd Vincent Nichols (Archbishop of Birmingham), appointed by the Birmingham Faith Leaders' Group
Professor David Cox and Ms Moira Dumma, both appointed by South Birmingham Primary Care Trust (Ms Dumma ceased to be a stakeholder governor on 12 January 2009 following constitutional changes)
Professor Edward Peck, appointed by the University of Birmingham (succeeding Professor Michael Clarke on 1 July 2008)
Lieutenant General Lillywhite MBE QHS MB BCh MSc psc, appointed by the Ministry of Defence
Cllr James Hutchings, appointed by Birmingham City Council
Ms Ruth Harker, appointed by the South West Area Network of the Secondary Education Sector in Birmingham

The following were stakeholder governors up to 12 January 2009 when the changes to the constitution became effective:

Mr Norman Cave, appointed by South West Birmingham Partnership for Further Education
Ms Nikki Walker, appointed by the Birmingham Chamber of Commerce and Industry
Professor David Tidmarsh, appointed by University of Central England in Birmingham
Ms Gisela Stuart MP, appointed by the Trust's South Birmingham MPs Liaison Group
Ms Marie Greer, appointed by Advantage West Midlands

During the year ending 31 March 2009, no elections were held for governor seats.

The Board of Governors met regularly throughout the year, holding four meetings in total.

*While a member of the Board of Governors.

Name of Governor	No. of meetings attended*
Patient Governors	
Paul Darby	2 out of 4
Rosanna Penn	All
Alan Bailey	All
Rita Bayley	All
Bridget Pearce	3 out of 4
Valerie Jones	1 out of 4
Public Governors	
Gwyneth Harbun	All
Martin Straker-Welds	3 out of 4
Brian Hanson	All
David Ward	None
Margaret Burdett	All
Hazel Flinn	3 out of 4
David Spilsbury	All
Geoffrey Oates	1 out of 4
Kadeer Arif	2 out of 4
Caroline Badley	2 out of 4
Shazad Zaman	2 out of 4
Joan Walker	3 out of 4
Anne Griffin	None
Stakeholder Governors	
Cllr James Hutchings	All
Prof. David Cox	2 out of 4
Prof. David Tidmarsh	1 out of 3
Marie Greer	2 out of 3
Lieutenant General Lillywhite	3 out of 4
Ruth Harker	All
The Most Revd Vincent Nichols	2 out of 4
Prof. Norman Cave	None
Nikki Walker	None
Prof. Michael Clarke	0 out of 1
Prof. Edward Peck	1 out of 3
Gisela Stuart, MP	1 out of 4
Moira Dumma	None
Staff Governors	
Barbara Tassa	3 out of 4
Prof. John Buckels	2 out of 4
Paul Brettle	1 out of 4
Anne Waller	2 out of 4
Erica Perkins	1 out of 4

Steps the Board of Directors, in particular the Non-Executive Directors, have taken to understand the views of the governors and members

- Attending, and participating in, Governor meetings
- Attending, and participating in, bi-annual joint Board of Governor and Director meetings to look forward and back on the achievements of the Trust
- Attendance and participation at the Trust's Annual General Meeting
- Governors and Non-Executive Directors are members of various working groups at the Trust eg Patient Care Quality Group

5.1 Board of Governors' Nomination Committee for Non-Executive Directors

The Nomination Committee for Non-Executive Directors is a sub-committee of the Board of Governors responsible for advising the Board of Governors and making recommendations on the appointment of new Non-Executive Directors, including the Chairman of the Trust. Its terms of reference, role and delegated authority have all been agreed by the full Board of Governors. The committee meets on an as-required basis.

The Nomination Committee for Non-Executive Directors comprises the Chairman and four Governors of the Trust. The Chairman chairs the committee, save when the post of chairman is the subject of nominations, in which case the committee is chaired by Brian Hanson, Governor Vice-Chair. The other members of the committee for the year ended 31 March 2009 were Erica Perkins, Ruth Harker and Margaret Burdett.

The Committee met four times during the year. All Committee members in office at the relevant times attended all Committee meetings with the exception of Erica Perkins and Ruth Harker who each attended three of the four meetings.

During the year, the Committee oversaw the re-appointment of two existing Non-Executive Directors and the appointment of a new Non-Executive Director. The Committee approved the recommendation of the Executive Appointments and Remuneration Committee that an appointee should be sought with financial/commercial experience at a senior level in a commercial organisation. Following open advertisement of the post, the Committee met to discuss and shortlist the applications, interview short-listed candidates and determine whether a recommendation should be made to the Board of Governors. The Committee decided to recommend to the Board of Governors that Stewart Dobson and Clare Robinson be re-appointed for a further term of three years and that Gurjeet Bains be appointed as a Non-Executive Director of the Trust for an initial period of three years.

5.2 Register of Interests

The Trust's Constitution and Standing Orders of the Board 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 the Foundation Secretary, University Hospitals Birmingham NHS Foundation Trust, Trust Headquarters, PO Box 9551, Main Drive, Queen Elizabeth Medical Centre.

6. Board of Directors

Throughout the year, the Board of Directors comprised the Chairman, six executive and seven Non-Executive Directors. The Chairman has been appointed for a period of four years commencing 1 December 2006.

Rt Revd Mark Santer (retired 30 November 2008) was the deputy chairman and senior independent director. On his retirement, Stewart Dobson was appointed as deputy chairman and Clare Robinson was appointed as senior independent director. The senior independent director is available to meet stakeholders on request and to ensure that the Board is aware of member concerns not resolved through existing mechanisms for member communications.

The Board is currently comprised as follows:

Chairman: Sir Albert Bore

Chief Executive: Julie Moore
Executive Director of Finance: Mike Sexton
Executive Medical Director: David Rosser
Executive Director of Delivery: Tim Jones
Executive Chief Nurse: Kay Fawcett
Chief Operating Officer (Acting): Kevin Bolger

Non-Executive Directors:
Professor David Bailey
Stewart Dobson
Tony Huq
David Ritchie
Clare Robinson
Professor Michael Sheppard
Gurjeet Bains (from 1 December 2008)

Caroline Wigley, Director of Organisation Development, left the Trust in August 2008. Tim Jones was appointed as Executive Director of Delivery and Kevin Bolger was appointed as Chief Operating Officer (Acting).

The Rt Revd Mark Santer retired as a Non-Executive Director on 30 November 2008. Ms Gurjeet Bains was appointed as a Non-Executive Director on 1 December 2008. Stewart Dobson and Clare Robinson were each reappointed for a further term of three years as Non-Executive Directors on 25 September 2009.

The Non-Executive Directors have all been appointed for terms of three years, with the exception of Tony Huq who was effectively reappointed for a second term of four years commencing 1 July 2005, and David Ritchie and David Bailey, who were both appointed for terms of four years, commencing 1 December 2006.

Name	Date of Appointment/ Latest Renewal	Term	Date of end of term
Sir Albert Bore	1 December 2006	4 years	30 November 2010
Rt Revd Mark Santer	1 December 2006	2 years	30 November 2008
Tony Huq	1 July 2005	4 years	30 June 2009
Clare Robinson	25 September 2008	3 years	24 September 2011
Stewart Dobson	25 September 2008	3 years	24 September 2011
David Bailey	1 December 2006	4 years	30 November 2010
David Ritchie	1 December 2006	4 years	30 November 2010
Gurjeet Bains	1 December 2008	3 years	30 November 2011
Michael Sheppard	5 December 2007	3 years	4 December 2010

The board considers the Rt Revd Mark Santer (retired 30 November 2008), Tony Huq, Clare Robinson, Stewart Dobson, David Bailey, David Ritchie and Gurjeet Bains to be independent.

6.1 Board meetings

The board met regularly throughout the year, holding 13 meetings in total.

Directors	No. of meetings attended*
Sir Albert Bore	All
Julie Moore	All
Mike Sexton	12 out of 13
Caroline Wigley	All
Tim Jones	All
Stewart Dobson	11 out of 12
Clare Robinson	10 out of 12
David Ritchie	11 out of 13
Rt Revd Mark Santer	7 out of 9
Prof Michael Sheppard	9 out of 13
David Rosser	12 out of 13
Tony Huq	All
Prof David Bailey**	6 out of 13
Kay Fawcett	12 out of 13
Gurjeet Bains	2 out of 4

*While a member of the Board of Directors
**David Bailey was granted a leave of absence from September 2008 to July 2009 with the approval of the Board of Governors

6.2 Nomination Committee

The Executive Appointments and Remuneration Committee did not appoint any nominations committees during the year.

6.3 The Board of Directors

Sir Albert Bore, Chairman

Sir Albert Bore was elected Chairman of the Trust on 1 December 2006 and appointed for a period of four years. He is the former leader of Birmingham City Council and the current leader of the council's principal opposition group (Labour). During his five years at the helm, Sir Albert was responsible for an annual budget of over £2.5billion and for shaping the strategic policy of the council. He also spearheaded key regeneration projects including Eastside and the Bullring. He holds a number of Non-Executive Director positions including Symphony Hall, Optima Community Housing Association, Marketing Birmingham, National Exhibition Centre Limited and Birmingham Technology Ltd, the joint venture company developing and managing Aston Science Park.

Julie Moore, Chief Executive

Julie is a graduate nurse who spent ten years in clinical practice before entering nurse management. During her time as nurse manager and later director, she undertook an MA in Health Services Studies at Leeds University and was seconded to work at the Department of Health on developing nursing roles. After a year in general management, in 1998, Julie became a director in the newly-merged Leeds Teaching Hospitals Trust. She was appointed to the Executive Director of Operations post at University Hospital Birmingham in 2002, where she was responsible for the day-to-day running of two acute hospital sites. University Hospital Birmingham became a foundation trust in July 2004 and Julie's role was expanded and she became the Chief Operating Officer. In July 2006, Julie became acting Chief Executive prior to being appointed as substantive Chief Executive in November 2006. Julie was a Governor at Harborne Hill School from June 2005-December 2008, was appointed Visiting Lecturer at Keele University in March 2009. She was a member of the National Organ Donation Taskforce in 2007 and 2008.

Kay Fawcett, Executive Chief Nurse

Kay qualified as a Registered General Nurse in 1980 and held a series of clinical posts before moving on to be a Clinical Teacher and then Nurse Tutor, before returning to clinical work as a Lecturer Practitioner and Emergency Care manager in 1995. In 1998, Kay became an Operational Manager at the George Eliot Hospital NHS Trust before joining the Trust in 2000 as Head of Nursing. She became Deputy Chief Nurse in 2002, took a part-time secondment to work with the Director of Nursing at Birmingham and Black Country Strategic Health Authority and in July 2005 took up post as Executive Director of Nursing for Derby Hospitals NHS Foundation Trust. She had responsibility for Nursing and Allied Health Professionals, Infection Prevention and Control, Clinical Governance and Quality, Risk Management and Emergency Planning. In January 2008 Kay was appointed as Executive Chief Nurse at the Trust.

Tim Jones, Executive Director of Delivery

After graduating from University College, Cardiff, with a joint honours degree in History and Economics, Tim joined the District Management Training scheme at City and Hackney Health Authority based at St Bartholomew's Hospital in London. He joined The Royal Wolverhampton NHS Trust in 1992 as Business Manager for Medicine before taking up his first post at the Trust in 1995 as the Directorate Manager for Medicine. In 1999 he became the first Divisional General Manager (now Directors of Operations) for Division Three and was then appointed as the Deputy Chief Operating Officer before becoming Chief Operating Officer in June 2006 (initially in an acting capacity). In September 2008 Tim was appointed as Executive Director of Delivery. His key responsibilities are to lead the Clinical Redesign Programme in preparation for the transition to the New Hospital, developing the Trust's Organisational Development programme and has Board responsibility for Human Resources.

David Rosser, Executive Medical Director

David trained at University of Wales College of Medicine and did his basic specialist training in medicine and anaesthesia in South Wales before becoming a research fellow and lecturer in Clinical Pharmacology at University College London Hospital. He joined the Trust in 1996, became lead clinician for the Queen Elizabeth Intensive Care unit in

December 1997 before becoming Group Director and then Divisional Director of Division One in 2002. Dr Rosser was also Senior Responsible Owner for Connecting for Health's e-prescribing programme, providing national guidance on e-prescribing to the Department of Health. Dr Rosser took up the role of Medical Director in December 2006.

Mike Sexton, Executive Director of Finance

Mike, who became FD in December 2006, spent five years in the private sector working for the accountancy firm KPMG and had a brief spell at the Regional Specialities Agency (RSA) before joining the Trust in 1995. Over the last 14 years he has held numerous positions including Finance Manager – Clinical Services, Acting General Manager – Neurosciences and Ophthalmology, Head of Operational Finance and Business Planning, Director of Operational Finance and Performance and Acting Director of Finance.

Kevin Bolger, Chief Operating Officer (Acting)

Kevin trained as a nurse at East Birmingham Hospital in the early eighties then worked in clinical haematology, respiratory and acute medicine before developing the Acute Assessment Unit. As a ward manager he gained a Masters in Business Administration. His career then moved away from clinical responsibilities into general management and operations including managing a variety of areas, from Theatres to Accident and Emergency. He moved to the Trust in 2001 as Group Manager for Neurosurgery and Trauma and after 12 months was promoted to Director of Operations for Division Three. In 2006 he moved to Division Two where he also became Deputy Chief Operating Officer. He was made Chief Operating Officer (Acting) in September 2008, responsible for the day-to-day running of the Queen Elizabeth and Selly Oak hospitals.

Stewart Dobson, Vice Chairman

Stewart, who worked for 32 years as a lawyer for various large local authorities, joined the board in 2004. His work included over 13 years working for Birmingham City Council, mainly as the Director of Legal Services but finishing up as Acting Chief Executive. He retired from the City Council in 2002 and was the Chief Executive of Millennium Point and Thinktank, within the Eastside area of Birmingham, from 2003 to 2005. He now works as a local government consultant.

Professor David Bailey

Professor David Bailey started his role as a new Professor at Coventry University's rapidly-expanding Business School on 1 May 2009. Prior to that, he was Director at the University of Birmingham's Business School. David has written extensively on globalisation, economic restructuring and policy responses, the auto industry, European integration and enlargement, and the Japanese economy. He has been involved in several major research projects and is currently leading an Economic and Social Research Council project on the economic and social impact of the MG Rover closure.

Tozammel (Tony) Huq, MBE

Tony Huq was appointed as a Non-Executive Director on 1 July 2002. His terms for the NHS trust rolled over upon attainment of FT status on 1 July 2004. He was reappointed for four years by the Board of Governors on 28 June 2005. Tony has had a long and distinguished career both in education and with UNESCO. He was a Senior Special Adviser to the Director General of UNESCO and was the Government of Bangladesh's Ambassador to France, Spain and UNESCO

in the 1980s. He is currently a visiting Lecturer in International Relations at the University of Birmingham; an Honorary Research Fellow at the University of Warwick and was awarded an Honorary Doctorate by the University of Birmingham for services to Community Development and Education.

David Ritchie CB

David Ritchie worked at a senior level in Government for a number of years most recently as Regional Director, Government Office for the West Midlands – the most senior official in the region. He was responsible for an annual budget approaching £1billion and around 300 staff, mostly engaged on the physical and industrial development of the region. He was also Chair of the Oldham Independent Review into the causes of the Oldham Race Riots in 2001.

Clare Robinson

Clare Robinson, who joined the board in 2004, is a highly experienced Chartered accountant and was appointed Senior Independent Director in 2008. She brings with her seven years experience as a Non-Executive Director at the Royal Orthopaedic Hospital NHS Trust where she was also Chair of the Audit Committee. Currently she is working as an independent Business Consultant including change management, strategic and operational reviews and management services.

Gurjeet Bains

Gurjeet Bains, who joined the Trust as Non-Executive Director on 1 December 2008, is a qualified nurse and a successful businesswoman. After starting her first business in Peterborough in 1986 she later became a journalist for the Northampton Chronicle which eventually led her to join The Sikh Times, Britain's first English Punjabi newspaper as Editor in 2001. Her role expanded and she has since become Editor of Eastern Voice – a successful national newspaper, and has established herself in a prominent role at Birmingham-based Eastern Media Group. Aside from being the editor of two national newspapers, she became the first woman to chair the Institute of Asian Businesses (IAB). Gurjeet won the 'Business Woman of the Year' award in 1991 and was recently awarded with an Honorary Degree from Aston University. Currently Gurjeet is Chief Executive of Women of Cultures, an organisation which empowers women from ethnic minorities and is also a member of the Birmingham Chamber of Commerce and Industry, a member on the Birmingham Diversity Board and one of fifty Ambassadors for the 2012 Olympics.

Professor Michael Sheppard

Professor Sheppard was appointed a Non-Executive Director of the Trust in December 2007 and is Vice-Principal of the University of Birmingham. He graduated from the University of Cape Town with MBChB (Hons), and was later awarded a PHD in Endocrinology. His career at Birmingham began in 1982, when he was appointed as a Wellcome Trust Senior Lecturer in the Medical School. He then subsequently held the roles of the William Withering Professor of Medicine, Head of the Division of Medical Sciences, Vice-Dean and Dean of the Medical School. Michael's main clinical and research interests are in thyroid diseases and pituitary disorders. He holds honorary consultant status at the Trust has published over 230 papers in peer reviewed journals and has lectured at national and international meetings, particularly the UK, Europe and the USA Endocrine Societies.

