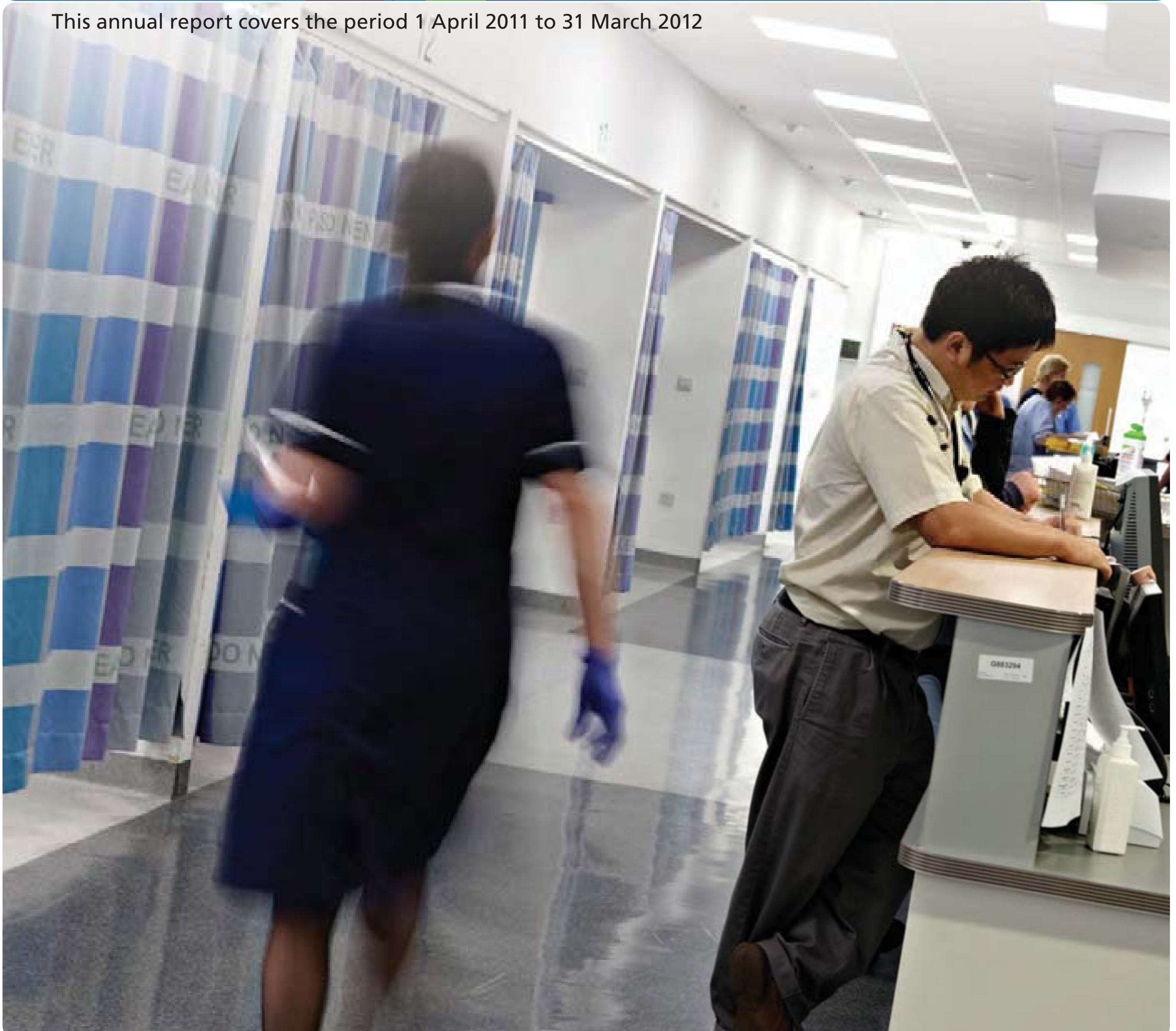
University Hospitals Birmingham
NHS Foundation Trust

NHS

Annual Report and Accounts 2011/2012

This annual report covers the period 1 April 2011 to 31 March 2012



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University Hospitals Birmingham NHS Foundation Trust
Annual Report and Accounts 2011/12

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University Hospitals Birmingham NHS Foundation Trust

Section 1 **Annual Report 2011/2012**

This annual report covers the period 1 April 2011 to 31 March 2012

Section 1 | Annual Report

Directors' Report

1. Overview

1.1 Names of persons who were Directors of the Trust

The Board is currently comprised as follows:

Chairman: Sir Albert Bore

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

Non-Executive Directors:
Professor David Bailey
Gurjeet Bains
David Hamlett
Angela Maxwell
David Ritchie
Professor Michael Sheppard
David Waller

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 during the year ran three hospitals, Queen Elizabeth Hospital Birmingham, the Queen Elizabeth and Selly Oak hospitals, which provided adult services to over 700,000 patients, 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. It is also the UK's first and only National Institute for Health Research Centre for Surgical Reconstruction and Microbiology and became one of the UK's 22 major trauma centres in March 2012.

The Trust employs around 7,200 staff and in March 2012 completed the transfer of clinical services into Birmingham's first new acute hospital in 70 years. This resulted in the closure for virtually all clinical purposes of the Selly Oak Hospital, after a distinguished history over 100 years of serving the people of Birmingham.

The Trust has four 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.

The Trust has one active subsidiary, Pharmacy@ QEHB Ltd, whose principal activity is the provision of Outpatient Pharmacy Services.

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.

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. Defence personnel are fully

integrated throughout the hospital 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".

1.4 Research and Development

The Trust continues to put clinical research at the centre of its core activities to ensure medical innovation remains a focus and priority, in line with Government objectives. Its commitment to deliver high-class, robust research will ensure that the Trust is able to lead the way as a world-class centre for discovery that will help us address future challenges and, ultimately, save and improve millions of lives.

To capture the wealth of clinical and academic expertise within UHB and the co-located University of Birmingham (UoB) campus, a new collaboration called Birmingham Health Partners (BHP) has been launched. This recent agreement (December 2011) will fuel partnership projects in key research areas, including cancer, immunology and infection; experimental medicine and chronic disease. It builds on a long history of achievement and is intended to strengthen and develop the global reputations of both institutions.

1.41 Funding

In January 2012, Health Secretary Andrew Lansley announced that the National Institute for Health Research (NIHR) had awarded Queen Elizabeth Hospital Birmingham £12.8 million over the next five years. The grant will be used by the Trust-based Wellcome Trust Clinical Research Facility (WTCRF), to fund the creative and technical process of producing new treatments for diseases and injuries which destroy thousands of lives in Britain every year.

Announcing the funding, Mr Andrew Lansley said: "These researchers will push forward the boundaries of what is possible. These are the people and the labs where the very best new treatments will be developed for a huge range of conditions. NHS patients are the ones who will see the benefit of their work."

In August 2011, the Trust was awarded more than £6.5 million, under the National Institute for Health Research (NIHR) Biomedical Research Unit funding scheme, to continue its cutting edge research into liver disease and liver cancer. The successful bid for funding was made jointly by the Trust and neighbouring University of Birmingham and the money – amounting to £1,312,340 a year over the next five years – will be used for translational research into liver disease.

The QEHB Charity has funded two clinical research fellows: one in Trauma and one in Neurology. The Charity has also contributed to posts at the Human Biomaterials Resource Centre and the Chronic Diseases Resource Centre. In support of Haematology, the Charity has funded the Haemato-oncology Diagnostic System. In summary, during the year the Charity will have funded nearly £0.5m of research grants and infrastructure.

1.42 Clinical Trials

UHB's commitment to developing its commercial trials activity is producing notable results, thanks to new R&D staff and systems and the continued commitment of our clinical staff.

During 2011, the Trust received 65 R&D submissions to carry out commercial trials compared with 48 in 2010. Of those submissions in 2011, 42 had been fully approved by January 2012.

Since September, the average time taken to respond to initial feasibility enquiries from pharmaceutical companies has dropped from nearly 35 days to just over 10 days. The number of feasibility enquiries climbed from an average of just five per month between January and August 2011 to over 12 per month in the three following months.

1.43 Public engagement

The Trust's partnerships and innovations were the focus of the second annual Research Showcase in March 2012 in which members

of the public, patients and staff were invited to see how their involvement in research could make a real difference to the healthcare of future generations.

