University Hospitals Birmingham
NHS Foundation Trust

2009/2010
Annual Report & Accounts

This annual report covers the period 1 April 2009 to 31 March 2010

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

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Section 1 **Annual Report**

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Directors' Report

1. Overview

1.1.1 Names of persons who were Directors of the Trust

The Board is currently comprised as follows:

Chairman: Sir Albert Bore

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

Non-Executive Directors:
Professor David Bailey
Gurjeet Bains
Stewart Dobson
Angela Maxwell
David Ritchie
Clare Robinson
Professor Michael Sheppard

Kevin Bolger was appointed as substantive Chief Operating Officer on 15 June 2009.

Tony Huq retired as a Non-Executive Director on 30 June 2009. Ms Angela Maxwell was appointed as a Non-Executive Director on 1 July 2009.

1.1.2 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 700,000 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 about to start transferring services into Birmingham's first new acute hospital in 70 years. The hospital will open its doors to patients on June 16, 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	

The Trust has five clinical divisions with each division 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.

1.1.3 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".

1.1.4 Research and Development

An on-going pilot to speed up the launch of cancer treatment trials is to be extended across all specialties within University Hospitals Birmingham NHS Foundation Trust.
The model involved the appointment of an oncology research team business manager and pharmacy manager who achieved a three-fold increase in the number of live trials – from 35 to more than 100 – by December 2009.

Income generated from pharmaceutical companies and through academic grants has funded an additional 14 posts. The commercial income for the first year of the pilot was £600k (March 2009-2010) and the projected income for the second year is £1.2 million (March

2010-2011). Previously there was no commercial income and no research staffing budget.

The Birmingham and Black Country CLAHRC, led by the Trust with the University of Birmingham as its main academic partner, staged a conference to mark its first year achievements at the Botanical Gardens in Edgbaston in November. Delegates heard from leaders of the nine applied health research or implementation projects within the collaboration, two of which are led by the Trust.

The Birmingham Clinical Research Academy, a joint venture between the Trust and the University of Birmingham marked its official launch with a seminar at the Post Graduate Medical Centre on February 22 2010.

Collaborative grant achievements so far include £3.75m for the National Institute for Health Research (NIHR) Biomedical Unit; £10m DoH plus £11m matched NHS funds for the NIHR CLAHRC (Collaborations for Leadership in Applied Health Research and Care); £2m from the Strategic Health Authority for the Quality Institute; £2m in the first instance for Health Innovation and Education Clusters; other grants from the NIHR, and assistance in selection of £1.5m grants from UHB Charities over the past year.

2. Management Commentary

2.1 Trust Development and Performance in 2009/10 and Position at Year End

2.1.1 Strategic Planning

The Trust has undertaken a significant amount of work in defining and developing its vision, values, and core purposes. This work has been further progressed with the development of a five-year strategy. The Trust Strategy has been developed with the objective of fulfilling its vision to deliver the best in care and the four core underpinning purposes (clinical quality, patient experience, education and training, and research and innovation). The Trust values (honesty, responsibility, respect, and innovation) have also played a significant role in the development of the strategy as they provide the governance framework within which it will be delivered. The Strategy considers the key challenges and drivers faced by the Trust:

- Ever higher expectations
- Demand driven by demographics
- Health in an age of information and connectivity
- The changing nature of disease
- Advances in treatment
- A changing health workplace
- The financial, political and local 'economy'

The Strategy was developed using a bottom-up approach and has benefited from comprehensive input ranging from clinical departments to the Board of Governors and Board of Directors. Consultation with the Trust's key strategic partners was also undertaken and feedback has been factored into the final strategy document.

The emerging Strategy has identified a number of overarching themes which provide the organisation with a foundation of common goals to meet and sustain:

- Quality driving efficiency underpinned by evidence
- A culture that focuses on what the patient needs and wants
- Infrastructure and business processes which enable the Trust to achieve the best in care
- Strengthening of internal and external partnerships at a local, national, and international level
- Maximising the potential of the UHB brand and reputation locally, nationally, and internationally
- Continued focus on operational performance and financial health

An assessment of the Strategy's resilience has

also been undertaken to ensure responsiveness and flexibility to changing drivers and challenges at a local and national level.

Following on from the challenges and overarching themes, the Trust Strategy has been distilled to four strategic aims categorised under each core purpose. To support this, a set of four strategic enablers and accompanying actions have been developed. These identify how the core purposes and strategic aims will be delivered. They also serve as a framework for the development of Trust annual plans.

Core Purpose 1:	Clinical Quality
Strategic Aim:	To deliver the highest levels of quality evidenced by technology, information, and benchmarking

Core Purpose 2:	Patient Experience
Strategic Aim:	To listen to what patients want and respond quickly and proactively

Core Purpose 3:	Education and Training
Strategic Aim:	To create a fit for purpose workforce for today and tomorrow

Core Purpose 4:	Research and Innovation
Strategic Aim:	To ensure UHB is a leader of research and innovation

2.2 Principal Risks and Uncertainties Facing the Trust

The Trust has a strong culture of risk identification and mitigation and there is a process in place for the development and ongoing review of risk registers from Ward to Board level.

One of the main factors determining the risks faced by the Trust is the impact of the economic climate. The Trust recognises that the state of the economy and decisions made by a range of external organisations will determine many of the individual factors that impact on the financial well-being of the Trust and the wider NHS. These risks primarily relate to income, cost, and activity.

The main uncertainties faced by the organisation relate to the external performance assessment framework determined by the Care Quality Commission, Monitor, and the standard NHS contract.

In terms of external regulatory requirements, performance against the cancer targets remains a risk along with the 18-week referral to treatment target. As UHB receives a high level of tertiary referrals due to the specialist services it provides, any referrals received late along the pathway make achievement of the targets more challenging. Infection control also remains a challenge even though significant reductions in MRSA and C.difficile rates were delivered in 2009/10.

The 2009/10 standard NHS contract carries a high level of risk due to the financial penalties that can be applied for a range of performance issues such as activity variance and under-achievement of targets.

The political climate and change of government presents uncertainty to the Trust. This could mark some significant changes in healthcare provision and configuration.

The recent reconfiguration of primary care trusts into clusters is likely to create instability across the local health economy driven by potential changes in personnel and revision of commissioning intentions.

2.3 Main Trends and Factors Likely to Affect Future Development, Performance, and Position of the Trust

As part of the development of the Trust's Five-Year Strategy, consideration was given to the main factors that will affect the organisation using the key challenges presented in 'High Quality Care For All' as a framework. These are described below.

2.3.1 Ever Higher Expectations

Wealth and technology have changed the nature of society's outlook and expectations. Patients expect more tailored treatment received at a time and place convenient to them. They will make greater demands and expect a more significant role in decision-making during their care. People are now more influenced by new technologies that provide unprecedented levels of control, personalisation, and connection. This puts the patient in a position to directly influence and shape healthcare.

The Trust has developed a core purpose to improve the patient experience which aligns with the national strategy to meet ever higher expectations. In 2009/10 UHB collected a wealth of information relating to how patients feel about the care they receive. This will be used as a platform to proactively listen to patients and respond to their needs.

2.3.2 Demand Driven by Demographics

The ever-growing life expectancy and ageing population poses a challenge to the sustainability of the NHS. By 2031, the number of over 75 year olds in the British population is predicted to increase from 4.7 million to 8.2 million. The NHS needs to be forward looking, proactively identifying, and mitigating health risks in order to cope with the increased demands of an ageing population.

The specialty clinical strategies have been developed specifically to meet the growing demand within this demographic area through a more proactive approach to care of the elderly and the delivery of synergistic services such as Stroke, Neurology, and Neurosciences through an aggregate service configuration.

2.3.3 Health in an Age of Information and Connectivity

The internet has transformed the relationship people have with information. This has profound implications for healthcare. It is now easier to access information on how to stay healthy than ever before. People are able to quickly and conveniently find information about their treatment and diseases in a way that was previously impossible. They want to do their own research, reflect on what their clinicians have told them, and discuss issues from an informed position. The challenge is ensuring that people are able to access reliable information.

UHB can pride itself on the advancements it has made with information and connectivity. Given the Government announcement to scale back the national IT programme, UHB is in a strong position to deliver local IT solutions and further reinforce its status as a leader in this arena with the development of items such as Prescribing Information and Communications System (PICS) and the clinical portal.

2.3.4 The Changing Nature of Disease

The NHS in the 21st Century increasingly faces a disease burden determined by the choices people make; to smoke, drink excessively, eat poorly, and not take enough exercise. Today, countless years of healthy life are lost as the result of these known behavioural or lifestyle factors. Unhealthy choices and missed prevention opportunities are, in part, the cause of the growth in the prevalence of conditions such as diabetes, depression, and chronic obstructive pulmonary disease. The NHS and all its partners must respond to this shifting disease burden and provide personalised care for long-term conditions.

The changing disease pattern is currently

manifesting itself in a growth in a number of specialist tertiary services such as Diabetes, Renal Medicine and Surgery, Cardiology, Spinal Surgery, Trauma and Cancer Services.

2.3.5 Advances in Treatment

The past 60 years have seen big developments in capacity to understand the nature and impact of existing disease. Also, with the advances in genomic testing, it may be possible to predict future disease rather than simply understand present illness. This presents the NHS with an unprecedented opportunity to move from reactive diagnosis and treatment to be able to proactively predict and prevent ill health. The NHS continues to develop pioneering treatments for diseases. For the same illness, open surgery leaves patients in hospital for several weeks where keyhole surgery enables them to go home in just a few days. With advances in robotics, patients can look forward to scar-free surgery.

The recent improvements in clinical trials recruitment within cancer services and the relatively poor NHS record in delivering effective commercial trials activity provides a fertile market for the expansion of research and development activity within the Trust. The establishment of the Birmingham Clinical Research Academy (BCRA) in collaboration with the University of Birmingham (UoB) and the links with the Royal Centre for Defence Medicine (RCDM) added to the internal reconfiguration of Research & Development, PICS, and Informatics capability. BCRA also adds to the optimal translational research environment available to UHB to proactively meet this challenge in the future.

2.3.6 A Changing Health Workplace

Healthcare has always been a knowledge-led sector, relying on expert learning and depth of experience. Healthcare professionals expect the depth of their expertise to be recognised and rewarded, and their skills to be developed and enhanced. High quality work is also about meeting the productivity challenge; high quality workplaces make best use of the talents of their people, ensuring that their skills are up to date, and their efforts never wasted. Creating high quality workplaces requires great leadership and good management.

The Trust has a core purpose relating to education and training of the workforce. This component of the Strategy focuses on developing a fit-for-purpose workforce that provides and continues to improve on delivering quality work. It also ensures that UHB meets not only its own workforce requirements but facilitates other health economy partners in further developing workforce capability through vehicles such as the Health Innovation and Education Clusters developed in collaboration with UoB. The New Hospital will also act as a major incentive for potential new recruits to the Trust given its state of the art facilities.

2.3.7 Financial Climate

The medium term economic outlook is significantly worse than at any time in the last 25 years. As a consequence of the recession and the global financial crisis the UK's public finances are now under severe strain. It is recognised that this current economic downturn will have a significant impact on healthcare and there will be further downward pressure on the national tariff with inflation uplifts continuing to fall. Higher efficiency gains will be required and there are significant opportunities for the NHS under the new cross-Government Operational Efficiency Programme. Reduced spending growth will also put significant pressure on PCTs to manage demand.

The state of the economy will impact directly on the Trust in many different ways, for example:

- NHS funding growth
- National tariff uplift
- Efficiency savings
- Inflation (RPI)
- Pay awards
- Interest rates

Whilst the individual variables are impossible to predict, it is clear that the Trust will face an

extremely challenging financial landscape over the medium term. Maintaining financial stability during this period is likely to require additional efficiency gains in order to increase productivity and deliver additional work through the available capacity and a tight control on costs.

2.4 Performance Governance Framework

The Trust has a robust and effective governance framework in place to provide assurance and monitors organisational performance. The Board of Directors and Executive Director level groups receive monthly performance reports which present performance against national and local targets/priorities. The reports adopt a risk-based approach so that performance underachievement and rectification plans are highlighted to the Executive Team and Board of Directors and Governors. Findings from Care Quality Commission assessments are also reported to the Board of Directors and Governors. This provides a good level of assurance and supports effective decision making. UHB also has a Clinical Quality Monitoring Group and a Care Quality Group in place led by the Executive Medical Director and the Executive Chief Nurse respectively. These forums provide additional assurance and effective accountability around clinical quality and the patient experience. See Quality Report – Section 3.

2.5 National Targets/Standards and the Standard NHS Contract

The financial year of 2009/10 was another very successful year for UHB. The Trust has successfully met or exceeded some very challenging targets.

The Trust has made significant reductions in infection rates. A total of 13 MRSA cases were reported against a trajectory of 30 and 178 C.difficile cases were reported against a trajectory of 348. Although this level of reduction has been made, infection control remains a priority for the Trust.

UHB saw nearly half a million outpatients, 67,000 inpatients, 32,000 daycases, and 83,000 A&E attendances. The Trust continues to ensure equitable access to services and over 98% of patients were treated, admitted, or discharged from A&E in less than four hours over the course of the year. UHB has also met the national 18-week referral- to-treatment target at Trust and Specialty level. The Trust continues to sustain some of the lowest inpatient and outpatient waiting times in the NHS and has successfully delivered against the national cancer waiting time targets.

The Trust also reported full compliance against the 44 core standards set by the Care Quality Commission demonstrating that the organisation has effective governance processes in place as well as delivering high levels of quality care.

2009/10 was the second year of the standard NHS contract. Contract performance is monitored and discussed with South Birmingham Primary Care Trust and the West Midlands Specialised Commissioning Team on a monthly basis. The Trust has successfully complied with the terms of the contract.

2.6 Clinical Quality and Patient Experience

The Trust has made significant progress in developing and delivering its quality agenda. The Quality Reports and the Commissioning for Quality and Innovation Indicators (CQUINs) have provided a framework for this work.

The priorities contained within the 2008/09 Quality Report have shown improvement:

- Reducing errors (with a particular focus on medication errors)
- Infection prevention and control
- Improve patient experience and satisfaction.

Please refer to the Quality Report - Section 3 for full details of performance and initiatives implemented during the year to deliver improvements.

The milestones and outcomes contained within the CQUIN priorities have also been successfully delivered:

- Privacy and dignity
- Medication safety
- Pressure sore management
- Urgent care

2.7 Trust Development and Performance during 2009/10

The Trust broadly met its objectives for 2009/10 and has successfully met or exceeded some very challenging targets, treating more patients than ever before.

	2008/09	2009/10	% change
Inpatient Finished Consultant Episodes	67,515	67,058	-0.68
Day-cases (excluding renal dialysis regular day attenders)	30,165	31,825	5.22
Outpatient attendances	461,080	499,981	7.78
A&E Attendances	82,838	82,632	-0.25
Total treatments	641,201	681,496	5.85

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.

2.8 Performance against Key Patient Targets

In October 2009, the Healthcare Commission published the performance ratings for 2008/09. The Trust achieved ratings of "excellent" and "excellent", 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 improving quality outcomes for patients. However, there is still much to do in both areas and the focus 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 Outpatient 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, which develops initiatives to enhance the patient experience and improve patient satisfaction.

The following table sets out performance against The Trust's main targets for 2009/10:

National Targets/Standards for 2009/10

Indicator	National Target	Data Period	YTD
Existing Commitments			
Data quality on ethnic group for patients	>=85%	Apr 09 – Feb 10	93.8%
Primary PCI - call to needle within 60 minutes	Thresholds not released by Care Quality Commission (CQC)	Apr 09 – Dec 09	68.4%
Delayed transfers of care	<=3.5%	Apr 09 – Mar 10	3.3%
A&E 4 hour waits	>=98%	Apr 09 – Mar 10	98.6%
Inpatient waits longer than 26 weeks	<=0.03%	Apr 09 – Mar 10	0.0%
Outpatient waits longer than 13 weeks	<=0.03%	Apr 09 – Mar 10	0.0%
Revascularisation 13 week waits	<=0.1%	Apr 09 – Mar 10	0.0%
Rapid access chest pain clinic 2 week waits	>=98%	Apr 09 – Mar 10	100%
% Operations cancelled on day or after admission	<=0.8%	Apr 09 – Mar 10	0.64%
Cancelled operations not admitted within 28 days	<5%		0%
National Priorities			
Participation in heart disease audits	Participation in line with indicator construction	Apr 09 – Mar 10	Awaiting final figures
Engagement in clinical audits	Yes for 5 questions including question 1	Apr 09 – Mar 10	6 (including Q1)
Stroke care: patients spending >90% of time on stroke unit	Thresholds not released by Care Quality Commission (CQC)	Apr 09 – Mar 10	64.6%
Number of MRSA bacteraemias	<=30	Apr 09 – Mar 10	13
Number of C. difficile cases >48 hours after admission	<=348	Apr 09 – Mar 10	178
18 week referral to treatment - admitted patients	>=90%	Apr 09 – Mar 10	95.0%
18 week referral to treatment - non-admitted patients	>=95%		97.8%

Indicator	National Target	Data Period	YTD
Cancer – 31 days from decision to treat to treatment – first treatments	>=96%	Apr 09 – Mar 10	97.4%
Cancer – 31 days from decision to treat to treatment – subsequent treatments – surgery	>=94%		96.6%
Cancer – 31 days from decision to treat to treatment – subsequent treatments – drug therapy	>=98%		99.1%
Cancer – 62 days from urgent GP referral to treatment – first treatments	>=95%	Apr 09 – Mar 10	Awaiting final figures
Cancer – 62 days from urgent referral from screening service to treatment – first treatments	>=90%		92.6%
Cancer – 62 days from consultant upgrade to treatment – first treatments	Thresholds not released by CQC		85.7%
Cancer – 2 weeks from urgent GP referral to first outpatient appointment – suspected cancer	>=93%	Apr 09 – Mar 10	94.6%
Cancer – 2 weeks from urgent GP referral to first outpatient appointment – breast symptoms	>=93%		98.6%
Experience of patients	Target construction and thresholds not released by CQC	2009	Awaiting construc-tion from CQC
NHS staff satisfaction	Target thresholds not released by CQC. UHB above national average.	2009	3.51

2.9 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 the Care Quality Commission assessments are also reported to Board level with detailed action plans incorporating any recommendations made.

2.10 Operational Efficiency

Operational efficiency remains a high priority for UHB and a number of initiatives were implemented in 2009/10 to drive improvements.

Length of stay is an important marker of the patient experience and efficiency of patient care. Work has therefore continued to ensure pathways are streamlined, non-value added steps removed, and the patient experience improved. Attention has also been focussed on improvement to pre-operative assessment practices. At a high level, the actions required for the delivery of streamlined pathways include an increase in the proportion of patients pre-admitted which will in turn improve the Trust's day of surgery admission rates. Work has also been undertaken to further increase daycase and ambulatory care rates.

UHB is working closely with South Birmingham Primary Care Trust to ensure the patient pathway is further streamlined so that discharge planning takes place at an early stage.

UHB has also been testing the new models of care prior to the physical transfer to the new hospital. The Trust recognises that significant changes to the models of patient care need to be made to enable services to function at an optimal level from the first day in the New Hospital. An example of this is the approach to the use of acute medical inpatient beds via the multi-speciality medicine model. In September 2008, this planned assessment model was implemented on the Selly Oak site and brought together the relevant wards as they are configured in the New Hospital.

The Trust has applied LEAN processes within Theatres to improve utilisation and planning. An outcome of this work includes the way in which capacity is planned for major surgical cases. In the New Hospital, there is critical care capacity that can be flexed to contribute to the Trust's ability to plan for elective admissions post procedure. This ensures that sufficient critical care capacity is identified.

The Trust has made strides in delivering activity in the community working closely with commissioners. In partnership with South Birmingham Primary Care Trust, UHB is delivering a range of clinics such as Diabetes, Ophthalmology, Ear, Nose and Throat, Plastic Surgery, and Orthopaedic Assessment and Triage in a community setting.

There is also an already established Orthopaedic Assessment and Triage Service provision in the community borne out of a partnership with Heart of Birmingham PCT.

2.11 Social and community issues

UHB is key to Birmingham's regeneration. The health and social care sector as a whole accounts for over 10% of West Midlands gross domestic product. UHB itself has a similar budget to Coventry City Council – one of the biggest local authorities in England – and is Birmingham's third largest employer, employing some 6,900 staff. The new Queen Elizabeth Hospital Birmingham, opening in June 2010, is one of the region's largest capital projects and is adjacent to Birmingham University, creating one of Europe's largest academic/medical complexes. It is a catalyst for the regeneration of south Birmingham.

UHB's contribution to regeneration is to deliver the best in healthcare through world-class clinicians in a world-class environment aided by medical technology and translational research. In turn this helps reduce social exclusion and increases prosperity in Birmingham and the broader West Midlands.

2.11.1 Reducing Disadvantage

A key priority of the Trust has been to broaden access to the jobs and training it and Balfour Beatty - the builder of the New Hospital - has to offer to unemployed people, particularly those living in the most disadvantaged parts of the city. UHB had been doing this in temporary premises for five years but the culmination was the opening in August 2008 of the Learning Hub close to the New Hospital. Over the last five years the training projects now in the Hub

have enabled almost 1,000 people to gain a job.

The Hub provides new, purpose-built accommodation to train unemployed people into entry level healthcare jobs and to help existing staff where they lack a basic skill. UHB runs the Learning Hub on behalf of the whole health and social care sector.

The Hub's ACTIVATE project provides induction and placement in a ward, technical or administrative area. Placements are not just in UHB and include Heart of England; the Women's and Children's Hospitals; the Royal Orthopaedic; Heart of Birmingham, South Birmingham and Birmingham East and North Primary Care trusts.

The model has been successfully extended by working with employers in other parts of the public sector.

Another Hub project 'Building Health' still targets unemployed people but complements ACTIVATE by "brokering" people into jobs. It works by particularly focusing on community and employer engagement so that target groups are far more aware of the jobs available and by providing job-specific pre-employment training.

'Building Health' covers both healthcare and construction jobs arising from the New Hospital and is aimed at the whole of the health and social care sector including private sector care homes. The Sector Skills Council for Construction has designated Balfour Beatty (the builder of the New Hospital) working through the Learning Hub as its first Academy of Construction Excellence in the West Midlands. The aim is to improve training for existing employees of Balfour Beatty and its supply chain, complementing the focus of 'Building Health' on unemployed people.

Some 70% of its beneficiaries are from Black and Minority Ethnic communities.

Key stakeholders in the Learning Hub include JobCentre Plus, the Learning and Skills Council, Birmingham City Council, Further Education Colleges and Consort/Balfour Beatty, as well as UHB and NHS partners. The Learning Hub brings together in one place the skills and experience of all these organisations.

UHB is currently planning to help train 40 apprentices and provide a further 60 placement opportunities for young people under the Government's Future Jobs Fund initiative.

The Hub provides a focal point for UHB's relationships with local disadvantaged communities and is expected to benefit some 5,000 unemployed people over the next three years.

UHB has signed both the Skills and Jobs Pledges and was one of the first NHS Trusts in Birmingham to sign a Local Employment Partnership (LEP) with JobCentre Plus, using the Learning Hub to help welfare claimants into training and work. The Learning Hub gained the 2009 West Midlands JobCentrePlus award for most innovative LEP and for the most outstanding contribution to LEPs. The Hub also gained a national Matrix excellence award for the quality of its information, advice and guidance.

2.11.2 Increasing Prosperity

Adjacent to Birmingham University the New Hospital will create one of the largest academic / medical complexes in Europe – at one of the key gateways to the region's Central Technology Belt.

The New Hospital will embody latest technology and be a catalyst for, and driver of, innovation in medical and healthcare technologies. Working with the best in Europe and beyond the Trust aims to further stimulate knowledge, technology transfer and best practice – very much in line with the direction of the Wanless Report, the Health Industries Task Force and, most recently, the Darzi Review. Locally, UHB has worked hard to ensure medical technology is integral to Advantage West Midlands' Regional Economic Strategy, the West Midlands Regional Competitiveness and

Employment Programme and the Birmingham Science City initiative.

UHB is already host to the Wellcome Trust's most successful clinical research facility and the largest transplant programme in Europe. Excellent academics, excellent clinicians together with a very large and diverse catchment area give Birmingham and the broader West Midlands a comparative advantage in translational research, in particular clinical trialling.

UHB's Centre for Clinical Haematology was funded (£2.25m) by Advantage West Midlands in March 2006. Since then it has grown to become one of the largest early phase clinical trial centres for Leukaemia in the country. The Centre has obvious benefits to the health of patients through the trialling of a range of new targeted drug and transplant therapies in Birmingham. But its economic benefits have also been significant in terms of job creation, private sector leverage and strengthening the bio-technology sector in Birmingham.

The Leukaemia Centre has undoubtedly helped develop a policy alignment around translational research in medicine including Advantage West Midlands, the regional development agency; Central Technology Belt and Birmingham Science City.

Most recently the Trust has been a leading partner in a successful Health Innovation Education Cluster bid to the Department of Health. UHB working with partners has also made a bid to be a national centre for proton therapy.

The potential prosperity benefits of this activity and investment to Birmingham and the West Midlands is huge by helping it move into high value-added growth sectors.

The land vacated by the two old hospitals when the new Queen Elizabeth Hospital Birmingham fully opens will also offer significant regeneration potential - with Selly Oak Hospital being one of the city's key strategic housing sites and the old Queen Elizabeth Hospital having further medical technology potential.

2.12 Patient Care

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

Following the development of a number of patient-focused initiatives last year, the Trust continues to improve patient care through the work of the Care Quality group chaired by the Executive Chief Nurse. Whilst the Trust has issues raised in patient advocacy and liaison contacts, complaints, and national and local surveys it also commenced its own electronic surveys last year enabling patients to give live feedback at the point of care.

These surveys have assisted the Trust in measuring the success of its patient improvement measures including a 20% increase in the number of patients who feel that they are always treated with dignity and respect.

It has also enabled the Trust to focus on the areas that patients indicate they are most concerned with. As a result of the feedback from patients, the Trust has changed its meal times, produced comfort packs to support better rest and improve issues with noise at night. The Ward Dashboard on each area allows staff to see their own progress against a number of clinical areas and act on them. Use of the national Releasing Time to Care project (Productive Ward) is providing the Trust with an opportunity to standardise storage and systems on the wards in the New Hospital which assists staff with familiarisation and efficiency.

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

The Trust's Infection Prevention and Control programme has continued to demonstrate excellent progress in the last year. MRSA has reduced by 66% and Clostridium difficile has reduced by over 50% in year.

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.

The Trust had its annual inspection against the Hygiene Code made by the Care Quality Commission in October 2009 and the report was positive with no breaches of the code identified.

The Trust took part in the Care Quality Commission's review of the arrangements for Safeguarding of Children and was passed as compliant against the standards reviewed.

2.12.3 Service improvements following staff, patient or carer surveys/ comments and Healthcare Commission reports

Following the last national Inpatient Survey, the Trust identified a number of areas to improve and reports the indicators in its Quality Report quarterly. It shows that across all indicators related to privacy, dignity, cleanliness and overall care the Trust has improved when measured in our real-time patient survey.

In response to its patients and to the Department of Health's campaign to virtually eliminate mixed sex accommodation, the Trust has made a number of changes to ensure that where possible patients will not share sleeping areas, that all toilet areas are clearly marked for male and female use and that privacy and dignity is maintained at all times. This will culminate in a major improvement as the Trust moves into its new hospital during 2010 when there will be single sex four-bedded rooms and 44% single rooms with en-suite toilets and showers.

2.14 Public and Patient Involvement

2.14.1 Patient and Carer Councils

There are two Patient and Carer Councils, one for each hospital site.

The purpose of the Councils is for patients, Foundation Trust 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.

The Selly Oak Hospital Council has continued to use the 'Adopt-A-Ward' scheme to facilitate partnership working with ward staff to provide a patient perspective to improving the experience of patients and their relatives. During 2009, the Queen Elizabeth Hospital Council introduced the scheme.

The work programme this year has included nutrition and hydration of inpatients, infection prevention and control, privacy and dignity, patient experience data collection, and a review of the bedside entertainment system.

2.14.2 Clean Your Hands Campaign led by Patient and Carer Councils

For the fourth 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.

Staff and Patient and Carer Council members

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 and recommendations was reported to the Infection Prevention and Control Committee in Spring 2010.

2.14.3 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 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.

Group members 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.

This year the group has had the opportunity to contribute to discussions and decisions on the productive ward project, patient information in the new hospital, patient transport, and the introduction of a 3D wayfinding system.

2.14.4 Information Group

The group was established four 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:

- Plasma Screens: the group has been involved in consultation on the messages and information to be displayed on the plasma screens
- Audit of the hospital information channel/ booklet which provides patients with various information about their hospital stay
- Information for patients being discharged from hospital
- Information for patients about their medication

2.14.5 Local Involvement Networks (LINks): UHB Working Group

The University Hospitals Birmingham Working Group is a sub group of the Birmingham LINks, and was established in April 2009. A good working relationship has continued with members, many of whom were members of the disbanded PPI Forum.

The Trust has hosted the monthly meetings and arranged talks by Trust representatives and fact-finding visits. Members have also been invited to take part in various engagement activities.

A representative from the group participated in the procurement process to award the contract to a provider of Non-Emergency Patient Transport.

A work programme has been developed for 2010/11 in collaboration with the Associate Director of Patient Affairs.