6.4 Directors' Interests

The Trust's Constitution and Standing Orders of the Board of Directors requires 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 the Foundation Secretary, University Hospitals Birmingham NHS Foundation Trust, Trust Headquarters, PO Box 9551, Main Drive, Queen Elizabeth Medical Centre, Edgbaston, Birmingham B15 2PR.

6.5 Audit Committee

The Audit Committee is a committee of the Board of Directors whose principal purpose is to assist the Board in ensuring that it receives proper assurance as to the effective discharge of its full range of responsibilities.

The Committee meets regularly and was chaired by Stewart Dobson. It comprises all the independent Non-Executive Directors of the Trust, with the external and internal auditors and other executive directors attending by invitation.

The Audit Committee is responsible for the relationship with the group's auditors, and its duties include providing an independent and objective review of the Trust's systems of internal control, including financial systems, financial information, governance arrangements, approach to risk management and compliance with legislation and other regulatory requirements, monitoring the integrity of the financial statements of the Trust and reviewing the probity of all Trust communications relating to these systems.

The Audit Committee undertakes a formal assessment of the auditors' independence each year, which includes a review of non-audit services provided to the Trust and the related fees. The Audit Committee also holds discussions with the auditors about any relationships with the Trust or its directors that could affect auditor independence, or the perception of independence. Parts of selected meetings of the Audit Committee are held between the Non-Executive Directors and internal and external auditors in private.

Directors	No. of meetings attended*
Clare Robinson	All
Gurjeet Bains	None (out of 2)
David Bailey	2 out of 6**
David Ritchie	All
Stewart Dobson	All
Mark Santer	3 out of 4
Tony Huq	All
Michael Sheppard	4 out of 6

*While a member of the Board of Directors
**David Bailey was granted a leave of absence from September 2008 to July 2009 with the approval of the Board of Governors

The Audit Committee has reviewed the Group's system of internal controls and reviews the performance of the internal audit function annually.

6.6 Independence of External Auditors

To ensure that the independence of the External Auditors is not compromised where work outside the audit code has been purchased from the Trust's external auditors, the Trust has a Policy for the Approval of Additional Services by the Trust's External Auditors, which identifies three categories of work as applying to the professional services from external audit, being:

a) Statutory and audit-related work - certain projects where work is clearly audit-related and the external auditors are best-placed to do the work (e.g. regulatory work, e.g. acting as agents to Monitor, the Audit Commission, the Healthcare Commission, for specified assignments

b) Audit-related and advisory services
- projects and engagements where the auditors may be best-placed to perform the work, due to:
- Their network within and knowledge of the business (e.g. taxation advice, due diligence and accounting advice) or
- Their previous experience or market leadership

c) Projects that are not permitted - projects that are not to be performed by the external auditors because they represent a real threat to the independence of the external auditor.

Under the policy:

- Statutory and audit-related work assignments do not require further approval from the Audit Committee or the Board of Governors. However, recognising that the level of non-audit fees may also be a threat to independence, a limit of £25,000 will be applied for each discrete piece of additional work, above which limit prior approval must be sought from the Board of Governors, following a recommendation by the Audit Committee.

- For advisory services assignments, the Trust's Standing Financial Instructions (SFIs) Procurement of Services should be followed and the prior approval of the Board of Governors, following a recommendation by the Audit Committee, must be obtained prior to commencement of the work. Neither approval of the Board of Governors nor a recommendation from the Audit Committee will be required for discrete pieces of work within this category with a value of less than £10,000, subject to a cumulative limit of £25,000 per annum.

6.7 Auditors' reporting responsibilities

KPMG LLP, our independent auditors, report to the Board of Governors through the Audit Committee. KPMG LLP's accompanying report on our financial statements is based on its examination conducted in accordance with UK Generally Accepted Accounting Practices and the Financial Reporting Manual issued by the independent regulator Monitor. Their work includes a review of our internal control structure for the purposes of designing their audit procedures.

The Trust has three membership constituencies: public, staff and a patient constituency.

Public Constituency

The public constituencies correspond to the Parliamentary constituencies of Birmingham. Public members are those individuals who are aged 16 or over and:

(a) who live in the area of the Trust; and
(b) who are not eligible to become members of the staff constituency

Staff Constituency

The staff constituency is divided into four classes:

(a) medical staff
(b) nursing staff
(c) clinical scientist or allied health professional staff
(d) ancillary, administrative and other staff

Patient Constituency

Patient members are individuals who are:

(a) patients or carers aged 16 or over;
(b) not eligible to become Members of the staff constituency; and
(c) not eligible to become Members of the Public constituency.

(N.B. Following changes to the Constitution approved by the Board of Governors in September 2008, a patient who lives in the area of the Trust will not be eligible to be a Member of the Patients' constituency.)

7.2 Membership Strategy

Background

University Hospital Birmingham was a first wave NHS FT in 2004 and took the unusual step of adopting an 'opt-out' strategy around membership. This resulted in a membership of circa 100,000 members. Over the next three years (up until 2007/08) this figure reduced to circa 81,000, mainly due to deceased and 'gone away' members being removed from the database.

In July 2007 the Board of Directors and Board of Governors approved a new Membership Strategy. The key component of the strategy was to rationalise the membership to those who explicitly expressed a wish to be a member of the Trust.

Those people would then form the basis of a new membership that would be active, effective and value for money, one which the Trust could genuinely engage with, ensure was representative and then grow, over the coming months and years.

7.1 Membership Overview by Constituency

Constituency	Total at 31/03/09	%	% change from previous year
Public	7,674	42.5	-85.1
Patient	3,986	22.1	-82.0
Staff	6,410	35.8	-8.3
Total Membership	**18,070**	**100%**	**-77.6**

*Numbers correct up to 31 March 2009

There was an acceptance that this was likely to result in a significant reduction in the number of members. This was articulated in the Trust's 2007/08 Annual Plan and Annual Report to Monitor.

The process

Three data capture mail-outs were issued to the 81,000-strong membership in May 2007, September 2007, and February 2008, asking members to fill in the required fields of information and indicate whether they wished to continue to be a member.

In April 2008, the Board of Directors and Board of Governors were informed that the above exercise had resulted in circa 8,000 people responding (excluding circa 6,900) staff. It was agreed by the Board of Directors and Board Governors that a fourth mail-out should be issued, asking one question only: 'Do you wish to be a member of Queen Elizabeth and Selly Oak hospitals?'

This exercise resulted in circa 11,500 people (excluding circa 6,900 staff) who actively wanted to remain a member of Queen Elizabeth and Selly Oak hospitals. This total of circa 18,000 (inclusive of staff) was significantly less than the 35,000 which was expected and articulated to Monitor in last year's Annual Plan and Annual Report.

In September 2008 the Trust went out to tender for a new database management company following persistent concerns with its existing provider. The key issues were: poor quality data, significant number of duplicate names, lack of robust cleansing of the database. Active were appointed in October 2008. A month later Active were taken over by Capita.

7.3 Membership recruitment campaign 2009/10

In November 2008 the Trust started to develop a membership recruitment campaign to increase membership to 35,000 in 12 months from March 2009.

The objectives of the campaign, to be launched in April 2009, are to provide a representative, quality, value-for-money membership that can help the Trust realise its vision of delivering the best in care.

The membership database will provide a robust customer relationship management system that will help provide the most appropriate communications and engagement.
The membership recruitment campaign adopts an 'inside-out' approach, first targeting those who already have an association/empathy with the hospitals (staff, current members, visitors to the hospitals, stakeholder groups). It then moves to associated groups and networks, eventually ending with a public campaign, if necessary.

We believe this is the most efficient and cost effective way of recruiting quality members.

Membership is split into four categories: thought donor, time donor, support donor, energy donor. Each category has an indicative menu of the types of initiatives members can get involved with depending on which type of membership they opt for.

The membership recruitment strategy will be linked with the recruitment of volunteers, charity fundraising strategy and the Trust's community visits programme to maximise all opportunities and ensure a 'joined-up' approach.

A monthly progress report against target will be produced.

The Board of Directors received an update on the Membership Strategy at its meeting in February 2009. It will receive a six-monthly report on the progress of the strategy against targets, engagement and future plans. Any major issues/risks will of course be drawn to the attention of the Board of Directors at any time, if appropriate.

The Board of Governors will receive a quarterly report on the above.

7.4 Contact procedures for members who wish to communicate with governors and/or directors

There are several ways for members to communicate with governors and/or directors. The principal ones are as follows:

- Face-to-face interaction at monthly Members' Seminars. Governors attend these meetings and use them as a 'surgery' for members
- Governors' Drop-in Sessions. New in 2008/09, these sessions are held on a monthly basis at either the Queen Elizabeth or Selly Oak hospitals. A mix of staff, patient and public governors 'set up camp' and talk to, advise, take comments from staff, patients and visitors. These are then fed back to the Executive Directors for comment/action
- The Annual General Meeting
- Telephone, written or electronic communications co-ordinated through the Communications office which then steers members to the appropriate Governor/ Director
- 'Trust in the Future' magazine – highlights a Governor each issue
- InsideOut magazine – runs an article In The Hot Seat, which is a questionnaire with a different governor. It also gives their contacts details
- Direct email and helpline number to the Members' Register management company who take any kind of membership query and then feed back into the Trust to action
- Chief Executive hotline – phone communication for queries, comments and ideas
- In 2008/09 Governors will start to attend community presentations in relation to the New Hospital held their constituency

8. Public Interest Disclosures

8.1 Consultation

The Trust's policy on consultation is outlined in point 1.8 on page 11.

8.2 Policies in relation to disabled employees and equal opportunities

These policies are outlined in point 1.7 on page 10.

8.3 Sickness absence

The Trust recorded an annual average sickness absence of 4.33% across all clinical and corporate divisions.

8.4 Cost allocation

The Trust has complied with the cost allocation and charging requirements as set out in HM Treasury and Office of Public Sector Information Guidance.

8.5 Serious untoward incidents

There have been no Serious Untoward Incidents reported during 2008/09 involving data loss or confidentiality breach (as required as part of NHS Information Governance rules).

8.6 Health and Safety

The staff incident rate for 2008/09 was 21.37 incidents per 100 staff. No Improvement Notices were issued by the Health and Safety Executive (HSE) during this period. The HSE did, however, undertake an audit of compliance with their Stress Management Standards following their initial visit in 2007. The audit took place over a four-day timeframe and involved meetings with staff groups and examination of policies and procedures. The HSE were assured the Trust has good systems in place to identify and reduce work-related stress. They were complementary about the way the Trust communicated with staff.

The most common injuries sustained by staff remain unchanged and relate to inoculation and musculo-skeletal injuries. A trial of safety cannulae introduced to reduce inoculation injuries had to be halted due to patients reporting discomfort when these were used. Further research will be undertaken to identify safer devices that are acceptable to patients. A programme for the replacement of an ageing stock of patient hoists was also implemented to reduce the risk of injury from moving and handling activities to the lowest achievable level.

An internal systems audit to measure compliance with health and safety legislation has been rolled out using the accredited ROSPA audit tool and the results are published on the Trust intranet. The aim is for each department to be audited within a two-year time frame and to be able to demonstrate continuous improvement in compliance.

8.7 Countering fraud and corruption

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. As part of this responsibility, regular reviews into security around the site are conducted. They are conducted by the NHS accredited Local Security Management Specialist, this post is required under Secretary of State Directions, and the Trust encourages a pro-security culture amongst its staff.

The Trust policy is to apply best practice regarding fraud and corruption and that the Trust fully complies with the requirements

made under the Secretary of State directions. The local counter fraud service is provided by its internal auditors (under a separate tender) and the counter fraud plan follows these directions. The Trust does not tolerate fraud and the plan is designed to make all staff aware of what they should do if they suspect fraud.

8.8 Better Payment Practice Code

The Better Payment Practice Code requires the Trust to aim to pay all valid non-NHS invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

	Number	£000
Total bills paid in the year	89,508	211,940
Total bills paid within target	88,274	210,428
Percentage of bills paid within target	98.62	99.29

8.9 The Late Payment of Commercial Debts (Interest) Act 1998

Nil interest was charged to the Trust in the year for late payment of commercial debts.

8.10 Management costs

Management costs, calculated in accordance with the Department of Health's definitions, are 4%.

University Hospitals Birmingham
NHS Foundation Trust

Section 2

2008›2009 Remuneration Report

This annual report covers the period
1 April 2008 to 31 March 2009

1. Executive Appointments and Remuneration Committee

The Executive Appointments and Remuneration Committee is a sub-committee of the Board of Directors responsible for reviewing and advising the Board of Directors on the composition of the Board of Directors and appointing and setting the remuneration of executive directors. Its terms of reference, role and delegated authority have all been agreed by the full Board of Directors. The committee meets on an 'as-required' basis.

The Executive Appointments and Remuneration Committee's terms of reference empower it to constitute a sub-committee to act as a Nominations Committee to undertake the recruitment and selection process, including the preparation of a description of the role and capabilities required and appropriate remuneration packages, for the appointment of the Executive Director posts on the Board of Directors.

The Executive Appointments and Remuneration Committee comprises the Chairman, all other Non-Executive Directors and, for appointments of executive directors other than the Chief Executive, the Chief Executive. The chairman of the Committee is the Chairman of the Trust.

The Executive Appointments and Remuneration Committee met regularly throughout the year, holding three meetings in total.

Directors	No. of meetings attended*
Albert Bore	All
Julie Moore	All
Mark Santer	All
Clare Robinson	All
Tony Huq	All
Stewart Dobson	All
David Bailey**	1 out of 3
David Ritchie	All
Michael Sheppard	2 out of 3
Gurjeet Bains	1 out of 2

*While a member of the Executive Appointments and Remuneration Committee
**David Bailey was granted a leave of absence from September 2008 with the approval of the Board of Governors

2. Executive Remuneration Policy

The Committee recognises that, in order to ensure optimum performance, it is necessary to have a competitive pay and benefits structure.

The remuneration policy was reviewed by the Committee in June 2005.

Executive Directors are on substantive contracts with a notice period of six months. Each Director has annual objectives which are agreed by the Chief Executive. Reviews on performance are quarterly. The Chairman agrees the objectives of the CEO and associated performance measures.

There were no termination payments to Senior Managers and the Contracts do not stipulate that there is any entitlement to them. No significant awards and no compensation for loss of office were made to Senior Managers during 2008/09.

3. Pensions

All the executive directors are members of the NHS Pensions Scheme. Under this scheme, members are entitled to a pension based on their service and final pensionable salary subject to HM Revenue and Customs' limits. The scheme also provides life assurance cover of twice the annual salary. The normal pension age for directors is 60. None of the Non-Executive Directors are members of the schemes. Details of the benefits for executive directors are given in the tables provided on page 5.

4. Other benefits

Where there were a number of months still under contract on their lease car, Directors were able to continue with the lease. Their annual salary entitlement has been reduced in line with the cost of providing this car.

5. Salary and Pension Entitlements of Senior Managers

A. Remuneration

Name and Title	Year Ended 31 March 2009			Year Ended 31 March 2008		
	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind Rounded to the Nearest £100	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind Rounded to the Nearest £100
Senior Managers						
Julie Moore, Chief Executive	205-210	0	0	200-205	0	0
Mike Sexton, Executive Director of Finance	135-140	0	0	130-135	0-5	0
Tim Jones, Chief Operating Officer (Up to 31/08/2008)	55-60	0	0	130-135	0	0
Tim Jones, Executive Director of Delivery (Commencing 01/09/2008)	75-80	0	0	0	0	0
Kay Fawcett, Chief Nursing Officer (Commenced office 14/01/2008)	120-125	0	0	25-30	0	0
Michelle Morris, Acting Chief Nursing Officer (Commenced 27/09/2007 and left 13/01/2008)	0	0	0	20-25	0	0
Trisha Curran, Acting Chief Nursing Officer (Left office 26/09/2007)	0	0	0	40-45	0	0
Kevin Bolger, Acting Chief Operating Officer Commenced office 01/09/2008)	75-80	0	0	0	0	0
Dr David Rosser, Executive Medical Director	85-90	95-100	0	80-85	90-95	0
Caroline Wigley, Director of Organisation Development (Left office 31/08/2008)	50-55	0	0	125-30	0	0
David Burbridge, Director of Corporate Affairs	90-95	0	0	75-80	0	0
Mike Sharon, Director of Policy, Planning and Performance Management (Left office 31/01/2009)	85-90	0	0	95-100	0	0
Sam Chittenden, Director of Strategic Developments (Commenced office 24/03/2008)**	115-120	0	100	0	0	0
Fiona Alexander, Director of Communications	95-100	0	0	95-100	0	0
Morag Jackson, New Hospitals Project Director	115-120	0	0	105-110	0	0
Non Executive Directors						
Sir Albert Bore, Chairman	45-50	0	0	45-50	0	0
David Bailey *	5-10	0	0	10-15	0	0
Stewart Dobson	10-15	0	0	10-15	0	0
Tony Huq**	10-15	0	100	10-15	0	0
David Ritchie	10-15	0	0	10-15	0	0
Clare Robinson	10-15	0	0	10-15	0	0
Rev Mark Santer (Left office 30/11/2008)	5-10	0	0	10-15	0	0
Professor Michael Sheppard (Commenced office 05/12/2007)	10-15	0	0	0-5	0	0
Gurjeet Bains (Commenced office 01/12/2008)	0-5	0	0	0	0	0

*Unpaid leave of absence from 01/10/2008 to 31/08/2009

**Benefits in kind relate to business miles at excess rate

B. Pension Benefits

Details provided by the NHS Pensions Agency.