1.44 NIHR Surgical Reconstruction and Microbiology Research Centre

January 2012 marked the first anniversary of the establishment of the NIHR Surgical Reconstruction and Microbiology Research Centre, which was set up to share lessons learned in treating injured forces personnel to benefit NHS patients.

Three major research strands that will see benefits for military and civilian trauma victims have already been established:

- Regenerative and Reconstructive Medicine
- Microbiology
- Acute Response to Injury

The centre has long-term plans to develop regenerative medicine capacity, working with the US Army Institute for Surgical Research and the US Department of Defence's Armed Forces Institute for Regenerative Medicine.

2. Management Commentary

2.1 Trust Development and Performance in 2010/12 and Position at Year End

The Trust has continued to build upon its work to deliver the vision, values, and core purposes during the financial year. This has been achieved through the development and delivery of the Annual Plan for 2011/12 which forms part of the overall Trust 5-Year Strategy. The strategy was developed in 2009 and a refresh exercise was undertaken during 2011. The main objective of the strategy and plan continues to be the vision to deliver the best in care. As part of the refresh exercise the four core purposes were reviewed. It was agreed to revise the purpose of 'Education and Training' to 'Workforce'. Each core purpose is underpinned by a strategic aim as follows:

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

Core Purpose 2:	Patient Experience
Strategic Aim:	To ensure shared decision making and enhanced engagement with patients

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 recognised as a leader of research and innovation

The Trust values provide the framework within which these purposes are delivered (honesty, responsibility, respect and innovation).

UHB has made good progress with delivery of its 2011/12 objectives and has achieved the following:

- **Infection Control:** A 63% reduction in the number of MRSA cases and 41% reduction in the number of C.difficile cases compared to 2010/11
- **Patient Experience:** A continued improvement in performance in the national Inpatient Survey score and positive responses received in the Trust local patient feedback surveys. The Trust currently collects around 3,000 items of patient feedback every month
- **Quality Priorities:** Delivery of quality priorities including a reduction in medication errors (missed doses), improvement in the completeness of observation sets (to produce an early warning score), improvement in

completion of venous thromboembolism risk assessment, enhanced quality of dementia care, and management of patients who are at risk of falling

- **Information for Patients and Shared Decision Making:** Implementation of electronic systems to improve the provision of information to patients and enable shared decision-making via the myhealth@qehb system which is anticipated to be used by 2,000 patients 12 months after implementation. Extensive information for patients and others about quality of care in on-line Quality Reports, well exceeding what the Trust is required to publish
- **Dignity in Care:** National recognition for Dignity in Care and Dementia including a prize awarded by Nursing Times and high profile media attention
- **Patient Pathways**: Successful collaboration with GPs and Commissioners to implement Acute Medical Care Clinics which has seen throughput of around 1,000 patients between October 2011 and March 2012
- **Research:** Successful Major Trauma Centre bid, clinical research facility awarded for another five years, and Biomedical research unit also awarded for another five years. The Trust has been awarded in the region of £21.6 million in research income in 2011/12
- **Digitisation of Patient Records:** Significant progress in the digitisation of patients' medical records enabling real-time access to, and analysis of, clinical data. Outpatients is now working on a largely paperless basis
- **Major Trauma Centre Status:** Establishment of Major Trauma Centre at the end of March 2012
- **System Automation:** Improved quality and efficiency through the automation of services/systems including aspects of Pharmacy and Clinical Laboratories and workforce management systems including me@qehb
- **Career Opportunities:** The number of Learning Hub trainees placed into jobs over-performed against target, with 155 placements
- **Staff Satisfaction:** Sustained performance above the national median against the staff satisfaction element of the National Staff Survey
- **Financial Health:** The Trust maintained its satisfactory financial risk rating as allocated by Monitor, the independent regulator for foundation trusts

The Trust has also made good progress with delivery of national targets and the performance and quality requirements of its contracts with commissioners.

2.2 Main trends and factors underlying the development, performance, and position of the business entity during the financial year and likely to affect the entity's future development, performance, and position

The strategy refresh exercise took account of local and national factors that would influence the focus and content. A review of national policy and strategy has been undertaken to identify the key challenges and drivers that face the NHS at present. Since the governmental change in 2010, there has been a commitment to the public to save £20 billion and a significant reform of NHS structures. Local factors have also been considered in relation to the changes across the local health economy as well as key drivers within the organisation itself. The main challenges and drivers internally and externally can be described as follows:

2.2.1 Assurance and Regulation

a. Financial Challenges

The country is currently experiencing weak economic growth and rising unemployment and it is unlikely that this position will change in the short term. This is having an impact on all sectors and the NHS is under pressure to contribute by delivering savings of £20 billion.

This is against a backdrop of rising inflation, the requirement for national pay settlements and tariff changes. Across the cluster, there

is a need to ensure financial balance or a saving which is planned to be achieved via the Quality, Innovation, Productivity, and Prevention (QIPP) work programme in collaboration with commissioners. Cost improvement programmes (CIP) have become even more challenging and there is a greater focus on delivering planned activity growth. Far tighter control will be required on managing cost pressures going forward. The unitary payment provides further pressure on the requirement to maintain financial probity.

It is vital that UHB maintains financial performance and delivers growth during this period of downturn. In order that stability is maintained across the local health economy the Trust will continue to focus on sustaining effective relationships with past, current, and future Commissioners and work jointly through the uncertainty while the reform settles.

b. NHS Commissioning Context

The Health and Social Care Act 2012 has already led to significant changes in the structure of the National Health Service in England. Locally, transition has commenced from Primary Care Trusts to Clusters and the Birmingham and Solihull Cluster is now in place. A Joint Clinical Commissioning Group has also been formed and the Trust regularly meets with GPs to discuss proposals to redesign pathways.

Commissioners are putting greater focus on clinical outcomes to drive their commissioning decisions and this is supported by national work such as the outcomes framework to support decision-making around where to commission services from.

c. NHS Regulatory Changes

Under the Act, Monitor will become the sector regulator for health. Monitor’s core duty will be to protect and promote patients' interests. In the medium term Monitor will also have a continuing role in assessing NHS trusts for foundation trust status, and for ensuring that foundation trusts are financially viable and well-led, in terms of both quality and finances. In carrying out the sector regulator role, Monitor will license providers of NHS services in England and exercise functions in three areas:

- regulating prices
- enabling integration and protecting against anti-competitive behaviour
- supporting service continuity

Monitor will also be expected to follow good regulatory practice in decision making, by using evidence, being consultative and acting transparently. In order to ensure that patients always remain at the heart of everything Monitor does, the Bill places the regulator under a new duty to carry out appropriate public and patient involvement in the exercise of our functions. It will also be under a new duty to obtain appropriate clinical advice and to promote the provision of care that is economic, efficient and effective. These proposals make it clear that Monitor's role would be to put patients first and to protect and promote their interests above all else.

The Care Quality Commission (CQC) regulates all health and adult social care services in England, including those provided by the NHS, local authorities, private companies, or voluntary organisations. It also protects the interests of people detained under the Mental Health Act.

The CQC makes sure that essential standards of quality and safety are being met where care is provided, from hospitals to private care homes. It has a wide range of enforcement powers to take action on behalf of people who use services if services are unacceptably poor. The CQC has made it clear that it is moving its regulatory model from primarily self-certification to regular inspections.

The national regulatory framework that was previously in place has had aspects of it devolved to a local level for commissioners to manage via the standard NHS contract. The Operating Framework is still published annually and indicates priority areas for performance delivery. However, far greater performance management is integrated into the contract.

Commissioners are therefore able to apply levers where contractual requirements are not being met and some of these carry heavy financial penalties.