2.14.6 Patient/Carer Consultations

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

- NHS Constitution - consultation on patients' rights
- Provider of cook-chill meals for inpatients
- 3D Wayfinding and Signage in the New Hospital - a consultation on the method of wayfinding for the New Hospital
- Care Quality Commission – User Involvement and Quality Reports

- Intra-Bladder temperature measurement
- Ward comfort rounds for patients
- Direct Payments/Personal Health Budgets
- CLAHRC Research on Patient Experience

2.14.7 Increase in volunteers from the local community

The Trust had 880 people registered as volunteers at the end of February 2010. A continued effort has been made to recruit from groups that would not traditionally be linked with hospital volunteering. The profile of volunteers is now:

- 31% male
- 38% black and Asian
- 40% under 30 years old
- 19% over 66 years old
- 17% employed

Good working relationships have continued with the Birmingham Voluntary Services Council, and service level agreements made to attract people from seldom heard groups to become volunteers. Engagement with other voluntary organisations, Birmingham City Council, local universities, colleges and community groups has enhanced the development of the voluntary services at the Trust. This has helped to establish further the infrastructure, ensuring a sustainable future for the service.

National recognition of the standard of practice and achievements of the Voluntary Services has been demonstrated through inclusion in the recently launched Department of Health Strategic Vision, 'Volunteering: Involving people and communities in delivering and developing health and social care services'. Also, the Associate Director of Patient Affairs was elected to a key National role as the Chair for the National Association of Voluntary Services Managers, the organisation that leads volunteering in the NHS.

2.15 Complaints

The Trust received 643 formal complaints in 2009/10, which was 5.6% higher than the number received in 2008/09. An increase in the number of complaints was anticipated as a result of improved access to the complaints process, following the implementation on 1 April 2009 of new legislation governing NHS and Social Care complaints. The Trust can now accept complaints by email and telephone, as well as in writing. Every effort is made to make contact with the complainant, on receipt of their complaint, to agree a way forward including the preferred method of resolving their concerns (letter, meeting or phone call) and an appropriate timescale.

Trends coming out of complaints are analysed, assessed and reported to the Audit Committee. The Trust responded fully to 91% of complaints within the timescale agreed with the complainant.

The main issues raised in complaints were:

- Perception of clinical treatment
- Communication/Information
- Staff attitude
- Outpatient appointments

Some of the actions taken as a result of feedback include:

- Revised policy, pro-forma and additional teaching session re: consultant input on back pain cases in A&E
- Recruitment of additional staff trained to administer specific chemotherapy treatment
- Improved handover and revised shift patterns to improve drug administration on wards
- Extra clinics, revised consultant rotas and nurse led clinics to reduce waiting times in Fracture Clinic

2.16 Patient Advice and Liaison Service (PALS)

The Trust runs a Patient Advice and Liaison Service (PALS). There were 2,688 PALS contacts in 2009/10 of which 1,300 (48%) were related to issues/concerns raised. This compares with 2,060 PALS contacts the year before of which 1,017 (49.5%) were related to issues/concerns raised. This equates to a 30% increase in PALS contacts overall but a 1.5% reduction in the percentage of issues/concerns in relation to the total number of PALS contacts. The main issues/concerns raised were similar to Complaints and were related to Communication and Information, perceptions around Clinical Treatment and Outpatient appointments being cancelled or delayed.

2.17 Stakeholders, Partnerships, alliances/contractual arrangements

Significant progress has been made in developing stakeholder relations as set out in the table below.

Local Health organisations	
South Birmingham PCT	Regular meetings between Chairs and CEOs and appropriate directors
	Primary secondary interface group
	Community services strategy being implemented and continually revised
	Negotiation and implementation of Local Delivery Plan
	Quarterly finance and quality performance meetings
GPs	Within South Birmingham, participating and leading work on Rheumatology, Pain and ENT redesigned pathways working in partnership on Diabetes redesign and community hub
	Early stages of discussion around provision of GI, TIA, Endoscopy and Community Infusions.
	Early stage discussions with Partners at Hall Green Health Centre to agree services that could be delivered within that locality
	Working closely with the GPs at Sutton Medical Consulting Centre (Ashfurlong) to further develop the services provided in that locality, e.g. Ophthalmology Rapid Access Service, Neurology and Urology
	Within Sandwell discussions are ongoing with Regent Street Medical Centre and opportunities are being explored with Dudley, Redditch and Bromsgrove Practice Based Commissioning (PBC) Leads
Heart of Birmingham PCT	Contract with HoB PCT for Orthopaedic Assessment & Treatment Services (OATS). Community based service for minor trauma and musclo-skeletal injuries and provides direct access x-ray & MRI service for GPs in HoB
	More complex cases referred to UHB
	Recently been awarded the tender for community cardiology services
	Community based ENT, liver medicine and neurology services currently under development
	Have lodged an expression of interest in managing Sexual Health Service currently based at Whittal Street Clinic

Birmingham East and North PCT and Specialised Commissioning Agency	Chief Operating Officer continues to hold regular meetings with the head of the SCA
	Exploring potential of improving rehabilitation facilities
West Midlands SHA	Chair and CEO regularly meet their SHA counterparts
	Attending professional fora
	Trust developed an 18-week breach sharing protocol that has been adopted throughout the SHA
	Helping establish the Quality Observatory
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
	Ongoing discussions with regard to operational issues
Sandwell and West Birmingham Trust	Continued co-operation with SWBH on the Pan Birmingham Decontamination project
	COO 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
	Regular operational meetings with Medical Director and Chief Operating Officer to ensure appropriate SLAs in place to support delivery of services
	Partner in Proton Therapy Centre project
	FD sits on Shared Services Group
West Midlands Ambulance Trust	Meeting of Chairs and Executive Directors has taken place
	Working together to improve turnaround times for patients
	Support the WMAs with patient transport
	Process developed to record the clinical handover of the patients so that we will be able to robustly monitor performance

National health bodies	
Monitor	Chair and CEO have met Monitor Chair on a number of occasions
	Trust hosted visit by Monitor Chief Operating Officer
	Quarterly finance and quality performance meetings to review quarter's performance against plan, national standards and declarations
	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
Care Quality Commission	Trust hosted visit by Head of Operations
	Pilot to be implemented re Learning Disabilities

Department of Health	Ongoing discussions between key personnel at both organisations
	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 as well as health and safety issues
B-Braun	Meetings every two weeks at operational level with UHB Contracts to measure quality standards
	Quarterly Joint Management Board with the Pan Birmingham Collaborative and BBraun
University of Birmingham	Quarterly liaison meetings
	The Birmingham Clinical Research Academy has been developed
	Working with Business School to Develop MBA Programme
	Progress on ongoing discussions on various agendas are regularly reported to Board of Directors
	UoB are partner in Proton Therapy project
Ministry of Defence	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 (incorporating Birmingham 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 opened in Worcester in 2009 and a further unit in Wood gate Valley has just opened
	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

Advantage West Midlands/Central Technology Belt	UHB chairs AWM Innovative Healthcare Group
	AWM grant (through European Regional Development Fund) for pan-European "Developing Centres of Excellence project focusing on translational research"
	AWM and Science City letters of support for HIEC status and Proton Therapy project and support for BCRA
	AWM grant support for translational research at UoB through Science City
	AWM part-funding of Selly Oak New Road
Birmingham City Council	Continuing planning relationship
	BCC involvement on strategic Transport Task and Finish Group
	Improvement of public transport access to QE – working with BCC, Centro and West Midlands Travel
	Community Transport link from Kings Norton 3 Estates to the QE and Selly Oak Hospitals – supported by BCC
	Inward investment strategy – integrating medical technology, especially translational research and clinical trialling
	Regular attendance at overview and scrutiny committee
Learning and Skills Council	UHB representation on the Birmingham and Solihull Employer Board
	Substantial benefit from work with the LSC through the Joint Investment Fund
	Apprentice training funding
	LSC awarded £2m Single Public Sector Hub contract for information, advice and guidance to unemployed people to a partnership where the Learning Hub leads on Healthcare for Birmingham and Solihull
	Train to Gain support for existing staff
JobCentre Plus	Continued effective working though Local Employment Partnership (LEP) with JCP
	JCP seconds member of staff to the Learning Hub
	JCP gives financial support for Learning Hub, particularly auxiliary nurse training programmes
	UHB chairs pan-Birmingham Access to Employment Group focusing on LEP grant-aided schemes
	Future Jobs Fund (44 FJF posts approved so far at UHB)
Government Office for the West Midlands (GOWM)	Supported HIEC status and Proton Therapy project
	Regional Health Strategy, especially the Employment chapter, which UHB is the co-lead for with the LSC
	Regional Procurement Strategy which provides a "tool-kit" for maximising benefits to West Midlands firms from public sector procurement

3. Financial Review

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.

3.1 Changes in accounting policies by The Trust in 2009/10

The financial statements have been prepared in accordance with International Financial Reporting Standards (IFRS) and International Finance Reporting Interpretation Committee (IFRIC) interpretations as endorsed by the European Union, applicable at 31 March 2010 and appropriate to NHS Foundation Trusts. This is the first set of full year results prepared in accordance with IFRS accounting policies. The previously reported 2008/09 financial statements have accordingly been restated to comply with IFRS, with the date of transition to IFRS being 1 April 2008, which is the beginning of the comparative period for the year ended 31 March 2010.

The principal effects of the adoption of IFRS are detailed in the reconciliation of taxpayers' equity (assets employed) and retained surplus under UK GAAP to IFRS stated in note 33 to the financial statements.

3.2 Financial Performance

In line with recent years the Trust has again reported strong financial results for 2009/10. Total income has increased by 6.8% to £496.2 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 £13.8 million which equates to 2.8% of turnover. This strong financial performance is expected to result in the Trust achieving an overall Financial Risk Rating of 4 (the second highest 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.

3.3 Income and expenditure

The table below compares the original planned income and expenditure with the outturn position for 2009/10.

Summary income and expenditure – plan v. outturn

The Trust's Summarised Income and Expenditure (£M's)		
	Plan 2009/10	Outturn Position 2009/10
Income	483.3	496.2
Expenditure	-452.9	-468.5
EBITDA	**30.4**	**27.7**
Depreciation	-12.5	-10.9
Impairment	0.0	-1.2
Dividend	-3.3	-2.4
Loss on asset disposal	0.0	-0.0
Interest	0.5	0.6
Net Surplus / (Deficit)	**15.1**	**13.8**

The largest component of the Trust's income is the provision of NHS healthcare, accounting for £393.8 million (79.4%) of the total. Non NHS clinical income contributes a further £15.0 million (3.0%) 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 £28.8 million (5.8%) of the Trust's income in 2009/10 and income associated with Research and Development (R&D) activities which totals £17.3 million (3.5%). 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 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 2009/10 include additional healthcare income primarily for high cost drugs and devices paid for on a cost-per-case basis and additional healthcare activity from the Ministry of Defence. 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 £275.5 million, equivalent to 58.8% of total expenditure. Other significant components include £50.0 million on drugs (10.7%) and £66.1 million on Clinical Supplies and Services (14.1%).

3.4 Capital Expenditure Plan

In 2009/10 the Trust incurred £18.3 million of capital expenditure on new facilities and improving old environments. This is summarised below:

Category	Capital Invested £ Million
Brought Forward Programmes from 2008/09	1.6
IT Replacement, Modernisation, Infrastructure and additional capacity	1.4
Retained Buildings	
Development of Wolfson building	1.2
Relocation of RRPPS service offsite	1.7
West End Development	1.0
Other Works	0.9
Replacement of Equipment	4.8
Modernisation and Discretionary Spend:	
New Equipment	9.2
Other	1.3
SUB TOTAL	**18.3**

In addition to the above, during 2009/10 the Trust incurred £13.8 million of expenditure on enabling works relating to the New Hospital.

The Trust's planned capital expenditure over the next three financial years (2010/11 to 2012/13) totals £61 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 £61 million capital programme, £21 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.

3.5 Value for Money

The Trust's Financial Plan for 2010/11 included the delivery of cash-releasing efficiency savings of 3.5% against relevant budgets. In order to achieve this, a formal cost improvement programme (CIP) totalling £12.0m 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 CIP, 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 Care Quality Commission as part of the Annual Health Check and is given a Financial Risk Rating by Monitor. In the latest results published in October 2009 the Trust again achieved a rating of 'Excellent' for the use of resources (based on 2009/10 outturn data).

3.6 Private Patient Income (PPI)

PPI was £2.8 million which is within the authorised limit of 1.23%.

3.7 University Hospital Birmingham Charities

The charitable funds for the Trust are administered by UHB Charities, a separate legal entity from the Trust. In 2009/10 the Trust received grants of £1.1 million from UHB Charities.

3.8 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.

3.9 External Auditors

The Trust's external auditors are KPMG LLP. The audit cost for the year is £168,000 of which £86,000 relates to statutory audit services, and £82,000 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.

3.10 Pensions

The accounting policy for pensions and other retirement benefits are set out in note 1.3.2 to the financial statements and details of senior employees' remuneration can be found in the Remuneration Report in Section 2.

3.11 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.

Julie Moore Date 3 June, 2010
Chief Executive

Governance

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. Although the 2006 Code has now been replaced by a new Code issued by Monitor in March 2010, it is the 2006 Code which still applies to this Annual Report for 2009/10.

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 2009/10.

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

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 43, 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 of Non-Executive Directors, but the Board of Governors has the responsibility for terminating individuals i.e. as a result of poor performance, misconduct etc.

Details of the composition of the Board of Governors are set out in Governors, page 38, 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. The term of appointment of Tony Huq expired on 30 June 2009 and 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. Details of the composition of that Committee and its activities are set out on page 53 of the Annual Report. Details of terms of office of the Directors are set out in Board of Directors, page 44, 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 Tenon 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 24 of the Annual Report and in Membership, page 54.

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.

E.2.3 The Board of Governors is responsible for setting the remuneration of non-executive directors and the chair. The Board of Governors should consult external professional advisers to market-test the remuneration levels of the Chairman and other non-executives at least once every three years and when they intend to make a large change to the remuneration of a non-executive.

The Board of Governors did not appoint external professional advisors to market-test the remuneration levels of the Chairman and other non-executives for the review carried out in the reporting year. Instead, proposed increases in remuneration were bench marked against other similar trusts through a remuneration survey carried out by the Foundation Trust Network.

Board of Governors

1. Overview

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).
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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 is now comprised as follows:

- 12 public Governors elected from the Parliamentary Constituencies in Birmingham
- 4 patient Governors elected by Patient members
- 5 staff Governors elected by the following staff groups:
    - Medical
    - Nursing (2)
    - Clinical Scientist/Allied Health Professional
    - Ancillary, Administrative and Other Staff
- 6 stakeholder Governors appointed by six 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 came into effect on 1 July 2009 and elections for all public and patient governor seats were held in June 2009. Governors appointed to public and patient seats at these elections were appointed for terms of either two or three years, commencing on 1 July 2009.

One by-election was held this year to fill a seat that was vacant. The Governor appointed to the public seat at this by-election was appointed for the remainder of a three year term commencing on 1 July 2009.

During this year, the Governors have been:

1.1 Patient (up to 30 June 2009)

Rita Bayley
Rosanna Penn
Valerie Jones

Paul Darby
Bridget Pearce
Alan Bailey

1.2 Patient (from 1 July 2009)

Shirley Turner
Colin McAllister
Valerie Jones
Jamie Gardiner

1.3 Public (by Parliamentary Constituency – up to 30 June 2009)

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
Vacant

Erdington
David Ward

Sutton Coldfield
Joan Walker

1.4 Public (by Parliamentary Constituency – from 1 July 2009)

Northfield
Margaret Burdett
Edith Davies

Selly Oak
Rita Bayley
John Delamere

Hall Green
Ann Durham (resigned 7 March 2010)
Tony Mullins MBE

Edgbaston
Rosanna Penn
Ian Trayer

Ladywood
Shazad Zaman

Yardley
Kadeer Arif

Perry Barr & Sutton Coldfield
Joan Walker

Erdington & Hodge Hill
Monica Quach (from August 2009)

1.5 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)

1.6 Stakeholder

Rabbi Margaret Jacobi, appointed by the Birmingham Faith Leaders' Group (succeeding The Most Revd Vincent Nichols, Archbishop of Birmingham) in July 2009)

Professor David Cox, appointed by South Birmingham Primary Care Trust Professor Edward Peck, appointed by the University of Birmingham

Vice Admiral Raffaelli, appointed by the Ministry of Defence (succeeding General Lillywhite in December 2009)

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

Name of Governor	No. of meetings attended*
Alan Bailey	None (out of 1)
Rita Bayley	All
Paul Darby	None (out of 1)
Edith Davies	All
Valerie Jones	2 out of 4
Bridget Pearce	All
Rosanna Penn	All
Shirley Turner	All
Jamie Gardiner	All
Colin McAllister	1 out of 3
Gwyneth Harbun	None (out of 1)
Martin Straker-Welds	None (out of 1)
Brian Hanson	All
David Ward	None (out of 1)
Margaret Burdett	All
Hazel Flinn	None (out of 1)
David Spilsbury	All
Geoffrey Oates	All
Kadeer Arif	2 out of 4
Caroline Badley	None (out of 1)
Shazad Zaman	None (out of 4)
Joan Walker	2 out of 4
Anne Durham	1 out of 3
John Delamere	All
Monica Quach	1 out of 3
Tony Mullins	1 out of 3
Ian Trayer	All
Stakeholder Governors	
Cllr James Hutchings	3 out of 4
Prof. David Cox	2 out of 4
Lieutenant General Lillywhite	1 out of 2
Ruth Harker	All
The Most Revd Vincent Nichols	None (out of 1)
Rabbi Margaret Jacobi	2 out of 3
Vice Admiral Raffaelli	All
Prof. Edward Peck	1 out of 4
Staff Governors	
Barbara Tassa	All
Prof. John Buckels	3 out of 4
Paul Brettle	None (out of 4)
Anne Waller	2 out of 4
Erica Perkins	1 out of 4

*While a member of the Board of Governors.

1.7 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 and monthly Governor seminars
- Attending, and participating in, tri-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

1.8 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 Director of Corporate Affairs, University Hospitals Birmingham NHS Foundation Trust, Trust Headquarters, PO Box 9551, Main Drive, Queen Elizabeth Medical Centre.

Board of Directors

1. Overview

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.

Stewart Dobson has been appointed as Vice Chairman and Clare Robinson 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
Executive Chief Operating Officer: Kevin Bolger

Non-Executive Directors:
Professor David Bailey
Gurjeet Bains
Stewart Dobson
Angela Maxwell (from 1 July 2009)
David Ritchie
Clare Robinson
Professor Michael Sheppard

Kevin Bolger was appointed as substantive Chief Operating Officer in June 2009.

Tony Huq retired as a Non-Executive Director on 30 June 2009. Ms Angela Maxwell was appointed as a Non-Executive Director on 1 July 2009.

The Non-Executive Directors have all been appointed for terms of three years, with the exception of David Ritchie and David Bailey, who were both appointed for terms of four years, commencing 1 December 2006.

NAME	Date of Appoint-ment/ Latest Renewal	Term	Date of end of term
Sir Albert Bore	1 December 2006	4 years	30 November 2010
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
Angela Maxwell	1 July 2009	3 years	30 June 2012

The Board of Directors considers Tony Huq (retired 30 November 2008), Clare Robinson,

Stewart Dobson, David Bailey, David Ritchie, Gurjeet Bains and Angela Maxwell to be independent.

2. Board meetings

The board met regularly throughout the year, holding 11 meetings in total.

Directors	No. of meetings attended*
Sir Albert Bore	All
Julie Moore	10 out of 11
Mike Sexton	All
Tim Jones	All
Stewart Dobson	All
Clare Robinson	All
David Ritchie	10 out of 11
Prof Michael Sheppard	7 out of 11
David Rosser	6 out of 11
Tony Huq	1 out of 4
Prof David Bailey**	5 out of 8
Kay Fawcett	10 out of 11
Gurjeet Bains	9 out of 11
Angela Maxwell	4 out of 7
Kevin Bolger	10 out of 11

*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

3. The Board of Directors composition

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 worked in clinical practice before nurse management during which she undertook an MA in Health Services Studies. While Nurse Director, she was seconded to work at the Department of Health on developing nursing roles. In 1998, Julie became an operational director in the 3000 bed Leeds Teaching Hospitals Trust.

She was appointed as Executive Director of Operations at University Hospital Birmingham (UHB) in 2002. UHB became a Foundation Trust in July 2004 and Julie's role expanded to become the Chief Operating Officer.

UHB has performed consistently highly in national quality rating systems and in 2008/09 achieved the highest possible ranking of double

"excellent" from the Care Quality Commission. It has 1250 beds, £500m turnover, 6900 staff and a £545m PFI programme for a state of the art new hospital on the Queen Elizabeth site due to open in 2010/2011. It is also host to the Royal Centre for Defence Medicine and the Birmingham Clinical Research Academy (a partnership with University of Birmingham established in 2007).

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 to December 2008 and was a member of the National Organ Donation Taskforces in 2007 and 2008. She has been a member of the International Advisory Board of the University of Birmingham Business School since January 2009 and a Visiting Lecturer at Keele University since March 2009. In July 2009 she was appointed as an Independent Member of the Board of the Office for Strategic Co-ordination of Health Research (OSCHR) and in 2010 she became a Fellow of the Royal Society of Arts.

Executive Directors

Kevin Bolger, Executive Chief Operating Officer

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. His position became substantive in June 2009.

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.

Non-Executive Directors

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.

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 Council and one of fifty Ambassadors for the 2012 Olympics.

Angela Maxwell

Angela achieved prominence as one of the region's most dynamic entrepreneurs after she powered Fracino, the UK's only manufacturer of espresso and cappuccino machines from a

£400,000 turnover in 2005 into a £2.6million world-class leading brand when she sold her interests in 2008. A former European adviser to UK Trade & Investment, a finalist in Businesswoman of the Year 2005, Angela is a Board member of Advantage West Midlands. Acuwomen, her latest enterprise, is the UK's first company to bring an all-women group of entrepreneurs under one roof. Angela is also an accredited business advisor for Business Link and UKTI.

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.

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.

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 Director of Corporate Affairs, University Hospitals Birmingham NHS Foundation Trust, Trust Headquarters, PO Box 9551, Main Drive, Queen Elizabeth Medical Centre, Edgbaston, Birmingham B15 2PR.

Audit Committee

1. Overview

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 Committee met regularly throughout the year, holding six meetings in total.

Directors	No. of meetings attended*
Clare Robinson	All
Gurjeet Bains	5 out of 6
David Bailey	3 out of 6
David Ritchie	5 out of 6
Stewart Dobson	All
Mark Santer	3 out of 4
Tony Huq	None (out of 2)
Michael Sheppard	4 out of 6
Angela Maxwell	2 out of 4

*While a member of the Audit Committee

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.

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

2. 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.

3. 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.

Nominations Committee

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 the Governor Vice-Chair (Brian Hanson up to 30 June 2009 and Margaret Burdett from 1 July 2009). The other members of the committee for the year ended 31 March 2010 were Erica Perkins, Ruth Harker and Margaret Burdett (up to 30 June 2009), and Shirley Turner, Ian Trayer, Erica Perkins and Ruth Harker (from 1 July 2009).

The Committee met twice 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 one of the two meetings.

During the year, the Committee oversaw the appointment of one 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 Angela Maxwell be appointed as a Non-Executive Director of the Trust for an initial period of three years.

2. Nominations Sub-Committee

The Executive Appointments and Remuneration Committee appointed a Nominations Sub Committee to deal with the substantial appointment of a Chief Operating Officer. The Nominations Sub Committee consisted of the Chairman, the Chief Executive, Gurjeet Bains and Clare Robinson. The Nominations Sub Committee met once during the year and all members were in attendance.

Membership

1. Overview

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.)

2. Membership Overview by Constituency

Constitu-ency	Total at 31/03/10	%	% change from previous year
Public	11,623	48.9	51.0
Patient	4,751	20.0	19.2
Staff	7,380	31.1	15.1
Total Membership	23,754	100	31.5

*Numbers correct up to 31 March 2010

3. Membership Strategy

3.1 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.

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.

3.2 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.

3.3 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, launched in June 2009, was 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 recruitment campaign adopted an 'inside-out' approach, first targeting those who already have an association/empathy with the hospitals (current members, visitors to the hospitals, stakeholder groups), in the belief this was most efficient and cost effective way of recruiting quality members.

Membership was split into four categories: thought donor, time donor, support donor, energy donor with each category having an indicative menu of the types of initiatives members could get involved with depending on which type of membership they opted for.

The membership recruitment strategy was 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 number of recruitment channels were used with the most-effective being direct mail-outs to strategically targeted groups to ensure a representative membership and current patients, as well as recruitment 'days' within the hospital.

In March 2009 the Trust had 18,070 members. By March 2010 some 7,794 new patients, staff and members of the public had chosen to become a member of UHB. This represents a 43% increase on this time last year.

However 2,110 members had to be taken off the database, again mainly due to the fact that

members had died or moved away.

Therefore the net total number of members at UHB as of March 31, 2010 was 23,754, an increase of over 31%.

3.4 Membership plans 2010/11

- To maintain the current number of quality members through the most effective and cost-efficient means
- To recruit an extra 5% of quality members
- To use the current membership to deliver tangible benefits for the members and for the Trust by strategically using the detailed membership database that has been established over the last 12 months.
- The membership database will drive the most effective communication and engagement strategy

3.5 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, and 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 2010/11 Governors will start to attend community presentations in relation to the hospital/patients issues held their constituency

3.6 Healthcare talks for Foundation Members

Each month the Trust holds healthcare talks 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 kidneys, to information about hospital services, such as the clinical decision unit, 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.

Sustainability / climate change

1. Overview

UHB aims to deliver the best in care and do this in a way which reduces disadvantage and increases prosperity and the sustainability agenda is part of this overall approach.

Sustainable development is an approach to business, whether public or private sector, that ensures minimal impact on the environment, maximum benefit for the health of employees and local communities, and does not compromise the opportunities for future generations.

In practical terms the Trust sees sustainable development as focusing on:

- ensuring buildings conform to best standards of sustainability and energy efficiency and waste is minimised
- reducing the harmful effects of transport
- procuring goods and services locally where possible and from organisations that encompass the principles of sustainability
- a workforce strategy which embeds sustainability through effective policies for a healthy workplace, valuing the workforce, diversity and inclusion, learning and development and broadening access for disadvantaged groups to the jobs healthcare can offer
- community engagement and participation
- considering sustainability during the formulation of the Trust's plans

There is a strong business case for enhanced action on sustainable development by UHB. This includes financial savings, improved staff morale, a healthier local population, reducing disadvantage and increasing local prosperity.

The Sustainable Development Commission has developed a Good Corporate Citizenship (GCC) Assessment Model especially for use within the NHS to help take a comprehensive approach to all aspects of sustainable development. The Trust scores highly as regards the buildings, facilities management and workforce elements of the GCC Index. The challenges of balancing energy savings against best value for procurement and reducing the carbon impact of business and visitor travel associated with a major hospital are recognised.

The new Queen Elizabeth Hospital Birmingham will meet the Department of Health energy efficiency target of 35-55GJ/100m3, at 54.9 GJ/100m3. Sustainability has been built in from the start. For example, wards have been built in an elliptical shape around inner courtyards to maximise natural light throughout. The ventilation system has been designed to minimise use of air conditioning and the lighting strategy designed to include installation of movement detectors in lower use areas. Demolition materials and excavated materials have been re-used in earthworks and landscaping. The new hospital grounds will incorporate green spaces including one of the largest plazas in Birmingham. Whole-life costing methods have been used.

The Trust's Learning Hub building has been made of 80% sustainable materials and features innovative natural ventilation chimneys, a green roof and solar panels. The New Hospital project team use whole-life costing methods and the New Hospital grounds will incorporate green spaces including one of the largest plazas in Birmingham.

UHB has also focussed on addressing transport issues in order to reduce car usage and improve accessibility, especially from disadvantaged areas, by public transport. Agreement has

been reached with CENTRO and National Express to improve bus services accessing the Queen Elizabeth site. The Trust has worked with Community Transport to run a successful scheme providing minibus access from the Kings Norton Three Estates to take residents to and from health appointments, jobs and training at the Trust. The Trust has a Green Travel Plan and is working with CENTRO to update this.

The environmental impact of waste is taken very seriously by UHB – especially reducing the amount of waste sent to landfill. This is a significant factor considered when awarding contracts for waste services. UHB is classified as an A rated Trust for carbon emissions/footprint associated with waste/water.

Carbon reduction crosses many components of sustainable development outlined above and is important in its own right because of the threats being posed by climate change.

The NHS provides enormous opportunities for action in sustainable development and reduction of greenhouse gas emissions. Nationally, the NHS has a carbon footprint of 21 million tonnes a year CO2 equivalent gasses. This is larger than some medium-sized countries. Work by the NHS Sustainable Development Unit indicates that these emissions are split as follows: 24% building energy, 17% transport and 59% procurement. Government has set challenging national targets for NHS England to reduce its emissions:

- a 10% reduction by 2015 from 21 million tonnes of CO2 equivalent (21mtCO2e) to 19 million tonnes
- an 80% reduction in CO2 equivalent gasses by 2050 which would reduce NHS England emissions to around 4m tonnes a year

April 2010 sees the introduction of the national Carbon Reduction Commitment (CRC) scheme - a new mandatory emissions trading scheme for the UK. UHB has been involved in carbon trading for some time and is fully aware of the importance of the CRC in terms of reducing energy and efficiency savings.