Name and Title	Real increase in pension at age 60 (bands of £2500) £000	Real increase in pension related lump sum at age 60 (bands of £2500) £000	Total accrued pension at age 60 at 31 March 2009 (bands of £5000) £000	Total accrued pension related lump sum at age 60 at 31 March 2009 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2008 £000	Cash Equivalent Transfer Value at 31 March 2009 £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension To nearest £100
Julie Moore, Chief Executive	2.5-5	7.5-10	70-75	220-225	1,032	1,407	244	N/A
Mike Sexton, Executive Director of Finance	0-2.5	5-7.7	40-45	125-130	588	819	151	N/A
Tim Jones, Chief Operating Officer)	0-2.5	5-7.5	25-30	80-85	293	411	151	N/A
Kay Fawcett, Chief Nursing Officer	5-7.5	20-22.5	45-50	140-145	587	900	209	N/A
Kevin Bolger, Acting Chief Operating Officer Commenced office 01/09/2008)	5-7.5	15-17.5	35-40	115-120	409	745	132	N/A
Dr David Rosser, Executive Medical Director	2.5-5	12.5-15	45-50	135-140	501	722	146	N/A
Caroline Wigley, Director of Organisation Development (Left office 31/08/2008)	2.5-5	27.5-30	55-60	175-180	810	1,267	128	N/A
David Burbridge, Director of Corporate Affairs	10-12.5	32.5-35	10-15	35-40	13	206	135	N/A
Mike Sharon, Director of Policy, Planning and Performance Management (Left office 31/01/2009)	0-2.5	2.5-5	30-35	90-95	431	585	84	N/A
Sam Chittenden, Director of Strategic Developments (Commenced office 24/03/2008)	5-7.5	15-17.5	15-20	55-60	197	333	92	N/A
Fiona Alexander, Director of Communications	0-2.5	2.5-5	0-5	10-15	31	56	17	N/A
Morag Jackson, New Hospitals Project Director	2.5-5	10-12.5	30-35	90-95	364	535	113	N/A

6. Non-Executive Directors' remuneration

Non-Executive Directors' remuneration consists of fees which are set by the Board of Governors. The Board of Governors has established a committee, the Board of Governors Remuneration Committee for Non-Executive Directors, to advise the Board of Governors as to the levels of remuneration for the Non-Executive Directors. NED fees are reviewed each year with advice taken from independent consultants where appropriate. During this year, an increase to the Chairman's and Non-Executive Directors' fees was approved following a benchmarking exercise against other similar Foundation Trusts. The Committee comprises Brian Hanson (chair), Barbara Tassa, David Spilsbury and James Hutchings. It met once during the year and all members attended that meeting.

June 4 2009

Julie Moore
Chief Executive

Date

University Hospitals Birmingham
NHS Foundation Trust

Section 3

2008 › 2009
Quality Report

This annual report covers the period
1 April 2008 to 31 March 2009

Chief Executive's Statement

The Vision of University Hospitals Birmingham NHS Foundation Trust (UHB) is "to deliver the best in care" to our patients.

Quality in everything we do underpins this vision - ranging from the direct care provided by our clinical staff, to the support services offered by our Hotel Services and Patient Administration, through to Finance and Human Resources.

Delivering high quality services has to be a team effort supported by our staff, governors, volunteers and members.

We achieve this by delivering our vision and key purposes which are to provide the highest possible clinical outcomes, the highest quality patient experience, high quality research and education.

To ensure we deliver this Vision we have clearly outlined our Values which provide the framework for staff to use in directing their daily work. We must always act with respect for our patients, their carers and relatives and to each other. We must take responsibility for our own actions and for those working with us. We must always act with honesty to ensure we are transparent in our actions and we have a duty to innovate to ensure we are delivering the best in care not only today but in the future.

Our approach to Quality within the Trust uses the framework of the Vision, Purpose and Values to support staff in delivering high quality care. We wish to empower staff delivering patient care to make decisions and improve the care to the patient they are treating.

The Trust is making great strides forward in improving the quality of services we provide. We have achieved significant reductions in the level of Healthcare Acquired Infections such as MRSA and *Clostridium Difficile* (C.diff) in the Trust. We have significantly reduced waiting times and have achieved the 18-week referral to treatment targets. We have also introduced a real-time patient experience monitoring system to allow us to intervene when patients believe care is not meeting their expectations.

We have established the Birmingham Clinical Research Academy in partnership with the University of Birmingham and other healthcare partners which has already led to significant investment in research.

The work we are undertaking on quality will be complemented by the opening of the Queen Elizabeth Hospital Birmingham from June 2010 when the quality of the service we provide will be matched by a world-class environment.

We are currently finalising our new clinical strategy which, in line with our Values, has been a bottom-up process led by our clinical teams. The consistent feature has been the potential for future clinical care development and excellence through bringing together all our services under one roof to create one of the most comprehensive adult healthcare providers in Europe.

This is an exciting time for University Hospitals Birmingham NHS Foundation Trust and the communities we serve. We have a lot of hard work ahead but we believe that the foundations we are laying will give us a firm base for continuing to provide high quality health care to our patients and their carers for many years to come.

Julie Moore, Chief Executive
June 4, 2009

1.1 Current view of Trust's position and status on quality

The information presented in the Trust's first Quality Report is a combination of conventional measures and more specific process measures which few other UK trusts report on a routine basis.

The most recent data has been included in the report wherever possible and updated information against the quality metrics will be provided during the course of the year. A quality report link will be available on the Trust's website later in the year.

The value of Quality Reports will increase once more robust data, standardised across all trusts, becomes available. This will enable trusts to be measured on a like-for-like basis and their performance on quality to be benchmarked and compared with that of others. This is not happening yet nationally as the quality of data and the mechanisms of data collection are inconsistent.

The Trust does have concerns about the methodology and specificity of alerts that are automatically generated using nationally collated data as a measure of quality care delivery. As well as the methodology, the lack of context to recently published data, e.g. Hospital Standardised Mortality Ratios (HSMRs), has significant potential to cause confusion and waste energy correcting data anomalies rather than addressing real quality concerns.

These concerns are increasingly being reflected in the academic press and a series of benchmarks and detailed analysis will need to be utilised by trusts to get a true picture of clinical outcomes.

1.2 Overview of organisational effectiveness initiatives

In line with its Vision ''to deliver the best in care", the Trust developed many organisational effectiveness initiatives during 2008-09 which focus on the key aspects of quality: patient safety, patient experience and effectiveness of care.

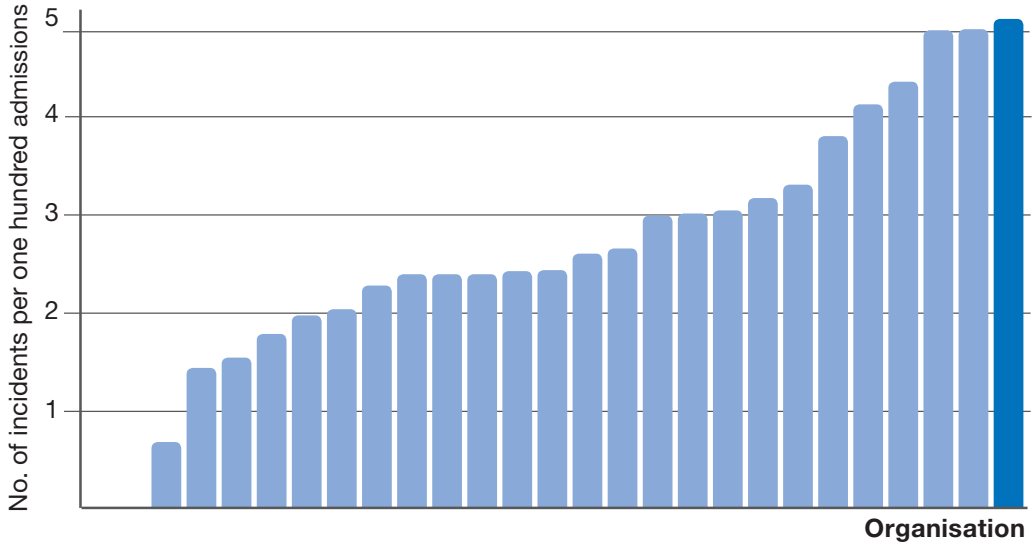
The Trust believes that quality should be monitored and managed with the same level of precision and high quality information which is routinely used in managing finances.

To this end, the Trust has invested significant time and resources into information technology systems over the past year to monitor and manage the quality of care provided to patients.

Paramount to improving quality is patient safety. Information provided by the National Patient Safety Agency (NPSA) demonstrates that the Trust has a good incident reporting culture where staff feel able to report incidents and near misses.

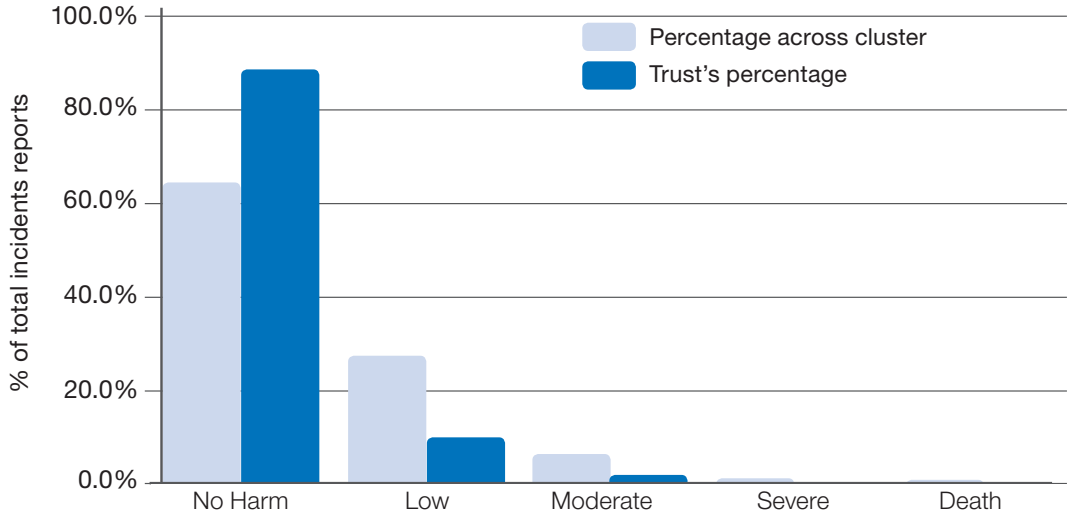
Figure 1 shows the rates of reported patient safety incidents per 100 admissions from acute teaching trusts during the period 1 April 2008 to 30 September 2008. The dark blue bar shows that University Hospitals Birmingham NHS Foundation Trust was the highest reporting trust out of 26 acute teaching trusts.

Figure 1



The dark blue bars in **Figure 2** show the proportion of no harm through to more serious incidents reported by the Trust. The light blue bars show the average proportion of the same incidents that occurred in all the organisations in the cluster group. The high ratio of no harm incidents to incidents which resulted in harm indicates a positive cultural approach to reporting and responding to potential incidents. Percentages have been used rather than actual numbers for this figure as the organisations in the acute teaching trust cluster group are of different sizes.

Figure 2



Source: Patient safety incident reports successfully submitted to the National Reporting and Learning System (NRLS) where the incident occurred during the period 1 April 2008 to 30 September 2008.

Some of the key organisational initiatives which were developed during 2008-09 and will be progressed further during 2009-10 include:

The Prescribing Information and Communication System (PICS)

The Trust's electronic, rules-based clinical information, drug prescribing and administration system has been in use and continuously developed over the past ten years and supports clinical decision-making, in a variety of different ways, for all inpatients. PICS allows the Trust to monitor and feedback to clinical teams on a weekly basis allowing them to deal with potential concerns in real-time.

The system is also able to enforce processes. For example, as part of the patient admission process there is a mandatory thromboprophylaxis risk assessment which means that 100% of the Trust's inpatients have undergone the risk assessment recommended by the National Institute for Health and Clinical Excellence (NICE). Also, the Trust began reporting the number of drugs prescribed to patients but not recorded as administered (omitted) on PICS in January 2009. The number and complexity of indicators used is rapidly increasing and will be further developed during 2009-10.

Mortality

The Trust does monitor its HSMR on a routine basis and the Trust's current overall mortality (1 year) HSMR value is 101.28 which is within the expected level. As noted above, the Trust has significant concerns with the validity of the current methodologies and relatively non-specific and retrospective nature of the HSMR indicator.

As part of our continuing efforts to provide the level of detail required to manage quality on a real-time basis, over the past 12 months senior managers across the Trust have received automated daily emails detailing mortality information including a live hyperlink to the underlying detailed data. Trend data and analysis is also monitored monthly including comparators with other trusts. Any anomalies or unexpected deaths are investigated immediately.

Clinical Quality Dashboard

The Trust developed a ward level digital Clinical Quality Dashboard with clinicians and divisional management teams, which went live in January 2009. This gives staff real-time information on a variety of clinical quality indicators for their ward area and the Trust overall - falls, infection control, length of stay, patient experience feedback, complaints, staff sickness levels, and pressure ulcer data - to enable them to better manage patient care. During 2009-10, the Trust will be configuring an automatic escalation system which sends notifications from the dashboard to alert different levels of management staff, including the Chief Operating Officer, Executive Medical Director and Chief Executive, depending upon the level of performance against each clinical quality indicator. All triggers of the escalation system will be reported to the Trust's Clinical Quality Monitoring Group and will be reported to the Board of Directors as part of the monthly Clinical Quality Monitoring Report.

Quality and Outcomes Research Unit

The Trust's Health Informatics and Cardiac Surgery teams have created a dedicated Quality and Outcomes Research Unit (QuORU). The unit has linked a wide variety of information systems together to enable all important elements of service delivery to be analysed and monitored in a sophisticated way in order to improve patient care, experience and outcomes. Further information can be found from the following website link: http://www.uhb.nhs.uk/Services/All/Quoro/Home.aspx

A plan to roll-out QuORU services to all other areas during 2009-10 has been agreed.

Emergency Readmissions

The Trust has a high rate of readmissions which it is committed to reducing in 2009-10 as a broad indicator of quality of care. Discharging and admitting consultants receive an automated email advising of patients who have been re-admitted to the hospital. Consultants are required to complete an online audit form for each readmission so that prompt action can be taken to prevent avoidable future readmissions and improve the clinical coding of readmissions.

Length of Stay

A patient's length of stay is an important marker of patient experience and the efficiency of patient care. The Trust has implemented an electronic tool in PICS to monitor and update patients' length of stay based initially on historical data and refined using clinicians' estimates. This tool not only helps in efficient discharge planning but contributes to the future modelling of patient movement within the organisation and assists in capacity planning. During 2009-10, Health Informatics will be working with clinicians to improve the real-time estimation of patients' length of stay.

1.3 How we have prioritised our quality improvement initiatives for 2009-10

In order to identify the three highest priorities for quality improvement in 2009-10, the Trust's Clinical Quality Monitoring Group, chaired by the Executive Medical Director, considered performance on patient safety, patient experience and effectiveness of care to improve quality. The Trust has agreed three priorities under which there are a number of current and planned initiatives, only a small selection of which are included in this report.

Reducing errors is a key component of improving patient safety. It is internationally recognised that medication errors are the most common healthcare error. The Trust's baseline PICS data, which has only been routinely reported since January 2009, although comparable with data elsewhere, has been identified as a key initiative supporting the priority of reducing errors.

Infection prevention and control is another key aspect of patient safety and effectiveness of patient care as healthcare acquired infections contribute to patients' length of stay, mortality, readmissions and experience. Whilst the Trust has reduced its MRSA and C.difficile rates during 2008-09, the Trust recognises there is a need for continued improvement in 2009-10 and beyond.

Patient experience is a critical indicator of the quality of care. The Trust has developed innovative ways of capturing and acting upon real-time feedback on its services during 2008-09, the National Inpatient Survey shows that patient satisfaction rates need to be improved.

The Board of Governors has discussed the proposals as part of the process and the Board of Directors has approved the priorities for 2009-10 to be:

Priority 1: Reducing errors (with a particular focus on medication errors)
Priority 2: Infection prevention and control
Priority 3: Improve patient experience and satisfaction

1.4 Our selected priorities and proposed initiatives

Each of the priorities above, with our proposed initiatives for 2009-10, are described in detail on the following pages:

Description of issue and rationale for prioritising

The Trust has recently developed the ability to report on the number of drugs prescribed to patients but not administered (omitted) on the Prescribing Information and Communication System. The system is able to log each drug administration (approximately 120,000 events per week) relating to every single prescription (approximately 20,000 events per week). Baseline data for January-March 2009 shows the percentage of antibiotic and other drug doses prescribed to patients but not administered (omitted) on PICS. This data includes both drug doses intentionally omitted (the vast majority being by nursing staff making appropriate clinical decisions) and unintentionally omitted due to a variety of administrative reasons. This data is now sent out to Divisional teams on a weekly basis. While the figures from the Trust are in line with internationally reported figures, the Trust has started working to reduce the number of drug dose omissions by improving the administration and prescribing practice across the Trust as part of the drive to improve the precision of care and reduce errors.