The national reforms call for stronger governance processes throughout the local health economy and within individual organisations. There is greater scrutiny of the organisation from Monitor, the Care Quality Commission, and commissioners to ensure that standards of quality and performance are maintained at an acceptable level. The need for effective internal assurance and regulation is therefore vital in order to deliver on strategic priorities and meet the external regulatory requirements while this goes through a period of flux also.

d. Developing the Healthcare Workforce

There have been signals of significant changes of the educational element to the health reforms. This will result in a transfer of education from the SHA to a local system owned and funded by healthcare providers. With regard to income, funding will ultimately come from a levy on healthcare providers and this will have major implications for UHB upon final agreement. The Trust will be required to face the education challenge by taking the lead on a local response to the national drivers.

e. Planned Growth for Research

In the Budget statement in 2011, the Chancellor announced the publication of the Government's Plan for Growth. The Healthcare and Life Sciences section of the Plan for Growth highlights that health research has a key role in the national economy as well as in improving health and care. In the Plan, the Government makes a series of announcements that will be of great significance for the health R&D community and for the National Institute for Health Research (NIHR) in the coming years. The NIHR will work with partners to plan for the implementation of these important policy developments.

f. NHS Chief Executive Innovation Review

The Innovation Review and Research Growth Plan stresses the importance of good governance further. The reforms introduce a number of standards to allow NIHR funding to flow to NHS organisations. The Trust has taken steps to address governance and quality issues around research and now further work is required to embed this throughout the organisation. It is important that the appropriate processes and infrastructure are in place to enable services to innovate and maximise on research outcomes. The Local Enterprise Partnership (LEP) has been in contact with UHB to discuss the potential to base a life science growth strategy on the new QEHB.

2.2.2 Quality

a. Quality Context

Quality is a driving factor across the NHS, informing national strategy and policy. The focus on quality has been further reinforced by the Francis Inquiry into Mid Staffordshire NHS Foundation Trust which has been the latest investigation into a number of health failures despite unprecedented investment.

b. Measuring the Quality of the Patient Outcomes

The Trust strategy has focused on clinical omissions of care as well as focusing on mortality as has been the case nationally. UHB has been innovative in the development and use of the e-prescribing and clinical decision support system (PICS) and reporting tools such as Healthcare Evaluation Data which drives improvements in quality outcomes and efficiency.

There has been a push nationally to embed transparency by recommending the publication of quality outcome data. UHB has been ahead of the game in this area through the implementation of a more rigorous approach to quality improvement through the executive level Root Cause Analysis meetings which have helped deliver demonstrable improvements.

The future focus will be to further develop IT solutions to support diagnostic capability and the quality and efficiency of patient pathways.

c. Maximising the Quality of the Patient Experience

As well as delivering metric-based quality outcomes, there is a need to improve the overall patient experience across the NHS. Again UHB has focused on developing its systems for collating patient feedback information and the Trust now receives in excess of 3,000 items of information per month. Good practice has been rolled out across the organisation via the Care Rounds and initiatives such as the Root Cause Analysis of complaints.

Important aspects of the patient experience include the non-clinical elements such as patient administration, portering, etc. Going forward these components of the patient pathway will receive focus to drive further improvements.

There are a number of significant service developments on the horizon so there is a need to make sure the Trust is operating as efficiently as possible and only opens up additional capacity where this is funded and the required income streams are in place. With this in mind, there may be a greater need to utilise the retained estate for new activity. There are cultural as well as physical aspects that need to be addressed to ensure the standard of care delivered in this part of the estate is in line with that of the new hospital. This is important at a patient and staff level so that expectations are met and the organisation is operating as a single site. This will involve staff working as single teams in a standardised way.

New developments need to have an even stronger focus on reduced length of stay and the release of beds to avoid a situation where the Trust outgrows its capacity. The impact on quality, patient experience, and use of resources will need to be carefully managed. This will support the Trust to look into the future and maximise its ability to innovate and build on projects such as myhealth@QEHB.
The new hospital offers potential to further improve the patient experience. Patient expectations are higher so there will be a continuing push to ensure these are met and exceeded.

d. Improving the Quality of Research and Innovation

Research and innovation are key to any healthcare provider within the current climate as emphasis is being placed on these two aspects as drivers to support a boost in the economy. UHB has worked effectively with its partners to build solid foundations via the Birmingham Clinical Research Academy, the National Institute for Health Research, the Biomedical Research Unit, etc. The Trust strategy for research is to maximise the areas of research excellence and develop strategies in areas where UHB has a competitive advantage.

There is further work to be done to ensure the Trust meets industry expectations around responsiveness. Work will also continue to drive forward the quality and quantity of research amongst healthcare partner organisations. See page 2 for Research & Development summary.

e. Fit for Purpose Workforce

The Trust is currently working to achieve the required standards around attendance, performance, mandatory training and retention of staff. There is a need to maintain the pressure in this area in order to create opportunities to innovate in the field of education and training. This will help address issues that are facing certain staff groups regarding qualification, such as scientists.

The Trust has a track record of attracting new entrants via initiatives such as the Learning Hub and this work will continue.

UHB has successfully implemented new roles such as the Junior Specialist Doctors and Physician’s Assistants to proactively address issues around gaps in the workforce and it is planned that roles such as these will be rolled out more widely. Strategic plans also include modernising roles and the structure of teams to ensure streamlined working where new

roles are introduced. This will help move away from the traditional training models that are no longer fit for purpose at UHB.

2.2.3 Collaboration and Integration

a. Collaboration with Primary Care

A strong theme coming through in the strategy is the need for further integration with primary and social care. A clear message being driven nationally is that the delivery of efficient and high quality pathways is a joint responsibility across organisations. A number of specialties have identified the need and opportunities where pathways can be improved to develop the patient experience while delivering a cost saving to the local health economy. UHB needs to play a role in influencing how these models of care are revised and work closely with commissioners and other providers. There is also a focus on the development and enhancement of networks, particularly as services are being consolidated and centralised across the region.

Integrated care is essential if patient pathways are to be effective, particularly during the period of reform. Work has commenced with primary care via the cluster and the clinical commissioning groups to look at more innovative ways of improving these pathways. To date work has been undertaken to redesign pathways by introducing acute medical clinics within the Emergency Department, by implementing advice and guidance pre-referral in selected specialties, and by providing rapid access to diagnostics. IT solutions are also being developed for primary and acute care to hold joint clinical records.

The structure of the contract and tariff changes around bundling and unbundling has triggered the need for risk sharing. This provides the opportunity for more formal integration with GP practices and the potential ultimately to partner with practices.

b. Collaboration with other Providers to Improve Outcomes

Discussions have already commenced regarding quality improvements required across the region and how this should be achieved. Any growth will ultimately lead to capacity issues and competing site master plan priorities. The strategy will therefore address these issues.

In order to further maximise on quality and maintain financial health, there is a requirement to focus on overseas collaborations and work has commenced in this area also.

c. Patient Experience

Work is being undertaken in collaboration with partners across the local health economy to improve patient pathways. This includes patient initiated follow-ups which allow patients to have greater control and involvement in the care they receive. Involvement with decision-making is further supported by the myhealth@QEHB initiative and this is being expanded to additional areas to maximise on the benefits delivered to date.

There will be further work to share data and information across primary and secondary care to support seamless pathways of care. There is also collaborative working around medicines management and shared care prescribing. Collaboration with Social Services departments on facilitating the return of patients to a home environment when they are no longer in need of hospital care has continued and work is ongoing to improve this further.

Other initiatives that will be developed include looking at alternatives to admission, one-stop clinics, and expansion of satellite units to improve local care provision.

Although there is a requirement for integration with external partners, there are still areas internally that need to integrate further. The physical co-location of services in the new hospital provides opportunities to improve these relationships within the organisation and deliver a more streamlined and improved patient experience. The refreshed strategy also contains a number of areas where the flow of patients needs to improve within and across services. The improved utilisation of resources will support more streamlined pathways,

reduced length of stay, a reduction in cancelled operations, a more efficient use of theatres, etc.

d. Research

As stated, UHB has established strong links with industry and healthcare partners to focus on improving research and development. Further development is required with the Royal Centre for Defence Medicine (RCDM) and Ministry of Defence (MoD) to build upon the existing foundations. The Trust will work with the Comprehensive Local Research Network (CLRN) to increase research activity within Birmingham and the Black Country. In addition, strategic alliances will be developed with other acute healthcare providers such as University Hospital North Staffs and University Hospital Coventry and Warwickshire. Research agreements will be developed with the Clinical Commissioning Groups in order to maximise the potential across the organisational boundaries. This will be supported by the provision of a research infrastructure to primary care and other trusts. UHB will take a lead in a city-wide strategy to open up access to clinical information to further support research potential.

e. Education

The reforms have indicated a need for local solutions around the provision of education and training. The current economic, political and policy changes have created a fertile environment for collaboration. The reforms also create an opportunity to influence the local health economy particularly in terms of service delivery, research and education.