The Trust is working with the Carbon Trust. An initial scoping study has already begun. This will provide the background information for UHB – working with the Carbon Trust – to develop a full Carbon Management Programme. The Carbon Management Programme will be completed by the end of the 2010/11 financial year and will provide detailed measurement of UHB's carbon footprint together with a strategic approach to reducing this carbon footprint and a detailed action programme with specific targets.

The Trust is also working in partnership with the Carbon Trust and has a Sustainability Group in place to implement Saving Carbon, Improving Health.

The current Sustainability Group is chaired by the New Hospitals Project Director. Its members are the Executive Director of Delivery, Executive Director of Finance, Head of Estates, Learning and Development Manager and Head of Regeneration.

2. Energy Usage and Expenditure 2008/09 to 2009/10

University Hospitals Birmingham						
		2008/09	2009/10 Estimate		2008/09	2009/10 Estimate
					£	£
Waste minimisation and management	Total amount of waste produced (tonnes)	2,626	2,650	Expenditure on waste disposal	620,700	677,500
Finite Resources Purchased	Water (cu m)	287,072	256,000	Water	490,290	671,000
	Electricity (GJ)	69,828	113,175	Electricity	2,017,268	2,600,000
	Gas (GJ)	244,963	187,872	Gas	1,904,127	1,500,000
	Oil (GJ)	4,500	464	Oil	30,877	4,000
	Coal (GJ)	110,204	95,576	Coal	427,428	132,000
				Total Cost	**4,379,699**	**4,907,000**

NB Waste and Energy data for 2009/2010 is not scheduled to be returned to the Department of Health until 30 June 2010 and most data is still being collated and validated. Hence all data for 2009/2010 is estimated.

The table above compares waste and energy use between 2008/09 and 2009/10. Waste produced is estimated to have increased by some 9% - largely associated with the move to the New Hospital. The best estimate for energy is for a 62% increase in electricity purchased and a 77% fall in gas purchased. This is explained by changed energy supply arrangements. Prior to September 2008 the Trust operated coal-fired steam boilers and a gas-fired combined heat and power plant (CHP) to generate steam and electricity. This reduced the amount of electricity purchased and increased the amount of gas (gas includes fuel used to generate electricity). In September 2008 the CHP and coal-fired boilers were decommissioned and now new gas fired boilers generate steam for the hospital and all electricity is purchased from the national grid.

Equality and Diversity

1. Overview

University Hospitals Birmingham NHS Foundation Trust is committed to delivering equality of opportunity for all staff and service users and is the responsibility of the Executive Director of Delivery. Equality of opportunity underpins three of our strategic aims and objectives which are:

- to improve access and facilities via capacity expansion and public/private joint ventures
- to reduce inequalities in Birmingham, which will enable us to better understand and remove barriers to access for patients from all demographical backgrounds
- to improve the working lives of our staff

Equality and Diversity are a component part of the Trust's Values which are Honesty, Respect, Innovation and Responsibility. Through our Annual Action Plan, and a particular focus on Inclusion, the Trust looks to build on the work conducted prevously and ensure that patients staff, and public are treated both fair and equitably.

The Trust publishes on its website the following information (which can be accessed from a prominent link on the homepage www.uhb.nhs.uk):

- Single Equality Scheme (SES)
- Race Equality Scheme – which the SES incorporates
- Gender Equality Scheme – which the SES incorporates
- Statements regarding Disability and Age schemes which have been incorporated into the SES
- Annual Equality Report which reviews previous action plans laid down by the Trust and sets out the annual action plan
- Workforce demographics that are included in the Annual Report
- Contact details for enquiries around Equality and Diversity matters
- Equal Opportunities of Employment statement and the Disability Two Ticks commitment
- Equality Impact Assessments results
- Recruitment analysis by Race
- Staff disciplinary and grievance monitoring report
- A review of arrangements in the Trust around safeguarding children
- Useful links page around Foreign Languages

This meets the requirements for the Trust's publication duties.

2. Summary of performance

The table below lists the Trust's workforce and membership statistics by age, ethnicity; gender and disability (staff recorded disability). This information and more below was included in the Annual Equality Report 2009/10 which was publicly released in March 2010.

	Staff 2008/09	%	Staff 2009/10	%	Member-ship (pa-tient and public) 2008/09	%	Member-ship (pa-tient and public) 2009/10	%
Age								
16 - 17	4	0.1	1	0.01	0	0.00	8	0.05
17-21	149	2.1	125	1.74	43	0.37	170	1.08
22+	6,802	97.8	7,076	98.25	11,480	99.63	15,493	98.86
Not known	0	0	0	0	115		703	
Ethnicity								
White	5,049	76.05	5,258	74.88	7,135	93.22	10,618	67.76
Mixed	96	1.45	105	1.50	13	0.17	111	0.71
Asian or Asian British	756	11.39	845	12.03	381	4.98	1,189	7.59
Black or Black British	504	7.59	539	7.68	67	0.88	397	2.53
Other	234	3.52	275	3.92	58	0.76	128	0.82
Not known					3,984		3,931	
Gender								
Male	1,981	28.5	2,070	28.74	5,390	46.32	7,616	46.49
Female	4,974	71.5	5,132	71.26	6,247	53.68	8,714	55.61
Not specified	0	0	0	0	1		46	
Recorded Disability	45	0.65	136	1.89				

* Percentages exclude numbers "not known" or "not specified" in some categories. These figures do not include Bank Staff.

3. Future priorities and targets

The Trust's key priorities for 2010/11 have a particular focus on Inclusion, both within our current workforce and future potential job applicants. We will be publishing our revised Single Equality and Human Right Scheme, including a three-year plan, later in the year, and will be working on a variety of service improvement projects including improving the effectiveness of the Equality Impact Assessment process and building the awareness of Human Rights and Learning Disability within the organisation.

4. Performance monitoring of Equality and Diversity

Performance is monitored in a variety of different methods including:

- Bi-monthly review of the Annual Equality Report Action Plan by the Trust Diversity Group
- Workforce statistics are reviewed on a monthly basis by the Executive Director as part of the HR KPI report
- Recruitment statistics are reviewed every 6 months
- The Annual Equality Report Actions are reviewed by the Chief Executive Advisory Group
- Pertinent issues around Equality and Diversity are monitored by the Strategic Delivery Group on a monthly basis

Staff Survey

1. Overview

The Trust is committed to engaging its workforce and recognises the contribution they make to the care of our patients. It works in partnership with our trade unions to engage with staff and value the feedback that is given through, and by, them. We strive to find ways to improve the working lives of staff and feedback is crucial to understanding their needs and views of our staff.

The Trust has many mechanisms to hear from staff including a Chief Executive hotline, e-mail addresses for staff questions to be directly answered and Divisional Consultative meetings and a Trust Partnership Team where staff feeling is fed back through the trade union interface with senior management including executive directors. Staff have been heavily engaged in the service redesign projects surrounding the new hospital.

The results of the Care Quality Commission 2009 National Staff Survey read very positively for the Trust with 28 out of 40 indicators in the highest 20% or above average. The Trust also improved in 14 areas.

The survey was completed by 446 staff which represented a response rate of 54.7%; average national response rate for acute trusts was 55%.

The Trust also performed well compared to other acute trusts in staff feeling that senior management communicate well with staff, appraisals and personal development planning, feeling that they get good support from their managers and the quality of job design.

Although the numbers are small, the Trust is concerned that staff are experiencing discrimination, bullying and harassment and is working with its trade unions to address these alongside issues relating to physical violence from patients and staff working extra hours.

Top 4 ranked scores	2009 Score	2008 Score	+/-	National Average
% feeling satisfied with the quality of work and patient care they are able to deliver	83%	75%	⇧	74%
% agreeing that their role makes a difference to patients	93%	91%	⇔	90%
% receiving health & safety training in last 12 months	74%	68%	⇧	76%
% that would recommend the Trust as a place to work or receive treatment	3.79	N/A	N/A	3.50

Bottom 4 ranked scores	2009 Score	2008 Score	+/-	National Average
% experiencing physical violence from patients/relatives in the last 12 months	11%	12%	⇔	11%
% experiencing harassment, bullying or abuse from staff in the last 12 months	20%	20%	⇔	18%
Working extra hours	72%	67%	⇔	65%
% experiencing discrimination at work in the last 12 months	10%	8%	⇔	7%

2. Future priorities and targets

The Trust recognises that staff feedback is an important starting point to improving the staff experience and an action plan for 2010/11 has been developed, agreed by the Chief Executive at her advisory group and is being implemented.

The action plan concentrates on five key areas and each concern has action points, a lead, timescales and measurements set against it.

The five key areas are as follows:

- % of staff working extra hours
- % of staff experiencing discrimination at work
- % of staff experiencing discrimination at work continued
- % of staff experiencing physical violence from patients
- % of staff experiencing bullying and Harassment

Regulatory ratings

1. Explanation of ratings

1.1 Finance Risk Rating

When assessing financial risk for the period 2009/10 Monitor assigned a risk rating using a scorecard which compared key financial metrics. The risk rating was intended to reflect the likelihood of a financial breach of the Authorisation.

The financial indicators used to derive the financial risk rating in both the annual planning process and Monitor's quarterly monitoring incorporate four key criteria:

1. Achievement of plan
2. Underlying performance
3. Financial efficiency
4. Liquidity

An overall score was then allocated using a scale of 1 to 5 with 5 indicating low risk and 1 indicating high risk.

1.2 Governance Risk Rating

Monitor's assessment of governance risk in 2009/10 was based predominantly on the NHS foundation trust's plans for ensuring compliance with its Authorisation, but also reflects historic performance where this may be indicative of future risk. Monitor considers seven elements when assessing the governance risk:

1. Legality of constitution
2. Growing a representative membership
3. Appropriate Board roles and structures
4. Service performance (targets and national core standards)
5. Clinical quality and patient safety
6. Effective risk and performance management
7. Co-operation with NHS bodies and local authorities

Governance risk ratings are allocated using a traffic light system of green-amber-red, where green indicates low risk and red indicates high risk.

1.3 Mandatory Services Risk Rating

When assessing mandatory services in 2009/10, Monitor considered two key elements:

1. Changes to mandatory service provision will trigger a requirement for a variation of the Authorisation. Monitor may evaluate a specific risk where the proposed service change has a material impact on the NHS foundation trust's business plan.
2. Disposals of protected assets (or removal of protected status) will trigger the asset protection process. This is to ensure that asset disposals affecting mandatory services undergo a formal structured approval process.

Mandatory services risk ratings are also allocated using a traffic light system of green-amber-red, where green indicates low risk and red indicates high risk.

1.4 Summary of rating performance throughout the year and comparison to prior year and analysis of actual quarterly rating performance compared with expectation in the annual plan

The tables below shows the risk ratings for UHB under the categories of Finance, Governance, and Mandatory Services identified in the Annual Plan and the quarterly self-certifications in 2008/09 and 2009/10. Additional detail is provided where risks are declared and have a contribution to the risk rating against the three categories.

1.5 Risks Declared in 2008/09

	Annual Plan 2008/09	Q1 2008/09	Q2 2008/09	Q3 2008/09	Q4 2008/09
Financial Risk Rating	5	5	5	5	5
Governance Risk Rating	Amber	Amber	Amber	Green	Green
Mandatory Services	Green	Green	Green	Green	Green

1.6 Governance Risks Declared in 2008/09

	Annual Plan 2008/09	Q1 2008/09	Q2 2008/09	Q3 2008/09	Q4 2008/09
Governance Risk Rating	MRSA C.difficile Thrombolysis	MRSA C.difficile Thrombolysis	C.difficile Thrombolysis	Thrombolysis 4 hour A&E	Cancer 31 day Cancer 62 day

In 2008/09, UHB declared and achieved low risk ratings for finance and mandatory services. With regard to the governance risk rating, this was declared as Amber in the Annual Plan due to risks associated with achievement of the national targets for MRSA, C.difficile, and Thrombolysis for people suffering a heart attack. A risk was also declared for the 4 hour A&E target as part of the quarter 3 self-certification. Due to effective contingency planning and performance improvement all of these targets were met for the year. The Trust declared the 31 day decision to treat to start of treatment cancer target, and the 62 day referral to treatment cancer target in quarter 4, however, Monitor did not include these in the assessment process to derive the Trust's governance rating.

1.7 Risks Declared in 2009/10

	Annual Plan 2009/10	Q1 2009/10	Q2 2009/10	Q3 2009/10	Q4 2009/10
Financial Risk Rating	4	4	4	4	4
Governance Risk Rating	Green	Green	Green	Green	Amber
Mandatory Services	Green	Green	Green	Green	Green

1.8 Governance Risks Declared in 2009/10

	Annual Plan 2009/10	Q1 2009/10	Q2 2009/10	Q3 2009/10	Q4 2009/10
Governance Risk Rating	4 hour A&E	Cancer 2 weeks Cancer 31 day Cancer 62 day	-	-	Cancer 62 day

In 2009/10, UHB declared low risk ratings for finance and mandatory services. A risk was declared regarding achievement of the national 4 hour A&E target, resulting in a green Governance rating. As part of the quarterly self-certifications, risks were declared against the 2 week, 31 day, and 62 day cancer targets. Again due to effective planning, the A&E and cancer targets were met for the full year.

1.9 Explanation for differences in actual performance versus expected performance at the time of the annual risk assessment

Achievement of the 4-hour A&E target was declared as a risk in the 2009/10 Annual Plan due to the unpredictability of emergency pressures that can cause significant spikes in activity and impact on achievement of the target. The Trust undertook a process of contingency planning to address the activity pressures and this supported the achievement of the target for the full year.

The cancer targets were declared as risks in 2009/10 via the quarterly self-certifications due to the change in methodology introduced that removed a number of existing waiting time adjustments that were valid under the previous methodology and the fact that operational thresholds had not been set at that point. Also, as a tertiary centre, the Trust receives a high number of patients being referred from neighbouring trusts late along the pathway which has an impact on target. UHB undertook contingency planning to mitigate the impact of these issues and the cancer targets were met for the full year.

1.10 Details and actions from any formal interventions

There were no formal interventions at UHB during the reporting period.

Public Interest Disclosures

1. 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 2009 survey 93% of staff indicated that the work they do makes a positive difference to patient care and were recognised as being in the best 20% of acute Trusts nationally for this indicator.

The Trust has a monthly newspaper, 'Inside Out' which is widely circulated and a weekly e-newsletter, 'In the Loop', that contain a wide range of information for staff much of which encourages staff engagement in a wide range of service developments and activities. This includes training and promotional 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 have been 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.

2. 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 and is being re-launched in the Summer of 2010. 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 is committed to the 'Positive about Disabled People' and was awarded the 'two ticks' symbol by Job Centre Plus 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 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

3. Public and patient involvement activities

Please see Public and Patient Involvement activities under Patient Care on page 21.

4. Sickness absence

The Trust recorded an annual average sickness absence of 4.39% across all clinical and corporate divisions.

5. 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.

6. Serious untoward incidents – Information Governance

The Trust has had no Information Governance Serious Untoward Incidents involving personal data as reported to the Information Commissioner's Office in 2009/10.

The table below sets out a summary of other personal data related incidents in 2009-10

Summary of Other Personal Data Related Incidents in 2009-10

Category	Nature of incident	Total
I	Loss/theft of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	
II	Loss/theft of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	
IV	Unauthorised disclosure	
V	Other	1

7. Health and Safety

The staff incident rate for 2009/10 was 15.02 incidents per 100 staff. No Improvement Notices were issued by the Health and Safety Executive (HSE).

The most common injuries sustained by staff remain unchanged and relate to inoculation and musculo-skeletal injuries. Trials of safety cannulae and needles are being undertaken in some clinical areas to reduce inoculation injuries and the products will be evaluated by the Trust Medical Equipment Group. The New Hospital is designed to reduce the risk of injury from moving and handling activities by the inclusion of ceiling track hoists and height adjustable baths and training for clinical staff in the use of this equipment is scheduled to commence prior to the move.

An internal systems audit to measure compliance with health and safety legislation is established and any ward or department found to be less than 75% compliant is issued with an action plan to improve their compliance within a three month time scale when they are then re-audited.

Swine Flu vaccination was made available to all frontline staff as close to their place of work as possible to reduce any disruption to services and this resulted in 41.4% of staff being vaccinated.

8. 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.

9. Better Payment Practice Code

	Number	£000
Total bills paid in the year	95,539	201,652
Total bills paid within target	94,269	199,643
Percentage of bills paid within target	98.67	99.00

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.

10. 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.

11. Management costs

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

University Hospitals Birmingham
NHS Foundation Trust

2009/2010

Section 2 **Remuneration Report**

This annual report covers the period 1 April 2009 to 31 March 2010

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 five meetings in total.

Directors	No. of meetings attended*
Albert Bore	All
Julie Moore	All
Clare Robinson	All
Tony Huq	None (out of 2)
Stewart Dobson	3 out of 5
David Bailey**	3 out of 5
David Ritchie	4 out of 5
Michael Sheppard	2 out of 5
Gurjeet Bains	All
Angela Maxwell	All

* While a member of the Executive Appointments and Remuneration Committee
** David Bailey was granted a leave of absence from September 2008 until July 2009 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 March 2010.

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 2009/10.

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 80 and 81.

5. Salary and Pension Entitlements of Senior Managers

A. Remuneration

Name and Title	Year Ended 31 March 2010			Year Ended 31 March 2009		
	Salary	Other Remuneration	Benefits in Kind	Salary	Other Remuneration	Benefits in Kind
	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100
SENIOR MANAGERS						
Julie Moore, Chief Executive	210-215	0	0	205-210	0	0
Mike Sexton, Executive Director of Finance	135-140	0	0	135-140	0	0
Tim Jones, Executive Director of Delivery (commencing 01/09/2008)	135-140	0	0	75-80	0	0
Tim Jones, Chief Operating Officer (up to 31/08/2008)	0	0	0	55-60	0	0
Kay Fawcett, Chief Nursing officer	120-125	0	0	120-125	0	0
Kevin Bolger, Chief Operating Officer (commenced office 01/09/2008 in acting capacity, appointed 15/06/2009 on permanent basis)	130-135	0	0	75-80	0	0
Dr David Rosser, Executive Medical Director	85-90	95-100	0	85-90	95-100	0
David Burbridge, Director of Corporate Affairs	90-95	0	0	90-95	0	0
Fiona Alexander, Director of Communications	95-100	0	0	95-100	0	0

Name and Title	Year Ended 31 March 2010			Year Ended 31 March 2009		
	Salary	Other Re-munera-tion	Benefits in Kind	Salary	Other Re-munera-tion	Benefits in Kind
	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100
Morag Jackson, New Hospitals Project Director	115-120	0	0	115-120	0	0
Sam Chittenden, Director of Strategic Developments (commenced office 24/3/2008, left office 1/11/2009) **	65-70	0	100	115-120	0	100
Caroline Wigley, Director of Organisation Development (Left office 31/08/2008)	0	0	0	50-55	0	0
Mike Sharon, Director of Policy, Planning and Performance Management (Left office 01/02/2009)	0	0	0	85-90	0	0
NON EXECUTIVE DIRECTORS						
Sir Albert Bore, Chairman	50-55	0	0	45-50	0	0
David Bailey *	10-15	0	0	5-10	0	0
Stewart Dobson	15-20	0	0	10-15	0	0
Gurjeet Bains (commenced office 1/12/2008)	10-15	0	0	0-5	0	0
Professor Michael Sheppard	10-15	0	0	10-15	0	0
Angela Maxwell (commenced office 01/07/2009)	10-15	0	0	0	0	0
David Ritchie	10-15	0	0	10-15	0	0
Clare Robinson	15-20	0	0	10-15	0	0
Rev Mark Santer (Left office 30/11/2008)	0	0	0	5-10	0	0
Tony Huq (Left office 30/06/2009)**	0-5	0	0	10-15	0	100

*Unpaid leave of absence from 01/10/08 to 31/08/09
**Benefits in kind relate to business miles at excess rate

B. Pension Benefits

Name and title	Real increase in pension at age 60	Real increase in pension related lump sum at age 60	Total accrued pension at age 60 at 31 March 2010	Total accrued pension related lump sum at age 60 at 31 March 2010	Cash Equiva-lent Transfer Value at 31 March 2009	Cash Equiva-lent Transfer Value at 31 March 2010	Real Increase in Cash Equivalent Transfer Value	Employers Contribu-tion to Stake-holder Pension
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000	To nearest £100
Julie Moore, Chief Executive	0-2.5	0-2.5	75-80	230-235	1,407	1,554	77	N/A
Mike Sexton, Executive Director of Finance	0-2.5	5-7.5	45-50	135-140	819	944	85	N/A
Tim Jones, Director of Delivery	0-2.5	5-7.5	25-30	85-90	411	485	53	N/A
Kay Fawcett, Chief Nursing officer	0-2.5	0-2.5	45-50	145-150	900	994	50	N/A
Kevin Bolger, Chief Operating Officer	5-7.5	15-17.5	45-50	135-140	745	939	157	N/A
Dr David Rosser, Medical Director	0-2.5	0-2.5	45-50	140-145	722	803	45	N/A
David Burbridge, Director of Corporate Affairs	0-2.5	2.5-5	10-15	40-45	206	241	24	N/A
Fiona Alexander, Director of Communications	0-2.5	2.5-5	5-10	15-20	56	79	20	N/A
Morag Jackson, New Hospitals Project Director	0-2.5	0-2.5	30-35	95-100	535	600	38	N/A
Sam Chittenden, Director of Strategic Developments (left office 01/11/09)	0-2.5	0-2.5	20-25	60-65	333	384	23	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. In addition to the Chairman (who does not attend when the committee considers matters relating to his own remuneration), the Committee comprised Brian Hanson, Barbara Tassa, David Spilsbury and James Hutchings, up until 30 June 2009, and Margaret Burdett, Jamie Gardiner, Ian Trayer, John Buckels and James Hutchings, from 1 July 2009. It met once during the year and all members attended that meeting.

Julie Moore, June 3, 2010
Chief Executive

University Hospitals Birmingham
NHS Foundation Trust

2009/2010

Section 3 **Quality Report**

This report covers the period 1 April 2009 to 31 March 2010

Part 1: 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 in the overall Trust Strategy and the Corporate, Divisional and Specialty Strategies which underpin it. Clinical Quality and Patient Experience are two of the Trust's Core Purposes and provide the framework for the Trust's robust approach to managing quality.

UHB is a high volume institution for many complex surgical interventions such as gastro-intestinal (oesophagus, stomach and pancreas) and head and neck cancer surgery, liver surgery and heart surgery.

Research shows that complex surgical procedures carried out by hospitals which do high volumes are associated with better short-term patient outcomes and long-term survival rates, fewer complications (such as infection and reoperation), reduced length of stay and a more efficient use of resources[1,2].

UHB has made good progress in relation to all three quality improvement priorities for 2009-10 identified in last year's Quality Report: reducing medication errors, reducing infection, and improving patient experience and satisfaction. The Trust has however chosen to continue with these priorities in 2010-11 to deliver further improvements for our patients, particularly around reducing omitted drug doses.

The Trust has also identified two further quality improvement priorities for 2010-11: completion of venous-thromboembolism (VTE) risk assessment on admission for all patients and improving timeliness of administration of first antibiotic doses.

The Trust has continued to communicate with and involve staff and stakeholders in delivering high quality services during 2009-10. For example, clinical staff and the Health Informatics team have developed a wide range of specialty level quality indicators, some of which are shown in Part 3 of this report.

A key part of UHB's commitment to quality is being open and honest about performance. The Quality web pages were launched in November 2009 and provide staff, patients, the public and other stakeholders with up to date information on the Trust's performance in relation to quality: http://www.uhb.nhs.uk/quality.htm Information provided includes regular Quality Report updates and performance for some of the specialty level indicators, which will be extended during 2010-11.

The Trust's focused approach to quality is driven by innovative and bespoke information systems which enable us to capture and use real-time data in ways which few other UK trusts are able to do. During 2009-10, the Trust has developed an interactive Healthcare Evaluation Data (HED) tool and further developments have been implemented within the Prescribing Information and Communication System (PICS) which are described in Part 3 of this report.

Data quality and the timeliness of data are fundamental aspects of UHB's management of quality. Data is provided to clinical and managerial teams as close to real-time as possible through various means such as the

1 Killeen, S.D., et al. (2005). Provider volume and outcomes for oncological procedures. *British Journal of Surgery*, 92(4), pp.289-402.

2 NHS Executive. (2001, January). Guidance on Commissioning Cancer Services: Improving Outcomes in Upper Gastro-intestinal Cancers. [Online]. (URL http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4080278.pdf)

Trust's digital Clinical Dashboard. Information is subject to regular review and challenge at specialty, divisional and Trust levels, by the Clinical Quality Monitoring Group, Care Quality Group and Board of Directors for example.

The Trust's internal auditors will also review some of the processes and mechanisms through which data is extracted and reported in the Quality Report during 2010-11 to provide further assurance. I can therefore confirm that to the best of my knowledge the information contained within this report is accurate.

Finally, the opening of the first phase of the Queen Elizabeth Hospital Birmingham in June 2010 will allow us to continuously improve the quality of care we provide in a world-class environment.

Julie Moore, June 3, 2010
Chief Executive

Part 2: Priorities for improvement and statements of assurance from the Board of Directors

2.1 Quality Improvement Priorities

The Trust's 2008-09 Quality Report set out three key priorities for improvement during 2009-10:

Priority 1:
Reducing errors
(with a particular focus on medication errors)

Priority 2:
Infection prevention and control

Priority 3:
Improve patient experience and satisfaction.

The Trust has made good progress in relation to all three quality improvement priorities during 2009-10 which is detailed further below. The Board of Directors has chosen to continue with these 3 improvement priorities for 2010-11 plus two additional ones (shown in bold) as follows:

Priority 1:
Reducing errors
(with a particular focus on medication errors)

Priority 2:
Time from prescription to administration of first antibiotic dose

Priority 3:
Venous thromboembolism (VTE) risk assessment on admission (within 24hrs)

Priority 4:
Improve patient experience and satisfaction

Priority 5:
Infection prevention and control

The improvement priorities for 2010-11 were initially selected by the Trust's Clinical Quality Monitoring Group chaired by the Executive Medical Director, following consideration of performance in relation to patient safety, patient experience and effectiveness of care. These were then shared with the Trust's Governors and the Birmingham Local Involvement Network (LINk). The focus of the patient experience priority was decided by the Care Quality Group which is chaired by the Executive Chief Nurse and also has Governor representation. The priorities for 2010-11 were then finally approved by the Board of Directors.

The performance in 2009-10 and the rationale for selection of each priority are provided in detail below. This report should be read alongside the Trust's Quality Report for 2008-09.

Priority 1: Reducing errors (with a particular focus on medication errors)

Performance

During 2008-09, the Trust developed the ability to report on the number of drugs prescribed to patients but not administered (omitted) on the Prescribing Information and Communication System (PICS). The system logs each drug administration relating to every single prescription. Baseline data for January-March 2009 showing the percentage of antibiotic and other drug doses prescribed to patients but not administered (omitted) on PICS was reported in the Trust's Quality Report for 2008-09. This data includes both drug doses which are appropriately omitted (by nursing staff making valid clinical decisions for example) and doses unintentionally omitted due to a variety of administrative reasons.

The percentage of omitted antibiotic and non-antibiotic drug doses is shown below for each month (October 2009-March 2010) and the full 2009-10 year. Whilst the Trust has reduced omitted antibiotic and non-antibiotic doses, performance remains unsatisfactory and this therefore remains a key improvement priority for 2010-11.

Drug Omissions

	Time Period							
Drug Type	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10	Mar 10	2009-10	Baseline (Jan-Mar 09)
Antibiotics	8.4%	8.2%	8.6%	7.9%	7.8%	7.7%	**8.7%**	11.2%
Non-Antibiotics	18.7%	18.1%	18.1%	17.2%	17.8%	16.5%	**18.5%**	20.1%

Initiatives implemented during 2009-10

- The recording of reasons for drug omissions was reviewed and rationalised within PICS to improve the quality of data capture and reduce inappropriate omissions.
- Pause button implemented within PICS to allow Doctors to pause prescriptions e.g., when a patient has gone to theatre and to quickly re-start them again when required.
- Monthly root cause analyses (in-depth reviews) of selected missed antibiotic dose cases by the Trust's Executive, divisional management and clinical teams began in March 2010.
- A change was implemented within PICS to enable Parkinson's drugs to be prescribed at non-standard times to improve the timeliness of administration.

Initiatives to be implemented in 2010-11

- Nurse pause function will be implemented within the Prescribing Information and Communication System to enable Nursing staff to pause prescriptions for certain drugs where clinically appropriate.
- Potential expansion of the Executive root cause analysis meetings to include other missed drugs.

How progress will be monitored, measured and reported

- Progress will continue to be measured at ward, specialty, divisional and Trust levels using information recorded in the Prescribing Information and Communication System. This includes automatic email alerts to different levels of management staff where specialty performance is outside agreed targets.
- Omitted drug doses will continue to be communicated daily to clinical staff via the Clinical Dashboard (which displays real-time quality information at ward-level) and monitored at divisional, specialty and ward levels.

- Performance will continue to be reported to the Chief Executive's Advisory Group, the Chief Operating Officer's Group and the Board of Directors each month to ensure appropriate actions are taken.
- Progress will also be reported in the quarterly Quality Report updates published on the Trust's quality web pages.