The Trust also monitors the number of times that serious alerts raised by the clinical decision support system lead to a proposed action being aborted, as well as "hard stops", where an action is prevented due to the embedded rules in the system (e.g. serious drug overdose or drug interaction). This is reported as potential or definite errors prevented.

Aim/Goal

Continue to reduce preventable errors in the care provided to patients.

Current status

Drug Omissions †		
Drug Classes	**Percentage of total doses due for administration**	**Time period**
1. Antibiotic doses omitted (both intentional and unintentional)	12.2%	Jan-Mar 2009
2. Non-antibiotic doses omitted (both intentional and unintentional)	20.2%	Jan-Mar 2009

† Data reported from prescription information in PICS for all inpatients – available from Jan 2009

Prescription Warnings ‡		
Level of Warning	**Percentage of total doses due for administration**	**Time period**
a. Password level warnings (potential errors prevented)	175,000 warnings Median of 197 warnings per doctor per 1000 prescriptions	Aug 2007 (week one) to Aug 2008 (week one)
b. Hard stop warnings (definite errors prevented)	12,100 warnings Median of 13 warnings per doctor per 1000 prescriptions	(12 months total)

‡ Audit data taken from junior doctor prescriptions (for annual junior doctor rotation) with a total of 850,000 prescriptions made by 410 junior doctors - Median of 1,400 prescriptions per junior doctor

Identified areas of improvement

- Improved ability to record the reason for omitted prescribed drugs to be incorporated into PICS.

Current initiatives in 2008-09

- The monitoring, reporting and action to improve the prescription and administration of drugs to patients and ensuring appropriate documentation is completed.
- Review of the current rules-based clinical decision support functions (passwords) of PICS to ensure accuracy and best practice.

New initiatives to be implemented in 2009-10

- PICS to be implemented in the day case/ Outpatient and A&E areas of the Trust.
- Ongoing monitoring, reporting and action to improve drug prescription and administration, identifying the reasons for omission of prescribed drugs.
- Further development of PICS functionalities (Ward Order Communications, rules-based electronic observation charts) to improve communication between clinicians as well as the care provided to patients.
- Educational initiatives using data from PICS to target specific medication safety issues in the Trust (e.g. inappropriate omission of pre-operative drugs).

Priority 2: Infection prevention and control

Description of issue and rationale for prioritising

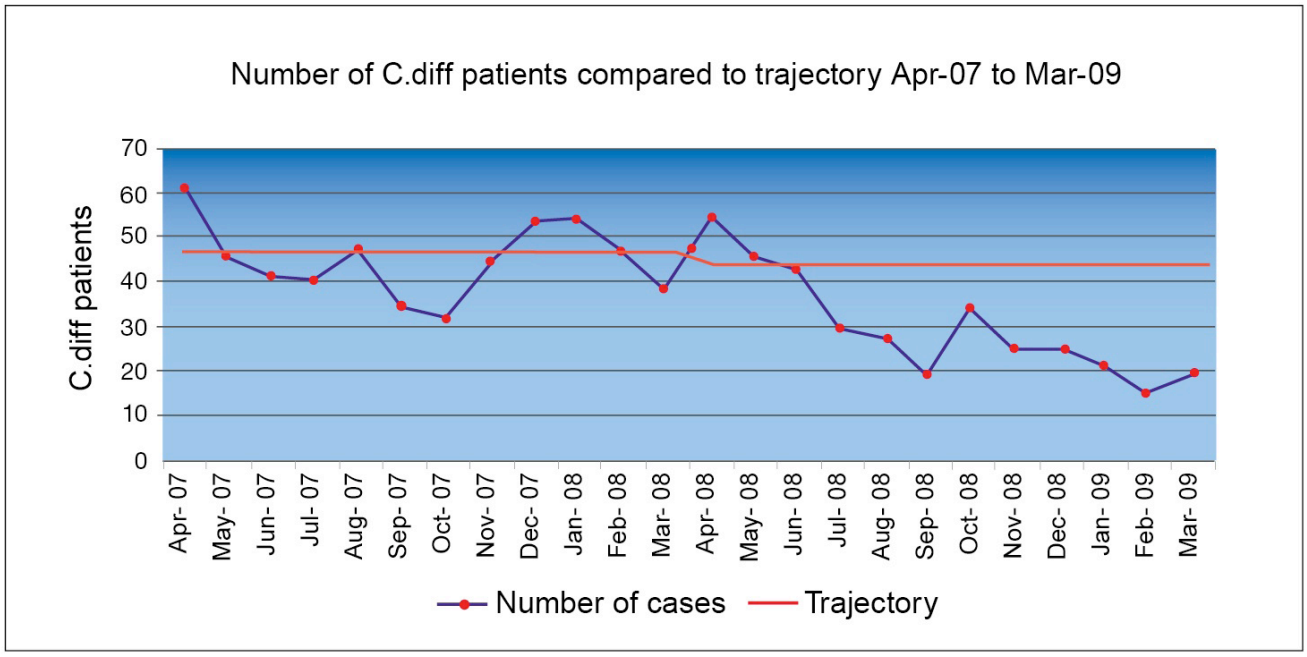
As described above, the reduction of health care associated infections continues to be a priority for the Trust as evidence shows that this is one of the most important factors influencing confidence in care that patients consider prior to admission to hospital.

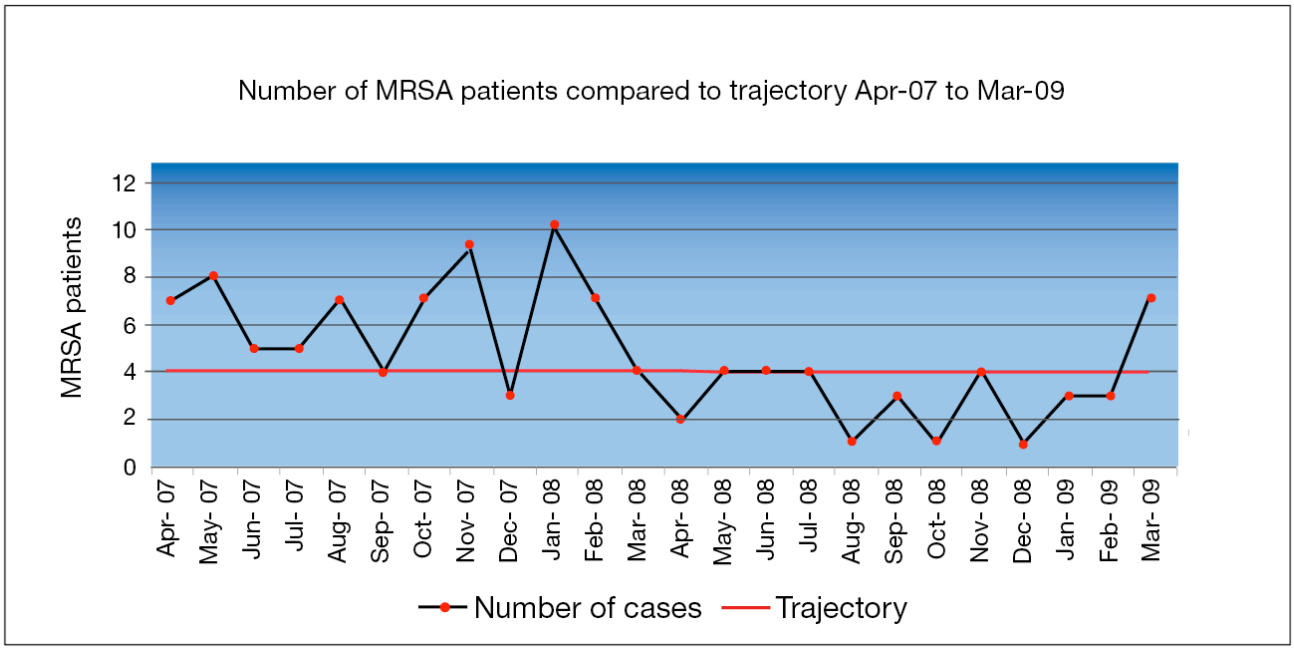
Aim/Goal

As for 2008-09, the Trust will continue to reduce MRSA bloodstream infections and C.difficile cases in line with 2009-10 trajectories.

Current status

National targets and regulatory requirements	2008-2009	2007-2008	Agreed Trajectory
Clostridium difficile year on year reduction (post-48 hour cases)	355	658	526 in 2008-09 (Not a target in 2007-08)
MRSA – maintaining the annual number of MRSA bloodstream infections at less than half the 2003-04 level (123 cases)	35	76	48 in 2008-09 & 2007-08





Identified areas of improvement

Both MRSA and C.difficile levels were successfully reduced in 2008-09 with the Trust performing well below the planned reductions (trajectories) agreed with the Primary Care Trust. It was disappointing to have 7 cases of MRSA in March 2009, partially explained by one patient with two positive results, but this was very much against the trend of performance in year. Work continues to reduce the levels still further in order to meet trajectories for 2009-10 and to meet the final reduction for C.difficile required by the outturn of 2010-11.

Current initiatives in 2008-09

- Comprehensive action plan based on the national Saving Lives campaign.
- Focus on hand hygiene and effective aseptic management.
- Enhanced environmental management and deep cleans.
- Enforcement of good prescribing practice using the PICS system.

New initiatives to be implemented in 2009-10

- Further develop the roll-out of High Impact Interventions focusing on clinical intervention and continued learning and improvement through Root Cause Analyses of both MRSA blood stream infections and C.difficile cases.

Priority 3: Improve patient experience and satisfaction

Description of issue and rationale for prioritising

The National Inpatient Survey provides the Trust with a yearly snapshot of patient satisfaction. The Trust is currently developing systems that will provide a daily trend on patient satisfaction to allow immediate and effective action to be undertaken.

Aim/Goal

The Trust's aim is to improve its performance across a range of patient experience measures which affect patient satisfaction. These are informed by national and local surveys of patient satisfaction.

Current status

Bedside TV survey results 2008-09

In the table below are survey results for the last year which have been taken from the Trust's bedside TV system. Through a section of the ward clinical dashboard, the views of patients can now be accessed for each clinical setting and rapid feedback or action is taken where concerns are raised. Email alerts have been developed to advise Matrons when a patient provides poor feedback relating to clinical care, which is then a factor in the new nursing "Back to the Floor" initiative aimed at raising the standard of care in all areas. The Trust's National Inpatient Survey results are detailed in section 2.1.

Results from approx 1,100 patients across both hospital sites (2.0% of total admissions during 2008-09)	
Dignity and respect	67.2% of patients said they were always treated with dignity and respect 92.8% of patients said they were always or sometimes treated with dignity and respect
Privacy	78.0% of patients said their privacy was always maintained whilst being examined or treated 94.0% of patients said their privacy was always or sometimes maintained whilst being examined or treated
Involvement in decisions	83.9% of patients said they were always involved, or involved to some extent, in decisions about their care and treatment
Cleanliness of room or ward	90.3% of patients rated their room/ward as very clean or fairly clean
Overall rating of care	61.9% of patients rated their overall care as very good or excellent 79.4% of patients rated their overall care as good, very good or excellent

Complaints

The Trust aims to respond to all complaints in a timely and effective manner and endeavours to respond to complaints within 25 working days wherever possible. During 2008-09, any complainant who was not satisfied with the Trust's response was able to refer their complaint to the Healthcare Commission (HC) for an independent review. From 2009-10, the Parliamentary and Health Service Ombudsman takes over responsibility for such reviews. The Trust has had relatively low proportions of complaints being referred to second and third stage; a reflection on the quality of our investigations, response letters and meetings with complainants.

Complaints data

	2008-09	2007-08	% increase/decrease
Total number of complaints	609	572	+ 8%
Response within 25 days	88%	92%	-4%
Referrals to HC by referral date	6	7	-14%
Referrals to HC by complaint date	4	5	-20%

Top 3 Complaints Categories	2008-09	2007-08
Main category		
1. Clinical treatment	254	185
2. Out-patient appointment delay/cancellation	97	92
3. Communication/ information	69	65
All issues		
1. Clinical treatment	732	522
2. Communication/ information	408	299
3. Out-patient appointment delay/cancellation	183	174

The table below shows the ratio of complaints to activity in different areas of the Trust. The Trust has undertaken some preliminary benchmarking activity around the number of complaints received and those referred for the second stage review compared with other trusts. This will be developed during 2009-10 and included in future reports.

		1 Oct 08 – 31 Mar 09	1 Apr 08 – 30 Sept 08	1 Oct 07 – 31 Mar 08	1 Apr 07 – 30 Sept 07
Inpatients	FCEs*	60743	60910	58159	56622
	Complaints	139	155	120	147
	Rate/1000 FCEs*	**2.29**	**2.54**	**2.06**	**2.60**
Outpatients	Appointments	234844	231954	210561	196308
	Complaints	120	143	134	131
	Rate/1000 appointments	**0.51**	**0.62**	**0.64**	**0.67**
A+E	Attendances	40800	42251	40243	41523
	Complaints	22	30	23	17
	Rate/1000 Attendances	**0.54**	**0.71**	**0.57**	**0.41**

*FCE = finished consultant episode which denotes the time spent by a patient under the continuous care of a consultant

Compliments

The majority of compliments are received in writing – by letter, email or comment card – with a small proportion received via telephone or in person and recorded by the Patient Advice and Liaison Service (PALS).

Compliment Subtype	Number Received in 2008-09	Number Received in 2007-08
Treatment received	157	123
Facilities	10	2
Friendliness of staff	18	1
Nursing care	4	1
Other	2	3
Medical care	3	3
Efficiency of service	4	4
Comment	1	1
Information provided	0	2
Totals:	**199**	**140**

Identified areas of improvement

The Trust's Care Quality Group has agreed actions required across a range of issues, primarily focusing upon privacy and dignity, communication, pain control and environmental cleanliness. Measures of improvement will be supported by increased surveying of patients through both the bedside TVs and via face-to-face surveys by volunteers and Patient and Carer Council members.

Current initiatives in 2008-09

- Collection of data from the bedside TV surveys.
- An internal audit on single sex accommodation and associated action plan.
- National Inpatient survey and Accident and Emergency survey action plans.
- Dignity in Care campaign underway.

New initiatives to be implemented in 2009-10

- The local patient surveys will provide evidence which will trigger the 'Back to the Floor' initiative focusing upon weekly observation and documentation by senior nursing teams in all wards and departments.
- A follow-up telephone survey is being developed for use with patients on discharge
- Immediate feedback of excellent or poor satisfaction at ward level via the newly developed Clinical Quality Dashboard, so that issues can be addressed quickly at ward level.
- A dedicated new analytics post with Health Informatics to help support the Trust's patient experience strategy that will use a comprehensive approach to support the collection, analysis and implementation of patient feedback.
- Opinion consoles are to be implemented in outpatient departments to allow further patient feedback

1.5 Response to regulators

The Trust received an unannounced visit from the Healthcare Commission (now the Care Quality Commission) on 27 and 28 August 2008 which found no material breaches of the Hygiene Code and was given a "green" rating for all areas inspected. The Trust has an ongoing relationship with the Department of Health Improvement Team for Infection Prevention and Control who have worked with the wider Infection Control Team to review clinical practices and have given advice and practical help, including training and external objective review of systems which have included Hotel Services.

The Trust received a letter from the Healthcare Commission in 2008-09 about being a potential outlier in 2007-08 in mortality for head injury with brain injury, primary diagnosis of traumatic subdural haemorrhage. The Trust carried out a rigorous assessment regarding this particular group of patients, using benchmarking, casemix adjustment, and found no cause for concern to this patient group. The Trust provided a full response to the Healthcare Commission in February 2009; the Care Quality Commission has since accepted the statistical methodology used by the Trust. The response can be viewed on the Trust's internet site: http://www.uhb.nhs.uk/Pdf/MortalityOutlierReport.pdf

1.6 Response to LINks and to feedback from Members and Governors

The Trust has hosted the meetings of the Birmingham Local Involvement Network (LINk) – University Hospitals Birmingham Working Group since it started in December 2008. Meetings have taken place between the LINks host organisation, Gateway, and the Trust to discuss potential ways forward.

The Models of Care Review group has met quarterly throughout 2008-09. The group is made up of members of the Patient and Carer Councils, Birmingham LINk – University Hospitals Birmingham Working Group and Foundation Members. The group reviews assumptions around how the new hospital will operate and asks for views of group members on practical issues for patients and visitors.

The Foundation Membership Strategy was reviewed in 2008 and the approach to recruiting members re-designed; new database management company appointed; recruitment campaign developed. Patient and Carer Council members, and members of the Birmingham LINk – University Hospitals Birmingham Working Group, were invited to take part in a consultation on the new membership recruitment packs.

Membership Seminars: a monthly programme of free health talks was provided throughout 2008. Topics included common health conditions and information about the various services the Trust provides. Around 25-40 people attended each seminar and were encouraged to ask questions and give feedback to clinicians and managers.

Governors hold monthly 'drop in sessions' at both hospitals for patients, visitors and staff. Comments and suggestions from the sessions are fed back to Divisions for information and action as appropriate.

Patient and Carer Councils are instrumental in the 'Clean Your Hands' campaign within the Trust and have adopted wards to provide a higher profile and ensure that patients can feedback to non clinical staff about their care.