The Trust plans to collaborate with UoB to develop a national leadership programme in nursing. Also, UHB will collaborate with West Midlands Deanery and main education providers to model a Learning and Education Training Board. The strategy for education and training also includes the expansion of the JSD programme to other local trusts and collaboration with Birmingham City University and Birmingham Metropolitan College to develop a University Technical College.

Internally, the physical elements of education and training have been combined in a single directorate. The next phase of work is to bring the cultural elements together and work to fully embed education and training within divisions and across the organisation.

Discussion with the specialties and corporate areas has highlighted the concerns with education and training structures externally available to staff in order that they meet their professional requirements. In some areas the national educational structures are not fit-for-purpose so there is a need to identify local solutions. The Trust also needs to take steps to develop itself as a degree-awarding body.

Another aspect of education and training that requires further work is clarity on educational roles within the organisation and having clear outputs attached to these roles.

The theme of ensuring a sustainable workforce that is fit for the future came up across the specialty strategies. This stemmed from the profile of the workforce and making sure that the right people are in the right roles and have the necessary skills. The age profile of the workforce in some areas means that specialist expertise will be lost. There is therefore an important need to make sure there is robust succession planning in place and the correct level of specialist skills are being ‘grown’. This will support the Trust to be in a strong position with regard to sustainable service delivery, the capability to take on new activity, and supporting staff to realise their potential so they deliver to the best of their ability.

There are also cultural aspects of a sustainable workforce that require further development. Where the organisation has implemented new roles to reduce the reliance on junior doctors for example, it is important that teams are working in a truly multi-disciplinary way and have progressed as a whole to work in line with the new roles.

Collaborating and integration also needs to be embedded across non-clinical service delivery such as education and training and research.

Elements of both of these areas have been physically integrated and now work is required to bring these together from a cultural and behavioural perspective.

2.2.4 Reputation

a. Local, National and International Reputation

The Trust has been undertaking work to obtain local, national and international recognition. Its local reputation is developing through the new hospital build alongside its improvements in the patient experience and quality. At a national level, the Trust is recognised for its work with the military, quality outcomes, research and development and again for the outstanding quality of the new QEHB. Internationally, UHB's reputation has grown as a result of the QEHB and the high level of quality outcomes.

Nationally there has been a push for greater transparency on quality and performance and UHB has been ahead of the game in this arena. The Trust has been working to enhance its reputation through various media and is developing an international reputation. There is a need to make sure that quality and performance is sustained consistently across the organisation therefore driving down the variability within the Trust. There is greater scrutiny making the need for ongoing performance improvement and consistency carry more significance.

The specialty strategy refresh demonstrates a real appetite for greater transparency around publishing performance and undertaking benchmarking at a global level. In some areas strong links are being established with overseas healthcare providers in order to share quality outcomes data and undertake comparative benchmarking. This will support the Trust in broadening the scope of areas upon which its reputation is built.

b. Patient Outcomes and Experience

The organisation has also worked to address its reputation as a result of the quality of accommodation prior to the new hospital move and the adverse media for military casualties. The media attention has taken a turn to a more supportive approach focusing on the high quality patient outcomes for military and civilian casualties. The national reputation has been supported by the work on indicator for mortality and the development of IT to focus on clinically relevant measures. The Trust has also gained recognition in the national media regarding the quality of care delivered to improve the patient experience.

c. Research and Innovation

UHB is developing a strong reputation as the leading Healthcare Research Organisation in collaboration with the Clinical Regional Network, Collaborations for Leadership in Applied Health Research and Care and Health Innovation and Education Cluster. The Trust also has a growing national reputation with the Biomedical Research Unit, National Institute for Health Research Surgical Reconstruction and Microbiology Research Centre and Preferred Partner Status with Industry. A total of twelve innovations have been brought to market including Prescribing Information and Communication System (PICS) and Healthcare Evaluation Data (HED).

d. Workforce

The Trust has been focusing on making sure the workforce is fit-for-purpose. The workforce forms a fundamental component to the reputation of the Trust in terms of attracting the best as well as delivering the best in care and being in a position to promote this. New roles such as the development of the Anaesthetic Practitioners and Cardiac Surgery Advanced Practitioners have been successful and call for wider roll-out.

Innovation has been delivered through the me@QEHB system to allow improved management of the workforce.

National recognition has been obtained via the Future Forum work and has helped enhance UHB's reputation. Further work is required to improve the reputation for junior doctor training and this has been incorporated into plans for 2012/13.

2.3 Performance against key Healthcare Targets

The Trust achieved all targets and indicators included in Monitor's Compliance Framework for the full year 2011/12 and treated more patients than ever before.

	2010/11	2011/12	Change
Inpatient Finished Consultant Episodes	70,612	68,805	-2.63%
Day-cases (excluding renal dialysis regular day attenders)	31,077	33,499	+7.23%*
Outpatient attendances	517,516	544,876**	+5.02%
A&E Attendances	82,632	82,925	+0.4%
Total treatments	681,496	700,285	+2.8%

* the increase reflects the first full year of the Ambulatory Care Department, treating many patients who would previously have been admitted as inpatients

**Outpatients attendances include Sexual Health Services activity for March 2012.

National targets and regulatory requirements	Time Period for 2011/12	2011/12 Performance	2011/12 Target
Clostridium difficile (post-48 hour cases)	Apr 2011 – Mar 2012	85	114
MRSA (post-48 hour cases)	Apr 2011 – Mar 2012	4	7
62-day wait for first treatment from urgent GP referral: all cancers	Apr 2011 – Mar 2012	85.2%	85%
62-day wait for first treatment from consultant screening service referral: all cancers	Apr 2011 – Mar 2012	94.7%	90%
31-day wait from diagnosis to first treatment: all cancers	Apr 2011 – Mar 2012	97.3%	96%
31-day wait for second or subsequent treatment: surgery	Apr 2011 – Mar 2012	98.1%	94%
31-day wait for second or subsequent treatment: anti cancer drug treatments	Apr 2011 – Mar 2012	99.7%	98%
31-day wait for second or subsequent treatment: radiotherapy	Apr 2011 – Mar 2012	99.9%	94%
Two week wait from referral to date first seen: all cancers	Apr 2011 – Mar 2012	98.2%	93%
Two week wait from referral to date first seen: breast symptoms	Apr 2011 – Mar 2012	98.6%	93%
Crude average of monthly 95th percentile Referral to treatment waiting times (admitted patients)	Apr 2011 – Mar 2012	17.8 weeks	23.0 weeks
Crude average of monthly 95th percentile Referral to treatment waiting times (non-admitted patients)	Apr 2011 – Mar 2012	15.0 weeks	18.3 weeks
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	Apr 2011 – Mar 2012	96.1%	95%
A&E: Total time in A&E (95th percentile)	Apr 2011 – Mar 2012	240 mins	240 mins
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	Apr 2011 – Mar 2012	Certification made	N/A

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

The Trust continues to have a robust and effective framework in place to provide assurance around the quality of care it offers and to monitor organisational performance. The Board of Directors and Executive Director-level groups receive monthly performance reports which present performance against national and local targets and priorities. The reports have strengthened the risk-based approach to reporting to ensure that the consequences of performance underachievement are highlighted to the Executive Team and Board of Directors as well as the actions that are in place to improve performance. Findings from Care Quality Commission assessments are also reported. The framework provides a good level of assurance and supports effective decision-making. 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 report to the Board of Directors and provide additional assurance and effective accountability around clinical quality and the patient experience. See the Trust's Quality Report (Section 3) for further details.

During the year the Trust has further developed its informatics capability by continuing to expand the range of performance indicators available on its web-based dashboard and by ensuring that this information is available in a timely manner to aid operational management.

2.5 Regulatory Action

No formal regulatory action was taken against the Trust in 2011/12.

During the year the Care Quality Commission inspected the Trust's services against the following outcomes from its Essential Standards of Quality and Safety:

- Outcome 1: Respecting and involving people who use services
- Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights
- Outcome 5: Meeting nutritional needs
- Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

The services inspected were found to be compliant with each outcome considered. The CQC did however identify minor concerns with Outcome 5. An action plan was developed and action taken to ensure that the Trust remains compliant with the outcome. The CQC were satisfied that the actions included will allow the Trust to maintain its compliance with this Outcome.