Priority 2: Time from prescription to administration of first antibiotic dose

Current Status

When treating certain conditions such as severe infections or sepsis, delays in administration of the first dose of antibiotic can result in considerable patient harm or even death. The National Patient Safety Agency released a Rapid Response Report in February 2010 which focuses on reducing harm from omitted or delayed medicines in hospital. There is evidence within the clinical literature that rapid antibiotic delivery can reduce patient harm and improve outcomes, and that the time from prescription to administration of first antibiotic dose for certain conditions should ideally be 60 minutes or less.

As outlined under Priority 1 above, the Trust is already focusing on omitted doses, and has extended this to specifically include delays in administration of first antibiotic doses. Although data on omitted doses is captured within the Prescribing Information and Communication System and timeliness of administration is an issue, it is currently difficult to assess delays. This is because some patients are prescribed antibiotics days or even weeks ahead at pre-admission clinics for example which inappropriately skews the prescription to administration time.

New initiatives to be implemented in 2010-11

- Identify clinical exception rules and refine methodology for indicator measurement.
- Establish process to undertake multi-disciplinary root cause analyses for reporting to the Executive Team.
- Provide education and training to improve communication and awareness of this issue.
- Establish baseline performance at Trust and specialty levels and identify trajectories to deliver reduction.

How progress will be monitored, measured and reported

- Performance will be measured and monitored against the Trust and specialty level trajectories (once they have been set) using PICS data and the Trust's usual reporting tools.
- Careful scrutiny of the data will also be undertaken to ensure that it does represent unintended delays.
- Progress will be monitored by the Clinical Quality Monitoring Group and reported in the quarterly Quality Report updates published on the Trust's quality web pages.

Priority 3: Venous thromboembolism (VTE) risk assessment on admission (within 24hrs)

Current Status

Venous Thromboembolism (VTE) is the term used to describe deep vein thrombosis (blood clot occurring in a deep vein, most commonly in the legs) and pulmonary embolism (where such a clot travels in the blood and lodges in the lungs) which can cause considerable harm or death. VTE is associated with periods of immobility and can largely be prevented if appropriate preventative measures are taken.

Whilst most other trusts have to rely on a paper-based assessment of the risk of VTE for individual patients, the Trust has been using an electronic risk assessment tool within the Prescribing Information and Communication System since June 2008 for all inpatient admissions. The tool provides tailored advice regarding preventative treatment based on the assessed risk. The Trust is therefore able to capture the data from all of these assessments which is shown in the table below for 2009-10:

Admission Year	Admission Month	Surgical and Non Surgical Combined	Postponed	Not Required	Surgical and Non Surgical assessments done within 24 hours of admission as a percentage of all assessments
2009	April	86.24%	6.06%	7.70%	73.52%
	May	86.95%	4.73%	8.32%	73.75%
	June	89.32%	5.06%	5.62%	75.00%
	July	86.83%	7.30%	5.87%	73.58%
	August	82.10%	9.52%	8.38%	69.42%
	September	81.63%	12.20%	6.17%	69.66%
	October	84.67%	8.24%	7.09%	72.89%
	November	84.71%	7.86%	7.43%	72.09%
	December	85.87%	8.20%	5.93%	72.89%
2009 Total		**85.35%**	**7.71%**	**6.94%**	**72.53%**
2010	January	84.63%	9.10%	6.26%	72.95%
	February	84.92%	8.69%	6.39%	73.66%
	March	84.97%	8.88%	6.15%	77.81%
2010 Total		**84.83%**	**8.90%**	**6.27%**	**74.64%**

Providing such tailored advice depends upon the level of information capture at admission, for example whether the patient is surgical or non-surgical where the preventative measures may be different. We also recognise that in some circumstances not all of the patient-specific information may be available immediately on admission (e.g., for unconscious or critically ill patients) and therefore other clinical priorities determine that the risk assessment may be postponed. In rare cases a risk assessment may not be required, such as for a patient who is being investigated for a VTE when treatment rather than prevention is required.

Considerable national attention has been given to this subject over the past few months by the Department of Health and the National Institute for Health and Clinical Excellence (NICE) which published new guidance in January 2010. Ensuring that 90% of all patients have a full VTE risk assessment completed within 24 hours of admission by the end of 2010-11 is now a mandatory, national Commissioning for Innovation and Quality (CQUIN) indicator which the Trust has agreed with NHS South Birmingham for 2010-11.

Initiatives implemented during 2009-10

- Automatic Doctor prompts at 24 hours for postponed risk assessments.
- Automatic reminders if preventative medication is not given despite advice from the assessment tool.
- Where elastic compression stockings are recommended for surgical patients, these are now automatically prescribed within PICS.

New initiatives to be implemented in 2010-11

- In the plans to update the risk assessment process in line with NICE recommendations, the option of 'not required' will be removed. An initial screening question will be used in the assessment tool instead that will determine for the clinician if a full risk assessment is actually not required (for example for a short stay patient who is likely to remain fully mobile).
- The electronic risk assessment tool will need to be implemented for day-case patients too.

How progress will be monitored, measured and reported

- Performance will be measured using PICS VTE risk assessment data and tracked against the year-end target.
- The Trust's Thrombosis Group working closely with the PICS team will be responsible for providing education and feedback about performance throughout the Trust.
- Performance will be monitored by the Trust's Clinical Quality Monitoring Group and the Board of Directors.
- Progress will also be reported in the quarterly Quality Report updates published on the Trust's quality web pages.

Priority 4: Improve patient experience and satisfaction

Performance

Ten times as many patients responded to the electronic patient survey during 2009-10 compared to 2008-09, providing a wealth of information about their experience:

Feedback method	2009-10	2008-09
Bedside TV	5,860	1,100
Hand-held devices	3,810	N/a
Discharge lounge	712	N/a
Total	**10,382**	**1,100**

The survey results show that the Trust has improved patient experience and satisfaction across all five aspects of care during 2009-10:

Electronic real-time patient survey responses

	Time period		
Survey Questions		2009-10	2008-09
Dignity and respect	Percentage of patients who said they were always treated with dignity and respect	86.9%	67.2%
	Percentage of patients who said they were always or sometimes treated with dignity and respect	98.6%	92.8%
Privacy	Percentage of patients who said their privacy was always maintained whilst being examined or treated	92.5%	78.0%
	Percentage of patients who said their privacy was always or sometimes maintained whilst being examined or treated	98.7%	94.0%
Involvement in decisions	Percentage of patients who said they were always involved in decisions about their care and treatment	70.6%	47.0%
	Percentage of patients who said they were always involved, or involved to some extent, in decisions about their care and treatment	93.6%	83.9%
Cleanliness of hospital and ward	Percentage of patients who rated the hospital and ward as very clean	70.3%	45.7%
	Percentage of patients who rated the hospital and ward as very clean or fairly clean	97.7%	90.3%
Overall rating of care	Percentage of patients who rated their overall care as very good or excellent	84.9%	61.9%
	Percentage of patients who rated their overall care as good, very good or excellent	95.2%	79.4%

The Trust's National Adult Inpatient Survey results for 2009 are shown in Part 3 of this report.

Complaints

In 2009-10, there was a 5.6% increase in the number of complaints received by the Trust compared to the previous year, although the ratio of complaints to inpatient activity has actually dropped.

	2009-10	2008-09
Total number of complaints	643	609
Response within deadline	92.2%	88%
Referrals for independent review by referral date	27	6
Referrals for independent review by complaint date	6	4

Top 3 Complaint categories	2009-10	2008-09
Main category		
1. Clinical treatment	272	254
2. Out-patient appointment delay/cancellation	109	97
3. Communication/information	76	69
All issues		
1. Clinical treatment	595	732
2. Communication/information	315	408
3. Attitude of Staff	150	103

Ratio of Complaints to Activity

		2009-10	2008-09
Inpatients	FCEs*	124,589	121,653
	Complaints	277	294
	Rate per 1000 FCEs*	**2.22**	**2.42**
Outpatients	Attendances**	499,981	454,514
	Complaints	309	263
	Rate per 1000 appointments	**0.62**	**0.58**
A&E	Attendances	82,632	83,051
	Complaints	57	52
	Rate per 1000 attendances	**0.69**	**0.63**

*FCE = finished consultant episode which denotes the time spent by a patient under the continuous care of a consultant.
** The Outpatients activity data for 2009-10 and 2008-09 relates to attendances only and also includes Therapy Outpatients data (physiotherapy, podiatry, dietetics, speech and language therapy and occupational therapy).

Compliments

Compliments are recorded by the Patient Advice and Liaison Service (PALS) on behalf of the Trust. The majority of compliments are received in writing – by letter, email or feedback leaflet – and the rest are received verbally via telephone or face to face.

The number of compliments recorded has risen significantly during 2009-10. The majority relate to treatment received although an increasing amount specifically mention medical or nursing care and friendliness of staff:

Compliments Subtype	Number Received in 2009-10	Number Received in 2008-09
Treatment received	132	141
Nursing care	85	10
Friendliness of staff	75	26
Efficiency of service	36	8
Medical care	20	7
Other	4	2
Facilities	4	11
Information provided	3	0
Comment	0	1
Totals:	**359**	**206***

* The number of compliments received in 2008-09 has increased slightly from that shown in the Trust's 2008-09 Quality Report due to some being received after year end which reflect care/treatment provided during 2008-09. Some of the 2008-09 compliments have also been re-categorised to provide more meaningful data e.g., moved from 'Treatment received' to a more specific category such as 'Nursing Care'.

Initiatives implemented during 2009-10

- Patient survey responses were uploaded every twelve hours onto the Clinical Dashboard for each ward, providing real-time feedback to wards to enable them to address any issues quickly. The Executive Chief Nurse and Associate Directors of Nursing have been alerted to the excellent and poor responses from patients.
- Patient experience surveys are currently being piloted in the Ophthalmology Outpatient Department using hand-held electronic tablets.
- A follow-up telephone survey has been developed for use with patients on discharge and staff have been recruited to conduct the surveys.
- The Patient Experience Analyst commenced in post at the end of August 2009 and provides a weekly patient feedback report to Divisions and a detailed quarterly report to the Care Quality Group.

Improving patient experience and satisfaction in 2010-11

The Trust has chosen to focus on measuring, monitoring and improving performance for the following National Adult Inpatient Survey questions during 2010-11:

- Involvement in decisions about treatment/care
- Hospital staff available to talk about worries/ concerns
- Privacy when discussing condition/treatment
- Informed about medication side effects
- Informed who to contact if worried about condition after leaving hospital
- Did staff do all they could to control pain?

These questions have been selected by the Trust's Care Quality Group which has Governor representation. They also include those covered by the nationally mandated Commissioning for Quality and Innovation (CQUIN) indicator for 2010-11.

New initiatives to be implemented in 2010-11

- Implement telephone survey and roll out survey used in Ophthalmology to other Outpatient areas.
- Use of an electronic stand in the Emergency Department to gain feedback from ambulatory patients.
- Development of a comprehensive Divisional report that brings together all elements of patient feedback, including survey responses, Patient Advice and Liaison Service (PALS) contacts, complaints, comments and compliments.
- Analysis of data via demographic information to identify the experience of patients from a range of diverse backgrounds to identify potential areas of inequity.

How progress will be monitored, measured and reported

- Feedback rates and responses will continue to be measured and communicated via the Clinical Dashboard.
- Performance will continue to be monitored as part of the Back to the Floor visits by the senior nursing team with action plans developed as required.
- Regular patient feedback reports will be provided to the Patient Experience Group, Care Quality Group and the Board of Directors.
- Progress will also be reported in the quarterly Quality Report updates published on the Trust's quality web pages.

Priority 5:
Infection prevention and control

Performance

2009-10 has been another excellent year with the numbers of both MRSA bloodstream infections and *C.difficile* cases halving compared with 2008-09 and well below the agreed trajectories:

	Time Period					
Infection Type	2009-10	Agreed Trajectory for 2009-10	2008-09	Agreed Trajectory for 2008-09	2007-08	Agreed Trajectory for 2007-08
C. difficile (post-48 hour cases)	178	348	357	526	658	N/a
MRSA bloodstream infections	13	30	35	48	76	48

Both of these organisms remain a high priority during 2010-11 as new trajectories come into play requiring even greater reductions. The Trust will need to reduce the number of MRSA bloodstream infections to 11 and *C.difficile* to 13 cases or fewer per month during 2010-11. C.difficile remains the greatest challenge due to the need to maintain a consistent performance across the year.

Initiatives implemented during 2009-10

- The Trust has continued to make good progress on the management of the High Impact Interventions and now completes root cause analyses for all MRSA blood stream infections and C.difficile cases, ensuring that learning is gained from each case.
- A high pressure wash decontamination unit has been implemented within the Trust, which has been associated with an overall reduction in MRSA bacteraemia and C diff cases during the past year. This will also be implemented in the new hospital.
- The National Patient Safety Agency (NPSA) Matching Michigan patient safety project commenced on 1 December 2009. Since 15 December 2009, UHB has been submitting monthly data to the NPSA from all four Intensive Care Units on bloodstream infections linked to the use of central venous catheters (CVCs).

Initiatives to be implemented in 2010-11

- Enhanced cleaning with vapour decontamination used as part of the standard terminal clean in the new hospital.
- Expansion of MRSA screening to include all admissions, including emergencies, and follow through to decolonisation in the community.
- Strengthening the use of learning outcomes from the root cause analyses for MRSA bacteraemia and C.difficile.
- Use of routine surveillance to identify those organisms which will be future priorities for reduction.

How progress will be monitored, measured and reported

- The number of MRSA and C.difficile cases will be measured and monitored against the 2010-11 trajectories.
- Performance will be monitored daily via the Clinical Dashboard and daily/weekly email alerts.
- All MRSA bloodstream infections will continue to be reported as serious incidents requiring investigation (SIRIs) to NHS South Birmingham.
- Monthly root cause analyses will continue to be undertaken for MRSA bloodstream infections and C.difficile outbreaks.
- Progress will also be reported in the quarterly Quality Report updates published on the Trust's quality web pages.
- Performance will be reported monthly to the Trust's Infection Prevention and Control Committee and the Board of Directors.

2.2 Statements of assurance

2.2.1 Information on the review of services

During 2009/10 the University Hospitals Birmingham NHS Foundation Trust* provided and/or sub-contracted 61 NHS services.

The Trust has reviewed all the data available to them on the quality of care in 61 of these NHS services**.

The income generated by the NHS services reviewed in 2009/10 represents 100% per cent of the total income generated from the provision of NHS services by the Trust for 2009/10.

* University Hospitals Birmingham NHS Foundation Trust will be referred to as the Trust/UHB in the rest of the report.

** The Trust has appropriately reviewed the data available on the quality of care for all its services. Due to the sheer volume of electronic data the Trust holds in various information systems, this means that UHB uses automated systems and processes to prioritise which data on the quality of care should be reviewed and reported on. These are described further in Part 3 of this report.
Data is reviewed and acted upon by clinical and managerial staff at specialty, divisional and Trust levels by various groups including the Clinical Quality Monitoring Group chaired by the Executive Medical Director.

2.2.2 Information on participation in clinical audits and national confidential enquiries

During 2009/10 36 national clinical audits and 3 national confidential enquiries covered NHS services that UHB provides.

During 2009/10 UHB participated in 83% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that UHB was eligible to participate in during 2009/10 are as follows: (see following table)

The national clinical audits and national confidential enquiries that UHB participated in during 2009/10 are as follows: (see table following)

The national clinical audits and national confidential enquiries that UHB participated in, and for which data collection was completed during 2009/10, are listed in the following table alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (see following table).

Audit Type	Audit UHB eligible to participate in	UHB Participation 2009-10	Percentage of required number of cases submitted
Part of the National Clinical Audit and Patient Outcomes Programme	Adult cardiac interventions (eg, angioplasty)	Yes	100%
	Adult cardiac surgery	Yes	100%
	Bowel Cancer (NBOCAP)	Yes	63.90%
	Cardiac Ambulance Services	Yes	N/A – specific number not required
	Cardiac rhythm management (Pacing/ Implantable Defibrillators)	Yes	100%
	Congenital heart disease (children and adults)	Yes	N/A - data entry deadline May 2010
	Continence	Yes	100%
	Head & neck cancer (DAHNO)	Yes	Not available
	Heart failure	Yes	N/A – data entry deadline May 2010
	Hip Fracture	Yes	Not available
	Lung cancer (LUCADA)	Yes	92%
	Mastectomy & Breast Reconstruction	Yes	66%
	Myocardial Ischaemia (MINAP)	Yes	N/A – specific number not required
	National Carotid Interventions Audit	Yes	Not available
	National Diabetes Audit	Yes	99%
	National Kidney Care - vascular access	No – planning to participate during 2010	-
	National Pain Audit	Yes	N/A – specific number not required
	National Stroke Audit - organisational audit	Yes	N/A – specific number not required
	Oesophago-gastric (stomach) cancer	Yes	100%

Audit Type	Audit UHB eligible to participate in	UHB Participation 2009-10	Percentage of required number of cases submitted
Not part of the National Clinical Audit and Patient Outcomes Programme	Adult Critical Care (ICNARC) - Case Mix Programme	Yes for 2 of the 4 ITUs (Intensive Care Units)	100% for 2 units
	British Thoracic Society - Adult Community Acquired Pneumonia	Yes	N/A - data entry deadline May 2010
	British Thoracic Society - NIV (Non-invasive ventilation) (Adult)	Yes	N/A - data entry deadline May 2010
	British Thoracic Society - Adult Asthma	No	-
	British Thoracic Society - Emergency Oxygen	No	-
	National Comparative Audit of Blood Transfusion - Audit of Blood Collection	Yes	100%
	National Elective Surgery PROMs* - hernia	Yes	55%
	National Elective Surgery PROMs* - varicose veins	Yes	38%
	College of Emergency Medicine - Pain in children	No	-
	College of Emergency Medicine - Hip Fracture	Yes	70%
	College of Emergency Medicine - Severe and Moderate Asthma	No	-
	Potential donor audit	Yes	100%
	Renal Registry	Yes	100%
	Renal Transplant	Yes	N/A – specific number not required
	Severe Trauma	No, data for 09-10 to be entered	-
	UK Cardiothoracic Transplant Audit	Yes	100%
	UK Liver Transplant Audit	Yes	100%

* PROMs = Patient Reported Outcome Measures

National Confidential Enquiries (NCEPOD)

National Confidential Enquiries (NCEPOD)	UHB Participation 09/10	Percentage of required number of cases submitted
Peri-Operative Study	Yes	47%
Emergency and Elective Surgery in the Elderly	Yes	Casenotes 100% Surgical Questionnaires 100% Anaesthetic Questionnaires 43%
Parenteral nutrition	Yes	73%

Percentages given are latest available figures. 'Not available' indicates that data has been submitted but the number of cases submitted as a percentage of the number of required cases is not available. This could be because the Trust is awaiting confirmation of percentage by the national body or the precise number of required cases is not available.

UHB's audit strategy has been to prioritise support for participation in the national audits included in the National Clinical Audit and Patient Outcomes Programme (NCAPOP), as agreed by the Clinical Audit and Effectiveness Committee, which directs audit priorities in the Trust. The NCAPOP consists of a series of audits commissioned and managed by the Healthcare Quality Improvement Partnership (HQIP), under the guidance of the National Clinical Audit Advisory Group (NCAAG), and funded by the Department of Health. Not all of the audits listed above provide reports or recommendations back to the Trust. UHB is currently reviewing and prioritising its audit strategy for 2010-11 to reflect clinical priorities and available resources.

The Trust's Clinical Governance Support Unit facilitates the reporting and monitoring of Trust participation in national audits and actions taken in accordance with recommendations of national audit reports. This activity is reported to the Clinical Audit and Effectiveness Committee and the Clinical Quality Monitoring Group which directs action to improve the quality of care. Exceptions are also reported to the Trust's Audit Committee.

The reports of 15 national clinical audits were reviewed by the provider in 2009/10 and UHB intends to take the following actions to improve the quality of healthcare provided:

Audit reports reviewed	Actions
Adult cardiac surgery	UHB demonstrated compliance with national recommendations and showed activity, surgical results and quality of care in line with the national data submitted around the country.
Adult Critical Care (ICNARC) - Case Mix Programme	The data is used for regular review of mortality rates, benchmarking and comparison against similar units and local audit and research projects.
Cardiac Ambulance Services	UHB is supporting ambulance services to make improvements by sharing information about the outcomes for patients having a heart attack, collected via the Myocardial Infarction National Audit Project (MINAP). The Ambulance outcomes audit aims to share MINAP data with the Ambulance Trusts by linking the ambulance job number with the relevant MINAP entry.
Congenital heart disease (children and adults)	UHB is working with the Birmingham Children's Hospital to ensure all the documentation for the surgical record contains the following information the NHS number, date of discharge, and mode of discharge. The action points following the recommendations of the inclusion of perfusion records in the patient notes are to be discussed.
Head & neck cancer (DAHNO)	The interval from biopsy to reporting should be less than 10 days; UHB achieved 92%. An audit has been carried out which has shown an improvement in waiting times. This will continue to be monitored.
Lung cancer (LUCADA)	Trust considered to meet all recommendations
Mastectomy & Breast Reconstruction	Trust considered to meet all recommendations
Myocardial Ischaemia (MINAP)	Improving primary angioplasty performance within 150 minutes reported at 73%. For patient quality improvement UHB has introduced 24/7 primary angioplasty. The facilities for primary Percutaneous Coronary Intervention (pPCI) are on a separate site to the A&E department. To improve on this figure close links with the ambulance service have been made so that crews can alert teams directly to activate the pPCI pathway more promptly, particularly during out of hours. A change to our system of pPCI activation is being introduced. All patients will be brought directly to the Percutaneous Coronary Intervention (PCI) site (QE cath labs) irrespective of time of presentation. If out of hours, the ambulance team have agreed to stay with the patient until the pPCI team arrive. This should avoid the additional delay caused by an out of hours inter hospital transfer. For those patients who do not get admitted to a cardiac facility a clinical pathway is in place that ensures all patients who are found to have a raised troponin are referred to the cardiologist.

Audit reports reviewed	Actions
National Falls and Bone Health in Older People	Improvements have been made to services for hip fracture patients. For example a trauma 'navigator' role has been put in place to speed up the whole patient journey including admission to theatre, new theatre sessions have been made available and where possible patients are cohorted together on one ward. Length of stay and mortality are regularly monitored.
National Kidney Care - Patient Transport Survey Report	The regional network in the West Midlands have put together a regional group. The first meeting of the Regional Transport Group will take place in April 2010. Each satellite unit has also set up regular meetings every two months with the transport department to discuss any issues, improvements etc. Each satellite unit is also working to set up a patient group.
National Stroke Audit	Improvements have been made to stroke services, such as direct admissions to the Acute Stroke Unit; re-design of Stroke Coordinator role; early multidisciplinary therapy assessments and patient centred goals; improved team communication about patients; improved written documentation of care and regular feedback sessions to all staff. Data on key indicators of quality is collected on an ongoing basis in order to monitor performance.
Renal Registry	Trust considered to meet all recommendations
Renal Transplant	Trust considered to meet all recommendations
Severe Trauma	Creation of an administrative post to assist with audit is in discussion. Specific cases highlighted to consultants for review - consultants to review major cases.
UK Cardiothoracic Transplant Audit	The audit reports centre-specific and total national data on outcomes for heart and lung transplantation in the UK. The unit was fully compliant with data collection and outcomes were comparable with other centres. No action points were raised specifically requiring this units attention apart from the need for continuous monitoring.

At UHB a wide range of local clinical audit is undertaken in clinical specialties and across the Trust. These may be highly specialised audits examining whether treatments or services for specific medical conditions, such as diabetes, are meeting standards of best practice; or they may be broader audits of particular aspects of services, such as monitoring staff compliance with infection control protocols or checking that standards of documentation are being met. A total of 677 clinical audits were registered with UHB's clinical audit team as having commenced or been completed at UHB during 2009-10.

The reports of 280 local clinical audits were reviewed by the provider in 2009/10 and UHB intends to take the following actions to improve the quality of healthcare provided:

This figure indicates that the results of 280 clinical audits were reported and fed back to staff within clinical areas and those reports were submitted to UHB's clinical audit team. At UHB, staff undertaking clinical audit are required to report any actions that should be implemented to improve service delivery and clinical quality. A list of examples of specific actions reported can be viewed on the Quality web pages: http://www.uhb.nhs.uk/quality.htm These include measures such as: updating patient information; developing new protocols or guidelines for staff; increasing

staff awareness of required standards through training or education sessions; making changes to staff roles; implementing new care plans or assessment tools for patients; and purchasing equipment.

Each clinical specialty at UHB is required to plan a programme of audit for the year ahead, based on national audit priorities, areas of risk and locally determined priorities.

2.2.3 Patient participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by UHB that were recruited during that period to participate in research approved by a research ethics committee was 5271.

This data reflects active research studies during 2009-10, some of which were initiated prior to April 2009. The level of patient recruitment has therefore been averaged across the duration of each study to identify patient recruitment for 2009-10.

2.2.4 Use of the Commissioning for Quality and Innovation (CQUIN) payment framework

A proportion of UHB's income in 2009/10 was conditional upon achieving quality improvement and innovation goals agreed between UHB and NHS South Birmingham, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2009/10 and for the following 12 month period are available on request from the Communications Team (Tel: 0121 627 2023 or email Communications@uhb.nhs.uk). This information is also listed on the Trust's quality web pages: http://www.uhb.nhs.uk/quality.htm

The amount of UHB's income in 2009/10 which was conditional upon achieving quality improvement and innovation goals was £1.85m and the Trust received £1.85m in payment.

This figure has been arrived at as a percentage of the healthcare income which will be included within the Trust's 2009-10 accounts and does not represent actual outturn (as an estimate has to be included for Month 12 income). The actual figure will not be known until June 2010 when we will have a final position as reconciled with the CBSA. Also whilst we have received payment throughout the year as each month has been agreed with CBSA, final payment of CQUIN will not take place until the June 2010 reconciliation point.

2.2.5 Care Quality Commission (CQC) registration status and periodic/ special reviews

UHB is required to register with the Care Quality Commission and its current registration status is registered without compliance conditions. UHB has the following conditions on registration: provider conditions only which stipulate that the regulated activities the Trust has registered for may only be undertaken at Queen Elizabeth Medical Centre and Selly Oak Hospital.

The Care Quality Commission has not taken enforcement action against UHB during 2009/10.

UHB is subject to periodic review by the Care Quality Commission and the last review was on 13 October 2009 (date of publication of the Annual Health Check scores for 2008-09). The CQC's assessment of the Trust following that review was Excellent for Quality of Services and Excellent for Quality of Financial Management.

UHB intends to take the following actions to address the points made in the CQC's assessment:

The Trust underachieved on the national priority performance indicator for stroke care based on the results of the 2008 National Sentinel Stroke Audit and has invested funding to improve the service. Key quality indicators for stroke patients, such as brain scan with 24 hours, are now monitored on an ongoing basis and action is taken to improve service as required. Quarterly audits are also undertaken and reported internally and to the Primary

Care Trust. The Trust will participate in the next national sentinel stroke audit in 2010.

Stroke indicators are reviewed monthly at the Clinical Quality Monitoring Group, chaired by the Executive Medical Director; and stroke data is part of the Trust's performance review process. There is also a Stroke Clinical Development multi-disciplinary team (MDT) group which meets on a monthly basis to review and implement actions required to improve the service.

UHB has made the following progress by 31 March 2010 in taking such action: the actions listed above were all in place by 31 March 2010.

UHB has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2009/10: Hygiene Code inspection on 22 October 2009. UHB intends to take the following action to address the conclusions or requirements reported by the CQC: no action required.

UHB has made the following progress by 31 March 2010 in taking such action: no action required.

The Trust received a letter from the Care Quality Commission in September 2009 about being a potential outlier in May 2009 in mortality for the primary diagnosis group 'Fluid and Electrolyte Disorders'. The Trust carried out a rigorous assessment of the mortality relating to this specific group of patients and found that the increased mortality rate was due to low activity and the complexity of patients treated. A review of the case notes for this group of patients was also undertaken to provide additional assurance; the Trust is satisfied that the care provided was appropriate.

2.2.6 Information on data quality

UHB submitted records during 2009/10 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS Number was: 97.1% for admitted patient care; 97.7% for outpatient care; and 89.9% for accident and emergency care.
- which included the patient's valid General Practitioner Registration Code was: 100% for admitted patient care; 100% for outpatient care; and 100% for accident and emergency care.

The percentages above have been calculated using the latest available published Secondary Uses Service data (April 2009-January 2010) and the data which UHB has submitted to SUS for February-March 2010 which is not yet published.

UHB's score for 2009/10 for Information Quality and Records Management, assessed using the Information Governance Toolkit was 76%.

UHB was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

Primary Diagnoses Incorrect 4.3%
Secondary Diagnoses Incorrect 3.8%
Primary Procedures Incorrect 8.6%
Secondary Procedures Incorrect 4.7%

The results should not be extrapolated further than the actual sample audited; General Medicine and Ear, Nose and Throat (ENT) were reviewed within the sample.

Part 3: Other information

3.1 Overview of quality of care provided during 2009-10

The tables below show the Trust's performance in 2009-10 and 2008-09 for a selection of indicators for patient safety, clinical effectiveness and patient experience. The Board of Directors has chosen to include the same selection of indicators as reported in the Trust's 2008-09 Quality Report to enable patients and the public to judge performance over time.

The patient safety and clinical effectiveness indicators were originally selected by the Clinical Quality Monitoring Group because they represent a balanced picture of quality at UHB. The patient experience indicators were selected in consultation with the Care Quality Group which has Governor representation to enable comparison with other NHS trusts.