The Trust's Care Quality Group has governor members who are involved in the development of initiatives to increase patient feedback and enhance the patient experience.

2.1 Performance of Trust against selected metrics

The infection prevention and control data published by the Health Protection Agency (HPA) is included in the tables below plus the Trust's data for 2008-09 where HPA data is not yet available. The Trust's data has been corrected to reflect specialty activity, taking into account that the Trust does not undertake paediatric, obstetric, gynaecology or elective orthopaedic activity; all known to be very low risk activities in terms of hospital acquired infection. A more accurate comparison can be made where these specialties are excluded from the denominator (bed day) data for the peer group (also shown in the tables below). The Trust believes that uncorrected figures are potentially misleading and emphasise the nature of non contextualised centrally processed data.

We have chosen to measure our performance against the following metrics	2008-2009	2007-2008	National Average	Peer Group Average
Safety measures reported				
1(a). MRSA: Patients with MRSA infection/10,000 bed days (includes all bed days from all specialties) *Lower rate indicates better performance*	**1.06**	**2.27**	**1.19**	**1.27**
Time period	2008-09	2007-08	2007-08	2007-08
Data source	Trust MRSA data reported to HPA, Dr Foster (bed days)	HPA	HPA	HPA (MRSA data), Dr Foster (bed days)
Peer group			All acute trusts	Acute trusts in West Midlands SHA
1(b). MRSA: Patients with MRSA infection/10,000 bed days (aged >15, excluding Obstetrics Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	**1.09**	**2.34**	*Not available*	**1.49**
Time period	2008-09	2007-08		2007-08
Data source	Trust MRSA data reported to HPA, Dr Foster (bed days)	HPA (MRSA data), Dr Foster (bed days)		HPA (MRSA data), Dr Foster (bed days)
Peer group				Acute trusts in West Midlands SHA

We have chosen to measure our performance against the following metrics	2008-2009	2007-2008	National Average	Peer Group Average
2(a). *C. difficile:* Patients with *C. difficile* infection/1,000 bed days (includes all bed days from all specialties) *Lower rate indicates better performance*	**1.02**	**3.04**	**1.18**	**1.76**
Time period	2008-09	2007-08	2007-08	2007-08
Data source	Trust C.diff data reported to HPA, Dr Foster (bed days)	HPA	HPA	HPA (C.diff data), Dr Foster (bed days)
Peer group			All acute trusts	Acute trusts in West Midlands SHA
2(b). *C. difficile:* Patients with *C. difficile* infection/1,000 bed days (aged >15, excluding Obstetrics Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	**1.04**	**3.17**	*Not available*	**2.06**
Time period	2008-09	2007-08		2007-08
Data source	Trust C.diff data reported to HPA, Dr Foster (bed days)	HPA (C.diff data), Dr Foster (bed days)		HPA (C.diff data), Dr Foster (bed days)
Peer group				Acute trusts in West Midlands SHA
3. Patient safety incidents (reporting rate per 100 admissions) *Higher rate indicates better performance*	**9.98**	*Not available*	*Not available*	**4.98**
Time period	April-Sept 08			April-Sept 08
Data source	NPSA			NPSA
Peer group				Acute teaching trusts in West Midlands
4. Percentage of patient safety incidents which are no harm incidents (April-Sept 08) *Higher % indicates better performance*	**88.4%**	*Not available*	*Not available*	**64.4%**
Time period	April-Sept 08			April-Sept 08
Data source	NPSA			NPSA
Peer group				Acute teaching trusts in West Midlands

We have chosen to measure our performance against the following metrics	2008-2009	2007-2008	National Average	Peer Group Average
Clinical outcome measures reported				
5(a). Readmissions: Readmission rate (Medical and surgical specialities - elective and emergency admissions aged >15)% *Lower % indicates better performance*	**8.34%**	**8.39%**	*N/A*	**6.96% (7.30%)**
Time period	April-Oct 08	2007-08		April-Oct 08
Data source	Dr Foster	Dr Foster		Dr Foster
Peer group				Acute trusts in West Midlands SHA **(**University Hospitals**)**
5(b). Readmissions: Readmission rate (all specialties) % *Lower % indicates better performance*	**8.45%**	**8.51%**	*N/A*	**6.50%**
Time period	April-Oct 08	2007-08		April-Oct 08
Data source	Dr Foster	Dr Foster		Dr Foster
Peer group				University Hospitals
6. Falls (incidents reported as % of elective and emergency admissions) *Lower % indicates better performance*	**3.59%**	**4.10%**	*Not available*	*Not available*
Time period	2008-09	2007-08		
Data source	Trust incident data	Trust incident data		
7. Percentage of stroke patients (infarction) on aspirin, clopidogrel or warfarin *Higher % indicates better performance*	**98%**	**97%**	*No UK comparator*	**98.6%**
Time period	2008-09	2007-08		2007 Calendar year
Data source	Trust PICS data	Trust PICS data		Cleveland Clinic, Ohio, U.S.A.
8. Percentage of beta blockers given on the morning of the procedure for patients undergoing first time coronary artery bypass graft (CABG) *Higher % indicates better performance*	**88%**	**88%**	*No UK comparator*	*Not available*
Time period	2008-09	2007-08		
Data source	Trust PICS data	Trust PICS data		

Note on clinical outcome measures

7: Aspirin, clopidogrel or warfarin are given to reduce the likelihood of recurrent stroke or transient ischaemic attack (TIA) in patients who have already suffered a stroke
The Cleveland Clinic, located in Ohio in the U.S.A., is a not-for-profit, multi-specialty academic medical centre that integrates patient care with research and education, and is widely regarded as being amongst the best healthcare providers in the U.S.A.
8: Beta blockers are given to reduce the likelihood of peri-operative myocardial infarction and early mortality.

We have chosen to measure our performance against the following metrics	2008-2009	Comparison with other NHS trusts 2008-2009	2007-2008	Comparison with other NHS trusts 2007-2008
Patient experience measures reported				
9. Overall were you treated with respect and dignity	**88**	**Intermediate 60% of trusts**	**89**	**Intermediate 60% of trusts**
Time period & data source	Trust's 2008 Inpatient Survey Report, Care Quality Commission		Trust's 2007 Inpatient Survey Report, Healthcare Commission	
10. Involvement in decisions about care and treatment	**70**	**Intermediate 60% of trusts**	**67**	**Worst performing 20% of trusts**
Time period & data source	Trust's 2008 Inpatient Survey Report, Care Quality Commission		Trust's 2007 Inpatient Survey Report, Healthcare Commission	
11. Did staff do all they could to control pain	**85**	**Intermediate 60% of trusts**	**84**	**Intermediate 60% of trusts**
Time period & data source	Trust's 2008 Inpatient Survey Report, Care Quality Commission		Trust's 2007 Inpatient Survey Report, Healthcare Commission	
12. Cleanliness of room or ward	**83**	**Intermediate 60% of trusts**	**80**	**Intermediate 60% of trusts**
Time period & data source	Trust's 2008 Inpatient Survey Report, Care Quality Commission		Trust's 2007 Inpatient Survey Report, Healthcare Commission	
13. Overall rating of care	**78**	**Intermediate 60% of trusts**	**79**	**Intermediate 60% of trusts**
Time period & data source	Trust's 2008 Inpatient Survey Report, Care Quality Commission		Trust's 2007 Inpatient Survey Report, Healthcare Commission	

Notes on patient experience measures
The scores included in the table above are benchmark scores rather than percentages, calculated by converting responses to particular questions into scores. For each question in the survey, the individual responses were scored on a scale of 0 to 100. The higher the score for each question, the better the trust is performing.

National targets and regulatory requirements

National targets and regulatory requirements	2008-2009	2007-2008	Target
The Trust has fully met the core standards	44/44 parts	43/43 parts	44 in 2008/09 (43 in 2007/08)
Clostridium difficile year on year reduction (post-48 hour cases)	357	658	526 in 2008/09 (Not a target in 2007/08)
MRSA – maintaining the annual number of MRSA bloodstream infections at less than half the 2003/04 level	35	76	48
Maximum waiting time of 31 days from decision to treat to start of treatment extended to cover all cancer treatments	96.9% (Jan-Mar 09)	New target from Jan 2009	To be confirmed
Maximum waiting time of 62 days from all referrals to treatment for all cancers	86.5% (Jan-Mar 09)	New target from Jan 2009	To be confirmed
18-week maximum wait from point of referral to treatment (admitted patients)	95.0% (Jan - Mar 09)	New target from Jan 2009	90%
18-week maximum wait from point of referral to treatment (non-admitted patients)	97.3% (Jan - Mar 09)	New target from Jan 2009	95%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	98.1%	98.3%	98%
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	99.5% (Apr to Dec 08)	99.8%	98%
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	97.4% (Apr to Dec 08)	98.2%	95%
People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack)	75%	70%	68%
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	100% (Apr to Dec 08)	100%	98%

University Hospitals Birmingham
NHS Foundation Trust

2008›2009
Annual Accounts

This annual report covers the period
1 April 2008 to 31 March 2009

Section 4

Section 10: Annual Accounts

University Hospitals Birmingham NHS Foundation Trust
Accounts for the year ended 31 March 2009

Contents

Foreword to the Accounts

University Hospitals Birmingham NHS Foundation Trust

These accounts for the year ended 31 March 2009 have been prepared by the University Hospitals Birmingham NHS Foundation Trust in accordance with paragraph 24 and 25 of Schedule 7 to the National Health Service Act 2006 in the form which Monitor has, with the approval of the Treasury, directed.

June 4 2009

Julie Moore
Chief Executive

Date

Statement of the Chief Executive's responsibilities as the accounting officer of University Hospitals Birmingham NHS Foundation Trust

The National Health Service 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 the Accounting Officer's Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

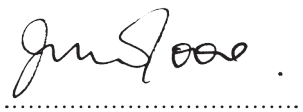
Under the National Health Service Act 2006, Monitor has directed the University Hospitals Birmingham NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of University Hospitals Birmingham 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 NHS Foundation Trust Financial Reporting Manual and in particular to:

- 'Observe the Accounts Direction issued by Monitor, 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 Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; 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 Trust and to enable him to ensure that the accounts comply with the requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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



June 4 2009

Julie Moore
Chief Executive

Date

Statement of Directors' responsibilities in respect of the accounts

The Directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. Monitor, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure of the Trust for that period. In preparing those accounts, the Directors are required to:

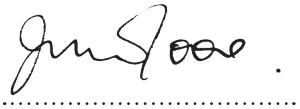
- select suitable accounting policies, as described on pages XVII to XXV, and then apply them consistently;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts;
- prepare accounts on the going concern basis unless it is inappropriate to presume that the Trust will continue in business.

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

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

The Directors confirm that as far as they are aware, there is no relevant audit information of which the Trust's auditors are unaware. They have taken all 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 Trust's auditors are aware of that information.

By order of the Board



June 4 2009

Julie Moore
Chief Executive

Date

June 4 2009

M Sexton
Director of Finance

Date

Independent Auditor's Report to the Board of Governors of University Hospitals Birmingham NHS Foundation Trust

Opinion on the financial statements

We have audited the financial statements of University Hospitals Birmingham NHS Foundation Trust for the year ended 31 March 2009 under the National Health Service Act 2006. These comprise the Income and Expenditure Account, the Balance Sheet, the Cash flow Statement, the Statement of Total Recognised Gains and Losses and the related notes. These financial statements have been prepared under the accounting policies relevant to NHS Foundation Trusts set out therein.

This report is made solely to the Board of Governors of University Hospitals Birmingham NHS Foundation Trust ('the Trust'), as a body, in accordance with the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Board of Governors of the Trust, as a body, those matters we are required to state to it 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 Trust and the Trust's Governors as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of directors and auditors

As described on page ii the Accounting Officer is responsible for the preparation of the financial statements in accordance with directions issued by Monitor. Our responsibilities, as independent auditors, are established by statute, the Code of Audit Practice issued by Monitor and our profession's ethical guidance.

We report to you our opinion as to whether the financial statements give a true and fair view of the state of affairs of the Trust and its income and expenditure for the year ended 31 March 2009.

We review whether the statement on internal control on pages vi to xii reflects compliance with Monitor's guidance issued in the NHS Foundation Trust Financial Reporting Manual. We report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information we are aware of from our audit of the financial statements. We are not required to consider, nor have we considered, whether the directors' statement on internal control covers all risks and controls. We are also not required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures. Our review was not performed for any purpose connected with any specific transaction and should not be relied upon for any such purpose.

We read the information contained in the Annual Report and consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the statement of accounts.

Basis of audit opinion

We conducted our audit in accordance with the National Health Service Act 2006 and the Code of Audit Practice issued by Monitor, which requires compliance with relevant auditing standards issued by the Auditing Practices Board.

An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements. It also includes an assessment of the significant estimates and judgements made by the Directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error. In forming our opinion we also evaluated the overall adequacy of the presentation of information in the financial statements.

Opinion

In our opinion:

- the financial statements give a true and fair view, in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts in England, of the state of the Trust's affairs as at 31 March 2009 and of its income and expenditure for the year then ended; and
- the part of the Remuneration Report to be audited has been properly prepared in accordance with the requirements of the NHS Foundation Trust Financial Reporting Manual.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of the National Health Service Act 2006 and the NHS Foundation Trust Audit Code of Practice issued by Monitor.

Trevor Rees (Senior Statutory Auditor)

for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants

2 Cornwall Street

Birmingham

4 June 2009

Statement of internal control

1. Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the University Hospitals Birmingham 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 University Hospitals Birmingham NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my other responsibilities as set out in the NHS Accounting Officer Memorandum.

2. The purpose of the system of internal control

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 ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of University Hospitals Birmingham 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 University Hospitals Birmingham Foundation Trust for the year ended 31 March 2009 and up to the date of approval of the annual report and accounts.

As an employer with staff entitled to membership of the NHS Pension Scheme control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with.

3. Capacity to handle risk

Overall responsibility for the management of risk within the Trust rests with the Board of Directors. Reporting mechanisms are in place to ensure that the Board of Directors receives timely, accurate and relevant information regarding the management of risks.

Risk issues are reported through the Clinical Governance Reporting Framework and the Trust's Management Structures. Management and ownership of risk is delegated to the appropriate level from Director to local management teams through the Divisional Management Structure.

The Audit Committee monitors and oversees both internal control issues and the process for risk management. RSM Bentley Jennison (internal audit) and KPMG (external audit) attend all Audit Committee meetings. The Audit Committee receives the executive summaries and action plans of all the reports of the Internal Auditors. Both the Board of Directors and the Audit Committee receive reports that impact on clinical risks.

All new staff joining the Trust are required to attend Corporate Induction which covers all key elements of risk management. Existing members of staff are trained in the specific elements of risk management relevant to their level within the organisation. Managers attend the 'Managing Risks' course that covers the principles of risk assessment and Risk Registers. There is

a guidance document, available to all staff via the Trust's intranet ('Guidance on the Implementation and Management of Risk Registers') that details the risk register process. Risk Management is taught on all Trust and Divisional development programmes. Learning from incidents and good practice is discussed at the Clinical Quality Group, reporting monthly to the Board of Directors, and with local departments and wards. Senior staff are trained in Root Cause Analysis and a programme for risk management training for Directors is in place.

All new staff joining the Trust are required to attend Corporate Induction which covers all key elements of risk management. Existing members of staff are trained in the specific elements of risk management relevant to their level within the organisation. Managers attend the 'Managing Risks' course that covers the principles of risk assessment and Risk Registers. There is a guidance document, available to all staff via the Trust's intranet ('Guidance on the Implementation and Management of Risk Registers') that details the risk register process. Risk Management is taught on all Trust and Divisional development programmes. Learning from incidents and good practice is discussed at the Clinical Quality Group, reporting monthly to the Board of Directors, and with local departments and wards. Senior staff are trained in Root Cause Analysis and a programme for risk management training for Directors is in place.

4. The risk and control framework

The Board of Directors is responsible for the strategic direction of the Trust in relation to Clinical Governance and Risk Management. It is supported by the Audit Committee which provides assurance to the Board of Directors on risk management issues.

The Board of Directors has established an Investment Committee to provide the Board of Directors with assurance over investments, borrowings and compliance with Trust treasury polices and procedures.

Clinical governance is overseen directly by the Board of Directors.

In November 2008, the Board of Directors approved the Trust's Risk Management Strategy and Risk Management Policy, which clearly define risk management structures, accountability and responsibilities, the level of acceptable risk for the Trust and the position of stakeholders.

In order to confirm its compliance with the Healthcare Commission Standards for Better Health, the Trust carried out a self assessment exercise against those standards. The declaration to the Commission is that the Trust is fully compliant with all core standards. This was approved at the Board of Directors' meeting of 23 April 2009. The Audit Committee reviewed the process that the Trust undertook before arriving at this declaration and was able to assure the Board of Directors that the process was appropriately robust. The Internal Auditors have also reviewed the process and have given the Trust a positive comment that the process is robust.

The Trust was assessed at level 2 against the NHSLA Risk Management Standards for Trusts (RMS) in February 2009. It was successful in achieving RMS level 2. There are elements of risk management where public stakeholders are closely involved.

Infection control is a high profile risk. Members of the public are encouraged to participate through the regular 'Clean your hands' campaign led by the Divisional

Patient Council supported by the Trust. There are patient representatives on the Trust Cleaning groups and involved in the PEAT environmental visits. Aspects of risk, including infection control are discussed at all Divisional Patient Council meetings.