2.6 Progress towards targets as agreed with local commissioners, together with details of other key quality improvements

As part of the contract the Trust holds with NHS South Birmingham for the provision of services the Trust is required to report its performance against a number of targets in the monthly Service Quality Performance Report.

The Trust achieved all targets with the following exceptions:

- Elective surgery cancelled for non-clinical reasons as % of elective admissions
- Slot unavailability
- Delayed transfers of care
- % of ambulance patients handed over within 30 minutes
- Stroke patients spending 90% of length of stay on the stroke unit

The Trust has ongoing engagement with its commissioners throughout the year to discuss the factors that have affected performance. Where performance is influenced by other organisations (e.g. delayed transfers of care, ambulance handover and stroke) the Trust has undertaken joint working, including whole pathway reviews, to identify how performance can be improved across the system. In each case the Trust has taken action to the satisfaction of its commissioners and no formal contractual action has been taken under the terms of the contract.

2.7 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 the challenge that the public sector currently faces and, in particular, the need for the NHS in England to make £20bn of efficiency savings by 2014/15. The Trust does, however, have a history of making its services more efficient whilst at the same time maintaining and improving the quality of care offered that puts it in a strong position to meet this challenge.

The effect that the new system will have on the Trust is currently uncertain with GP consortia expecting to take over commissioning of the Trust's services by 2013. The commissioning environment is however already in transition with clusters taking on the responsibility of primary care trusts. There is potential for key knowledge and skills to be lost and it is possible that instability will be created across the local health economy driven by potential changes in personnel and revision of commissioning intentions.

In terms of external regulatory requirements, although they were achieved in 2011/12, performance against the cancer targets remains a risk. As the Trust 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. See Regulatory Ratings page 50.

2.8 Social and community issues

The Trust is key to Birmingham's regeneration. The health and social care sector as a whole accounts for over 10% of the West Midlands' gross domestic product and the Trust itself is Birmingham's third largest employer. The Queen Elizabeth Hospital Birmingham, adjacent to University of Birmingham, has created one of Europe's largest academic/medical complexes. It is a catalyst for the regeneration of south Birmingham.

The Trust'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.

2.8.1 Reducing Disadvantage

A key priority for 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. Over the past five years the training projects now in the Learning Hub have enabled almost 1,400 people to gain a job.

The Learning 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. The Trust continues to run the Learning Hub on behalf of the whole health and social care sector.

The Learning Hub's ACTIVATE project provides induction and placement in a ward, technical or administrative area. Placements are not just in the Trust and in 2011/12 included Heart of

England NHS Foundation Trust; 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 Learning Hub project, Building Health, still targets unemployed people but complements ACTIVATE by "brokering" people into jobs. It works by 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 Balfour Beatty Workplace 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 Learning Hub has positively responded to the challenge of reduced public sector resources for skills training by entering into new partnerships to help unemployed people back into work; for example, with Pertemps People Development Group under the Government's Work Programme and with Birmingham City Council through its Adults and Communities Directorate. The latter has, in particular, provided funding for pre-employment training for apprentices (notably with Birmingham Community Healthcare Trust) maximising the take-up from disadvantaged areas and the chances of a successful outcome.

The Learning Hub introduced in December 2010 a new initiative - Inspired - which provides long-term patients with educational and vocational skills and mentoring support whilst being treated. This highly innovative project, originally funded through the QEHB Charity, has been substantially expanded during the past year with the success of a bid to the national Adult Community Learning Fund. Some 127 patients were provided with information, advice and guidance during 2011/12 with many undertaking direct training and seven taking up employment. Inspired has significantly contributed to the Trust's Diversity and Equal Opportunities Strategy.

Key stakeholders in the Learning Hub remain JobCentre Plus, Birmingham City Council, further education colleges and Consort/Balfour Beatty, as well as the Trust and NHS partners and, increasingly, private sector partners such as Pertemps.

The Learning Hub provides a focal point for the Trust's relationships with local disadvantaged communities.

2.8.2 Increasing Prosperity

Adjacent to the University of Birmingham, the new hospital has created one of the largest academic/medical complexes in Europe – at one of the key gateways to the region's Central Technology Belt.

The hospital embodies latest technology and will 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.
Locally, the Trust has worked hard to ensure life sciences is integral to the strategy and priorities of the Birmingham Solihull Local Enterprise Partnership which has taken over many of the responsibilities of the former regional development agency, Advantage West Midlands.

The Trust 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.

The Trust's Centre for Clinical Haematology is a very good example of what can be achieved. Funded by Advantage West Midlands in 2006, 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 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 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.

2.9 Patient Care

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

The Trust continues to improve patient care through the work of the Care Quality Group chaired by the Executive Chief Nurse. A number of patient-focused initiatives were developed last year in response to feedback from patients and carers. The Trust has monitored feedback via the patient advice and liaison contacts, complaints, compliments, and national surveys.

Ward-based feedback is well established at the point of care via an electronic bedside survey. These surveys have assisted the Trust in benchmarking the success of its patient improvement measures against the results of the National Patient Survey, which has demonstrated significant improvements in rating of overall care, helping to control pain, cleanliness of the ward and bathrooms, patients feeling that they are involved in decisions about their care, patients not receiving conflicting information, being helped to rest and sleep, being treated with dignity and respect, and given privacy when being treated.

A Patient Experience Champion initiative was introduced across the Trust to engage staff and patient and public representatives in ways of using the feedback from patients and carers to enhance their experience of services. There are currently over 250 champions registered, some of whom have undertaken a lead champion programme to provide them with the information and skills they need to take the lead within their ward or department.

The Trust has changed its catering systems and supplier resulting in an improved patient experience and satisfaction rating.

Care Rounds have been introduced by the Trust, partly in response to patients who were feeling isolated as a result of being cared for in one of the 44% of single rooms available in the new hospital. Care Rounds provide a method in which patients are seen at least every hour and a full assessment of their needs is reviewed. The Trust has also introduced a red tray and beaker system for early identification of patients who have special eating and drinking requirements.

The Ward Dashboard on each area allows staff to see their own progress against a number of clinical requirements and they can then act on any issues. The dashboard has been further developed to include information about falls, patient height and weight and the observations undertaken.

2.9.2 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. Continued focus on initiatives to standardise clinical practice has enabled the Trust to reduce the number of cases of MRSA bacteraemia by 64% in 2011/12 and end the year three cases under the national objective of seven. In addition, the

Trust has further reduced cases of *Clostridium difficile* infection (CDI) by 42% in 2011/12, ending the year 29 cases under the national objective of 114.

Performance against, and monitoring of, improvements related to healthcare associated infections are monitored monthly at the 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. They are also reported monthly to the Board.

The Trust took part in the Care Quality Commission's review of the arrangements for the healthcare of disabled children and young people. The results will be published later during the year.

2.9.3 Service improvements following staff, patient or carer surveys/comments and Care Quality 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.

A Trust-wide audit of noise at night was undertaken following national survey results that indicated that this was a problem for patients. The outcome has been awareness raising with staff who work nights and the development of a set of guidelines for staff and patients to aid rest and sleep. Continuous monitoring is in place via the bedside electronic survey.

In response to its patients and to the Department of Health's campaign to virtually eliminate mixed sex accommodation, the Trust has made further 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.

2.10 Public and Patient Involvement

2.10.1 Patient and Carer Councils

A review of the Patient and Carer Councils took place this year following the final move of services from two hospitals into the new hospital. The review took account of the way in which care was provided in the new environment. There are now four Patient and Carer Councils: one for wards (inpatients), one for outpatients, a Mystery Patient Council and a Young Person's Council.

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. All of the councils have been active in seeking patients' views to influence the improvements in care.

The wards and outpatients councils have continued to use the 'Adopt-A-Ward or Department' scheme to facilitate partnership working with staff to provide a patient perspective to improving the experience of patients and their relatives.

The work programmes this year have concentrated on establishing the new councils and how they can best support wards and departments to improve the experience of patients, carers, relatives and visitors. Councils have continued to be actively involved with ongoing work on nutrition and hydration of inpatients, privacy and dignity, and patient experience data collection.

2.10.2 Young Person's Council

The Young Person's Council has provided a way of involving young people aged 16-25 years in the development and improvement of services within our hospitals to ensure they have the best possible experience. The group have been involved in the development of a business case to develop facilities and support for young people in the hospital. The council has

developed a logo to be used in any information, publicity and promotion that the council does. The council is continuing to work on an interactive website for patients and their carers, and methods of gaining patient experience feedback.