The latest available data is shown below and has been subject to the Trust's usual data quality checks by the Health Informatics team. Benchmarking data has also been included where possible. Performance has been monitored and challenged during the past year by the Clinical Quality Monitoring Group and the Board of Directors. In addition, the Trust has reported on performance against these indicators during the past year in the Quality Report updates published on its quality web pages: http://www.uhb.nhs.uk/quality.htm

3.2 Performance of Trust against selected indicators

Indicators	2009-10	Peer Group Average (where available)	2008-09*
Patient safety indicators			
1(a). MRSA: Patients with MRSA infection/10,000 bed days (includes all bed days from all specialties) *Lower rate indicates better performance*	0.42	0.39	1.15
Time period	2009-10	2009-10	2008-09
Data source	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	HPA Website
Peer group		Acute trusts in West Midlands SHA	

Indicators	2009-10	Peer Group Average (where available)	2008-09*
1(b). MRSA: Patients with MRSA infection/10,000 bed days (aged >15, excluding Obstetrics Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	**0.43**	**0.45**	**1.18**
Time period	2009-10	2009-10	2008-09
Data source	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	HPA (MRSA data), HES data (bed days)
Peer group		Acute trusts in West Midlands SHA	
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*	**0.53**	**0.38**	**1.62**
Time period	2009-10	2009-10	2008-09
Data source	Trust C.diff data reported to HPA, HES data (bed days)	Trust C.diff data reported to HPA, HES data (bed days)	HPA Website
Peer group		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*	**0.55**	**0.44**	**1.66**
Time period	2009-10	2009-10	2008-09
Data source	Trust C.diff data reported to HPA, HES data (bed days)	Trust C.diff data reported to HPA, HES data (bed days)	HPA (C.diff data), HES data (Bed days)
Peer group		Acute trusts in West Midlands SHA	

Indicators	2009-10	Peer Group Average (where available)	2008-09*
3. Patient safety incidents (reporting rate per 100 admissions) *Higher rate indicates better reporting*	**8.5**	**5.8**	**10.2**
Time period	2009-10	April-September 2009	2008-09
Data source	Datix (incident data), Trust admissions data	National Patient Safety Agency	Datix (incident data), Trust admissions data
Peer group		Acute teaching trusts in West Midlands SHA	
4. Percentage of patient safety incidents which are no harm incidents *Higher % indicates better performance*	**86.6%**	**69.6%**	**89%**
Time period	2009-10	April-September 2009	2008-09
Data source	Datix (incident data)	National Patient Safety Agency	Datix (incident data)
Peer group		Acute teaching trusts in West Midlands SHA	
Clinical effectiveness indicators			
5(a). Readmissions: Readmission rate (Medical and surgical specialties - elective and emergency admissions aged >15)% *Lower % indicates better performance*	**7.59%**	**7.14%**	**8.5%**
Time period	April-Dec 09	April-Dec 09	2008-09
Data source	HES data	HES data	HES data
Peer group		University hospitals	
5(b). Readmissions: Readmission rate (all specialties) % *Lower % indicates better performance*	**7.69%**	**6.33%**	**8.57%**
Time period	April-Dec 09	April-Dec 09	2008-09
Data source	HES data	HES data	HES data
Peer group		University hospitals	

Indicators	2009-10	Peer Group Average (where available)	2008-09*
6. Falls (incidents reported as % of elective and emergency admissions) *Lower % indicates better performance*	**1.97%**	**Not available**	**1.99%**
Time period	2009-10		2008-09
Data source	Datix (incident data), Trust admissions data		Datix (incident data), Trust admissions data
7. Percentage of stroke patients (infarction) on aspirin, clopidogrel or warfarin *Higher % indicates better performance*	**99.7%**	**99.7%**	**98%**
Time period	2009-10	2008 Calendar year	2008-09
Data source	Trust PICS data	Cleveland Clinic website	Trust PICS data
Peer group		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*	**93.3%**	**88%** NB This data is for all surgery patients with heart conditions who were on betablockers	**86.6%**
Time period	2009-10	Jan-Jun 09	2008-09
Data source	Trust PICS data	Cleveland Clinic website	Trust PICS data
Peer group		Cleveland Clinic, Ohio, U.S.A.	

* The data presented for 2008-09 is the latest available and therefore updates some of the data reported in the Trust's 2008-09 Quality Report.

Notes on clinical outcome measures

The data shown is subject to standard national definitions where appropriate. The Trust has also chosen to include infection and readmissions data which has been corrected to reflect specialty activity, taking into account that the Trust does not undertake paediatric, obstetric, gynaecology or elective orthopaedic activity. These specialties are known to be very low risk in terms of hospital acquired infection for example and therefore excluding them from the denominator (bed day) data enables a more accurate comparison to be made with peers.

6: The admissions data for 2009-10 and 2008-09 includes daycase patients as well as all elective and emergency admissions.

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.

Any patients who are identified as not having been given aspirin, clopidogrel or warfarin during their stay are followed up to ensure they have been discharged on these drugs if clinically appropriate. 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. This indicator relates to patients already on beta blockers and whether they are given beta blockers on the day of their operation. All incidences of beta blockers not being given on the day of operation are investigated to understand the reasons why and to reduce the likelihood of future omissions.

We have chosen to measure our performance against the following metrics	2009-10	Comparison with other NHS trusts 2009-10	2008-09	Comparison with other NHS trusts 2008-09	2007-08	Comparison with other NHS trusts 2007-08
Patient experience indicators						
9. Overall were you treated with respect and dignity Time period & data source	**89** Trust's 2009 Inpatient Survey Report, Care Quality Commission	**Intermediate 60% of trusts**	**88** Trust's 2008 Inpatient Survey Report, Care Quality Commission	**Intermediate 60% of trusts**	**89** Trust's 2007 Inpatient Survey Report, Healthcare Commission	**Intermediate 60% of trusts**
10. Involve-ment in decisions about care and treatment Time period & data source	**70** Trust's 2009 Inpatient Survey Report, Care Quality Commission	**Intermediate 60% of trusts**	**70** Trust's 2008 Inpatient Survey Report, Care Quality Commission	**Intermediate 60% of trusts**	**67** Trust's 2007 Inpatient Survey Report, Healthcare Commission	**Worst performing 20% of trusts**
11. Did staff do all they could to control pain Time period & data source	**80** Trust's 2009 Inpatient Survey Report, Care Quality Commission	**Worst performing 20% of trusts**	**85** Trust's 2008 Inpatient Survey Report, Care Quality Commission	**Intermediate 60% of trusts**	**84** Trust's 2007 Inpatient Survey Report, Healthcare Commission	**Intermediate 60% of trusts**
12. Clean-liness of room or ward Time period & data source	**84** Trust's 2009 Inpatient Survey Report, Care Quality Commission	**Worst performing 20% of trusts**	**83** Trust's 2008 Inpatient Survey Report, Care Quality Commission	**Intermediate 60% of trusts**	**80** Trust's 2007 Inpatient Survey Report, Healthcare Commission	**Intermediate 60% of trusts**
13. Overall rating of care Time period & data source	**78** Trust's 2009 Inpatient Survey Report, Care Quality Commission	**Intermediate 60% of trusts**	**78** Trust's 2008 Inpatient Survey Report, Care Quality Commission	**Intermediate 60% of trusts**	**79** Trust's 2007 Inpatient Survey Report, Healthcare Commission	**Intermediate 60% of trusts**

Notes on patient experience measures

9-13: The scores included in the previous table 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.

3.3 Performance against key national priorities and Core Standards

Key national priorities and Core Standards	Time Period for 2009/10	2009-10	2009-10 Target	2008-09	2008-09 Target
The Trust has fully met the core standards	Apr 2009 – Mar 2010	44	44	44	44
Clostridium difficile year on year reduction (post-48 hour cases)	Apr 2009 – Mar 2010	178	348	357	526
MRSA – maintaining the annual number of MRSA bloodstream infections at less than half the 2003/04 level	Apr 2009 – Mar 2010	13	30	35	48
62-day wait for first treatment from urgent GP referral: all cancers[1]	Apr 2009 – Mar 2010	85.12%[2]	85.0%	82.7% (Jan - Mar 09)	85%
62-day wait for first treatment from consultant screening service referral: all cancers[1]	Apr 2009 – Mar 2010	92.6%	90.0%	94.4% (Jan - Mar 09)	90%
31-day wait from diagnosis to first treatment: all cancers[1]	Apr 2009 – Mar 2010	97.4%	96.0%	96.7% (Jan - Mar 09)	96%
31-day wait for second or subsequent treatment: surgery[1]	Apr 2009 – Mar 2010	96.6%	94.0%	95.3% (Jan - Mar 09)	94%
31-day wait for second or subsequent treatment: anti cancer drug treatments[1]	Apr 2009 – Mar 2010	99.1%	98.0%	98.4% (Jan - Mar 09)	98%
Two week wait from referral to date first seen: all cancers[1]	Apr 2009 – Mar 2010	94.6%	93.0%	92.8% (Jan - Mar 09)	93%
18-week maximum wait from point of referral to treatment (admitted patients)	Apr 2009 – Mar 2010	95.4%	90.0%	95.0% (Jan - Mar 09)	90%
18-week maximum wait from point of referral to treatment (non-admitted patients)	Apr 2009 – Mar 2010	98.1%	95.0%	97.3% (Jan - Mar 09)	95%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge[3]	Apr 2009 – Mar 2010	98.5%	98.0%	98.1%	98%
People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack)	N/A	No longer a target as Trust will have fewer than 20 cases in 2009/10.		75%	68%
Screening all elective in-patients for MRSA[4]	Apr 2009 – Mar 2010	121.4%	100%	135.3% (Jan - Mar 09)	100%

1 The national targets for cancer were changed from 1 January 2010 so the Trust's performance for 2008-09 now uses the new definitions to aid comparison.
2 The Trust is still awaiting final confirmation of the percentage achieved for 2009-10.
3 Data includes patients who attended South Birmingham GP Walk In Centre (Katie Road) from July 2009.
4 Some patients are screened more than once for MRSA.

The Trust has signed a contract with West Midlands Strategic Health Authority (SHA) to form a Quality Institute with the University of Birmingham to help provide support to the regional Quality Observatory. UHB has also mapped NHS diagnostic and procedural coding structures to those used in the U.S.A. which means we will be able to directly compare patient care provided at UHB with that provided by U.S.A. hospitals in the future.

3.4 Specialty Quality Indicators

The Trust's Quality and Outcomes Research Unit (QuORU) was set up in 2008-09. The unit has linked a wide range of information systems together to enable all important elements of service delivery to be analysed and monitored in a sophisticated way. In 2009-10, the unit has focused on supporting clinical teams to develop useful and innovative quality indicators to use within their specialties to monitor and improve patient care, experience and outcomes. Clinical staff have proposed a huge number of specialty quality indicators across the three domains of quality – patient safety, clinical effectiveness and patient experience – which are at various stages of development:

Indicator Development Stage	Number of Indicators
Stage 3: Metric signed off by QuORU Board as an appropriate measure of quality	88
Stage 2: Data shared with clinical staff concerned for validation and refinement of methodology as necessary.	18
Stage 1: Health Informatics and clinical staff meet to understand the proposed indicator, check whether the data is recorded and can be extracted and to verify it makes sense.	57
In preliminary discussion	158
Total	**321**

The following table shows performance at a specialty level for a wide selection of the quality indicators developed by clinicians, Health Informatics and the Trust's Quality and Outcomes Research Unit. Performance is shown for 2009-10 and 2008-09 where possible (some of the data has only started to be recorded during 2009-10) and benchmarking data is also provided where possible. In line with the Trust's commitment to transparency, the data shown is not just limited to good performance; areas where performance can be improved will be taken forward by the specialties concerned during 2010-11. The methodology and data for all indicators have been checked and validated by the appropriate clinical staff to ensure they accurately reflect the quality of care provided.

The Trust has signed a contract with West Midlands Strategic Health Authority (SHA) to form a Quality Institute with the University of Birmingham to help provide support to the regional Quality Observatory. UHB has also mapped NHS diagnostic and procedural coding structures to those used in the U.S.A. which means we will be able to directly compare patient care provided at UHB with that provided by U.S.A. hospitals in the future.

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
A&E	Average (median) delay from arrival in A&E to performance of emergency CT head scan				2 hours (for 46 patients)			2 hours (for 37 patients	CRIS Symphony	
A&E	Average (median) delay from arrival in A&E to performance of emergency CT head with contrast scan				2 hours (for 1146 patients)			2 hours (for 750 patients)	CRIS Symphony	
Acute Medicine	7 day readmissions to:	<4% for							Lorenzo	
	Acute Medicine	Acute	885	25724	3%	749	25637	3%		
	Medical Admissions Unit	Medicine	324	7141	5%	273	7386	4%		
Ambulatory Care	Proportion of patients who were intended to be treated as a daycase but were admitted to hospital as an inpatient	<5%	712	16573	4.3%	686	16262	4.2%	Lorenzo Galaxy	
Anaesthetics	Post operative nausea and vomiting All high risk patients (Ear, Nose and Throat, General Surgery and Laparoscopic Surgery) should be prescribed with antiemetics (anti-sickness medication) so they can be given promptly after the operation if they need them	95%	2322	2822	82.3%	2476	3000	82.5%	Lorenzo PICS	
Anaesthetics	Post operative Nausea & Vomiting High risk patients (Ear, Nose and Throat, General Surgery and Laparoscopic Surgery) given antiemetics (anti-sickness medication) after the operation		1273	2822	45.1%	1395	3000	46.5%	Lorenzo PICS	

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - Average post-operative length of stay			313 patients	9.7 days		396 patients	10 days	PATS Lorenzo	
Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - Average total length of stay			313 patients	14.5 days		396 patients	15 days	PATS Lorenzo	
Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - C.difficile	0	0	313	0.0%	4	396	1.0%	PATS Lorenzo	
Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - Emergency readmissions within 28 days		15	307	4.9%	14	391	3.6%	PATS Lorenzo	
Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - Hospital survival		307	313	98.1%	391	396	98.7%	PATS Lorenzo	Cleveland Clinic 95.3% (2008 calendar year)
Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - Median post-operative length of stay			313 patients	7 days		396 patients	8 days	PATS Lorenzo	
Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - Median total length of stay			313 patients	10 days		396 patients	10 days	PATS Lorenzo	
Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - Patients discharged on angiotensin converting enzyme (ACE) inhibitors	100% of eligible patients	275	307	89.6%	315	391	80.6%	PATS PICS	
Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - Patients discharged on antiplatelet therapy	100% of eligible patients	306	307	99.7%	356	391	91.0%	PATS PICS	

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - Patients discharged on statins	100% of eligible patients	295	307	96.1%	344	391	88.0%	PATS PICS	
Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - Patients on betablockers who were given them on the day of surgery	100% of eligible patients	125	134	93.3%	162	192	84.4%	PATS PICS	Cleveland Clinic 88% (Jan- Jun 09) Average for all other hospitals in Ohio 89% (Jan- Jun 09) Average for all reporting hospitals in US 87% (Jan- Jun 09) NB This data is for all surgery patients with heart conditions who were on betablockers
Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - Post-operative stroke		7	313	2.2%	4	396	1.0%	PATS Lorenzo	
Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - Re-operation (all causes)		24	313	7.7%	28	396	7.1%	PATS Lorenzo	Cleveland Clinic 17% (2008 calendar year). This data also includes the referrals for reoperation from other hospitals.
Cardiac Surgery	First-time, isolated coronary artery bypass graft (CABG) - MRSA bacteraemia		0	313	0.0%	0	396	0.0%	PATS Lorenzo	

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Cardiology	Ensure all patients are discharged on clopidogrel or prasugrel following percutaneous coronary intervention (PCI)	100%	792	792	100.0%	1052	1053	99.9%	Lorenzo PICS	Cleveland Clinic 99% (2008) Other US Hospitals 98% (2008) (This data relates to clopidogrel only as prasugrel is a new drug)
Dermatology	Incidence of wound infection post skin graft	0%	0	114	0%	0	106	0%	Lorenzo	
Dermatology	Proportion of suspected skin cancer cases seen within 2 weeks by a Consultant	93%	1414	1502	94.1%	1428	1499	95.3%	Cancer database	
Diabetes	Percentage of patients under Diabetic Centre follow up (attending follow-up outpatient appointments) who have a lower limb amputation. Note: The Diabetes Team are also planning to develop a similar indicator for patients with diabetes not under Diabetic Centre follow up.		12	3462	0.35%	19	3590	0.53%	Lorenzo	
Elderly Care	Percentage of elderly care patients discharged to their normal place of residence		4277	4705	90.9%	4379	4804	91.2%	Lorenzo	
Emergency Surgery	Emergency admissions for non severe gall stone pancreatitis (no Intensive Care Unit admission) should have surgery (gallbladder removal) within two weeks	90%	227	250	90.8%	203	221	91.9%	Lorenzo	

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Endocrinology	Fraction of patients discharged on hydrocortisone post pituitary surgery	100%	63	63	100%	53	54	98%	Lorenzo PICS	
ENT	To ensure all patients receiving treatment for head and neck cancer have seen the pre treatment assessment team.	100%	40	92	43.5%				Head & Neck database Lorenzo	
Gastro-enterology	Proportion of patients admitted with inflammatory bowel disease receiving low molecular weight (LMW) heparin	90%	53	56	94.6%	43	51	84.3%	Lorenzo PICS	
Haematology	Bone Marrow Transplant-related mortality:								BMT database	
	During index (first) admission - autologous (patient's own bone marrow) transplants		0	66 (April 09-Mar 10)	0%	0	80	0%		
	During index (first) admission - allogeneic (donor bone marrow) transplants		0	74 (April 09-Mar 10)	0%	5	71	7%		
	Within 100 days - autologous (patient's own bone marrow) transplants		0	48 (April 09-Dec 09)	0%	2	80	3%		
	Within 100 days - allogeneic (donor bone marrow) transplants		3	55 (April 09-Dec 09)	5.5%	7	71	10%		
Heart Failure	Percentage of heart failure patients discharged on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)	93%	178	254	70%	257	359	72%	Heart Failure database PICS	Cleveland clinic 94% (July 08 - June 09) Average for all other US hospitals 90% (July 08 - June 09)

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Heart Failure	Percentage of patients with a primary diagnosis of acute heart failure who had an echocardiogram (ECHO) prior to discharge	100%	196	254	77%	253	359	70%	Heart Failure Database PICS	
HIV	Uptake of HIV testing amongst inpatients when clinically indicated (for specific conditions which can be associated with HIV/AIDS)	90%	1798	9709	19%	1940	10570	18.4%	Lorenzo PICS	
Imaging	A&E - Report turnaround times for other radiology reports e.g. CT, MRI, ultrasound and angiography								CRIS	
	0 to < 2 days		1618	2079	77.8%	714	930	76.8%		
	2 to < 5 days		134		6.4%	52		5.6%		
	>= 5 days		327		15.7%	164		17.6%		
Imaging	A&E - Report turnaround times for plain imaging (basic x-rays)								CRIS	
	0 to < 2 days		3388	9734	34.8%	2376	4383	54.2%		
	2 to < 5 days		5013		51.5%	1893		43.2%		
	>= 5 days		1333		13.7%	114		2.6%		
Imaging	Inpatients - Report turnaround times for other radiology reports e.g. CT, MRI, ultrasound and angiography								CRIS	
	0 to < 2 days		13107	17428	75.2%	5803	8047	72.1%		
	2 to < 5 days		2817		16.2%	1304		16.2%		
	>= 5 days		1504		8.6%	940		11.7%		

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Imaging	Inpatients - Report turnaround times for plain imaging (basic x-rays)								CRIS	
	0 to < 2 days		14616	27337	53%	6345	13254	47.9%		
	2 to < 5 days		9817		36%	5595		42.2%		
	>= 5 days		2904		11%	1314		9.9%		
Imaging	Outpatients - Report turnaround times for imaging (basic x-rays)								CRIS	
	0 to < 2 days		3968	14557	27.3%	3349	7008	47.8%		
	2 to < 5 days		5810		39.9%	2914		41.6%		
	>= 5 days		4779		32.8%	745		10.6%		
Imaging	Outpatients - Report turnaround times for other radiology reports e.g. CT, MRI, ultrasound and angiography								CRIS	
	0 to < 2 days		15221	40689	37.4%	8093	19674	41.1%		
	2 to < 5 days		11625		28.6%	5408		27.5%		
	>= 5 days		13843		34.0%	6173		31.4%		
Intensive Care	Intensive care readmission rate (Readmissions to ITU during the same inpatient admission)		April 09 - Feb 10)	April 09 - Feb 10)	April 09- Feb 10)				ICNARC	
			283	2191	12.9%	335	2418	13.9%		
	Excludes Wellcome Building Critical Care (WBCC) unit which does not submit data to the Intensive Care National Audit & Research Centre (ICNARC)									

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Liver Medicine	Percentage of patients who have endoscopic retrograde cholangio-pancreatography (ERCP) who develop pancreatitis. ERCP involves a doctor examining the common bile duct and pancreatic duct through a flexible tube which is passed down the mouth, stomach and into the small intestine (bowel).	<5%	5	357	1.4%	7	420	1.7%	ERCP database Lorenzo PICS	
Liver Medicine/ Surgery	90 day patient mortality (%) and graft loss (%), with 95% confidence intervals, for all adult patients who received a planned (non-emergency) first liver transplant. Number of Transplants 90 day mortality (95% Confidence Intervals) 90 day graft loss (95% Confidence Intervals)				Time Period - Oct 08 - Sep 09 67 6.0 (2.3, 15.1) 9.0 (4.1, 18.9)			Time Period - Apr 07 - Mar 08 89 9.0 (4.6, 17.2) 3.4 (6.2, 19.9)	Annual NCG Report	
Liver Transplant	Use of Valganciclovir in CMV (Cytomegalovirus) mismatched liver transplant patients. Valganciclovir is an antiviral medication used to prevent CMV infection in liver transplant patients who have not previously had CMV but the donor has.	100%	62	62	100%	48	49	98%	Liver database PICS	

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Max Fax	Proportion of patients who had surgery for fractured mandible on the same day or day after emergency admission	90%	157	224	70%	163	218	75%	Lorenzo	
Neurosurgery	Time from emergency admission with subarachnoid haemorrhage (SAH) to surgery	90% within 2 days			65% Average 3.28 days (150 patients)			72.3% Average 3.7 days (131 patients)	Lorenzo	
Ophthalmology	Overall, how would you rate the care you received at the Outpatients Department today?*		1 March 10 - 10 April 10	1 March 10 - 10 April 10	1 March 10 - 10 April 10				Outpatient Survey	
	Excellent		11	23	48%					
	Very Good		10		43%					
	Good		2		9%					
	Fair		0		0%					
	Poor		0		0%					
	Very Poor		0		0%					
Ophthalmology	Was your appointment changed to a later date by the hospital?*		1 March 10 - 10 April 10	1 March 10 - 10 April 10	1 March 10 - 10 April 10				Outpatient Survey	
	No		186	227	82%					
	Yes, once		34		15%					
	Yes, 2 or 3 times		6		3%					
	Yes, 4 or more times		1		0%					
Ophthalmology	Would you recommend this Outpatients Department to your family and friends?*		1 March 10 - 10 April 10	1 March 10 - 10 April 10	1 March 10 - 10 April 10				Outpatient Survey	
	Yes, definitely		21	24	88%					
	Yes, probably		3		13%					
	No		0		0%					

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Palliative Care	100% of patients with palliative care diagnosis code who are receiving regular analgesic medication for background pain (Morphine Sulphate Tablets, Zomorph, Fentanyl, Oxycontin) should also be prescribed with analgesia (e.g. Oramorph, Oxynorm) for breakthrough pain.	100%	145	148	98.0%	91	96	94.8%	Lorenzo PICS	
Palliative Care	100% of above patients (who were prescribed with both analgesic medication for background pain and analgesia for breakthrough pain) should also be prescribed with laxatives.	100%	145	145	100%	91	91	100%	Lorenzo PICS	
Pathology	Turnaround times Cholesterol - 100% within 24 hours**	100% within 24 hours	7	7	100%	Jul 08 - Sep 08 3	Jul 08 - Sep 08 3	Jul 08 - Sep 08 100%	Pathology database	
Pathology	Turnaround times C-Reactive Protein - 100% within 24 hours**	100% within 24 hours	9005	9104	98.9%	Jul 08 - Sep 08 1848	Jul 08 - Sep 08 1858	Jul 08 - Sep 08 99.5%	Pathology database	
Pathology	Turnaround times Full Blood Count - 100 % within 24 hours**	100% within 24 hours	18203	18265	99.7%	Jul 08 - Sep 08 4454	Jul 08 - Sep 08 4464	Jul 08 - Sep 08 99.8%	Pathology database	
Pathology	Turnaround times Urine - 90% within 48 hours**	90% within 48 hours	2079	2368	87.8%	Jul 08 - Sep 08 757	Jul 08 - Sep 08 779	Jul 08 - Sep 08 97.2%	Pathology database	

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Pharmacy	Dispensing error rate (nationally these are measured as no of errors per 100,000 dispensed items)		11.025	100000	0.01%	11.65	100000	0.01%	Pharmacy database	
Radiotherapy	85% of patients should commence treatment (first dose of radiotherapy) within 14 calendar days from CT scan. Note: Some of the patients not treated within the target timeframe had chosen to delay their treatment.	85% within 14 calendar days	Jul 09 - Mar 10 1820	Jul 09 - Mar 10 2317	Jul 09 - Mar 10 78.5%				Radio-therapy database	
Renal Medicine	Percentage of patients on haemodialysis programme with a urea reduction ratio (URR) of >65% All patients on haemodialysis Patients who have been on haemodialysis for 90 days or more	90%			 89.8% 90.2%			 85.6% 86.4%	MARS	Data from 57 UK dialysis centres in 2007 reported in the renal registry report of 2008 show that 81% of reported patients achieve a URR ≥ 65% (centre range 47% – 97%).
Renal Medicine/ Surgery	Percentage of patients attending the low clearance clinic (which aims to get patients ready for dialysis) who had had an arteriovenous fistula (to create access for dialysis) made before starting haemodialysis.	80%	61	80	76.3%	72	98	73.5%	MARS Lorenzo	
Respiratory	Percentage of asthmatic patients are discharged on inhaled steroids	95%	236	272	86.8%	252	295	85.4%	PICS	

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Rheumatology	An indication of continuity of care, did the patient attend the same Consultant's clinic at least 5 times out of 6 previous visits	100%	315	315	100%	221	221	100%	Lorenzo	
Routine Surgery / Care	Unplanned return to theatre for all non-emergency surgical patients	>2.5%	500	32762	1.5%	500	29538	1.7%	Galaxy	
Stroke Medicine	30 day mortality following stroke		77	324	23.8%	92	331	27.8%	Lorenzo	
Stroke Medicine	Percentage of patients admitted with cerebral infarction who received aspirin, clopidogrel or warfarin	98.8% (CQUIN target)	298	299	99.7%			98%	Lorenzo PICS	Cleveland Clinic 99.7% (2008 calendar year) US National Average 98.9% (2008 calendar year)
Therapy Services	90% of inpatient referrals should be responded to by the Therapy Services on the same day they are identified to the service	90% on same day	25449	26424	96.3%	23268	24065	96.7%	Therapy database	
Therapy Services	95% of inpatient referrals are responded to by the Therapy Services within two working days of the patient being identified to the service	95% within two working days	26105	26424	98.8%	23785	24065	98.8%	Therapy database	
Trauma & Orthopaedics	Proportion of patients who had surgery within 2 days of admission for fractured neck of femur (fractured hip)	90%	206	281	73%	243	353	69%	Lorenzo	

Speciality	Indicator	Goal	Numerator (Apr 09 - Mar 10)	Denominator (Apr 09 - Mar 10)	% (Apr 09 - Mar 10)	Numerator (Apr 08 - Mar 09)	Denominator (Apr 08 - Mar 09)	% (Apr 08 - Mar 09)	Data Source	Benchmarking
Urology	All patients admitted with acute retention to be discharged on alpha blockers (if not put on waiting list for transurethral resection of the prostate (TURP))	70%	34	70	48.6%	58	109	53.2%	Lorenzo PICS	
Vascular Surgery	Rates of daycase versus inpatient varicose vein procedures	<5% in-patients							Lorenzo	
	Daycase		485	513	94.5%	448	540	83%		
	Inpatients		28	513	5.5%	92	540	17%		

* The Outpatient survey comprises two parts: one for patients to complete on arrival to the department and one for patients to complete after their appointment. The survey has only been piloted since 1 March 2010 so increasing the number of responses, particularly for the second part of the survey, will be a priority during 2010-11.

** Data shown relates to Royal Orthopaedic Hospital patients' specimens which are processed by UHB; turnaround times are indicative of all specimens processed by UHB.