The Board of Directors has reviewed, revised and enhanced its arrangements for ensuring that it is compliant with the Code of Practice on Healthcare Associated Infections and is assured that suitable systems and arrangements are in place to ensure that the Code is being observed and that no significant lapses have been identified.

There are clear policies and escalation procedures for the management of HCAI, which form part of the Infection Prevention and Control Plan for the Trust which has been reviewed and updated in February 2009. The Trust Action Plan makes clear reference to the Code of Practice and there are plans in place to continue the ongoing yearly improvement of performance within the Trust.

The Trust received an unannounced visit from the HCC on 27 and 28 August 2008 which found no material breaches of the Hygiene Code. The Trust has an ongoing relationship with the Department of Health who have worked with the wider infection control team to review clinical practices and have given advice and practical help including training and an objective review of systems, including those relating to hotel services. The Department of Health continues to be engaged in this work and is supportive of the Trust's approach.

The Infection Prevention and Control report is a standing item on the agendas for meetings of the Board of Governors, the Board of Directors and the Chief Executive's Advisory Group.

All serious untoward incidents are reported to the South Birmingham PCT, including MRSA bacteraemia and C difficile deaths.

Risks to information are managed and controlled through the Information Governance Group, chaired by the Director of Corporate Affairs, who has been appointed as the Senior Information Risk Officer. The Executive Medical Director, as Caldicott Guardian, is responsible for the protection of patient information, although all information governance issues are integrated through the Working Group. The Board of Directors has received a report regarding its systems of control for information governance. These include satisfactory completion of its annual self-assessment against the Information Governance Toolkit, mapping of data flows, monitoring of access to data and reviews of incidents. The Trust has not experienced any Serious Untoward Incidents involving data loss or confidentiality breach.

4.1 Risk Identification and Evaluation

Risks are identified via a variety of mechanisms, which are briefly described below.

All areas within the Trust report incidents and near misses in line with the Trust's Incident Reporting Policy. Details of incidents are reported through the Divisional Clinical Governance Team meetings and to the Clinical Quality Group.

Risk Assessments, including Health and Safety and Infection Control Audits are undertaken throughout the Trust. All identified risks at all levels are evaluated using a common methodology based on the risk matrix contained in the Risk Management Standard AS/NZ 43360:1999.

Registers are generated through the assessment process and reviewed on a quarterly basis to ensure that action plans are being carried out and that risks are being added or deleted, as appropriate. High level risks identified by the Divisional Management Teams and corporate risks are reported regularly through Performance Review and the Audit Committee. Every quarter the Audit Committee undertakes a detailed examination of the Risk Register, and the associated risk management processes, relating to a specific high risk area of activity. This Committee assesses whether the level of assurance is sufficient for the Board of Directors to accept.

Other methods of identifying risks include complaints and Healthcare Commission Independent Review Panel Reports and recommendations, inquest findings and recommendations from HM Coroners, Health and Safety visits undertaken by the Director of Operations of each Division, medico-legal claims and litigation, ad hoc risk issues brought to either the Divisional Clinical Governance Team meetings, Health, Safety and Environment Committee or the Clinical Quality Group, incident reports and trend analysis, internally generated reports from the Health Informatics Team, internal and external audit reports and Performance Reviews.

4.2 Risk Control

Clinical risks are reported directly to the Board of Directors through the Clinical Governance Reporting Framework. Non-clinical risks are reported to the Board of Directors through the responsible Executive Directors and the Risk Management Structure. The process of reporting of risks is monitored and overseen by the Audit Committee.

Compliance with the Health Care Commissions Standards for Better Health is reported to the Board of Directors. The assurance on this process was provided by Internal Audit.

Risk Management is well embedded throughout the organisation. Risks are reported locally at divisional level through the Clinical Governance structure.

The Infection Control Committee, chaired by the Executive Chief Nurse, meets on a monthly basis. In addition, key infection control indicators (MRSA/*Clostridium difficile)* are reported to the Board of Directors on a monthly basis. This data is also reported to Divisional Clinical Governance teams for local follow up action.

Risk Management is embedded into the organisation in many ways. The culture of the organisation aids the confident use of the incident reporting procedures throughout the Trust.

The Trust has undertaken an exercise to determine its strategic objectives and, through its Assurance Framework, assesses the potential risks that threaten the achievement of the organisational objectives, the existing control measures that are in place and where assurances are gained. Corporate Risk Assessments provide supportive evidence to the Assurance Framework. The Board of Directors has been involved in this process and all members are aware of the Assurance Framework. Further improvements to the assurance framework and the high level assurance reporting to the Audit Committee are planned for 2009/10, focussing on the use of technology to manage risks, controls and assurance.

The Trust is progressing with its Joint PFI scheme with the South Birmingham and

Solihull Mental Health Trust, and the New Hospital Programme has been identified as a major potential risk to the Trust. The New Hospital Programme is overseen by a Strategic Clinical Development Board which is chaired by the Chief Executive. This Board oversees both progress on the New hospital building and the clinical redesign projects. The Strategic Clinical Development Board reports monthly to the Board of Directors. The New Hospital Programme has an integrated risk log and a robust risk management structure to ensure that all programme risks are appropriately managed.

There are regular reports on the main New Hospital Programme risks to the Strategic Clinical Redesign Group, the Board of Directors and the Audit Committee. A programme of audits was undertaken by the Trust internal auditors to provide assurance to the Board of Directors on the management of the Programme. In addition, the Trust undertook a Department of Health Gateway Project Review Process at stage 0 (Strategic Assessment) in October 2008, which provided further external assurance to the Trust Board of Directors.

5. Review of Economy, Efficiency and Effective Use of Resources

The Trust's Financial Plan for 2008/09 was approved by the Board of Directors in May 2008. Achievement of the financial plan relied on delivery of cash releasing efficiency savings during the financial year. This has been accomplished through the establishment of a cost improvement programme applied to all relevant budgets across Divisions and Corporate Departments. Progress against delivery of cost improvements is monitored throughout the year and quarterly updates are included in the Finance and Activity Performance Report presented to the Board of Directors each month.

In addition to the agreed annual cost improvement programme, further efficiency savings are realised in year through initiatives, such as ongoing tendering and procurement rationalisation and review of all requests to recruit to both new and existing posts via the Workforce Approval Committee. The Trust has continued to embed its clinical redesign programme and is achieving significant reductions in average length of stay and pre-admission length of stay as a consequence. Other initiatives have been introduced to further streamline processes such as the multi-specialty ward, reduced inpatient beds through increased capacity within ambulatory care and anaesthetist led pre-admission screening.

During 2008/09 the Board of Directors has continued to receive and consider a monthly report on Key Performance Indicators. This includes trend data on a number of measures of efficiency and use of resources such as the average length of stay, day case rates, theatre utilisation and sickness absence. Performance is measured against national benchmarks where available, for example the Audit Commission basket of day case procedures.

The objectives set out in the Trust's Internal Audit Plan include ensuring the economical, effective and efficient use of resources and this consideration is applied across all of the work-streams carried out. The findings of internal audit are reported to the Board of Directors through the Audit Committee.

As part of the annual health check, the Trust's use of resources is also assessed by the Healthcare Commission, based on the Financial Risk Ratings assigned by Monitor. In the latest results published in October 2008

the Trust achieved a rating of 'excellent for the use of resources' (based on 2007/08 outturn data).

6. Review of Effectiveness

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 and the executive managers within the Trust who have responsibility for the development and maintenance of the internal control framework and 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, Internal Audit, the Foundation Secretary and External Audit. The system of internal control is regularly reviewed and plans to address any identified weaknesses and ensure continuous improvement of the system are put in place.
The processes applied in maintaining control include:

- the maintenance of a view of the overall position with regard to internal control by the Board of Directors through its routine reporting processes and its work on Corporate risks;

- regular reviews of the Assurance Framework;

- the receipt of Internal and External Audit reports by the Audit Committee;

- personal input into the controls and risk management processes from all Executive Directors, Senior Managers and individual clinicians;

- the provision of comment by the Internal Auditors on the Trust's system of Internal Control. In their annual report, the Internal Auditors state their opinion as to whether assurance can be given that there is a sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. Additionally, both the Internal and the External Auditors have direct access to the Chair of the Audit Committee and meet privately with the members of the Audit Committee at least once each year.

- measures in place to ensure all the organisation's obligations under equality, diversity and human rights legislation are complied with.

Conclusion

- There are no significant internal control issues I wish to report. I am satisfied that all internal control issues raised have been, or are being, addressed by action plans and that these action plans are subject to appropriate monitoring.

June 4 2009

Julie Moore
Chief Executive

Date

Income and Expenditure account for the year ended 31 March 2009

	NOTE	**Year Ended 31 March 2009 £000**	Year Ended 31 March 2008 £000
Income from activities	2	**387,548**	352,856
Other operating income	3	**77,149**	71,610
Operating expenses	4 - 5	**(442,494)**	(405,792)
OPERATING SURPLUS		**22,203**	18,674
Loss on disposal of fixed assets	6	**(386)**	(886)
SURPLUS BEFORE INTEREST		**21,817**	17,788
Interest receivable	7.1	**3,404**	2,446
Interest payable	7.2	**0**	0
Other net gains/(losses) on financial instruments		**0**	0
Other finance costs - unwinding of discount		**(34)**	(27)
Other finance costs - change in discount rate on provisions		**0**	0
SURPLUS BEFORE TAXATION		**25,187**	20,207
Taxation	8	**0**	0
SURPLUS AFTER TAXATION		**25,187**	20,207
Public Dividend Capital dividends paid		**(5,884)**	(7,721)
RETAINED SURPLUS FOR THE YEAR		**19,303**	12,486

The notes on pages XVII to XLIV form part of these accounts.
All income and expenditure is derived from continuing operations.

Balance Sheet as at 31 March 2009

	NOTE	Year Ended 31 March 2009 £000	Year Ended 31 March 2008 £000
FIXED ASSETS			
Tangible assets	9.2	**181,689**	182,135
		181,689	182,135
CURRENT ASSETS			
Stocks and work in progress	10	**9,601**	9,741
Debtors	11	**42,272**	25,440
Cash at bank and in hand	16.3	**97,793**	71,434
		149,666	106,615
CREDITORS: Amounts falling due within one year	12	**(99,493)**	(77,366)
NET CURRENT ASSETS		**50,173**	29,249
TOTAL ASSETS LESS CURRENT LIABILITIES		**231,862**	211,384
CREDITORS: Amounts falling due after more than one year	12	**0**	0
PROVISIONS FOR LIABILITIES AND CHARGES	13	**(8,137)**	(8,580)
TOTAL ASSETS EMPLOYED		**223,725**	202,804
FINANCED BY:			
TAXPAYERS' EQUITY			
Public dividend capital	20	**171,012**	168,612
Revaluation reserve	15	**72,329**	72,445
Donated asset reserve	15	**8,197**	8,942
Income and expenditure reserve	15	**(27,813)**	(47,195)
TOTAL TAXPAYERS EQUITY		**223,725**	202,804

June 4 2009

Julie Moore
Chief Executive

Date

Statement of Total Recognised Gains and Losses for the year ended 31 March 2009

	Year Ended 31 March 2009 £000	Year Ended 31 March 2008 £000
Surplus for the financial year before dividend payments	**25,187**	20,207
Disposal of donated assets	**(31)**	(140)
Impact of disposals on revaluation reserve	**(37)**	(182)
Unrealised surplus on fixed asset and current asset investments and revaluations	**0**	5,618
Increases in the donated asset reserve due to receipt of donated assets	**291**	392
Reductions in the donated asset reserve due to the depreciation, impairment and disposal of donated assets	**(1,036)**	(920)
Total recognised gains for the financial year	**24,374**	24,975

Cash Flow Statement for the year ended March 2009

	NOTE	**Year Ended 31 March 2009 £000**	Year Ended 31 March 2008 £000
OPERATING ACTIVITIES			
Net cash inflow from operating activities	16.1	**36,847**	61,871
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:			
Interest received		**3,482**	2,602
Net cash inflow from returns on investments and servicing of finance		**3,482**	2,602
CAPITAL EXPENDITURE			
(Payments) to acquire tangible fixed assets		**(10,814)**	(14,047)
Receipts from sale of tangible fixed assets		**37**	0
Net cash (outflow) from capital expenditure		**(10,777)**	(14,047)
DIVIDENDS PAID		**(5,884)**	(7,721)
Net cash inflow before management of liquid resources and financing		**23,668**	42,705
MANAGEMENT OF LIQUID RESOURCES		**0**	0
Net cash inflow before financing		**23,668**	42,705
FINANCING			
Public dividend capital received		**2,400**	13,917
Public dividend capital repaid (not previously accrued)		**0**	(6,000)
Other capital receipts		**291**	392
Net cash inflow from financing		**2,691**	8,309
Increase in cash		**26,359**	51,014

Notes to the Accounts

1 Accounting Policies

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Reporting Manual which shall be agreed with HM Treasury. Consequently, the financial statements and notes to the accounts have been prepared in accordance with the 2008/09 NHS Foundation Trust Financial Reporting Manual issued by Monitor. The accounting policies contained in that Manual follow UK generally accepted accounting practice for companies (UK GAAP) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of tangible fixed assets at five yearly intervals. NHS foundation trusts, in compliance with HM Treasury's Financial Reporting Manual, are not required to comply with the FRS3 requirements to report 'earnings per share' or historical profits and losses.

1.2 Income Recognition

Income is accounted for by applying the accruals convention. The main source of income for the Trust is under contracts from commissioners in respect of healthcare services. Income is recognised in the period in which services are provided.

When a patient is admitted and treatment begins, then the income for that treatment or spell can start to be recognised. Income relating to those spells which are partially completed at the financial year end is therefore accrued for.

Partially completed spells of patient care relate to Finished Consultant Episodes (FCEs). An income value is attributed to these spells by reference to episode type (elective, non-elective, etc.) the relevant HRG, and any local or national tariff.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

1.3 Expenditure

Expenditure is accounted for by applying the accruals convention.

1.4 Tangible Fixed Assets

Capitalisation

Tangible assets are capitalised if they are capable of being used for a period which exceeds one year and they:

- Individually have a cost of at least £5,000; or
- Form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, 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 setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost; or

- Are not part of any land or buildings scheduled for demolition or disposal under the new hospital PFI.

Valuation

Tangible fixed assets are stated at the lower of depreciated replacement cost and net realisable value. On initial recognition they are measured at cost including any costs directly attributable to bringing them into working condition. The carrying values of tangible fixed assets are reviewed for impairments in period if events or changes in circumstances indicate the carrying value may not be recoverable.

Land and buildings are revalued using professional valuations in accordance with FRS15 every five years with an interim valuation carried out in year three. The last full valuation was carried out in 2004 and accounted for on 31 March 2005. A professional interim valuation was carried out in 2007/08 and accounted for at 31 March 2008.

Assets in the course of construction are valued at cost.

Depreciation and Amortisation and Impairments

Tangible fixed assets are depreciated at rates calculated to write them down to estimated residual value on a straight-line basis over their useful lives. No depreciation is provided on freehold land.

Buildings, installations and fittings not scheduled for disposal/demolition, are depreciated on their current value over the estimated remaining life of the asset as assessed by the Trust's professional valuer.

Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust respectively.

Equipment is depreciated on current cost evenly over the estimated life:-

Short life medical equipment	5 years
Medium life medical equipment	10 years
Long life medical equipment	15 years
IT assets	5 years

1.5 Donated Fixed Assets

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the income and expenditure account.

1.6 Government Grants

Government grants are grants from Government bodies other than income from Primary Care Trusts or NHS Trusts for the provision of services. Grants from the Department of Health are accounted for as Government grants. Where the grant is used to fund revenue expenditure it is taken to the income and expenditure account to match that expenditure. Where the grant is used to fund capital expenditure the grant is held as a creditor and released to the income and expenditure account over the life of the asset on a basis consistent with the depreciation charge for that asset.

1.7 Private Finance Initiatives (PFI) Transactions

Where existing Trust Buildings are to be retained as part of the PFI scheme, a deferred asset will be created at the point that the Trust transfers those buildings to the PFI partner. The deferred asset will be written off through the income and expenditure account over the life of the concession.

Where current estate will be retained in use and maintained by the PFI provider but the risks and rewards will not pass to the provider, that part of the estate will remain on balance sheet and refurbishment costs which are included in the PFI will also be capitalised.

At the end of the concession period all buildings included within the PFI scheme will pass to the Trust at nil consideration. These buildings will have a remaining useful economic life which will constitute an asset which the Trust will have paid for during the concession period. In accordance with the guidance set out in Land and Buildings in PFI Deals (version 2) and Treasury Technical Note 1 the residual value will be built up over the concession period.

PFI transactions include an injection of cash to the private partner in exchange for a reduction in future payment rentals. Where this has occurred, the value of the reduction in future payment is recorded in long term debtors if there is any delay in the realisation of benefits beyond one year, or included as a prepayment in debtors whereby reduced charges begin to crystallise within one year.

Deferred assets are written off to the income and expenditure account over the period of the service payment reductions.

Details of the impact of the PFI on the Trust's Financial Statements in the year to 31 March 2009 can be found in Note 22 to the accounts on page XL.