2.10.3 Mystery Patient Council

Council members have been involved in a new Mystery Patient initiative and have been testing services and facilities in the hospital. The initiative has been very useful in highlighting key areas for improvement. Group members have worked with the staff in a variety of areas and have reported their findings which have been used to inform education and training programmes for staff.

The council has concentrated on main reception areas and the hospital switchboard this year, but plans to roll out the initiative to specific departments and services in 2012/13. As a result of this work members have contributed to the development of customer care standards for receptionists; staff training has been targeted to specific areas for improvement, e.g. Ambulatory Care reception, and signage has been improved in outpatient areas.

2.10.4 Information Group

The group was established five 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:

- Information for patients admitted to the Clinical Decision Unit
- Development of an information booklet for patients about their admission and discharge from hospital
- Development of reducing noise at night guidelines for staff and patients
- Development of a Patient and Carer Council promotional leaflet
- Development of a welcome pack for new members of the Patient and Carer Councils

2.10.5 Carers' Advisory Group

As a result of the work last year to develop guidelines for relatives and carers to stay overnight on a ward, the need was identified to establish a Carers' Advisory Group to explore the specific needs of carers when those they care for are admitted to the hospital. The group consists of carers, members of Birmingham Carers' Association, Birmingham City Council communities department, Patient & Carer Council representatives, Governors and staff. The group has developed a set of Principles for Carers based on the publication Carers Matter and the Government's Carers' Strategy.

The principles were launched in February 2012 and achieved a recognition of good practice award in the National Patient Experience Network Awards.

2.10.6 Local Involvement Networks (LINks): the Trust 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 second successful event to promote and publicise the work and support provided by more than 15 patient and carer support and information groups was hosted by the group.

2.10.7 Patient/Carer Consultations

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

- Equality Delivery System
- Diarising the patient's day
- General Medical Council – Good Medical Practice Guidance
- Principles for Carers
- Delayed discharge letter and procedure
- Letter following a fall in hospital

2.10.8 Volunteers from the local community

The Trust had over 670 people registered as volunteers at the end of March 2012. 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:

32% male
27% black and Asian
23% under 30 years old
24% over 66 years old
14% employed

A Volunteer Committee, established in 2011 and chaired by a Governor, continues to formally involve volunteers in the development of the voluntary services within the Trust. The Committee reviewed recruitment methods and support mechanisms for new volunteers. They have also been involved in promoting and publicising the role of volunteers in the hospital and are planning some fundraising events to support the activities volunteers contribute to.

Good working relationships have continued with the Birmingham Voluntary Services Council, and the Associate Director of Patient Affairs continues to be an active member of the Birmingham Action Resource for Voluntary Organisations.

National recognition of the standard of practice and achievements of the Voluntary Services has been demonstrated again this year through inclusion in the recently refreshed Department of Health Strategic Vision for Volunteering. Also, the Associate Director of Patient Affairs has continued for a third year in a key national role as the Chair for the National Association of Voluntary Services Managers, the organisation that leads volunteering in the NHS.

2.11 Complaints

The Trust received 797 formal complaints in 2011/12, compared with 840 in 2010/11, a decrease of over 5%. The decrease was due, at least in part, to the pro-active 'triaging' of complaints by the Executive Chief Nurse, to ensure all such contacts received are actioned promptly in the most appropriate way. For example, this may involve an early telephone call from a Matron to provide an immediate, appropriate response, which may negate the need for a formal response, depending on the complainant's wishes.

The overriding objective for the Trust is to ensure that patients' and relatives' concerns are handled promptly, by the most appropriate means, in consultation with the complainant and responded to in a timely manner.

A review of the Trust's complaint handling process has recently been undertaken, which has identified a number of areas for improvement. These proposed changes are currently being discussed and evaluated with the relevant senior staff. Proposed improvements include some system enhancements to underpin a more efficient service to users.

Trends identified in complaints are analysed, assessed and regularly reported to the Chief Executive's Advisory Group, the Audit Committee and the Executive Chief Nurse's Care Quality Group. More detailed analysis of issues is undertaken at Divisional level by the senior Divisional management team within the Divisional Clinical Quality Group, where complaints data is reviewed alongside Incidents and Patient Advice and Liaison Service (PALS) contacts.

The top three main issues raised in complaints were:

- Perception of clinical care and treatment
- Delay/Cancellation of Outpatient appointments
- Delay/Cancellation of Inpatient appointments

Following the appointment of a Customer Care Facilitator in January 2011, over 2,000 staff received some form of customer care training in 2011/12. The sessions have provided an opportunity to emphasise to front-line staff the importance of positive customer care and the impact on patients and relatives where we fail to deliver this. Skills for dealing with difficult situations have been explored and the sessions have examined ways in which barriers to the delivery of positive customer care can be highlighted and addressed where possible. The number and ratio of complaints principally about staff attitude has fallen in 2011/12 compared to the previous year. Other initiatives have included the creation of a multi-disciplinary Customer Care Group to drive the agenda forward, the Customer Care Awards scheme to celebrate and reward staff who deliver great customer care and initial exploration of customer care standards for reception areas.

We were advised by the Parliamentary and Health Service Ombudsman that 16 enquiries had been received from people who wished to have further investigation of their complaints against the Trust. Of those, eight have been assessed and will not be investigated, whilst six are at the assessment stage. In another case the Ombudsman has suspended the investigation, pending the outcome of an associated inquest by HM Coroner. A final case was referred back to the Trust for further investigation and local resolution, the outcome of which the Ombudsman was satisfied with.

2.12 Patient Advice and Liaison Service (PALS)

The Trust runs a Patient Advice and Liaison Service (PALS). There were 5,451 PALS contacts in 2011/12 of which 1,513 (28%) were related to concerns raised. This compares with 3,977 PALS contacts the year before of which 1,421 (36%) were related to concerns raised. Concerns as a percentage of all PALS contacts have dropped by 8% but there has been a small increase of 6% in the actual number received.

The main concerns raised relate to Communication and Information, and Outpatient or Inpatient appointments being cancelled or delayed and perceptions around clinical treatment.

Compliments accounted for 1,960 (36%) of all PALS contacts in 2011/12. This is an increase of 76% on the number received for 2010/11 which was 1,116 (28% of all PALS contacts). Enquiries totalled 1,606 (29%) which is an increase of 30% compared to the previous year.

2.13 Stakeholders, Partnerships, alliances/contractual arrangements

Significant progress has been made in developing stakeholder relations as set out as follows.

Local Health organisations	
Birmingham & Solihull Cluster	Regular meetings between Chairs and CEOs and appropriate directors
	Negotiation and implementation of Local Delivery Plan
	Quarterly finance and quality performance meetings
	Member of system plan group
	Member of frail elderly programme board
	Member of enablement working group
GPs/GP Consortia	Within South Birmingham, participating and leading work on trauma, hand surgery, ophthalmology, respiratory, cardiology redesigned pathways working in partnership with primary care and community trust
	Working group to develop enhanced advice and guidance service and direct access to imaging service for primary care
	Working group to develop and pilot changed models of care in Emergency Department and Clinical Decision Unit (admission avoidance)
	Working closely with the GPs at Sutton Medical Consulting Centre (Ashfurlong) to further develop the services provided in that locality
	Discussions are ongoing and opportunities are being explored with Solihull GP Consortium
	Formed Clinical Commissioning and Contracting Board with representatives from local CCGs and cluster representatives. Used to agree commissioning intentions and develop service improvement plans
	Trust's Associate Medical Director is the lead clinician with GP Consortia and holds regular meetings with CCG lead doctors.
	Established Medicines Management Group across primary and secondary care
	Hold regular meetings between Trust Executive Team and GP Consortia Boards
Specialised Commissioning Agency	Chief Operating Officer continues to hold regular meetings with the head of the SCA
	Member of major trauma network
Midlands & East SHA	Chair and CEO regularly meet their SHA counterparts
	Attending professional fora
	Member of provider CEO forum
Heart of England NHS Foundation Trust	Ongoing discussions with regard to operational issues
Sandwell and West Birmingham NHS Trust	Continued co-operation with SWBH on the Pan-Birmingham Decontamination project
	COO holds meetings with SWBH Director of Strategy and COO