Notes on data sources:

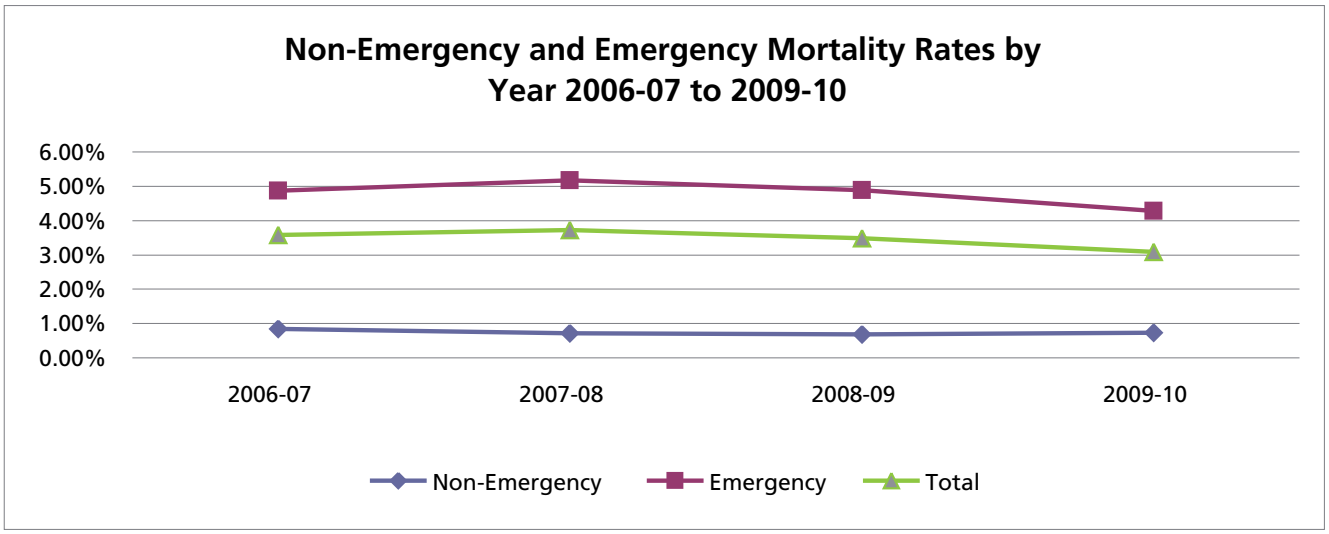
Cleveland Clinic and US data = published on Cleveland Clinic website
CRIS = Radiology database
Galaxy = Theatres database
ICNARC = Intensive Care National Audit & Research Centre
Lorenzo = Patient administration system
MARS = Renal database
NCG = National Commissioning Group
PATS = Cardiac database
Symphony = A&E patient management system

3.5 Mortality

The Trust continues to monitor mortality as close to real-time as possible with senior managers and clinicians receiving regular communication detailing mortality information, more retrospective and longer term comparative analysis is reported monthly to the Trust's Clinical Quality Monitoring Group. Any anomalies or unexpected elevated death rates are promptly investigated with thorough clinical engagement.

Although the Trust is generally treating more elderly patients and patients with complex conditions, mortality remains stable. In line with the national trend, emergency and overall mortality rates have reduced slightly over the last four financial years as shown in the graph below.

A statistical review of the Trust's mortality rates for 2008-09 was completed during 2009-10 by senior clinical statisticians at the Cleveland Clinic in the U.S.A., and the analysis showed no cause for concern.



3.6 Clinical Portal

During 2009-10, the Trust has developed the first stage of an in-house electronic patient record (EPR) solution called the Clinical Portal in conjunction with clinical and managerial staff, overseen by the Trust's EPR Executive Group. The Clinical Portal brings together a wide range of patient information sources including the Trust's Prescribing Information and Communication System (PICS), iPM (patient administration system), imaging, laboratory results and Outpatient clinical correspondence in an electronic format. The aim of the Clinical Portal is to significantly reduce organisational reliance on paper records alongside the opening of the new hospital. The Clinical Portal is currently being rolled out across specialties to be used for Outpatient services. The plan is for the Clinical Portal to eventually be implemented for all inpatients in the longer term.

3.7 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 for all inpatients. A significant amount of work has been done during 2009-10 with clinical staff to develop a version of PICS for Outpatients and Daycase patients which will be implemented during 2010-11. The Trust is also developing a version of PICS for use in A&E which will take longer

as it is dependent upon integration with other systems such as Symphony (the patient management system used in A&E).

An electronic observation chart was developed during 2009-10 within PICS which has been successfully piloted in multi-specialty medicine and Burns, and will be implemented across another twelve wards during 2010-11. The electronic observation chart incorporates a standardised early warning score so that when observation data indicates a patient is deteriorating, an electronic message is automatically sent to the Outreach Team Blackberry smartphone. Ward order communications have also been implemented during 2009-10 which enable staff to request services within PICS for patients from ten departments such as x-ray and physiotherapy. This function has been widely used as shown in the table below and will be rolled out to other departments during 2010-11:

Service Request Type	Number Requested
Diabetes	248
Endocrinology	20
Gastro-intestinal Endoscopy	32
Gastro-intestinal Physiology	1
Imaging (x-ray, MRI, CT scans, ultrasound)	44,918
Nutrition and Dietetics	1,050
Occupational therapy	784
Physiotherapy	363
Respiratory	142
Speech therapy	647
Grand Total	**48,205**

3.8 Healthcare Evaluation Data (HED) tool

The Trust has developed an interactive tool which enables clinical and managerial staff to evaluate the quality of healthcare delivery and operational efficiency in comparison to acute and mental health trusts in England.

The tool uses Hospital Episode Statistics (HES) data and applies an advanced methodology which accounts for casemix and other variables, incorporates all care delivered and can drill down to a patient level (anonymised).

A wide range of aspects of care delivery are included in the tool: activity, mortality, length of stay, DNAs (number of patients who did not attend their outpatient appointments), new to follow-up appointment ratios and market share (GP referrals).

The Care Quality Commission (CQC) is currently reviewing the Trust's HED tool and UHB has already entered into commercial contracts to provide the tool to a range of interested providers.

3.9 Clinical Dashboard

The Trust's ward-level digital Clinical Dashboard has been widely used by clinical and managerial staff during 2009-10: more than 1,600 users have logged into the system over 19,000 times in total. A number of developments have been made to the Clinical Dashboard over the past year which include:

- A dial showing the percentage of nutritional supplements prescribed but not administered for individual wards has been added.
- Nursing dependencies have been added to the dashboard for each ward to show patient complexity in relation to the number of nursing staff on the ward.
- A visual bed management tool has been piloted on five wards (medical, multi-specialty and admissions unit) to enable staff to see at a glance bed occupancy, patients' length of stay, gender, infection status, whether the patient is waiting for TTOs (drugs to take home) and whether beds need cleaning. The plan is to eventually implement this for all wards in the new hospital.

3.10 My Health at UHB

The Trust has developed a secure, prototype website called 'My Health at UHB' where patients with chronic long-term conditions can view information about their condition, appointments, blood results (within certain parameters), how to contact other patients with the same condition and to access advice. The Trust intends to pilot this within Liver Medicine during 2010-11, and potentially within other specialties as appropriate. Access to the website will be only be granted following discussion between individual patients and their Consultants to ensure appropriate Governance arrangements are in place.

3.11 Quality Web Pages

The Trust launched the Quality web pages on its website in November 2009 which provide information relating to quality for patients and the public: http://www.uhb.nhs.uk/quality.htm

Information published includes:

- Quality Reports: this includes the Trust's 2008-09 Quality Report plus quarterly update reports on progress.
- Specialty Quality Indicators: graphs showing performance and explanatory text for specialty quality indicators which are updated monthly
- Department of Health Quality Indicators: graphs showing performance for some of the indicators suggested by the DH which are updated quarterly
- Other information: this includes some Annual Reports on specialised services such as HIV and national audit reports for example.

The Trust intends to publish regular data for more of the specialty quality indicators during 2010-11 on the new website due to be launched in June 2010 with the opening of the new hospital.

3.12 Incident Reporting

An electronic reporting system ensures a more efficient and effective means of reporting incidents. The Risk Management Team have focused on the roll out of the electronic DatixWeb system in 2009/10. The electronic system enables staff, when submitting an online form, to select which line manager the form should be sent to for completion and provides assurance to staff that the form will be processed. From 1 April 2010, DatixWeb will be the principal medium used across the Trust for incident reporting; in areas where staff do not have access to a PC a paper report can still be completed, however the responsible line manager will be expected to input the form into the electronic reporting system. The system enables improved monitoring of reporting across the Trust and ensures early detection of areas or individuals who are experiencing difficulties with the process providing a focused approach to support and additional training from the Risk team.

3.13 Risk Dashboard

To supplement the electronic incident reporting system a Risk Dashboard has been developed which provides clinical staff with access to real time data from incident reports submitted within their clinical area and Division. The Risk Dashboard uses the live online data from the DatixWeb reporting system to identify information regarding the top 5 incident types reported, the rate of reporting as well as allowing direct access to incident summaries. The Risk Team will work with clinical teams, using the dashboard to analyse trends and to formulate action plans to mitigate any risk. Actions identified from serious incidents requiring investigation (SIRIs) will also be included in the action plan to ensure that recommendations from these investigations are implemented appropriately. The action plans are an integral part of the dashboard and will form a monitoring and assurance tool for the Risk Department. The introduction of the Risk Dashboard is a relatively new development for the Trust which will be regularly reviewed and refined throughout 2010-11.

Annex: Statements from stakeholders

The Trust has shared its 2009-10 Quality Report with the commissioning Primary Care Trust, NHS South Birmingham, the Birmingham Local Involvement Network (LINk) UHB Action Group and Birmingham City Council Overview and Scrutiny Committee.

NHS South Birmingham and the Birmingham LINk UHB Action Group have reviewed the Trust's Quality Report for 2009-10 and provided the statements below. Birmingham City Council Overview and Scrutiny Committee has chosen not to provide a statement but plans to do so for the 2010-11 Quality Report.

Statement provided by NHS South Birmingham:

NHS South Birmingham welcomes the opportunity to contribute to the Quality Account through this corroborated statement with regards to the existing contracts it holds with the Trust and any associated information. The whole commissioning organisation has had an opportunity to provide feedback, including the Public Involvement Action Group.

This is a comprehensive technical account providing a detailed presentation of performance throughout the year including monitoring, measuring and reporting arrangements. There is evidence to support quality as a theme through all of the strategic developments within the account, inclusive of audit, performance and quality improvement. There is evidence of participation in clinical audits and examples of how this has led to service improvements.

We have an on-going quality monitoring process with the Trust which includes monthly contract meetings, quality reviews and quarterly performance meetings. This provides the PCT with a good understanding of the issues facing the Trust, its internal systems and processes that are in place to provide assurance. Given the significant challenges that lie ahead across South Birmingham's health economy it is imperative that University Hospitals Birmingham Foundation Trust strengthens engagement with the PCT to ensure a consistent targeted approach to delivering the QIPP agenda.

NHS South Birmingham can verify the reported MRSA and Clostridium Difficile infection rates within the Trust and acknowledges the improvements made during the last year from previous years. The Trust has achieved the performance of the 4 elements of the CQUIN.

The Account reflects a number of innovative and bespoke systems to capture and use data, including an electronic patient record, collection of real time patient experience information and others, all supporting quality improvement. The PCT acknowledges the publication of quality information on the Trusts website, allowing continual publication of quality improvement throughout the year.

In summary, the Quality Account provides a balanced view of both the Trust's achievements throughout 2009-10 and has set clear priorities for quality improvement in 2010-11 as the Trust moves into the new hospital from June 2010.

Statement provided by Birmingham LINk:

QUALITY ACCOUNT STATEMENT
Birmingham LINk UHB Action Group

The Trust has demonstrated improvements in care in the three priority areas identified in the 2008 – 2009 Quality Report to address during 2009 – 2010.

Priority 1 – Reducing errors (particularly medication errors)

Priority 2 – Infection prevention and control.

Priority 3 – Improve patient experience and satisfaction.

As well as evidencing improvements relating to the above, the Trust has not only decided to continue these priorities but has identified two additional priorities for 2010 – 2011:-

Time from prescription to administration of first antibiotic.

Venous thromboembolism (VTE) risk assessment on admission (within 24 hours).

The priorities were based on sound quality measures / monitoring processes and took account of patients' views relating to their experience of care.

Birmingham LINk via UHB Action Group has been informed of the targets and improvements in a timely fashion as were the Trust Governors. Additionally, one UHB Action Group LINk member is a serving member of the Trust's Care Quality Group chaired by the Chief Executive Nurse. A wide variety of sound evidence related to patient care and patient experience came from this group.

The Quality Report gives evidence of sound and robust systems for measuring progress in relation to the stated priorities for improvement and has provided this information in a transparent way throughout the year. Birmingham LINk members at UHB have received timely information and been consulted on their views throughout the year. The Trust has been open about areas of weakness and how these might be improved and incorporated this into the data provided.

The Associate Director of Patient Affairs has been a helpful and useful conduit for information between LINk members and the Trust. There is scope for this to be strengthened by involving LINk members in matters related to patient care / satisfaction e.g. Surveys, campaigns such as 'Hand-washing' and nutrition. This might well be achieved through collaborative ventures with Patient Councils and other groups.

Birmingham LINk
University Hospital Action Group

University Hospitals Birmingham
NHS Foundation Trust

2009/2010

Section 4 **Annual Accounts**

This annual report covers the period 1 April 2009 to 31 March 2010

Section 4 | Annual Accounts

University Hospitals Birmingham NHS Foundation Trust
Financial Statements for the year ended 31 March 2010

Contents

Foreword to the Financial Statements

University Hospitals Birmingham NHS Foundation Trust

These financial statements for the year ended 31 March 2010 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.

..... Date June 3 2010

Julie Moore
Chief Executive

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 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 Annual 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 Annual 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.

Date June 3 2010

Julie Moore
Chief Executive

KPMG

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 2010 under the National Health Service Act 2006. These comprise, the Statement of Comprehensive Income, the Statement of Financial Position, the Cash flow Statement, the Statement of Changes in Taxpayers' Equity 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 2010

We review whether the statement on internal control on pages v to xi reflects compliance with Monitor's guidance issued in the NHS Foundation Trust Annual 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 of the state of affairs of University Hospitals Birmingham NHS Foundation Trust as at 31 March 2010 and of its income and expenditure for the year then ended.

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

One Snowhill

Birmingham

3 June 2010

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 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 University Hospitals Birmingham NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

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 NHS Foundation Trust for the year ended 31 March 2010 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

3.1 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.

3.2 Risk issues are reported through the Clinical Quality 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.

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

3.4 All new staff joining the Trust are required to attend Corporate Induction which covers key elements of risk management. Existing members of staff are trained in the specific elements of risk management dependent on their level within the organisation. Managers attend the 'Managing Risks' course that covers the principles of risk assessment and the management of Risk Registers. The Trust's guidance document, available to all staff via the Trust's intranet ('Guidance on the Implementation and Management of Risk Registers') sets out the processes for managing risk at all levels within the Trust. Risk Management is included on all Trust and Divisional development programmes. Learning from incidents and good practice is discussed at the Clinical Quality Monitoring Group, reporting monthly to the Board of Directors, and locally at department and ward level. Senior staff are trained in Root Cause Analysis, which is carried out on all Serious Incidents that Require Investigation. Learning from Root Cause Analysis is disseminated through the organisation in a number of ways, including Executive reviews for Infection Control and Clinical RCA reviews overseen by the Chief Executive.

4. The risk and control framework

4.1 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. Clinical governance is overseen directly by the Board of Directors, which, in addition to receiving reports, carries out regular unannounced clinical governance visits.

4.2 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.

4.3 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 and the level of acceptable risk for the Trust. The Board of Directors reviewed and approved the Board Assurance Framework, identifying key risks that related to the Trust's corporate aims and objectives. The Assurance Framework is reviewed on a quarterly basis by Executive Directors who review the Annual Plan risks and the high level Divisional risks. The Board Assurance Framework is reviewed regularly by the Audit Committee, which then provides assurance to the Board of Directors.

4.4 The Trust was successfully assessed at level 2 against the NHSLA Risk Management Standards for Trusts (RMS) in February 2009.

4.5 Risk identification and evaluation

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

4.5.2 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 Quality Monitoring Group meetings and to the Clinical Quality Monitoring Group

4.5.3 Risk Assessments, including Health and Safety and Infection Control Audits are undertaken throughout the Trust. 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.

4.5.4 Other methods of identifying risks are:

a) Complaints and Care Quality Commission reports and recommendations;

b) Inquest findings and recommendations from HM Coroners;

c) Health and Safety visits undertaken by Director of Operations of each Division;

d) Medico-legal claims and litigation;

e) Ad hoc risk issues brought to either the Divisional Clinical Quality Group meetings, Health, Safety and Environment Committee,Clinical Quality Monitoring Group, Care Quality Group or Safeguarding Group;

f) Incident reports and trend analysis;

g) Internally generated reports from the Health Informatics Team;

h) Internal and external audit reports; and

i) Regular Performance Reviews.

4.5.5 Identified risks are added to the Risk Registers 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 Divisional Performance Reviews and the Audit Committee, through the Assurance Framework process.

4.5.6 Every quarter the Audit Committee undertakes a detailed examination of the Assurance Framework and the associated risk management processes. This Committee

assesses whether there are any gaps in assurance or weaknesses in the effectiveness of controls.

4.6 Risk Control

4.6.1 Clinical risks are reported directly to the Board of Directors through the Clinical Quality 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.

4.6.2 Compliance with the Care Quality Commission Core Standards Declaration in December 2009 was reported to the Board of Directors. The assurance on this process was provided by Internal Audit and the Audit Committee. Compliance with registration with the Care Quality Commission was reported to the Board of Directors by the Director of Corporate Affairs.

4.6.3 Risks to information are managed and controlled in accordance with the Trust's Risk Management Policy and framework, 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 Information Governance 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.

4.6.4 The Trust completed the Information Governance Toolkit assessment for 2009/10 and achieved a score of 80%, which is a green score and demonstrated an improvement against the previous year's assessment of 79%.

4.6.5 Risk Management is well embedded throughout the organisation. Risks are reported locally at Divisional level through the Clinical Quality Framework.

4.6.6 The culture of the organisation aids the confident use of the incident reporting procedures throughout the Trust. The introduction of online reporting has enabled a tighter management of incident reporting and has enabled more efficient and rapid reporting with the development of specific report forms for categories of incidents.

4.6.7 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 the Assurance Framework is formally reviewed on a quarterly basis. The arrangements for reporting the assurance framework and the high level assurance reporting to the Audit Committee are regularly reviewed with the aim of further improving reporting.

4.6.8 All new and revised policies undergo an equality impact assessment as part of the approval process.

4.7 Risks associated with the new hospital

4.7.1 The Trust is progressing with its Joint PFI scheme with Birmingham and Solihull Mental Health NHS Foundation 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 Programme Board, chaired by the Executive Director of Delivery who reports directly to the Board of Directors. The Programme Board oversees progress on the New Hospital building, operational commissioning and the move into the new hospital, as well as the clinical redesign projects. The New Hospital Project Director 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.

4.7.2 There are regular reports on the main Programme risks to 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.

4.8 Major Risks

4.8.1 The move into the New Hospital (commencing June 2010) has been identified as a major risk to the Trust. The risks associated with the move are managed through the New Hospital Board and Commissioning Group, where mitigation against the controls and action plans are monitored in line with the overall project plan.

4.8.2 The financial risks associated with the new hospital project are also identified as a major risk both in year and for the future. These are managed through financial controls, including a ten year plan and regular reports to the Audit Committee.

4.8.3 The change in government and the impact of the current economic climate on public funding has been identified as a major risk, both in year and for the future. The Trust has completed a robust downside assessment, submitted to Monitor and will continue to apply effective financial controls to mange this risk.

4.8.4 Changes in the regulatory framework for FTs resulting from the change in government may also present a risk to the Trust. The Trust will manage this risk by ensuring it has a comprehensive, effective and robust governance framework that is regularly reviewed and supported by the Trust's informatics and data gathering systems.

4.9 Infection Prevention and Control

4.9.1 Infection control is a high profile risk. The Infection Prevention and Control Committee, chaired by the Executive Chief Nurse (Executive Director of Prevention and Control), 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 Quality Groups for local follow up action.

4.9.2 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 in this Trust, and that no significant lapses have been identified. Executive and Non-Executive members of the Board of Directors carry our regular visits to operational areas to observe compliance with infection control procedures.

4.9.3 There are clear policies and escalation procedures for the management of HAI, which form part of the Infection Prevention and Control Plan for the Trust, which has been reviewed and updated in February 2010. 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.

4.9.4 The Trust received an unannounced visit from the CQC in October 2009, 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 view of systems, including those relating to hotel services. 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.

4.10 There are elements of risk management where public stakeholders are closely involved. 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 Governors of the Trust represented on the Care Quality Group and receives regular reports on care quality, infection control and the new hospital project.

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

5. Annual Quality Report

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

5.2 The content of the Trust's Quality Report for 2009-10 builds on the 2008-09 report and was agreed by the Clinical Quality Monitoring Group, chaired by the Executive Medical Director, and the Board of Directors with input from the Trust's Governors and Birmingham Local Involvement Network (LINk) UHB Action Group.

5.3 The Trust uses the same systems and processes to collect, validate, analyse and report on data for the annual Quality Reports as it does for other clinical quality and performance information. Information is subject to regular review and challenge at specialty, divisional and Trust levels, by the Clinical Quality Monitoring Group, Care Quality Group and Board of Directors for example.

5.4 The quality improvement priorities and metrics identified in the Quality Report form part of the Trust's Annual Plan objectives for 2009-10 and 2010-11. In line with the Trust's commitment to transparency, the data included is not just limited to good performance and is publicly reported on a quarterly basis.

5.5 During 2010/11, both the Trust's external auditors and internal auditors will be reviewing the effectiveness of some of the processes through which data is extracted and reported in the Quality Report. The Trust intends to use the recommendations from these reviews to further improve the robustness of the processes underpinning the Quality Reports.

6. The Foundation Trust is fully compliant with the Core Standards for Better Health.

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

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

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

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

10.1 The Trust's Financial Plan for 2009/10 was approved by the Board of Directors in April 2009. Achievement of the financial plan relied on delivery of cash releasing efficiency savings of over £12m during the financial year. This has been accomplished through the establishment of a 4.5% 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.

10.2 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.

10.3 During 2009/10 the Board of Directors have continued to receive 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.

10.4 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 through the Audit Committee.

10.5 As part of the annual health check, the Trust's use of resources is also assessed by the Care Quality Commission, based on the Financial Risk Ratings assigned by Monitor. In the latest results published in Oct 2009 the Trust achieved a rating of 'excellent for the use of resources' (based on 2008/09 outturn data).

11. Review of effectiveness

11.1 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.

11.2 The processes applied in maintaining and reviewing the effectiveness of the system of control include:

11.2.1 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 maintained a view of the overall position;

11.2.2 review of the Assurance Framework and the receipt of Internal and External Audit reports on the Trust's internal control processes by the Audit Committee;

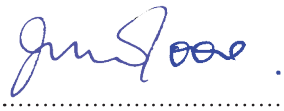
11.2.3 personal input into the controls and risk management processes from all Executive Directors and Senior Managers and individual clinicians; and

11.2.4 the provision of comment by Internal Audit, through their annual report, on the Trust's system of Internal Control.

11.3 The Board's review of the Trust's risk and internal control framework is supported by the Annual Head of Internal Audit opinion which states that significant 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.

12. 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 the Trust through appropriate action plans and that the implementation of these action plans is monitored.



..... Date June 3 2010

Julie Moore
Chief Executive

Statement of Comprehensive Income for the year ended 31 March 2010

	Notes	Year Ended 31 March 2010 £000	Year Ended 31 March 2009 £000
Operating Revenue	3 - 4	**496,194**	464,697
Operating Expenses	5	**(480,597)**	(443,020)
Operating surplus		**15,597**	21,677
Finance Costs			
Finance income	10	**664**	3,404
Finance expense - financial liabilities	11	**(8)**	(12)
Finance expense - unwinding of discount on provisions		**(39)**	(34)
PDC Dividends payable		**(2,433)**	(5,884)
Net finance costs		**(1,816)**	(2,526)
Surplus for the year		**13,781**	19,151
Other comprehensive income			
Revaluation gains / (losses) on property		**(11,617)**	0
Receipt of donated assets		**369**	291
Transfers from donated asset reserve		**(937)**	(1,036)
Donated assets disposed of		**0**	(31)
Other recognised losses		**0**	(37)
Total comprehensive income for the year		**1,596**	18,338

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

Statement of Financial position as at 31 March 2010

	Notes	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Non-Current Assets				
Intangible assets	13	**753**	897	871
Property, plant and equipment	14	**125,721**	130,946	131,424
Trade and other receivables	17	**2,769**	2,836	2,486
Other assets	18	**30,249**	16,535	375
Total non-current assets		**159,492**	151,214	135,156
Current Assets				
Inventories	16	**10,851**	9,601	9,741
Trade and other receivables	17	**37,513**	22,860	22,538
Other current assets	18	**41**	41	41
Cash and cash equivalents	19	**96,290**	97,793	71,434
Total current assets		**144,695**	130,295	103,754
Current Liabilities				
Trade and other payables	21	**(62,604)**	(47,058)	(42,924)
Borrowings	24	**(68)**	(84)	(56)
Provisions	25	**(3,646)**	(5,054)	(4,899)
Tax payable	22	**(6,054)**	(5,530)	(5,667)
Other liabilities	23	**(27,469)**	(19,042)	(12,738)
Total current liabilities		**(99,841)**	(76,768)	(66,284)
Non-Current Liabilities				
Borrowings	24	**(7)**	(75)	(104)
Provisions	25	**(2,220)**	(3,967)	(4,419)
Other liabilities	23	**(27,688)**	(27,864)	(16,037)
Total non-current liabilities		**(29,915)**	(31,906)	(20,560)
Total assets employed		**174,431**	172,835	152,066
Financed by Taxpayers' Equity				
Public dividend capital		**171,012**	171,012	168,612
Revaluation reserve		**64,052**	75,884	74,184
Donated asset reserve		**7,735**	8,197	8,942
Income and expenditure reserve		**(68,368)**	(82,258)	(99,672)
Total taxpayers' equity		**174,431**	172,835	152,066

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Date: June 3 2010

Julie Moore Chief Executive

Statement of Changes in taxpayers' equity

	Public Dividend Capital	Revaluation Reserve	Donated Asset Reserve	Income and Expenditure Reserve	**Total**
	£000	£000	£000	£000	**£000**
Taxpayers' Equity at 1 April 2008	168,612	72,445	8,942	(47,195)	**202,804**
Prior period adjustments - restatement to IFRS	0	1,739	0	(52,477)	**(50,738)**
Taxpayers' Equity at 1 April 2008 as restated	168,612	74,184	8,942	(99,672)	**152,066**
Surplus for the year	0	0	0	19,151	**19,151**
Transfers in respect of assets disposed of	0	(116)	0	79	**(37)**
Receipt of donated assets	0	0	291	0	**291**
Transfers in respect of depreciation, impairment and disposal of donated assets	0	0	(1,036)	0	**(1,036)**
Public Dividend Capital received	2,400	0	0	0	**2,400**
Other transfers between reserves	0	1,816	0	(1,816)	**0**
Taxpayers' Equity at 31 March 2009	**171,012**	**75,884**	**8,197**	**(82,258)**	**172,835**
Surplus for the year	0	0	0	13,781	**13,781**
Transfers in respect of assets disposed of	0	(109)	0	109	**0**
Revaluation gains / (losses) on property	0	(11,723)	106	0	**(11,617)**
Receipt of donated assets	0	0	369	0	**369**
Transfers in respect of depreciation, impairment and disposal of donated assets	0	0	(937)	0	**(937)**
Taxpayers' Equity at 31 March 2010	**171,012**	**64,052**	**7,735**	**(68,368)**	**174,431**

Statement of Cash Flows for the year ended 31 March 2010

	Notes	Year Ended 31 March 2010 £000	Year Ended 31 March 2009 £000
Cash flows from operating activities			
Operating surplus for the year		**15,597**	21,677
Depreciation and amortisation		**10,840**	10,789
Impairments		**1,232**	0
Loss on disposal of property, plant and equipment		**51**	386
Transfer from donated asset reserve		**(937)**	(1,036)
(Increase) / decrease in inventories		**(1,250)**	140
(Increase) / decrease in trade and other receivables		**(14,576)**	(750)
(Increase) / decrease in other assets		**(13,714)**	(16,160)
Increase / (decrease) in trade and other payables		**12,562**	4,092
Increase / (decrease) in other liabilities		**8,251**	18,131
Increase / (decrease) in provisions		**(3,194)**	(331)
Net cash generated from operating activities		**14,862**	36,938
Cash flows from investing activities			
Interest received		**666**	3,482
Payments to acquire property, plant and equipment		**(14,760)**	(10,590)
Receipts from sale of property, plant and equipment		**0**	37
Payments to acquire intangible assets		**(103)**	(224)
Net cash used in investing activities		**(14,197)**	(7,295)
Cash flows from financing activities			
Public dividend capital received		**0**	2,400
Public dividend capital repaid		**0**	0
Capital element of finance lease rental payments		**(84)**	(79)
Interest element of finance leases		**(8)**	(12)
PDC dividends paid		**(2,445)**	(5,884)
Other capital receipts		**369**	291
Net cash used in financing activities		**(2,168)**	(3,284)
(Decrease) / increase in cash and cash equivalents	19	**(1,503)**	26,359
Cash and cash equivalents at 1 April 2009		**97,793**	71,434
Cash and cash equivalents at 31 March 2010	19	**96,290**	97,793

Accounting Policies

1. Basis of preparation

Monitor has directed that the financial statements of the NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2009/10 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) 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 financial statements.

1.1.1 Transition to IFRS

The financial statements have been prepared in accordance with IFRSs and International Finance Reporting Interpretation Committee (IFRIC) interpretations as endorsed by the European Union, applicable at 31 March 2010 and appropriate to this Foundation Trust as noted above. This is the first set of full year results prepared in accordance with IFRS accounting policies. The previously reported 2008/2009 financial statements have accordingly been restated to comply with IFRS, with the date of transition to IFRS being 1st April 2008, which is the beginning of the comparative period for the year ended 31 March 2010.