1.8 Stocks and Work-in-Progress

Stocks and work-in-progress, except pharmacy and warehouse stock, are valued at the lower of cost and net realisable value. Pharmacy and warehouse stocks are valued at average cost. This is considered to be a reasonable approximation to current cost due to the high turnover of stocks. Work-in-progress comprises goods and services in intermediate stages of production.

1.9 Cash, Bank and Overdrafts

Cash, bank and overdrafts are recorded at the current values of these balances in the Trust's cash book. These balances exclude monies held in the Trust's bank account belonging to patients (see third party assets below). Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases overdrafts are disclosed within creditors. Interest earned on bank accounts and interest charged on overdrafts are recorded as, respectively, 'interest receivable' and 'interest payable' in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

1.10 Research and Development

Expenditure on research is not capitalised, it is treated as an operating cost in the year in which it is incurred.

Research and development activity cannot be separated from patient care activity and is therefore not separately disclosed.

1.11 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure 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 HM Treasury's discount rate of 2.2% in real terms.

1.12 Contingencies

Contingent liabilities are provided for where a transfer of economic benefits is probable. Otherwise, they are not recognised but are disclosed in note 19 on page XXXVIII unless the probability of a transfer of economic benefits is remote. 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 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 13 on page XXXIV.

1.14 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. The Trust has also taken out additional insurance to cover claims in excess of £1million.

1.15 Pension Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.pensions.nhsbsa.nhs.uk. The scheme is an unfunded, defined benefit scheme that covers NHS employers general practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying Scheme assets and liabilities. Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

The Scheme is subject to a full actuarial valuation every four years (until 2004, based on a five year valuation cycle), and a FRS17 accounting valuation every year. An outline of these follows:

a) 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 its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date.

The conclusion from the 2004 valuation was that the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the Scheme actuary reported that employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the Scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008, the vast majority of employees paid contributions at the rate of 6% of pensionable pay. From 1 April 2008, employees contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

b) FRS17 Accounting valuation

In accordance with FRS17, a valuation of the Scheme liability is carried out annually by the Scheme Actuary as at the balance sheet date by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the Scheme Actuary. At this point the assumptions regarding the composition of the Scheme membership are updated to allow the Scheme liability to be valued.

The valuation of the Scheme liability as at 31 March 2008, is based on detailed membership data as at 31 March 2006 (the latest midpoint) updated to 31 March 2008 with summary global member and accounting data.

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) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

Scheme provisions as at 31 March 2008

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement, less pension already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die after retirement, is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the income and expenditure account at the time the Trust commits itself to the retirement, regardless of the method of payment.

The Scheme provides the opportunity to members to increase their benefits through money purchase Additional Voluntary Contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee/member can make contributions to enhance an employee's pension benefits. The benefits payable relate directly to the value of the investments made.

Scheme provisions from 1 April 2008

From 1 April 2008 changes have been made to the NHS Pension Scheme contribution rates and benefits. Further details of these changes can be found on the NHS Pensions website www.pensions.nhsbsa.nhs.uk.

1.16 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.17 Corporation Tax

The Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to disapply the exemption in relation to specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities where income is received from a non public sector source. HM Treasury have stated that corporation tax will be applied to Foundation Trusts from the financial year commencing 1st April 2010.

1.18 Foreign Exchange

Transactions that are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the income and expenditure account.

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 in accordance with the requirements of HM Treasury Financial Reporting Manual.

1.20 Leases

Operating lease rental costs are charged to the income and expenditure account on a straight line basis over the term of the lease. The Trust does not have any finance leases.

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 ie. the net assets of a public benefit corporation.

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 real rate set by HM Treasury (currently 3.5% on the average relevant net assets of the Trust). Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and cash held with the Office of the Paymaster General. Average relevant net assets are calculated as a simple mean of opening and closing relevant net assets.

1.22 Financial Instruments

All financial instruments are held for the sole purpose of managing the cash flow of the Trust on a day to day basis or arise from the operating activities of the Trust. The management of risks around these financial instruments therefore relates primarily to the Trust's overall arrangements for managing risks to their financial position.

Financial assets and liabilities have been reviewed upon adoption of FRS 25 and 26 in line with FReM. PDC is not considered to be a financial instrument.

The Trust can borrow within the limits set by Monitor's Prudential Borrowing Code. The Trust's position against its prudential borrowing limit is disclosed in note 12.2 on page XXXIII. To date the Trust has not utilised any of its available prudential borrowing.

1.23 Losses and Special Payments

Losses and special payments are charged to the relevant functional headings on a cash basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

2. Income from Activities

	Year Ended 31 March 2009 £000	Year Ended 31 March 2008 £000
Foundation Trusts	**180**	64
NHS Trusts	**6**	154
Strategic Health Authorities	**14,235**	13,982
Primary Care Trusts	**336,229**	305,555
Department of Health - other	**21,107**	19,979
NHS Other	**3,273**	2,318
Private Patients	**3,504**	2,903
NHS Injury Scheme	**3,024**	1,916
Non NHS: Other	**5,990**	5,985
	387,548	352,856

Included within 'Non NHS Other' is £5,989,966 relating to the Trust contract with the Royal Centre for Defence Medicine (2007/08 - £5,707,034).

NHS Injury Scheme income is subject to a provision for doubtful debts of 7.8% to reflect expected rates of collection.

2.1 Income from Activities

	Year Ended 31 March 2009 £000	Year Ended 31 March 2008 £000
Elective income	**75,805**	84,700
Non elective income	**87,631**	87,870
Outpatient income	**49,860**	43,431
A & E income	**7,267**	6,948
Other NHS clinical income	**151,194**	116,785
Private patient income	**3,504**	2,903
Other non-protected clinical income	**12,287**	10,219
	387,548	352,856

2.2 Private Patient Income

	Financial Year	Base Year
	2008/09	2002/3
	£000	£000
Private patient income	**3,504**	2,773
Total patient related income	**387,548**	225,193
Proportion (as percentage)	**0.90%**	1.23%

The note above confirms that the Trust has complied with the condition imposed at the time of receiving Foundation status with regard to Private Patient Income.

3. Other Operating Income

	Year ended	Year Ended
	31 March	31 March
	2009	2008
	£000	£000
Research and development	**10,848**	7,402
Education and training	**28,924**	27,774
Charitable and other contributions to expenditure	**831**	1,082
Transfers from donated asset reserve	**1,036**	920
Non-patient care services to other bodies	**11,756**	13,986
Other income	**23,754**	20,446
	77,149	71,610

Other income includes £4,086,000 from Clinical Excellence Awards (2007/08 - £3,870,000); recharges of £2,916,000 to the Ministry of Defence to fund the training expenditure of Nurses along with catering and car parking costs associated with the military contract (2007/08 - £2,862,000); £1,775,000 from the National Quality Assurance Service (2007/08 - £1,554,000).

4. Operating Expenses

4.1 Operating expenses comprise:

	Year Ended to 31 March 2009 £000	Restated Year Ended to 31 March 2008 £000
Services from Foundation Trusts	**1,206**	783
Services from other NHS Trusts	**4,678**	4,594
Services from other NHS bodies	**1,769**	1,977
Purchase of healthcare from non NHS bodies	**8,174**	10,580
Executive directors' costs	**1,703**	1,693
Non-executive directors' costs	**139**	149
Staff costs	**255,754**	239,111
Drug costs	**45,214**	39,556
Supplies and services - clinical	**62,283**	56,828
Supplies and services - general	**6,064**	5,446
Establishment	**3,861**	4,046
Transport	**949**	975
Premises	**20,753**	17,333
Bad debts	**235**	135
Depreciation and amortisation	**10,705**	9,706
Audit services - statutory audit	**69**	68
Other auditors remuneration - taxation services	**30**	55
Clinical negligence	**2,379**	1,817
Other	**16,529**	10,966
Fixed asset reversal of impairments	**0**	(26)
	442,494	405,792

Other expenditure includes Research Grants distributed to other West Midlands NHS organisations of £3,475,000 (2007/08 - £90,000) due to the Trust acting as host body for the Comprehensive Local Research Network; and Training, Courses and Conference fees of £3,049,000 (2007/08 - £3,243,000).

4.2 Operating leases

Operating expenses (note 4.1) include:

	Year Ended 31 March 2009 £000	Year Ended 31 March 2008 £000
Hire of plant and machinery	**74**	112
Other operating lease rentals	**877**	853
	951	965

	Land and Buildings		**Other leases**	
	Year Ended 31 March 2009 £000	Year Ended 31 March 2008 £000	**Year Ended 31 March 2009 £000**	Year Ended 31 March 2008 £000
Operating leases which expire:				
Within 1 year	**0**	83	**57**	73
Between 1 and 5 years	**530**	91	**81**	133
After 5 years	**129**	553	**0**	0
	659	**727**	**138**	**206**

5. Staff costs and numbers

5.1 Staff costs

	Year Ended 31 March 2009			Year Ended 31 March 2008
	Total	**Permanently Employed**	**Other**	Total
	£000	**£000**	**£000**	£000
Salaries and wages	**208,901**	**195,019**	**13,882**	194,958
Social Security Costs	**16,561**	**16,561**	**0**	15,806
Employer contributions to NHSPA	**23,247**	**23,247**	**0**	21,618
Other pension costs	**0**	**0**	**0**	0
Agency/contract staff	**8,748**	**0**	**8,748**	8,422
	257,457	**234,827**	**22,630**	240,804

5.2 Average number of persons employed

	Year Ended 31March 2009			Year Ended 2008
	Total	**Permanently Employed**	**Other**	Total
	Number	**Number**	**Number**	Number
Medical and dental	**874**	**798**	**76**	769
Administration and estates	**1,387**	**1,387**	**0**	1,362
Healthcare assistants and other support staff	**644**	**644**	**0**	586
Nursing, midwifery and health visiting staff	**2,246**	**2,246**	**0**	2,588
Scientific, therapeutic and technical staff	**964**	**964**	**0**	830
Bank and agency staff	**140**	**0**	**140**	147
	6,255	**6,039**	**216**	6,282

5.3 Retirements due to ill-health

During the year to 31 March 2009 there were 10 early retirements from the Trust agreed on the grounds of ill-health (31 March 2008 -13). The estimated additional pension liabilities of these ill-health retirements will be £404,724 (31 March 2008 - £426,811). The cost of these ill-health retirements will be borne by the NHS Pensions Agency.

6. Loss on Disposal of Fixed Assets

	Year ended 31 March 2009 £000	Year ended 31 March 2008 £000
Loss on disposal of plant and equipment	**(386)**	(886)
	(386)	(886)

7. Interest

	Year Ended 31 March 2009 £000	Year Ended 31 March 2008 £000
7.1 Interest Receivable		
Bank interest receivable	**3,404**	2,446
	3,404	2,446
7.2 Interest Payable		
Interest paid in year	**0**	0
	0	0

8. Taxation

8.1 Corporation Tax Payable

The activities of the Trust have not given rise to any corporation tax liability in the year (year ended 31 March 2008- £nil).

9. Fixed Assets

9.1 The net book value of land, buildings and dwellings at 31 March 2009 comprises:

	31 March 2009 £000	31 March 2008 £000
Freehold	**143,234**	142,506
Long leasehold	**0**	0
Short leasehold	**0**	0
	143,234	142,506

9.2 Tangible Fixed Assets

Tangible fixed assets at the balance sheet date comprise the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2008	92,499	88,886	3,595	5,125	61,029	119	10,757	5,095	267,105
Additions purchased	0	748	0	4,773	4,672	0	200	35	10,428
Additions donated	0	0	0	0	291	0	0	0	291
Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	1	3,181	(439)	(4,247)	1,206	0	188	110	0
Other in year revaluation	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(4,523)	0	0	0	(4,523)
At 31 March 2009	**92,500**	**92,815**	**3,156**	**5,651**	**62,675**	**119**	**11,145**	**5,240**	**273,301**
Depreciation at 1 April 2008	0	41,164	1,310	0	35,287	119	2,987	4,103	84,970
Provided during the year	0	2,657	106	0	5,899	0	1,634	409	10,705
Impairments	0	0	0	0	0	0	0	0	0
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Other in year revaluation	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(4,063)	0	0	0	(4,063)
Depreciation at 31 March 2009	**0**	**43,821**	**1,416**	**0**	**37,123**	**119**	**4,621**	**4,512**	**91,612**
Net book value									
- Purchased at 1 April 2008	92,499	42,000	2,249	4,992	22,757	0	7,768	928	173,193
- Donated at 1 April 2008	0	5,722	36	133	2,985	0	2	64	8,942
Total at 1 April 2008	**92,499**	**47,722**	**2,285**	**5,125**	**25,742**	**0**	**7,770**	**992**	**182,135**
- Purchased at 31 March 2009	92,500	43,526	1,705	5,518	23,030	0	6,524	689	173,492
- Donated at 31 March 2009	0	5,468	35	133	2,522	0	0	39	8,197
Total at 31 March 2009	**92,500**	**48,994**	**1,740**	**5,651**	**25,552**	**0**	**6,524**	**728**	181,689

9.3 Analysis of Tangible fixed assets

Net book value	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
- Protected assets at 31 March 2009	0	19,175	0	0	0	0	0	0	**19,175**
- Unprotected assets at 31 March 2009	92,500	29,819	1,740	5,651	25,552	0	6,524	728	**162,514**
Total at 31 March 2009	**92,500**	**48,994**	**1,740**	**5,651**	**25,552**	**0**	**6,524**	**728**	**181,689**

10. Stocks and Work in Progress

	31 March 2009 £000	31 March 2008 £000
Raw materials and consumables	**9,410**	9,378
Work-in-progress	**13**	0
Finished goods	**178**	363
	9,601	9,741

11. Debtors

	31 March 2009 £000	31 March 2008 £000
Amounts falling due within one year:		
NHS debtors	**8,641**	13,226
Non NHS trade debtors	**8,734**	3,760
Provision for irrecoverable debts	**(873)**	(318)
Other prepayments and accrued income	**1,764**	2,926
Deferred asset	**41**	41
Other debtors	**4,594**	2,944
	22,901	22,579
Amounts falling due after more than one year:		
NHS debtors	**468**	541
Provision for irrecoverable debts	**(200)**	(163)
Deferred asset	**16,535**	375
Other debtors	**2,568**	2,108
	19,371	2,861
	42,272	25,440

The deferred assets of £40,630 falling due within one year (31 March 2008: £40,630) and £16,535,156 falling due after one year (31 March 2008: £375,828) are payments made in relation to the New Hospital PFI (see note 22).

12. Creditors

	31 March 2009 £000	31 March 2008 £000
Amounts falling due within one year:		
NHS creditors	**7,046**	9,332
Non - NHS trade creditors - revenue	**19,038**	17,339
Non - NHS trade creditors - capital	**2,047**	2,142
Other tax and social security costs	**5,530**	5,667
Other creditors	**3,185**	2,993
Accruals and deferred income	**62,647**	39,893
	99,493	77,366
Amounts falling due after more than one year:	**0**	0

NHS creditors include pension contributions of £2,876,779 outstanding at the 31 March 2009 (31 March 2008: £2,660,178).

12.2 Prudential borrowing limit:

	31 March 2009 £000	31 March 2008 £000
Prudential borrowing limit set by Monitor	**78,600**	77,100
Working capital facility	**1,000**	32,000
Actual borrowing in year - long term	**0**	0
Actual borrowing in year - working capital	**0**	0
Minimum dividend cover	**6.2**	4.2
Minimum interest cover	**0.0**	0.0
Minimum debt service cover	**0.0**	0.0
Maximum debt/capital ratio	**0.0**	0.0
Maximum debt service to revenue	**0.0**	0.0

The Trust is required to comply and remain within a prudential borrowing limit. This is made up of two elements:

- the maximum cumulative amount of long term borrowing. This is set by reference to the five ratios test set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit.

- the amount of any working capital facility approved by Monitor.

Further information on the NHS Foundation Trust Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of NHS Foundation Trusts.

There has been no necessity to make use of the Trust's Prudential Borrowing Limit or to use its overdraft facility.

13. Provisions for liabilities and charges

	Pensions relating to former directors	Pensions relating to other staff	Legal claims	Other	**Total**
	£000	£000	£000	£000	**£000**
At 1 April 2008	0	234	3,440	4,906	**8,580**
Change in discount rate	0	0	0	0	**0**
Arising during the year	0	15	1,148	1,989	**3,152**
Utilised during the year	0	(32)	(607)	(1,964)	**(2,603)**
Reversed unused	0	0	(626)	(400)	**(1,026)**
Unwinding of discount	0	5	29	0	**34**
At 31 March 2009	**0**	**222**	**3,384**	**4,531**	**8,137**
Expected timing of cash flows:	£'000	£'000	£'000	£'000	**£'000**
Within one year	0	33	1,188	2,949	**4,170**
Between one and five years	0	120	1,023	1,582	**2,725**
After five years	0	69	1,173	0	**1,242**

The provisions included under 'legal claims' are for personal injury £1,562,313 (31 March 2008: £1,433,460), employers and public liability £212,685 (31 March 2008: £256,807) and other claims notified by the Trust's solicitors £1,609,426 (31 March 2008: £1,749,676). The provisions for employers and public liability have been calculated based on information received from the NHS Litigation Authority (NHSLA) taking into account indications of uncertainty and timing of payments. Injury benefit has been calculated based on guidance received from the NHS Pensions Agency.