Birmingham Children's NHS 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
	Finance Director sits on Shared Services Group
	Shared group to look at transition arrangements for young people with chronic illness/disease
Birmingham Women's Hospital NHS Foundation Trust	The Trust provides a number of services to the Women's eg. anaesthetics; critical care; finance; steam
	Regular meetings of Chairs and Executive Directors
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
	Meetings with newly-appointed Director of Strategy to explore potential for changed working patterns
	Local operational manager now part of 'Front door working group'
	Trust Chief Operating Officer is an Ambulance Trust Governor
Birmingham Community Trust	Agreed pathways for a number of different patient groups including fractured neck of femur and the elderly
	Agreed shared database to be used for early identification of patients requiring hospital based rehabilitation services
	Development of shared proposals for early supported discharge for stroke patients
	Monthly meetings to discuss capacity issues and shared service models
	Local operational managers now part of 'front door working group'
	Involved Community in our work on transition of care for young people with chronic disease/illness
	Provide pre-employment training for apprentices

Hospices	The Trust is working closely with local hospices – Marie Curie, St Giles, St Mary's and John Taylor – to develop models of care for people at end of life to prevent inappropriate hospital admissions and facilitate appropriate rapid discharge to enable people to die in their place of choice
National health bodies	
Monitor	Chair and CEO have met Monitor Chair on a number of occasions
	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's Medical Director is a member of Monitor's working group developing Quality metrics
Care Quality Commission	Routine contact with Relationship Manager
	Regular contact with Regional Director to discuss any particular issues of risk/concern
Department of Health	Ongoing discussions between key personnel at both organisations
	The Trust has agreed two secondments to DH to influence policy
National Institute of Health Research	Partnership to deliver the UK's first and only Surgical Reconstruction and Microbiology Centre
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, 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
	Birmingham Health Partners was developed and launched
	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
	Working in partnership to develop a proposal for medical devices testing

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	Fresenius provides UHB's community dialysis service across nine sites
Greater Birmingham and Solihull Local Enterprise Partnership (LEP)/ Science City	New body set up by the Government to provide a clear vision and strategic leadership to drive economic growth and job creation
	The LEP has assumed most of the economic development responsibilities of the former regional development agency, Advantage West Midlands
	UHB has developed close working relationships with the LEP, especially around life sciences, and hosted a recent LEP Board meeting
	Science City still provides a strategic framework for innovation and is the lead adviser on innovation to the LEP
	UHB has a seat on the Board of Science City and chairs the Science City Innovative Healthcare Group
	AWM grant (through European Regional Development Fund) for pan-European "Developing Centres of Excellence project focusing on translational research" more than hit targets
Birmingham City Council	Member of citywide enablement forum
	Continuing planning relationship
	Improvement of public transport access to QE – working with BCC, Centro and West Midlands Travel
	Inward investment strategy – integrating medical technology, especially, life sciences, translational research and clinical trialling
	Regular attendance at Overview and Scrutiny Committee
	Increasing working relationship with BCC on training for unemployed people as a result of BCC being passed additional responsibilities following the abolition of the Learning and Skills Council
	Worked with Social Services to develop an enablement service with therapy provided by UHB
	Member of senior level group to review delayed transfers of care and develop changed service models

	Involved BCC in our work on transition of care for young people with chronic disease/illness
	Worked in partnership with the local Community Links service resulting in them providing a service to users of the hospital, and their carers, providing additional care and support for our patients on discharge
	Worked with Social Services to develop an enablement service with therapy provided by UHB
Skills Funding Agency and Birmingham Employer Board	UHB representation on the Birmingham and Solihull Employer Board
	Apprentice training funding
JobCentre Plus	Continued effective working through the Learning Hub
	JCP gives financial support for Learning Hub, particularly auxiliary nurse training programmes
	UHB and JCP jointly chair pan-Birmingham Access to Employment Group focusing on LEP grant-aided schemes
	Learning Hub delivery through the ‘prime’ contractor Pertemps as part of the Government’s new Work Programme
Third Sector partners	Working with a number of partners around the equality and diversity agenda as well as the broader dignity in care work - Worked with SENSE, Royal National Institute for Blind People, Lesbian, Gay, Bi-Sexual and Transgender community, MENCAP, AGE UK and others to obtain their views on aspects of UHB’s services and how they need to be adjusted to take account of the special needs of its service users - The Trust allows the groups to make use of its facilities in return for their input into tailored training programmes for UHB staff - The Trust delivers some training sessions, such as our COPD nurse going out to SENSE staff who work in residential homes, to offer them advice and support on how they provide appropriate care
Queen Elizabeth Hospital Birmingham Charity	QEHB Charity is the official charity of the Queen Elizabeth and Selly Oak hospitals, providing equipment, research and facilities that are over and above those provided by the NHS. The charity is currently raising money for a Cyberknife and for Fisher House, a home away from home for military patients and their families

3. Financial Review

On 1 July 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 an NHS trust.

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

The Trust wholly owns a subsidiary company 'Pharmacy@QEHB' Limited, which commenced trading on 4 July 2011 as an Outpatients Dispensary service in the Queen Elizabeth Hospital Birmingham. The results of the subsidiary company are consolidated with those of the Trust to produce the group financial statements enclosed.

3.1 Changes in accounting policies by the Trust in 2011/12

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 2012 and appropriate to NHS Foundation Trusts. This is the third set of full year results prepared in accordance with IFRS accounting policies. The previously reported 2010/11 financial statements have been restated where IFRS has required this; with the date of transition being 1 April 2010, which is the beginning of the comparative period for the year ended 31 March 2012.

There have been two significant amendments to accounting standards in 2011/12 affecting the Trust. The revised HM Treasury application of IAS 18 'Revenue' and IAS 20 'Accounting for Government granted assets' to donated and granted non-current assets respectively, has resulted in the following changes to the disclosure of other operating revenue. There are no longer any transfers from donated asset reserves or granted asset deferred income balances as these no longer exist, due to any conditions or restrictions of use being in force upon any applicable Trust asset at the reporting date. The fair value of the donated or granted asset is recognised as revenue in the reporting year the Trust becomes entitled to the economic benefit, subject to any conditions of use, as detailed in accounting policy notes 1.8 and 1.9 respectively within the financial statements.

3.2 Financial Performance

Despite the challenging economic climate the Trust has again reported strong financial results for 2011/12. Total income has increased by 9.3% to £586.6 million (including revenue due to the receipt of donated assets) ensuring that the Trust remains amongst the largest foundation trusts in the country. This includes the transfer of the contract for the provision of community sexual health services from Heart of Birmingham Primary Care Trust and growth in a number of the existing service lines. Within this the Trust has achieved an operational income and expenditure surplus of £2.4 million before any exceptional costs. The recurring deficit of (£0.1m) is after impairment to the Trust's existing estate of £2.5m. The non recurring 'exceptional costs' of £33.5m comprise restructuring costs of £4.3m associated with the transition to the new hospital and an impairment loss of £29.2m on the new building. This results in an overall retained deficit of (£33.6m) for the financial year.

The new hospital and existing estate impairments are a non-cash technical adjustment to the accounts (rather than an actual payment by the Trust) and are excluded by Monitor from the calculation of the Financial Risk Rating (FRR). The new hospital impairment arises from the difference between the value directly attributable to the construction of the new private finance initiative hospital (along with interest charges and fees) and the asset's fair value in operational use, as measured at 31 March 2012.

Therefore the organisation remains financially sound despite this accounting deficit. The

recurring financial performance has resulted in the Trust achieving an overall Financial Risk Rating of 3 (out of 5) from Monitor.

3.3 Income and expenditure

The table below compares the original planned income and expenditure with the outturn position for 2011/12.

Summary income and expenditure – plan v. outturn

The Trust's Summarised Income and Expenditure (£M's)		
	Plan 2011/12	Outturn Position 2011/12
Income	552.9	584.3
Expenditure	-516.0	-545.3
EBITDA	**36.9**	**39.0**
Depreciation	-18.2	-20.1
Donated Asset Revenue	2.4	2.3
Interest receivable	0.6	0.7
Interest Payable	-19.6	-19.5
Operational Surplus	**2.1**	**2.4**
Impairments on existing property	0.0	-2.5
Recurring Surplus	**2.1**	**-0.1**
Transition costs	-3.5	-4.3
Impairments on New Hospital	-49.1	-29.2
Retained Deficit	**-50.5**	**-33.6**

The largest component of the Trust's income is the provision of NHS healthcare, accounting for £454.7 million (77.8%) of the total. Non-NHS clinical income contributes a further £14.3 million (2.4%) 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 education levies which account for £32.3 million (5.6%) of the Trust's income in 2011/12 and funding associated with Research and Development (R&D) activities, which totals £24.9 million (4.2%). 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, including 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 2011/12 include additional healthcare income, reflecting growth in tertiary referrals and high cost drugs and devices paid for on a cost-per-case basis, and increases in Research and Development income associated with new grant awards.