1.1.2 Accounting convention

These financial statements have been prepared under the historical cost convention, on a going concern basis, except where modified to account for the revaluation of property, plant and equipment.

1.2 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from commissioners in respect of healthcare services. revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay.

Partially completed spells of patient care relate to Finished Consultant Episodes (FCEs). An revenue 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 revenue is received for a specific activity which is to be delivered in the following financial years, that revenue is deferred.

1.3 Employee benefits

1.3.1 Short term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from the employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that the employees are permitted to carry forward leave into the following period.

1.3.2 Post employment benefits - 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.nhsbsa.nhs.uk/pensions. 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.

Employers pensions cost contributions are charged to the operating expenses as and when they become due.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an 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. In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%. Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation
A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period 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 2010, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2010 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.

c) Scheme provisions
In 2008-09 the NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:"

Annual Pensions
The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service. With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Pensions Indexation
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.

Lump Sum Allowance
A lump sum is payable on retirement which is normally three times the annual pension payment.

Ill-Health Retirement
Early payment of a pension, with enhancement in certain circumstances, is available to members of the Scheme who are permanently incapable of fulfilling their duties or regular employment effectively through illness or infirmity.

Death Benefits
A death gratuity of twice their final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable."

Additional Voluntary Contributions (AVCs)
Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

Transfer between Funds
Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

Preserved Benefits
Where a scheme member ceases NHS employment with more than two years service they can preserve their accrued NHS pension for payment when they reach retirement age.

Compensation for Early Retirement
Where a member of the Scheme is made redundant they may be entitled to early receipt of their pension plus enhancement, at the employer's cost."

1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.5 Property, plant and equipment

1.5.1 Recognition

Property, plant and equipment assets are capitalised where:

- They are held for use in delivering services or for administration purposes;
- It is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- They are expected to be used for more than one financial year;
- The cost of the item can be measured reliably;
- Individually they have a cost of at least £5,000; or
- They 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, have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- They 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.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own estimated useful economic lives.

1.5.2 Valuation

All property, plant and equipment are stated initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable

of operating in the manner intended by management. All assets are measured subsequently at fair value.

Property used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

Land and non specialised buildings - existing use value

Specialised buildings - depreciated replacement cost

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. HM Treasury, and confirmed by Monitor, has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. HM Treasury, and confirmed by Monitor has agreed that NHS FTs must apply these new valuation requirements by 1 April 2010 at the latest. A full valuation was undertaken in respect of the land and buildings accounted for as at 31 March 2010.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historical cost as this is not considered to be materially different from the fair value of assets which have a low value and / or short useful lives.

1.5.3 Revaluation

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

1.5.4 Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised.

1.6 Intangible assets

Expenditure on computer software which is deemed not to be integral to the computer hardware and will generate economic benefits beyond one year is capitalised as an intangible asset. Computer software for a computer-controlled machine tool that cannot operate without that specific software is an integral part of the related hardware and it is treated as property, plant and equipment.

1.7 Depreciation, amortisation and impairments

Freehold land and properties under construction are not depreciated. Otherwise, depreciation and amortisation are charged on a straight line basis to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life

of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. The estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful economic lives or, where shorter, the lease term.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

If there has been an impairment loss, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to the income statement. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to the Statement of Comprehensive Income to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.8 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to the donated asset reserve. Donated assets are valued, depreciated and impaired as described for purchased assets. Gains and losses on revaluations and impairments are 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 offset the expenditure. On the sale of donated assets, the net book value is transferred from the donated asset reserve to retained earnings.

1.9 Government grants

Government grants are grants from government bodies other than revenue from NHS bodies or the MOD for the provision of services. Revenue grants are treated as deferred income initially and credited to income to match the expenditure to which they relate. Capital grants are recognised as a 'non-current liability' and are released to the Statement of Comprehensive Income over the life of the asset in a manner consistent with the depreciation and impairment charges for that asset. Assets purchased from government grants are valued, depreciated and impaired as described above for purchased assets.

1.10 Leases

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

1.10.1 The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are charged directly to the Statement of Comprehensive Income.

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

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

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

1.10.2 The Trust as lessor

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

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

1.11 Private Finance Initiatives (PFI) transactions

1.11.1 Recognition

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes following the principles of the requirements of IFRIC 12. Where the government body (the Grantor) meets the following conditions the PFI scheme falls within the cope of a 'service concession' under IFRIC 12:

- The grantor controls the use of the infrastructure and regulates the services to be provided to whom and at what price; and
- The grantor controls the residual interest in the infrastructure at the end of the arrangement as service concession arrangements.

The Trust therefore recognises the PFI asset as an item of property, plant and equipment on the Statement of Financial Position together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

1.11.2 Valuation

The PFI assets are recognised as property, plant and equipment, when they come into use, see the accounting policy 'Standards, amendments and interpretations applicable to the Trust for future accounting periods'. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

A PFI liability is recognised at the same time as the PFI asset is recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

1.11.3 Subsequent expenditure

The annual contract payments are apportioned, using appropriate estimation techniques between the repayment of the liability, a finance cost, lifecycle replacement and the charge for services.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term. The annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.11.4 Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.11.5 Other assets contributed by the Trust to the operator

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 Statement of Comprehensive Income 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.

Details of the impact of the PFI hospital under construction (the 'Queen Elizabeth Hospital') on the Trust's Financial Statements in the year to 31 March 2010 can be found in note 29 on page XLVII.

1.12 Inventories

Inventories are valued at the lower of cost and net realisable value. Pharmacy and warehouse stocks are valued at weighted average cost, other inventories are valued on a first-in first-out basis. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Work-in-progress comprises goods and services in intermediate stages of production.

1.13 Cash and cash equivalents

Cash and cash equivalents includes cash in hand, deposits held at call with banks, other short-term highly liquid investments with original maturities of three months or less and bank overdrafts. Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases bank overdrafts are shown within borrowings in 'current liabilities' on the Statement of Financial Position. In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. These balances exclude monies held in the Trust's bank accounts belonging to patients, see accounting policy note 1.26 for third party assets.

1.14 Finance income and costs

Interest earned on bank accounts and interest charged on overdrafts is 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.

1.15 Financial assets and financial liabilities

1.15.1 Recognition and de-recognition

Financial assets and financial liabilities are recognised when the Trust becomes party to the contractual provision of the financial instrument, or in the case of trade receivables and payables, when the goods or services have been delivered or received, respectively. Financial assets and financial liabilities are initially recognised at fair value. Public Dividend Capital is not considered to be a financial instrument, see accounting policy note 1.21 and is measured at historical cost.

Financial assets are de-recognised when the contractual rights to receive cashflows have expired or the asset has been transferred.

Financial liabilities are de-recognised when the obligation has been discharged, cancelled or has expired.

1.15.2 Classification

Financial assets are classified as:' financial assets at fair value through income and expenditure'; 'held to maturity investments'; 'available for sale financial assets'; or as 'loans and receivables'.

Financial liabilities are classified as: 'financial liabilities at fair value through income and expenditure'; or as 'other financial liabilities'.

1.15.3 Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets, except for those with maturities greater than 12 months after the reporting date, which are classified as non-current assets.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS and trade debtors, accrued income and 'other debtors'.

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. Interest is recognised using the effective interest method and is credited to 'finance income'. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

1.15.4 Other financial liabilities

Other financial liabilites are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. Interest is recognised using the effective interest method and is charged to 'finance costs'. The effective interest rate is the rate that exactly discounts estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities, except for those amounts payable more than 12 months after the reporting date, which are classified as non-current liabilities.

The Trust's other financial liabilities comprise: finance lease obligations, NHS and trade creditors, accrued expenditure and 'other creditors'.

1.15.5 Impairment of financial assets

At the end of the reporting period, the trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

1.15.6 Accounting for derivative financial instruments

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through income and expenditure. They are held at fair value, with any subsequent movement recognised as gains or losses in the Statement of Comprehensive Income.

1.16 Trade receivables

Trade receivables are recognised and carried at original invoice amount less provision for impairment. A provision for impairment of trade receivables is established when there is objective evidence that the Trust will not be able to collect all amounts due according to the original terms of receivables. The movement of the provision is recognised in the Statement of Comprehensive Income.

1.17 Deferred income

Deferred income represents grant monies received where the expenditure has not occurred in the current financial year. The deferred income is included in current liabilities unless the expenditure, in the opinion of

management, will take place more than 12 months after the reporting date, which are classified in non-current liabilities.

1.18 Borrowings

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 24.1 on Page XLIII. To date the Trust has not utilised any of its available prudential borrowing.

1.19 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the reporting 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.

1.19.1 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 in note 25 on page XLIV.

1.19.2 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.

1.20 Contingencies

Contingent liabilities are not recognised but are disclosed in note 27 on page XLV 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 or non-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.

1.21 Public Dividend Capital

Public Dividend Capital (PDC) represents taxpayers' equity in the Trust. At any time the Secretary of State can issue new PDC to, and require repayments of, PDC from the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, HM Treasury has determined that PDC is not an equity financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. From the 1 April 2009, the dividend payable is calculated at the rate set by HM Treasury (currently 3.5%) on the actual relevant net assets of the Trust during the financial year, instead of forecast relevant net assets. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and cash with the Office of the Paymaster General.

1.22 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 not a material operating segment within the Trust. It is therefore not separately disclosed.

1.23 Value Added Tax

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

1.24 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 1 April 2011.

1.25 Foreign exchange

The functional and presentational currency of the Trust is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Statement of Comprehensive Income in the period in which they arise.

1.26 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 financial statements in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.27 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS foundation trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.28 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

The judgements and key sources of estimation uncertainty that have a significant effect on the amounts recognised in the financial statements are detailed below:

a) Determination of useful lives for property, plant and equipment and intangible assets
Buildings, dwellings 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.

Depreciation is provided so as to write down the other assets on a straight line basis over the estimated life:

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

b) Provisions
Provisions have been made for pension and legal liabilities based on information received from the NHS Pensions Agency, NHS Litigation Agency and the Trust's own solicitors. Trust management has also made provisions for legal and constructive obligations where past events are known, settlement by the Trust is probable and a reliable estimate can be made. These provisions are estimates of the actual costs of future cash flows and are dependent on future events. Any difference between expectations and the actual future liability will be accounted for in the period when such determination is made.

The holiday pay provision represents management's best estimate of the cost of annual leave entitlement earned but not taken by employees at the period end.

The carrying amounts of the Trust's provisions are detailed in note 25 on page XLIV.

1.29 New Accounting Standards

1.29.1 The standards, amendments and interpretations effective as at 31 March 2010

The Trust has applied International Financial Reporting Standards for the first time in preparing its financial statements for the year ended 31 March 2010. All standards, amendments and interpretations effective in the year to 31 March 2010 which are relevant to the Trust's operations have been adopted.

1.29.2 The standards, amendments and interpretations effective as at 31 March 2010 that are relevant to the Trust for future financial periods

IFRIC 12 "Service Concession Arrangements" requires assets built under the Private Finance Initiative (PFI) and their associated liabilities to be disclosed in the financial statements of NHS Foundation Trusts, where certain conditions are met. The Trust will open a new PFI hospital (the 'Queen Elizabeth Hospital') on 16th June 2010 and as this infrastructure asset falls within the scope of a 'service concession' under IFRIC 12, this interpretation will be adopted for the accounting period to 31 March 2011 as it is expected to have a material effect on the Trust's financial statements.

1.29.3 Applicable standards, amendments and interpretations that are not yet effective and have not been early adopted by the Trust

The following amendment to IAS 17 "Leases" is expected to have a material impact on the Trust's financial statements:

IAS 17 "Classification of Leases of Land and Buildings. This amendment effective for accounting periods commencing on or after 1 January 2010 would classify leased land as a finance lease where certain conditions are met. Land leased for several decades or more, even if at the end of the lease term no title can pass to the lessee, can be classified as a finance lease because substantially all risks and rewards are transferred to the lessee and the present value of the residual value of the leased asset is considered to be negligible. This amendment would reclassify the land on the Queen Elizabeth Hospital Site which is leased over 999 years, from an operating lease to a finance lease. This would have a material impact on the Trust's financial statements and therefore, require the Trust to present a restated Statement of Financial Position from the beginning of the comparative period under IAS 1 "Presentation of Financial Statements". The land asset transferring onto the Trust's

Statement of Financial Position as a finance lease, would result in Net Assets and Total Equity being increased by £45 million. This land is treated as an operating lease under the IAS 17 standard as effective at 31 March 2010 and is off Statement of Financial Position at the reporting date.

The following standards, amendments and interpretations are relevant to the Trust, but are not expected to have a material impact on the financial statements:

- IAS 39 (amendment) 'Financial Instruments: Recognition and Measurement'
- IAS 38 (amendment) 'Intangible Assets: various'
- IFRS 8 (amendment) 'Operating Segments: disclosure requirements'
- IAS 24 (amendment) 'Related Party Transactions: disclosure requirements related to the public sector'

The Trust does not consider that any other standards, amendments or interpretations issued by the IASB, but not yet applicable, will have a significant impact on the financial statements.

2. Segmental Analysis

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

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

Revenue from activities (medical treatment of patients) is analysed by customer type in note 3 to the financial statements on page XXIX. Other operating revenue is analysed in note 4 to the financial statements on page XXX and materially consists of revenues from healthcare research and development, medical education and the provision of services to other NHS bodies. Total revenue by individual customers within the whole of HM Government and considered material, is disclosed in the related parties transactions note 28 to the financial statements on page XLV.

The percentage of total revenue receivable from within the whole of HM Government is disclosed below, the significant factor behind which is the 'mandatory services requirement', as set out in the Trust's Terms of Authorisation from Monitor.

	Year ended 31 March 2010		Year Ended 31 March 2009	
	£000	**%**	£000	%
Revenue from whole HM Government	**477,656**	**96.3%**	442,063	95.1%
Revenue from non HM Government sources	**18,538**	**3.7%**	22,634	4.9%
	496,194	**100.0%**	464,697	100.0%

Healthcare activity revenue from non HM Government sources (private patients) is restricted by legislation, see note 3.2 to the financial statements on page XXX.

3. Revenue from Activities

	Year Ended 31 March 2010 £000	Year Ended 31 March 2009 £000
Foundation Trusts	**102**	180
NHS Trusts	**353**	6
Strategic Health Authorities	**13,570**	14,235
Primary Care Trusts	**374,900**	336,229
Department of Health - other	**88**	21,107
NHS Other	**4,791**	3,273
Private Patients	**2,799**	3,504
NHS Injury Cost Recovery scheme	**3,051**	3,024
Non NHS: Other	**9,170**	5,990
	408,824	387,548

Included within 'Non NHS Other' is £9,169,814 relating to the Trust contract with the Royal Centre for Defence Medicine (2008/09 - £5,989,966).

The £88,000 (2008/09 - £21,107,000) of income from the Department of Health is the original Market Forces Factor. This has been superseded in 2009/10 by a new income stream based on an additional 6.85% of elective income received from Primary Care Trusts and is disclosed in the PCT line above.

NHS Injury Cost Recovery scheme income is subject to a provision for impairment of receivables of 7.8% to reflect expected rates of collection.

3.1 Revenue from Activities

	Year Ended 31 March 2010 £000	Year Ended 31 March 2009 £000
Elective	**88,704**	75,805
Non elective	**80,948**	87,631
Outpatients	**51,788**	49,860
A & E	**7,032**	7,267
Other NHS clinical	**165,332**	151,194
Private patients	**2,799**	3,504
Other non-protected clinical	**12,221**	12,287
Non NHS: Other	**408,824**	387,548

With the exception of private patient and other non-protected clinical revenue, all of the above revenue from activities arises from mandatory services as set out in the Trust's Terms of Authorisation from Monitor.

3.2 Private patients

	Financial Year	Base Year
	2009/10	2002/3
	£000	£000
Private patients	**2,799**	2,773
Total patient related revenue	**408,824**	225,193
Proportion (as percentage)	**0.68%**	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 Patients revenue.

4. Other Operating Revenue

	Year ended	Year Ended
	31 March	31 March
	2010	2009
	£000	£000
Research and development	**17,275**	10,848
Education and training	**28,799**	28,924
Charitable and other contributions to expenditure	**1,132**	831
Transfers from donated asset reserve	**937**	1,036
Non-patient care services to other bodies	**11,842**	11,756
Other revenue	**27,385**	23,754
	87,370	77,149

Other revenue includes £4,391,000 from Clinical Excellence Awards (2008/09 - £4,086,000); recharges of £5,377,000 to the Ministry of Defence to fund the training expenditure of Nurses along with catering and car parking costs associated with the military contract (2008/09 - £2,916,000); £1,951,000 from the National Quality Assurance Service (2008/09 - £1,775,000).

Revenue is almost totally from the supply of services. Revenue from the sale of goods is immaterial.

5. Operating Expenses

	Year Ended 31 March 2010 £000	Year Ended 31 March 2009 £000
Services from Foundation Trusts	**2,007**	1,206
Services from other NHS Trusts	**4,536**	4,678
Services from PCTs	**913**	1,517
Services from other NHS bodies	**135**	252
Purchase of healthcare from non NHS bodies	**9,551**	8,174
Directors' costs	**1,552**	1,703
Non executive directors' costs	**159**	139
Staff costs	**273,827**	255,900
Supplies and services - clinical	**116,116**	107,406
Supplies and services - general	**6,296**	6,064
Consultancy services	**4,086**	3,590
Establishment	**4,415**	3,861
Transport	**916**	949
Premises	**20,084**	20,753
Provision for Impairment of Receivables	**1,035**	235
Depreciation on property, plant and equipment	**10,593**	10,591
Amortisation on intangible assets	**247**	198
Impairments of property, plant and equipment	**1,232**	0
Loss on Disposal of property, plant and equipment	**51**	386
Audit services - statutory audit	**86**	69
Other auditors remuneration - other services	**82**	30
Clinical negligence	**3,501**	2,379
Other	**19,177**	12,940
	480,597	443,020

Other expenditure includes Research Grants distributed to other West Midlands NHS organisations of £9,278,000 (2008/09 - £3,475,000) due to the Trust acting as host body for the Comprehensive Local Research Network; Training, Courses and Conference fees of £4,009,000 (2008/09 - £3,049,000) and fees payable to RSM Tenon with regard to internal audit services of £161,000 (2008/09 - £181,000).

The impairment of property is due to the opening of the HUB Learning building and is described in note 14.5 to the financial statements on page XXXIX.

The loss on disposal of property, plant and equipment arises entirely from the disposal of non protected assets, which had supported continuing operations.

The Trust's contract with its external auditors, KPMG LLP, provides for a limitation of the auditors liability of five hundred thousand pounds sterling.

6. Operating Leases

6.1 As Lessee

Payments recognised as an expense	**Year Ended 31 March 2010 £000**	Year Ended 31 March 2009 £000
Minimum lease payments	**1,225**	1,095
Contingent rents	**0**	0
Sub-lease payments	**0**	0
	1,225	1,095

Total future minimum lease payments	**Year Ended 31 March 2010 £000**	Year Ended 31 March 2009 £000
Payable:		
Not later than one year	**1,041**	1,103
Between one and five years	**1,717**	2,430
After 5 years	**1,915**	2,132
Total	**4,673**	5,666

6.2 As Lessor

Rental revenue	**Year Ended 31 March 2010 £000**	Year Ended 31 March 2009 £000
Contingent rent	**0**	0
Other	**424**	345
	424	345

Total future minimum lease payments	**Year Ended 31 March 2010 £000**	Year Ended 31 March 2009 £000
Receivable:		
Not later than one year	**189**	345
Between one and five years	**432**	421
After 5 years	**1,111**	1,156
Total	**1,732**	1,922

7. Employee costs

7.1 Employee costs and numbers

	Year Ended 31 March 2010			Year Ended 31 March 2009		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	£000	**£000**	**£000**	£000	£000	£000
Short term employee benefits - salaries and wages	**219,346**	**204,210**	**15,136**	209,008	195,126	13,882
Short term employee benefits - social security costs	**17,463**	**17,463**	**0**	16,580	16,580	0
Post employment benefits - employer contributions to NHS pension scheme	**24,405**	**24,405**	**0**	23,267	23,267	0
Termination benefits	**187**	**187**	**0**	0	0	0
Agency/contract staff	**14,165**	**0**	**14,165**	8,748	0	8,748
	275,566	**246,265**	**29,301**	257,603	234,973	22,630

7.2 Average number of persons employed

	Year Ended 31 March 2010			Year Ended 31 March 2009		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	£000	**£000**	**£000**	£000	£000	£000
Medical and dental	**897**	**830**	**67**	874	798	76
Administration and estates	**1,470**	**1,470**	**0**	1,387	1,387	0
Healthcare assistants and other support staff	**581**	**581**	**0**	644	644	0
Nursing, midwifery and health visiting staff	**2,331**	**2,331**	**0**	2,246	2,246	0
Scientific, therapeutic and technical staff	**1,015**	**1,015**	**0**	964	964	0
Bank and agency staff	**232**	**0**	**232**	140	0	140
	6,526	**6,227**	**299**	6,255	6,039	216

7.3 Key Management Compensation

	Year Ended 31 March 2010 £000	Year Ended 31 March 2009 £000
Salaries and short term benefits	**1,222**	1,472
Social Security Costs	**149**	173
Employer contributions to NHSPA	**181**	197
	1,552	1,842

Key management compensation consists entirely of the emoluments of the Board of Directors of the Trust. Full details of Directors' remuneration and interests are set out in the Directors' Remuneration Report which is a part of the annual report and financial statements.

8. Retirements due to ill-health

During the year to 31 March 2010 there were 8 early retirements from the Trust agreed on the grounds of ill-health (31 March 2009: 10). The estimated additional pension liabilities of these ill-health retirements will be £580,494 (31 March 2009: £404,724). The cost of these ill-health retirements will be borne by the NHS Pensions Agency.

9. Better Payment Practice Code

9.1 Better Payment Practice Code - measure of compliance

	Year Ended 31 March 2010		Year Ended 31 March 2009	
	Number	**£000**	Number	£000
Total trade bills paid in the year	**95,539**	**201,652**	89,508	211,940
Total trade bills paid within target	**94,269**	**199,643**	88,274	210,428
Percentage of trade bills paid within target	**98.67%**	**99.00%**	98.62%	99.29%
Total NHS bills paid in the year	**5,020**	**89,613**	5,502	82,996
Total NHS bills paid within target	**4,669**	**85,191**	4,792	73,897
Percentage of NHS bills paid within target	**93.01%**	**95.07%**	87.10%	89.04%

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

9.2 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.

10. Finance Income

	Year Ended 31 March 2010 £000	Year Ended 31 March 2009 £000
Interest on loans and receivables	**664**	3,404
	664	3,404

11. Finance Expense

	Year Ended 31 March 2010 £000	Year Ended 31 March 2009 £000
Interest on obligations under finance leases	**8**	12
	8	12

12. Taxation

The activities of the Trust have not given rise to any corporation tax liability in the year (2008/09 - £nil).

13. Intangible Assets

13.1 Year Ended 31 March 2010:

	Computer software - purchased £000	Licences and trademarks £000	Intangible assets under construction £000	Total £000
Gross cost at 1 April 2009	1,057	164	59	1,280
Additions purchased	103	0	0	103
Additions donated	0	0	0	0
Reclassifications	59	0	(59)	0
Gross cost at 31 March 2010	**1,219**	**164**	**0**	**1,383**
Amortisation at 1 April 2009	345	38	0	383
Provided during the year	214	33	0	247
Amortisation at 31 March 2010	**559**	**71**	**0**	**630**
Net book value				
Purchased	660	93	0	753
Donated	0	0	0	0
Total at 31 March 2010	**660**	**93**	**0**	**753**

13. Intangible Assets (cont.)

13.2 Year Ended 31 March 2009:

	Computer software - purchased £000	Licences and trademarks £000	Intangible assets under construction £000	Total £000
Gross cost at 1 April 2008	949	107	0	1,056
Additions purchased	108	57	59	224
Additions donated	0	0	0	0
Gross cost at 31 March 2009	**1,057**	**164**	**59**	**1,280**
Amortisation at 1 April 2008	168	17	0	185
Provided during the year	177	21	0	198
Amortisation at 31 March 2009	**345**	**38**	**0**	**383**
Net book value				
Purchased	712	126	59	897
Donated	0	0	0	0
Total at 31 March 2009	**712**	**126**	**59**	**897**

13.3 Valuation and economic useful lives

The valuation basis is described in note 1.6 to the accounts. There is no active market for the Trust's intangible assets and there is no revaluation reserve.

The estimated useful economic lives of intangible assets are finite and are described in note 1.28 to the financial statements.

14. Property, plant and equipment

14.1 Year Ended 31 March 2010:

	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
Gross cost at 1 April 2009	42,500	92,815	3,156	5,592	62,160	119	10,677	5,240	222,259
Additions purchased	0	4,142	0	1,331	10,670	0	1,632	124	17,899
Additions donated	0	129	0	3	237	0	0	0	369
Reclassifications	0	2,755	0	(3,545)	602	0	188	0	0
Impairments to operating expenses	0	(1,232)	0	0	0	0	0	0	(1,232)
Impairments to revaluation reserve	(15,000)	0	(1,808)	0	0	0	0	0	(16,808)
Revaluation surpluses	0	(39,559)	0	0	0	0	0	0	(39,559)
Disposals other than by sale	0	0	0	0	(4,587)	0	0	(199)	(4,786)
Gross cost at 31 March 2010	**27,500**	**59,050**	**1,348**	**3,381**	**69,082**	**119**	**12,497**	**5,165**	**178,142**
Depreciation at 1 April 2009	0	43,821	1,416	0	37,157	119	4,288	4,512	91,313
Provided during the year	0	2,892	106	0	5,735	0	1,525	335	10,593
Reclassifications	0	0	0	0	0	0	0	0	0
Impairments to revaluation reserve	0	0	(1,522)	0	0	0	0	0	(1,522)
Revaluation surpluses	0	(43,228)	0	0	0	0	0	0	(43,228)
Disposals other than by sale	0	0	0	0	(4,536)	0	0	(199)	(4,735)
Depreciation at 31 March 2010	**0**	**3,485**	**0**	**0**	**38,356**	**119**	**5,813**	**4,648**	**52,421**
Net book value									
- Purchased at 31 March 2010	27,500	50,108	1,322	3,244	28,630	0	6,684	498	117,986
- Donated at 31 March 2010	0	5,457	26	137	2,096	0	0	19	7,735
Total at 31 March 2010	**27,500**	**55,565**	**1,348**	**3,381**	**30,726**	**0**	**6,684**	**517**	**125,721**
Analysis of property, plant and equipment									
Net book value									
- Protected assets at 31 March 2010	0	26,665	0	0	0	0	0	0	26,665
- Unprotected assets at 31 March 2010	27,500	28,900	1,348	3,381	30,726	0	6,684	517	99,056
Total at 31 March 2010	**27,500**	**55,565**	**1,348**	**3,381**	**30,726**	**0**	**6,684**	**517**	**125,721**
Asset Financing									
Net book value									
- Owned	27,500	55,565	1,348	3,381	30,656	0	6,684	517	125,651
- Finance Leased	0	0	0	0	70	0	0	0	70
Total at 31 March 2010	**27,500**	**55,565**	**1,348**	**3,381**	**30,726**	**0**	**6,684**	**517**	**125,721**

14. Property, plant and equipment

14.2 Year Ended 31 March 2009:

	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
Gross cost at 1 April 2008	42,499	88,886	3,595	5,125	61,100	119	9,790	5,095	216,209
Additions purchased	0	748	0	4,714	4,693	0	92	35	10,282
Additions donated	0	0	0	0	291	0	0	0	291
Reclassifications	1	3,181	(439)	(4,247)	599	0	795	110	0
Disposals other than by sale	0	0	0	0	(4,523)	0	0	0	(4,523)
Gross cost at 31 March 2009	**42,500**	**92,815**	**3,156**	**5,592**	**62,160**	**119**	**10,677**	**5,240**	**222,259**
Depreciation at 1 April 2008	0	41,164	1,310	0	35,247	119	2,842	4,103	84,785
Provided during the year	0	2,657	106	0	5,973	0	1,446	409	10,591
Reclassifications	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(4,063)	0	0	0	(4,063)
Depreciation at 31 March 2009	**0**	**43,821**	**1,416**	**0**	**37,157**	**119**	**4,288**	**4,512**	**91,313**
Net book value									
- Purchased at 31 March 2009	42,500	43,526	1,705	5,459	22,481	0	6,389	689	122,749
- Donated at 31 March 2009	0	5,468	35	133	2,522	0	0	39	8,197
Total at 31 March 2009	**42,500**	**48,994**	**1,740**	**5,592**	**25,003**	**0**	**6,389**	**728**	**130,946**
Analysis of property, plant and equipment									
Net book value									
- Protected assets at 31 March 2009	0	19,175	0	0	0	0	0	0	19,175
- Unprotected assets at 31 March 2009	42,500	29,819	1,740	5,592	25,003	0	6,389	728	111,771
Total at 31 March 2009	**42,500**	**48,994**	**1,740**	**5,592**	**25,003**	**0**	**6,389**	**728**	**130,946**
Asset Financing									
Net book value									
- Owned	42,500	48,994	1,740	5,592	24,849	0	6,389	728	130,792
- Finance Leased	0	0	0	0	154	0	0	0	154
Total at 31 March 2009	**42,500**	**48,994**	**1,740**	**5,592**	**25,003**	**0**	**6,389**	**728**	**130,946**

14. Property, plant and equipment (cont.)

14.3 Revaluation

The land, buildings and dwellings were valued at 31 March 2010 by an independent valuer. The valuation basis is described in note 1.5.2 to the financial statements. The surpluses and deficits upon the valuation exercise are detailed below in note 14.5 and 14.6.