Provisions within the annual accounts of the NHS Litigation Authority at 31 March 2009 include £9,208,043 in respect of clinical negligence liabilities of the Trust (31 March 2008 - £9,853,630).

14 Movement in taxpayers' equity

	31 March 2009 £000	31 March 2008 £000
Taxpayers' equity at start of period	**202,804**	177,493
Prior period adjustments	**0**	0
Taxpayers equity at start of period, as restated	**202,804**	177,493
Surplus/(deficit) for the financial year	**25,187**	20,207
Public dividend capital dividends	**(5,884)**	(7,721)
Fixed asset impairments	**0**	0
Surplus/(deficit) from revaluations of fixed assets	**0**	4,240
New public dividend capital received	**2,400**	13,917
Public dividend capital repaid in year	**0**	(6,000)
Public dividend capital repayable (creditor)	**0**	0
Public dividend capital written off	**0**	0
Other movements in public dividend capital in year	**0**	0
Additions/(reductions) in donated asset reserve	**(745)**	668
Net gains/(losses) on available for sale investments	**0**	0
Additions/(reductions) in other reserves	**(37)**	0
Taxpayers' equity at 31 March 2009	**223,725**	202,804

15. Movements on Reserves

	Revaluation Reserve	Donated Asset Reserve	Income and Expenditure Reserve	**Total**
	£000	£000	£000	**£000**
At 1 April 2008	72,445	8,942	(47,195)	**34,192**
Prior Period Adjustments	0	0	0	**0**
At 1 April 2008 as restated	72,445	8,942	(47,195)	**34,192**
Transfer from the income and expenditure account	0	0	19,303	**19,303**
Fixed asset impairments	0	0	0	**0**
Surplus/(deficit) on the revaluation of fixed assets and current asset investments	0	0	0	**0**
Revaluations of available for sale investments - gross	0	0	0	**0**
Revaluations of available for sale investments - tax	0	0	0	**0**
Net gains/(losses) on available for sale investments through the Income and Expenditure account	0	0	0	**0**
Receipt of donated assets	0	291	0	**291**
Transfers to the Income and Expenditure Account for depreciation, impairment and disposal of donated assets	0	(1,036)	0	**(1,036)**
Other transfers between reserves (see below)	(116)	0	79	**(37)**
Other movements on reserves	0	0	0	**0**
Transfer of realised profits/(losses) to Income and Expenditure Account reserve	0	0	0	**0**
At 31 March 2009	**72,329**	**8,197**	**(27,813)**	**52,713**

Other transfers relate to the release from the revaluation reserve to the income and expenditure reserve in respect of the depreciation charge applied to fixed assets in excess of historic cost. The transfer avoids the anomaly of the revaluation reserve remaining in perpetuity after an asset has become fully depreciated.

16. Notes to the Cash Flow Statement

16.1 Reconciliation of operating surplus to net cash flow from operating activities:

	31 March 2009 £000	31 March 2008 £000
Total operating surplus	**22,203**	18,674
Depreciation and amortisation charge	**10,705**	9,706
Fixed asset impairments	**0**	0
Fixed asset reversal of impairments	**0**	(26)
Transfer from donated asset reserve	**(1,036)**	(920)
(Increase) / decrease in stocks	**140**	(158)
(Increase) / decrease in debtors	**(16,910)**	3,375
Increase / (decrease) in creditors	**22,222**	31,293
Increase / (decrease) in provisions	**(477)**	(73)
Other movements	**0**	0
Net cash inflow from operating activities	**36,847**	61,871

16.2 Reconciliation of net cash flow to movement in net debt

	31 March 2009 £000	31 March 2008 £000
Increase in cash in the period	**26,359**	51,014
Cash inflow from new debt	**0**	0
Cash outflow from debt repaid and finance lease capital payments	**0**	0
Cash (inflow)/outflow from (decrease)/increase in liquid resources	**0**	0
Change in net debt resulting from cash flows	**26,359**	51,014
Non - cash changes in debt	**0**	0
Net debt at 1 April 2008	**71,434**	20,420
Net debt at 31 March 2009	**97,793**	71,434

16.3 Analysis of changes in net debt

	As 1 April 2008	Cash changes in year	**At 31 March 2009**
	£000	£000	**£000**
Paymaster General Account	69,598	26,782	**96,380**
Commercial bank and cash in hand	1,836	(423)	**1,413**
Bank overdrafts	0	0	**0**
Debt due within one year	0	0	**0**
Debt due after one year	0	0	**0**
Finance leases	0	0	**0**
Current asset investments	0	0	**0**
	71,434	**26,359**	**97,793**

17. Capital Commitments

Commitments under capital expenditure contracts at the balance sheet date were £20,933,574 (31 March 2008 - £2,513,019). The increase as at 31 March 2009 reflects committed orders to purchase equipment for the new PFI Hospital of £16,258,228.

18. Post Balance Sheet Events

The Trust does not have any post balance sheet events.

19. Contingencies

There are £48,988 (31 March 2008 - £88,395) which relates to amounts notified by the NHSLA for potential employer and public liability claims over and above the amounts provided for in note 14.

20. Public Dividend Capital dividend

The Trust is required to absorb the cost of capital at a rate of 3.5% of average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital,totalling £5,884,000 (2007/08 - £7,721,000), bears to the average relevant net assets of £121,729,000 (31 March 2008 - £141,345,000), that is 4.8% (31 March 2008 - 5.5%).

Movements in public dividend capital:

	31 March 2009	31 March 2008
	£000	£000
Public dividend capital at 1 April	**168,612**	160,695
New public dividend capital received	**2,400**	13,917
Public dividend capital repaid in year	**0**	(6,000)
Public dividend capital at 31 March	**171,012**	168,612

21. Related Party Transactions

University Hospitals Birmingham NHS Foundation Trust is a corporate body established by order of the Secretary of State for Health.

The Trust considers other NHS Foundation Trusts to be related parties, as they and the Trust are under the common performance management of Monitor. During the year the Trust contracted with certain other Foundation Trusts for the provision of clinical and non clinical support services. The value of activity undertaken with these organisations was not material to the accounts.

Mr Kevin Bolger - an acting Executive Director of the Trust is the partner of Ms Michelle McLoughlin - an Executive Director of Birmingham Childrens Hospital Foundation Trust. The Trust's formal Service Level Agreement with the Birmingham Childrens Hospital Foundation Trust for the year ended 31 March 2009 has resulted in an income to the Trust of £1,903,971 and an expenditure of £182,069.

The Department of Health is also regarded as a related party. During the year University Hospitals Birmingham NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent department. These entities are listed below:

	Income	Expenditure
	£'000	£'000
Department of Health	6,687	1,224
South Birmingham PCT	125,209	1,771
Heart of Birmingham Teaching PCT	19,279	1,010
Birmingham East and North PCT	11,497	71
Pan Birmingham LCCB	77,106	0
Black Country LCCB	10,871	0
West Midlands South LCCB	19,611	0
West Midlands North LCCB	5,905	0
West Midlands Specialised Services Agency	17,739	0
West Midlands Strategic Health Authority	33,169	49
Dudley PCT	5,181	23
Sandwell PCT	8,874	94
Solihull PCT	6,409	0
Warwickshire PCT	5,015	4
Worcestershire PCT	15,000	0
South Staffordshire PCT	7,311	1
London Strategic Health Authority	14,235	0
NHS Blood and Transplant Agency	712	8,126
NHS Business Services Authority	0	3,739

The West Midlands Local Collaborative Commissioning Boards (LCCB) and Specialised Services Authority are all administered by the Birmingham East and North Primary Care Trust. The London Strategic Health Authority administers the National Commissioning Group.

21. Related Party Transactions (cont'd)

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies, in particular the Ministry of Defence - income of £9,186k and expenditure of £835k. The Trust also had a significant level of transactions with The University of Birmingham.

The debtors balance for NHS bodies as at 31 March 2009 stood at £8.6m. The creditors balance for NHS bodies as at 31 March 2009 stood at £7.0m.

The Trust has also received revenue and capital payments from a number of charitable funds, certain of the Trustees for which are also members of the NHS Foundation Trust Board. Brian Hanson, who was a Trustee of UHB Charities throughout 2008/09, was also a Governor of University Hospitals Birmingham NHS Foundation Trust.

22. Private Finance Transactions

22.1 PFI schemes deemed to be off-balance sheet - New Hospital Project

A contract for the development of the new hospital was signed by the Trust and its PFI partner on 14 June 2006. The purpose of the scheme is to deliver a modern, state of the art acute hospital facility on the QE site which is due to be fully operational in 2012. This is part of a wider PFI deal between the Trust, Birmingham & Solihull Mental Health Trust and a consortium led by Consort Healthcare.

The scheme is contracted to end on 14 August 2046 at which time the building will revert to the ownership of the Trust. Good progress is being made on the construction of the new building with all programme deadlines being met on time or delivered ahead of schedule.

Impact On Accounts

	31 March 2009 £000	31 March 2008 £000
Gross charge included within operating expenses in respect of PFI transactions deemed to be off-balance sheet - gross	**3,118**	2,093
Amortisation of PFI deferred asset	**(41)**	(41)
Net charge to operating expenses	**3,077**	2,052

The Trust is committed to make the following payments during the next year ended 31 March 2010:

	£000
PFI scheme which expires 36th to 40th years (inclusive)	**8,305**

The estimated annual payments in future years are expected to be materially different from those which the Trust is committed to make during the next year. In the fourth to fifth years of the scheme, the Trust is committed to make average payments of £41.0m with the annual commitment rising to £50.3m in the remaining years of the PFI scheme.

	£000
Estimated capital value of the PFI scheme	**484,889**
Contract Start date:	14 June 2006
Contract End date:	14 August 2046

In the accounts there are a number of balances relating to the PFI scheme as follows;

Within debtors falling due over one year, £335,198 relates to the deferred asset of a bullet payment to the PFI partner. This will reduce payments made to the PFI partner over the next 11 years and will be amortised over that period.

Within debtors falling due within one year, £40,630 relates to the element of the bullet payment to the PFI partner for which the benefit will be realised within one year of the balance sheet date.

The remainder of the deferred asset falling due over one year, £16,199,958 relates to the deferred assets of payments to the PFI partner with respect to building works variations. The Trust is making payments for this additional building work direct to the PFI partner in order to leave the contracted PFI unitary payments unchanged and will amortise the deferred assets over the term of the PFI contract.

As at the balance sheet date there were 51 formal contract variations which relate to the Trust. The cost of the approved variations have been included in the accounts where the work has been completed.

22.2 PFI schemes deemed to be on-balance sheet

The Trust does not have any PFI schemes which are deemed to be on-balance sheet.

23. Derivatives and Financial Instruments

23.1 FRS 29 Financial Instruments Disclosures

IFRS 29 requires that entities quantify and disclose the role financial instruments have played in creating or changing their exposure to risk. A Financial Instrument is any contract that gives rise to a financial asset of one company and a financial liability or equity instrument in another company. Examples of financial assets are cash, deposits in other companies, trade receivables, loans to other companies, investments in debt instruments, investments in shares and other equity instruments. Examples of financial liabilities are trade payables, loans from other companies and debt instruments issued by the company. The Standard also applies to more complex derivative financial instruments such as call options, put options, forwards, futures and swaps. Due to the Trust's terms of authorisation and our use of public funds, our activities to deal in instruments are limited. A derivative is a financial asset or liability that requires no initial investment, will be settled at a future date and whose value changes in relation to a specified interest rate, index or other variable.

Derivatives can be found within PFI contracts and contracts for the supply of goods and services. To this end we have reviewed our contracts and found that the although they contain derivatives in relation to price increases over the life of contracts, the price increases are in line with UK Retail price index which is deemed to be a closely related economic market and therefore does not require separate disclosure.

The Trust is required to be a member of the EU Carbon Emissions Trading Scheme due to the Trust's level of emissions. The scheme meets the definition of a derivative financial instrument under FRS 29. However as Treasury rules prohibit government bodies from trading in carbon allowances solely for the purposes of trading in the financial markets, this means that the Trust cannot speculate on the future value of carbon allowances.

23.2 Liquidity risk

The NHS Trust's net operating costs are incurred under annual service agreements with local Primary Care Trusts, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from funds made available from Government under an agreed borrowing limit. University Hospitals Birmingham NHS Foundation Trust is not, therefore, exposed to significant liquidity risks.

23.3 Interest-Rate Risk

100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. University Hospitals Birmingham NHS Foundation Trust is not, therefore, exposed to significant interest-rate risk.

23.4 Foreign Currency Exchange Risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations. The benefit or loss from foreign currency exchange is taken to the I&E as it arises.

23.5 Credit Risk

The majority of the Trust's income comes from contracts with other public sector bodies, resulting in a low exposure to credit risk. The maximum exposures as at 31 March 2009 are in receivables from customers, as disclosed in the Debtors note. The Trust mitigates its exposure to credit risk through regular review of debtor balances and by calculating a bad debt provision at year end.

23.6 Fair Values

All the financial assets and all the financial liabilities of the Trust are measured at fair value on recognition and subsequently at amortised cost.

Set out below is a comparison, by category, of book values and fair values of the Trust's financial assets and liabilities as at 31 March 2009.

	Book Value	Fair Value
	£000	£000
Financial assets		
Debtors over 1 year:	2,836	2,836
Other:	119,139	119,139
	121,975	**121,975**
Financial liabilities		
Provisions under contract :	8,137	8,137
Other:	46,996	46,996
	55,133	55,133

Notes

a These debtors include agreements with commissioners to cover provisions over 1 year for early retirements and provisions under contract, and their related interest charge/unwinding of discount.

b Fair value is not significantly different from book value since, in the calculation of book value, the expected cash flows have been discounted by the Treasury discount rate of 2.2% in real terms.

24 Third Party Assets

The Trust held £3,629 cash at bank and in hand at 31 March 2009 (31 March 2008: £5,430) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

The Trust held £nil cash at bank and in hand for other third parties at the 31 March 2009 (£nil - 31 March 2008).

25 Losses and Special Payments

There were 2,215 cases of losses and special payments (31 March 2008 - 408 cases) totalling £257,639 (31 March 2008 - £577,268) approved in the year.

There were no clinical negligence cases where the net payment exceeded £100,000 (2007/08: no cases).

There were no fraud cases where the net loss exceeded £100,000 (2007/08: no cases).

There were no personal injury cases where the net payment exceeded £100,000 (2007/08: no cases).

There were no compensation under legal obligation cases where the net payment exceeded £100,000 (2007/08: one case of £171,550 with respect to compensation for loss of office for a consultant).

There were no fruitless payment cases where the net payment exceeded £100,000 (2007/08: no cases).

National Health Service Act 2006

Direction by Monitor, Independent Regulator of NHS Foundation Trusts in respect of the keeping of accounts and the preparation of Annual Accounts

Monitor, the Independent Regulator of NHS Foundation Trusts, in exercise of powers conferred on it by paragraph 24 and 25 of schedule 7 to the National Health Service Act 2006, hereby directs that the keeping of accounts and the annual report and accounts of each NHS foundation trust shall be in the form as laid down in the annual reporting guidance for NHS foundation trusts with the NHS Foundation Trust Financial Reporting Manual, known as the NHS foundation trust FReM, that is in force for the relevant financial year.

Signed by authority of Monitor, the Independent Regulator of NHS foundation trusts.

Signed:

.....

Name: Dr William Moyes (Chairman)

Dated: 17 January 2009

National Health Service Act 2006

Directions by Monitor in respect of National Health Service Foundation Trusts' Annual Accounts

Monitor, the Independent Regulator of NHS Foundation Trusts, with the approval of HM Treasury, in exercise of powers conferred on it by paragraph 25(1) of schedule 7 to the National Health Service Act 2006, (the 2006 Act) hereby gives the following Directions:

1. Application and Interpretation

(1) These Directions apply to NHS foundation trusts in England.

(2) In these direction "The Accounts" means:

for an NHS foundation trust in its first operating period since authorisation, the accounts of an NHS foundation trust for the period from authorisation until 31 March; or

for an NHS foundation trust in its second or subsequent operating period following authorisation, the accounts of an NHS foundation trust for the period from 1 April until 31 March.

"the NHS foundation trust" means the NHS foundation trust in question.

2. Form of accounts

(1) The Annual Accounts submitted under paragraph 25 of Schedule 7 to the 2006 Act shall show, and give a true and fair view of, the NHS foundation trust's gains and losses, cash flows and financial state at the end of the financial period.

(2) The annual Accounts shall meet the accounting requirements of the NHS Foundation Trust Financial Reporting Manual (FT FReM) as agreed with HM Treasury, in force for the relevant financial year.

(3) The Balance Sheet shall be signed and dated by the chief executive of the NHS foundation trust.

(4) The Statement on Internal Control shall be signed and dated by the chief executive of the NHS foundation trust.

3. Statement of accounting officer's responsibilities

(1) The statement of accounting officer's responsibilities in respect of the accounts shall be signed and dated by the chief executive of the NHS foundation trust.

4. Approval on behalf of HM Treasury

(1) These Directions have been approved on behalf of HM Treasury

Signed by authority of Monitor, the Independent Regulator of NHS foundation trusts.

Signed:

.....

Name: Dr William Moyes (Chairman)

Dated: 17 January 2009