14.4 Estimated useful economic lives

The estimated useful economic lives of property, plant and equipment are described in note 1.28 to the financial statements.

14.5 Impairments of property, plant and equipment

	Year Ended 31 March 2010 £000	Year Ended 31 March 2009 £000
Impairment charged to Statement of Comprehensive Income	**(1,232)**	0
	(1,232)	0

During the year the Trust opened the Learning HUB building - a centre for education, which gave rise to an impairment resulting from the difference between the cost directly attributable to the construction and the fair value in operational use, as measured at 31 March 2010. The impairment is disclosed in Operating Expenses within the Statement of Comprehensive Income, in note 5 to the financial statements on page XXXI.

14.6 Revaluation gains / (losses) on property, plant and equipment

The valuation of the remainder of the Trust's land and buildings as at 31st March 2010 resulted in the following surpluses and deficits being charged to the revaluation and donated asset reserves, see the Statement of Changes in Taxpayers' Equity on page XIV of the financial statements.

	Revaluation Reserve £000	Donated Asset Reserve £000	**Total £000**
Land	(15,000)	0	**(15,000)**
Buildings	3,556	113	**3,669**
Dwellings	(279)	(7)	**(286)**
	(11,723)	106	**(11,617)**

15. Capital commitments

Commitments under capital expenditure contracts at the end of the period, not otherwise included in these financial statements, were £10,257,294 (31 March 2009 - £20,933,574). This amount relates entirely to property, plant and equipment, there are nil contracted capital commitments for intangible assets. Included within these amounts are £5,996,190 (31 March 2009 - £16,258,228) for committed orders to purchase equipment for the new PFI Hospital.

16. Inventories

16.1 Inventories

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Materials	**10,846**	9,410	9,378
Work in progress	**0**	13	0
Finished goods	**5**	178	363
	10,851	9,601	9,741

Inventories carried at fair value less costs to sell where such value is lower than cost are nil (31 March 2009 - £nil).

16.2 Inventories recognised in expenses

	Year Ended 31 March 2010 £000	Year Ended 31 March 2009 £000
Inventories recognised as an expense	**113,296**	100,922
Write-down of inventories recognised as an expense	**33**	18
	113,329	100,940

17. Trade and other receivables

17.1 Trade and other receivables

	Current			Non - Current		
	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000	**31 March 2010 £000**	31 March 2009 £000	1 April 2008 £000
NHS receivables	**13,114**	8,641	13,226	**370**	468	541
Non NHS trade receivables	**11,420**	8,734	3,760	**0**	0	0
Provision for impaired receivables	**(1,772)**	(873)	(318)	**(203)**	(200)	(163)
Prepayments	**9,069**	1,514	3,145	**0**	0	0
Accrued income	**1,086**	250	(219)	**0**	0	0
Other receivables	**4,584**	4,594	2,944	**2,602**	2,568	2,108
PDC receivable	**12**	0	0	**0**	0	0
	37,513	22,860	22,538	**2,769**	2,836	2,486

17.2 Provision for impairment of receivables

	31 March 2010 £000	31 March 2009 £000
Balance at 1 April	**1,073**	481
Increase in provision	**1,513**	954
Amounts utilised	**(133)**	(349)
Unused amounts reversed	**(478)**	(13)
Balance at 31 March	**1,975**	1,073

18. Other non financial assets

	Current			Non - Current		
	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000	**31 March 2010 £000**	31 March 2009 £000	1 April 2008 £000
PFI deferred assets - building works variations	**0**	0	0	**29,955**	16,200	0
PFI deferred assets - bullet payment	**41**	41	41	**294**	335	375
	41	41	41	**30,249**	16,535	375

Deferred assets - building works variations arise from the Trust making payments, for additional construction work to the new Private Finance Initiative (PFI) hospital, direct to the PFI partner in order to leave the contracted PFI unitary payments unchanged. Upon opening of the PFI hospital, the deferred assets will be reclassified as property, plant and equipment as part of the fair valuation of the new PFI hospital building, see note 1.29.2 to the financial statements.

Deferred assets - bullet payment arises from the Trust making payments direct to the PFI partner for the provision of IT services. This payment made to the PFI partner will be amortised over the remaining 8 years of the contract.

19. Cash and cash equivalents

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Cash and cash equivalents	**96,290**	97,793	71,434
Made up of			
Cash with Office of HM Paymaster General	**95,897**	96,380	69,598
Commercial banks and cash in hand	**393**	1,413	1,836
Current investments	**0**	0	0
Cash and cash equivalents as in statement of financial position	**96,290**	97,793	71,434
Bank overdraft - Office of HM Paymaster General	**0**	0	0
Bank overdraft - Commercial banks	**0**	0	0
Cash and cash equivalents as in statement of cash flows	**96,290**	97,793	71,434

20. Non-current assets held for sale

The Trust has no non-current assets held for sale (31 March 2009 - £nil).

21. Trade and other payables

	Current			**Non - Current**		
	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000	**31 March 2010 £000**	31 March 2009 £000	1 April 2008 £000
NHS payables	**19,884**	9,923	9,332	**0**	0	0
Non NHS trade payables	**19,923**	19,038	17,339	**0**	0	0
Trade payables - capital	**5,555**	2,047	2,142	**0**	0	0
Other payables	**392**	308	2,993	**0**	0	0
Accruals	**16,370**	15,681	9,939	**0**	0	0
Receipts in advance	**480**	61	1,179	**0**	0	0
	62,604	47,058	42,924	**0**	0	0

NHS payables include pension contributions of £3,115,796 outstanding (31 March 2009: £2,876,779 and 1 April 2008: £2,660,178).

22. Tax payable

	Current			**Non - Current**		
	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000	**31 March 2010 £000**	31 March 2009 £000	1 April 2008 £000
Taxes payable	**6,054**	5,530	5,667	**0**	0	0

Tax payable consists of employment taxation only (Pay As You Earn and National Insurance Contributions), owed to Her Majesty's Revenue and Customs at the period end .

23. Other liabilities

	Current			Non - Current		
	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000	**31 March 2010 £000**	31 March 2009 £000	1 April 2008 £000
Deferred income	**27,423**	18,766	12,538	**25,040**	24,787	12,684
Deferred government grant	**46**	276	200	**2,648**	3,077	3,353
	27,469	19,042	12,738	**27,688**	27,864	16,037

24. Borrowings

24.1 Prudential borrowing limit

	31 March 2010 £000	31 March 2009 £000
Prudential borrowing limit set by Monitor	**592,100**	78,600
Working capital facility	**1,000**	1,000
Actual borrowing in year - long term	**0**	0
Actual borrowing in year - working capital	**0**	0
Minimum dividend cover	**11.7**	6.2
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. The increase in the Trust's Prudential Borrowing Limit to £592.1m (31 March 2009: £78.6m) is in anticipation of the opening of the new hospital in the next financial year; the assets and associated liabilities of this private finance initiative scheme will be accounted for on-Statement of Financial Position, see note 1.29.2 to the financial statements.

The increase in the minimum dividend cover disclosed above for the year to 31 March 2010 is attributable to the decrease in PDC dividends paid to the Department of Health of £2,433,000 (2008/09 - £5,884,000), see the Statement of Comprehensive Income on page XII.

24. Borrowings (cont).

24.2 Finance lease obligations

Amounts payable under finance leases:	Minimum lease payments			Present value of minimum lease payments		
	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000	**31 March 2010 £000**	31 March 2009 £000	1 April 2008 £000
Within one year	**72**	92	64	**68**	84	56
Between one and five years	**8**	80	113	**7**	75	104
After five years	**0**	0	0	**0**	0	0
Less future finance charges	**(5)**	(13)	(17)			
	75	159	160	**75**	159	160
Included in:						
Current borrowings	**68**	84	56	**68**	84	56
Non-current borrowings	**7**	75	104	**7**	75	104
Deferred government grant	**75**	159	160	**75**	159	160

25. Provisions

	Current			Non - Current		
	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000	**31 March 2010 £000**	31 March 2009 £000	1 April 2008 £000
Pensions relating to other staff	**34**	33	31	**169**	189	203
Legal claims	**1,201**	1,188	338	**1,681**	2,196	3,102
Other	**2,411**	3,833	4,530	**370**	1,582	1,114
	3,646	5,054	4,899	**2,220**	3,967	4,419

	Pensions relating to former directors £000	**Pensions relating to other staff £000**	**Legal claims £000**	**Other £000**	**Total £000**
At 1 April 2009	0	222	3,384	5,415	9,021
Arising during the year	0	10	458	1,271	1,739
Used during the year	0	(34)	(352)	(3,877)	(4,263)
Reversed unused	0	0	(642)	(28)	(670)
Unwinding of discount	0	5	34	0	39
At 31 March 2010	**0**	**203**	**2,882**	**2,781**	**5,866**
Expected timing of cash flows:					
Within one year	0	34	1,201	2,411	**3,646**
Between one and five years	0	127	363	370	**860**
After five years	0	42	1,318	0	**1,360**

25. Provisions (cont).

The provisions included under 'legal claims' are for personal injury pensions £1,775,117 (31 March 2009: £1,562,313 and 1 April 2008: £1,433,460), employers and public liability £223,834 (31 March 2009: £212,685 and 1 April 2008: £256,807) and other claims notified by the Trust's solicitors £882,638 (31 March 2009: £1,609,426 and 1 April 2008: £1,749,676). The provisions for personal injury pensions have been calculated on guidance received from the NHS Business Services Authority - Pensions Division. 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.

Early retirement pension provisions of £202,769 (31 March 2009: £221,624 and 1 April 2008: £223,866), the latter disclosed as 'pensions relating to other staff' have been calculated on guidance received from the NHS Business Services Authority - Pensions Division.

The 'other' provisions include annual leave entitlement earned but not taken by employees at the period end £802,208 (31 March 2009: £884,128 and 1 April 2008: £737,731) and provisions in respect of NHS pay agreements £1,513,848 (31 March 2009: £2,876,237 and 1 April 2008: £3,755,958).

Provisions within the annual accounts of the NHS Litigation Authority at 31 March 2010 include £18,206,952 in respect of clinical negligence liabilities of the Trust (31 March 2009: £9,208,043 and 1 April 2008: £9,853,630).

26. Events after the reporting period
The Trust does not have any post reporting period events.

27. Contingencies
There are £125,973 of contingent liabilities at 31 March 2010 which relate to amounts notified by the NHSLA for potential employer and public liability claims over and above the amounts provided for in note 24 (31 March 2009: £48,988 and 1 April 2008: £88,395).

28. 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 Executive Director of the Trust is the partner of Ms Michelle McLoughlin - an Executive Director of Birmingham Childrens Hospital NHS Foundation Trust. The Trust's formal Service Level Agreement with the Birmingham Childrens Hospital Foundation NHS Trust for the year ended 31 March 2010 has resulted in an income to the Trust of £2,041,171 and an expenditure of £318,869.

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 to the right:

	Receivables £'000	Payables £'000	Revenue £'000	Expenditure £'000
Department of Health	75	(1)	11,810	(519)
South Birmingham PCT	992	(5,288)	121,877	(1,962)
Heart of Birmingham Teaching PCT	0	(282)	23,067	(1,120)
Birmingham East and North PCT	0	(1,260)	13,646	(632)
Pan Birmingham LCCB	0	0	83,788	0
Black Country LCCB	0	0	11,708	0
West Midlands South LCCB	0	0	18,907	0
West Midlands North LCCB	0	0	6,429	0
West Midlands SSA	0	0	17,996	0
West Midlands SHA	166	(2,273)	33,642	(51)
Dudley PCT	27	0	6,630	0
Sandwell PCT	914	0	11,201	(16)
Solihull PCT	0	(76)	6,959	0
Warwickshire PCT	0	(35)	5,490	(4)
Worcestershire PCT	392	0	16,555	(19)
South Staffordshire PCT	370	0	8,906	0
Walsall PCT	34	0	5,014	(1)
London Strategic Health Authority	0	(30)	13,571	(30)
NHS Blood and Transplant Agency	30	(470)	2,084	(8,591)
NHS Business Services Authority	0	(1,855)	0	(5,668)

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

In addition, the Trust has had a number of material transactions with other Government Departments and local Government bodies. These are detailed below:

	Receivables £'000	Payables £'000	Revenue £'000	Expenditure £'000
Ministry of Defence	7,985	(38)	14,565	(897)
Birmingham City Council	626	(438)	755	(3,005)

The Trust has also received revenue and capital payments from the University Hospital Birmingham Charities. David Ritchie who was a Trustee of UHB Charities throughout 2009/10, was also a non-executive director of the Trust. Brian Hanson, who was a Trustee of UHB Charities throughout 2009/10, was also a Governor of the Trust.

29. Private Finance Initiative contracts

29.1 PFI schemes off-Statement of Financial Position - 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. The construction of the new building is substantially complete as at the reporting date, with all programme deadlines being met on time or delivered ahead of schedule.

	Year Ended 31 March 2010 £000	Year Ended 31 March 2009 £000
Gross charge included within operating expenses in respect of PFI transactions deemed to be off-statement of financial position	**4,803**	3,118
Amortisation of PFI deferred asset	**(41)**	(41)
Net charge to operating expenses	**4,762**	3,077

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)	**33,652**

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 resulting in deferred assets at the period end, see note 18 to the financial statements on page XLI.

As at the reporting date there were 69 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.

29.2 PFI schemes on-Statement of Financial Position

The Trust does not have any PFI schemes which are deemed to be on-Statement of Financial Position at the period end. Upon opening of the PFI - New Hospital Project described in note 28.1 to the financial statements, the PFI scheme will be reclassified as on-Statement of Financial Position, see note 1.29.2 to the financial statements.

30. Financial instruments and related disclosures

A financial instrument is a contract that gives rise to a financial asset in one entity and a financial liability or equity instrument in another entity. The nature of the Trust's activities means that exposure to risk, although not eliminated, is substantially reduced.

The key risks that the Trust has identified are as follows:-

30.1 Financial risk

Because of the continuing service provider relationship that the Trust has with primary care trusts (PCTs) and the way those PCTs are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Investment Committee.

30.2 Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

30.3 Market (Interest rate) risk

All of the Trust's financial assets and all of its financial liabilities carry nil or fixed rates of interest. The Trust is not, therefore, exposed to significant interest-rate risk.

30.4 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 2010 are in receivables from customers, as disclosed in note 17 to the financial statements on page XLI. The Trust mitigates its exposure to credit risk through regular review of debtor balances and by calculating a bad debt provision at the period end.

The following shows the age of such financial assets that are past due and for which no provision for bad or doubtful debts has been raised:

	31 March 2010	31 March 2009	1 April 2009
	£000	£000	£000
By up to three months	**2,131**	4,026	2,785
By three to six months	**1,655**	539	365
By more than six months	**2,478**	904	2,129
	6,264	5,469	5,279

The Trust has not raised bad or doubtful debt provisions against these amounts as they are considered to be recoverable based on previous trading history.

30.5 Liquidity risk

The 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 obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

30.6 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.

The following table is a comparison by category of the carrying amounts and the fair values of the Trust's financial assets and financial liabilities at 31 March 2010, 31 March 2009 and 1 April 2008.

	Carrying Value	**Fair Value**	**Carrying Value**	**Fair Value**	**Carrying Value**	**Fair Value**
	31 March 2010	**31 March 2010**	31 March 2009	31 March 2009	1 April 2008	1 April 2008
	£000	**£000**	£000	£000	£000	£000
Current financial assets						
Cash and cash equivalents	**96,290**	**96,290**	97,793	97,793	71,434	71,434
Loans and receivables:						
Trade and receivables	**28,432**	**28,432**	21,346	21,346	19,393	19,393
	124,722	**124,722**	119,139	119,139	90,827	90,827
Non-current financial assets						
Loans and receivables:						
Trade and receivables	**2,769**	**2,769**	2,836	2,836	2,486	2,486
Total financial assets	**127,491**	**127,491**	121,975	121,975	93,313	93,313
Current financial liabilities						
Financial liabilities:						
Finance leases	**68**	**68**	84	84	56	56
Trade and other payables	**62,124**	**62,124**	46,997	46,997	41,745	41,745
Provisions under contract	**3,517**	**3,517**	4,940	4,940	4,795	4,795
	65,709	**65,709**	52,021	52,021	46,596	46,596
Non-current financial liabilities						
Financial liabilities:						
Finance leases	**7**	**7**	75	75	104	104
Provisions under contract	**371**	**371**	2,297	2,297	2,856	2,856
	378	**378**	2,372	2,372	2,960	2,960
Total financial liabilitie	**66,087**	**66,087**	54,393	54,393	49,556	49,556
Net financial assets	**61,404**	**61,404**	67,582	67,582	43,757	43,757

The fair value on all these financial assets and financial liabilities approximate to their carrying value.

31. Third Party Assets

The Trust held £4,288 cash at bank and in hand at 31 March 2010 (31 March 2009: £3,629 and 1 April 2008: £5,430) which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

32. Losses and Special Payments

There were 2,091 cases of losses and special payments (2008/09 - 2,215 cases) totalling £316,386 (2009/10 - 257,639) approved in the year.

There were no clinical negligence, fraud, personal injury, compensation under legal obligation or fruitless payment cases where the net payment or loss for the individual case exceeded £100,000.

33. Transition to IFRS

The Trust reported under UK GAAP in its published financial statements for the year ended 31 March 2009. The Trust has adopted International Financial Reporting Standards (IFRS) for these financial statements for the year ended 31 March 2010.

Key impacts

The main impacts of IFRS on the reported results of the Trust are listed below and are described in greater detail in the following sections.

- Operating leases (IAS 17) - a 999 year lease of land previously catagorised within tangible fixed assets, has been reclassified as an operating lease.

- Employee benefits (IAS 19) - employee annual leave entitlement earned but not taken in the financial year has been recognised as a liability at the year end.

- Finance leases (IAS 17) - leases previously categorised as operating leases have been reclassified as finance leases, where the Trust has substantially all the risks and rewards incidental to ownership.

- Intangible assets (IAS 38) - expenditure on software which is deemed not to be integral to the computer hardware and will generate economic benefits beyond one year is capitalised as an intangible asset.

The analysis below shows a reconciliation of tax payers' equity (assets employed) and comprehensive income reported under UK GAAP for the year to 31 March 2009 to the revised tax payers' equity and comprehensive income under IFRS as reported in these financial statements. There is a reconciliation of the tax payers' equity under UK GAAP to IFRS at the transition date for the Trust being 1 April 2008.

	Year Ended 31 March 2009 £000
Retained surplus under UK GAAP as previously reported	**19,303**
Annual leave entitlement earned but not taken	(146)
Reclassification of assets from operating leases to finance leases	(5)
Translation of foreign currency transactions	(1)
Surplus for the year under IFRS	**19,151**

33. Transition to IFRS (cont).

	31 March 2009 £000	1 April 2008 £000
Tax payers' equity under UK GAAP as previously reported	**223,725**	202,804
Queen Elizabeth Hospital land reclassified as an operating lease	(50,000)	(50,000)
Annual leave entitlement earned but not taken	(884)	(738)
Reclassification of assets from operating leases to finance leases	(5)	0
Translation of foreign currency transactions	(1)	0
Total taxpayers' equity (total assets employed) under IFRS	**172,835**	**152,066**

Reconciliation of the statement of comprehensive income for the year ended 31 March 2009

	Ref	UK GAAP Year Ended 31 March 2009 £000	IFRS Year Ended 31 March 2009 £000	Difference £000
Operating Income		464,697	464,697	0
Operating Expenses	1.1	(442,880)	(443,020)	(140)
Operating surplus		**21,817**	**21,677**	**(140)**
Finance Costs				
Finance income		3,404	3,404	0
Finance expense - financial liabilities	1.2	0	(12)	(12)
Finance expense - unwinding of discount on provisions		(34)	(34)	0
PDC Dividends payable		(5,884)	(5,884)	0
Net finance costs		(2,514)	(2,526)	(12)
Surplus for the year		**19,303**	**19,151**	**(152)**

There is no change in the 'other comprehensive income' disclosures due to the adoption of international Financial Reporting Standards.

33. Transition to IFRS (cont).

The differences are explained as follows:

	Year Ended 31 March 2009 £000
Reference 1.1	
Operating Expenses	
Employee benefits (IAS 19) - employee annual leave entitlement (holiday pay) earned but not taken in the financial year.	**(146)**
Finance leases (IAS 17) - operating leases rentals have been reclassified as depreciation on property, plant and equipment on assets held as finance leases.	**7**
Changes in foreign exchange rates (IAS 21) - foreign currency liabilities are presented at the rate of currency exchange prevailing at period end.	**(1)**
	(140)
Reference 1.2	
Operating Expenses	
Finance leases (IAS 17) - operating leases rentals have been reclassified as interest payable on finance leases.	(12)

33. Transition to IFRS (cont).

Reconciliation of total tax payers' equity (total assets employed) at 31 March 2009 and 1 April 2008 (date of transition to IFRS)

	UK GAAP 31 March 2009 £000	IFRS 31 March 2009 £000	Difference £000	UK GAAP 1 April 2008 £000	IFRS 1 April 2008 £000	Difference £000
Non-Current Assets						
Intangible assets	**0**	**897**	**897**	0	871	871
Property, Plant and Equipment	**181,689**	**130,946**	**(50,743)**	182,135	131,424	(50,711)
Trade and other receivables	**2,836**	**2,836**	**0**	2,486	2,486	0
Other assets	**16,535**	**16,535**	**0**	375	375	0
	201,060	**151,214**	**(49,846)**	184,996	135,156	(49,840)
Current Assets						
Inventories	**9,601**	**9,601**	**0**	9,741	9,741	0
Trade and other receivables	**22,860**	**22,860**	**0**	22,538	22,538	0
Other current assets	**41**	**41**	**0**	41	41	0
Cash at bank and in hand	**97,793**	**97,793**	**0**	71,434	71,434	0
	130,295	**130,295**	**0**	103,754	103,754	0
Current Liabilities						
Trade and Other Payables	**(93,963)**	**(47,058)**	**46,905**	(71,699)	(42,924)	28,775
Borrowings	**0**	**(84)**	**(84)**	0	(56)	(56)
Provisions	**(4,170)**	**(5,054)**	**(884)**	(4,161)	(4,899)	(738)
Tax Payable	**(5,530)**	**(5,530)**	**0**	(5,667)	(5,667)	0
Other liabilities	**0**	**(19,042)**	**(19,042)**	0	(12,738)	(12,738)
	(103,663)	**(76,768)**	**26,895**	(81,527)	(66,284)	15,243
Non-Current Liabilities						
Borrowings	**0**	**(75)**	**(75)**	0	(104)	(104)
Provisions	**(3,967)**	**(3,967)**	**0**	(4,419)	(4,419)	0
Other Liabilities	**0**	**(27,864)**	**(27,864)**	0	(16,037)	(16,037)
	(3,967)	**(31,906)**	**(27,939)**	(4,419)	(20,560)	(16,141)
Total assets employed	**223,725**	**172,835**	**(50,890)**	202,804	152,066	(50,738)
Financed by Taxpayers' Equity						
Public dividend capital	**171,012**	**171,012**	**0**	168,612	168,612	0
Revaluation reserve	**72,329**	**75,884**	**3,555**	72,445	74,184	1,739
Donated asset reserve	**8,197**	**8,197**	**0**	8,942	8,942	0
Income and expenditure reserve	**(27,813)**	**(82,258)**	**(54,445)**	(47,195)	(99,672)	(52,477)
Total taxpayers' equity	**223,725**	**172,835**	**(50,890)**	202,804	152,066	(50,738)

The differences are explained as follows:

Reference 2.1	**Year Ended 31 March 2009 £000**	Year Ended 1 April 2008 £000
Intangible assets		
Intangible assets (IAS 38) - requires the reclassification of capitalised expenditure on software from property, plant and equipment to intangible assets	**897**	871

33. Transition to IFRS (cont).

	31 March 2009	1 April 2008
Reference 2.2		
Property, plant and equipment	**£000**	£000
Operating leases (IAS 17) - the Queen Elizabeth Hospital Site which in 1974 was leased from Birmingham City Council on a 999 year has been reclassified as an operating lease, because no title can pass to the Trust (the lessee). The land was previously categorised within property, plant and equipment.	**(50,000)**	(50,000)
Finance leases (IAS 17) - leases of equipment previously categorised as operating leases have been reclassified as finance leases, where the Trust has substantially all the risks and rewards incidental to ownership, including options to purchase outright. See reference 2.4 below.	**154**	160
Intangible assets (IAS 38) - requires the reclassification of capitalised expenditure on software from property, plant and equipment to intangible assets.	**(897)**	(871)
	(50,743)	(50,711)
Reference 2.3		
Trade and Other Payables		
Presentation of financial statements (IAS 1) - deferred income and government grant income for capital expenditure are reclassified from trade and other payables to current and non-current 'other liabilities'. See		
Changes in foreign exchange rates (IAS 21) - trade payables that have arisen from foreign currency ference 2.6 below.	**46,906**	28,775
Changes in foreign exchange rates (IAS 21) - trade payables that have arisen from foreign currency transactions are presented at the rate of currency exchange prevailing at period end.	**(1)**	0
	46,905	28,775
Reference 2.4		
Borrowings		
Finance leases (IAS 17) - leases of equipment previously categorised as operating leases have been reclassified as finance leases. See reference 2.2 above. Liability - due within one year	**(84)**	(56)
Finance leases (IAS 17) - leases of equipment previously categorised as operating leases have been reclassified as finance leases. See reference 2.2 above. Liability due over one year -	**(75)**	(104)
	(159)	(160)
Reference 2.5		
Provisions		
Employee benefits (IAS 19) - employee annual leave entitlement (holiday pay) earned but not taken in the financial year has been recognised as a liability at the year end.	**(884)**	(738)
Reference 2.6		
Other Liabilities		
(IAS 1) - deferred income reclassified as current other liabilities.	**(18,766)**	(12,538)
(IAS 1) - capitalised government grant income reclassified as current other liabilities.	**(276)**	(200)
	(19,042)	(12,738)
(IAS 1) - deferred income reclassified as non-current other liabilities.	**(24,787)**	(12,684)
(IAS 1) - capitalised government grant income reclassified as non-current other liabilities.	**(3,077)**	(3,353)
	(27,864)	(16,037)
See reference 2.3 above	**(46,906)**	(28,775)

33. Transition to IFRS (cont).

	31 March	1 April
Reference 2.7	**2009**	2008
Revaluation reserve	**£000**	£000
Operating leases (IAS 17) - the Queen Elizabeth Hospital Site which in 1974 was leased from Birmingham City Council on a 999 year has been reclassified as an operating lease, because no title can pass to the Trust (the lessee). The land was previously categorised within property, plant and equipment. See reference 2.2 above and reference 2.8 below.	**(35,379)**	(35,379)
Finance leases (IAS 17) - due to the classification of the land above as an operating lease, an amount equal to the fair value of the buildings on the land is transferred from the revaluation reserve to the income and expenditure reserve. See reference 2.8 below.	**19,521**	17,705
Property, plant and equipment (IAS 16) - requires the transfer of negative balances on the revaluation reserve to the income and expenditure reserve.	**19,413**	19,413
	3,555	1,739

Reference 2.8		
Income and expenditure reserve		
Operating leases (IAS 17) - the Queen Elizabeth Hospital Site land. See reference 2.2 and 2.7 above	**(14,621)**	(14,621)
Finance leases (IAS 17) - leases of equipment previously categorised as operating leases have been reclassified as finance leases. See references 2.2 and 2.4 above.	**(5)**	0
Employee benefits (IAS 19) - holiday pay. See reference 2.5 above	**(884)**	(738)
Changes in foreign exchange rates (IAS 21) - foreign currency. See reference 2.3 above	**(1)**	0
Finance leases (IAS 17) - transfer of fair value of buildings on leased land to the revaluation reserve. See reference 2.7 above.	**(19,521)**	(17,705)
Property, plant and equipment (IAS 16) - transfer to the revaluation reserve. See reference 2.7 above.	**(19,413)**	(19,413)
	(54,445)	(52,477)

Reconciliation of the statement of cash flows for the year ended 31 March 2009

There is no change in the cash and cash equivalents of the Trust due to the adoption of International Financial Reporting Standards

NATIONAL HEALTH SERVICE ACT 2006

DIRECTION BY MONITOR, INDEPENDENT REGULATOR OF NHS FOUNDATION TRUSTS IN RESPECT OF FOUNDATION TRUSTS' ANNUAL REPORTS AND THE PREPARATION OF ANNUAL REPORTS

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 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 Annual Reporting Manual,* known as the *FT ARM*, that is in force for the relevant financial year.

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

Signed:

Name: Chris Mellor (acting Chairman) Date 7 April 2010

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 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 accounts shall meet the accounting requirements of the *'NHS Foundation Trust Annual Reporting Manual 2009/10' (FT ARM)* as agreed with HM Treasury, in force for the relevant financial year.

(3) The Statement of Financial Position 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 the authority of Monitor, the Independent Regulator of NHS foundation trusts

Signed:

Name: Chris Mellor (acting Chairman) Dated: 7 April 2010