The largest item of expenditure is salaries and wages, accounting for £306.3 million, equivalent to 56.2% of total expenditure. Other significant components include £63.7 million on drugs (11.6%) and £72.2 million on Clinical Supplies and Services (13.2%).

Non-recurring restructuring expenditure of £4.3 million has been incurred in 2011/12 and this relates to the additional one-off costs associated with the transfer of services to the New Hospital.

3.4 Capital Expenditure Plan

In 2011/12 the Trust incurred £11.5 million of capital expenditure on equipment, new facilities and improvements to existing buildings. This is summarised below:

Category	Capital Invested £ Million
Brought Forward Programmes from 2010/11	0.2
IT Replacement, Modernisation, Infrastructure and additional capacity	1.1
Trust Buildings	
• Existing Estate	0.9
• New Hospital	0.9
	3.1
Trust Equipment	
• Tomotherapy Equipment	3.8
• Replacement and other Equipment	4.6
	8.4
TOTAL	**11.5**

The Trust's planned capital expenditure over the next three financial years (2012/13 to 2014/15) totals £32.4 million. This plan runs alongside the payments relating to the new hospital. It is not anticipated that there will be any requirement to borrow against the Prudential Borrowing Limit during these years.

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

3.5 Value for Money

The Trust's Financial Plan for 2011/12 included the delivery of cash-releasing efficiency savings of 4.0% against relevant budgets. In order to achieve this, a formal cost improvement programme (CIP) totalling £18.8m 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.

3.6 Private Patient Income (PPI)

PPI was £2.7 million which is well within the authorised limit of 1.23% of patient care income.

3.7 QEHB Charity

The charitable funds for the Trust are administered by QEHB Charity, a separate legal entity from the Trust. In 2011/12 the Trust received grants of £1.1 million and donated assets worth £2.1m from the QEHB Charity.

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 £130,448 of which £90,321 relates to statutory audit services, and £40,127 which relates to non-audit work.

The appointment of external audit services from 2007/08 to 2011/12 was made by the Board of Governors, following a competitive tender exercise. Following a similar exercise in March 2012, the Board of Governors have reappointed KPMG as external auditors for 2012/13 onwards (maximum of five years). In addition following a competitive tendering exercise from 1 April 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 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.

Dame Julie Moore Date 24 May 2012
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. The Code was revised and re-issued by Monitor in March 2010.

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 2011/12. 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 Council 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 Council 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 36, of the Annual Report, together with information about the Committees of the Board, their membership and attendance by individual directors.

B. The Council of Governors

The Council 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 Council of Governors appoints and determines the remuneration and terms of office of the Chairman and Non-Executive Directors and the external auditors. The Council 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 Council of Governors has the responsibility for terminating individuals i.e. as a result of poor performance, misconduct etc.

Details of the composition of the Council of Governors are set out in Governors, page 33 of the Annual Report, together with information about the activities of the Council 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 terms of appointment of three non-executive directors, Stewart Dobson, Clare Robinson and Gurjeet Bains, expired during the reporting year. Gurjeet Bains, having only served one term, was re-appointed for a further term of three years by the Council of Governors and David Hamlett and David Waller were appointed to initial terms of three years, on recommendations from the Council of Governors' Nomination Committee for Non-Executive Directors. Details of the composition of that Committee and its activities are set out on page 42 of the Annual Report. Details of terms of office of the Directors are set out in Board of Directors, page 36, of the Annual Report.

D. Information, development and evaluation

The Board of Directors and the Council of 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 the Board and the Council are agreed in the form of an annual cycle and are subject to periodic review.

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

Both the Board of Directors and the Council of Governors regularly review their performance and that of their committees and, in the case of the Board of Directors, the 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 Council 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 Council of Governors as the Trust's External Auditor. The Trust has appointed Deloitte as internal auditors for the reporting year. The Board of Directors undertakes 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 which comes directly to the Board itself or 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 20 of the Annual Report and in Membership, page 43.

1.2 Compliance with the Code

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

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

Non-Executive Directors may in exceptional circumstances serve longer than six years (e.g. two three-year terms following authorisation of the NHS foundation trust), but subject to annual re-appointment.

Prior to December 2008, the Council 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. As a result of this, two of the Non-Executive Directors, Clare Robinson and Stewart Dobson, served for more than six years without being subject to annual re-election. Their current term expired in September 2011.

E.2.3 The Council of Governors is responsible for setting the remuneration of Non-Executive Directors and the Chair. The Council 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 Director.

The Council of Governors did not appoint external professional advisors to market-test the remuneration levels of the Chairman and other Non-Executive Directors for the review carried out in 2009/10. Instead, proposed increases in remuneration were benchmarked against other similar trusts through a remuneration survey carried out by the Foundation Trust Network. There has not been any review of the remuneration levels of the Chairman and other Non-Executive Directors in the reporting year.

2. Quality Governance Framework

The Board of Directors takes direct responsibility for service quality and receives regular reports regarding clinical quality and care quality. Operationally, the Clinical Quality Monitoring Group, the Care Quality Group and the Patient Safety Group provide a framework for quality governance. Comprehensive use of electronic decision-support and monitoring tools enables the Trust to monitor compliance with essential clinical protocols and to identify potential risk areas at an early stage. Additional investigations and audits can be undertaken following such triggers. The effectiveness of this monitoring system is backed up by regular unannounced governance inspections by board members.

In March 2011 the Director of Corporate Affairs led a gap analysis against Monitor's quality governance framework, engaging with the relevant stakeholders. The overall assessment of the group was that the Trust met the requirements of the framework, with some areas identified for consideration in current and future developments. The outcome of the gap analysis was reported to the Board of Directors. The analysis has been reviewed in August 2011, December 2011 and March 2012 and the Trust continues to meet the requirements of the framework.

The Trust continually seeks to improve its quality governance framework and current action plans include the development and implementation of an integrated quality governance dashboard at divisional and specialty level, and roll-out of an integrated governance assurance monitoring system.

Additional information regarding quality governance and quality is set out in the Quality Report (page 63) and the Annual Governance Statement (page V of Section 4).

Council of Governors

1. Overview

The Trust's Council of Governors was established in July 2004, with 24 representatives (increased to 25 on 13 March 2007 due to Parliamentary constituency boundary changes).

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 its future.

In September 2008 and June 2011, the Council of Governors voted to amend the Constitution of the Trust so that the Council of Governors is now comprised as follows:

- 9 public Governors elected from the Parliamentary Constituencies in Birmingham
- 3 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

Elections for 5 public and 2 patient governor seats were held in December 2011. Governors appointed to public and patient seats at these elections were appointed for terms commencing on 1 January 2012 and ending on 30 June 2014.

One by-election, for the Selly Oak area of the Public constituency, has been held.

During this year, the Governors have been:

1.1 Patient

Up to 31 December 2011	From 1 January 2012
Shirley Turner	Shirley Turner
Colin McAllister	Ian Fairbairn
Valerie Jones	Aprella Fitch
Jamie Gardiner	

1.2 Public (by Parliamentary Constituency)

Up to 31 December 2011	From 1 January 2012
Northfield	**Northfield**
Margaret Burdett	Margaret Burdett
Edith Davies	Edith Davies
Selly Oak	**Selly Oak**
Rita Bayley	Valerie Reynolds (from 1 February 2012)
John Delamere	John Delamere
Hall Green	**Hall Green**
David Spilsbury	David Spilsbury
Tony Mullins MBE	Tony Mullins MBE
Edgbaston	**Edgbaston**
John Coleman	John Coleman
Rosanna Penn	Ian Trayer
Ian Trayer	
Ladywood	**Ladywood, Yardley, Perry Barr, Sutton Coldfield, Erdington & Hodge Hill**
Shazad Zaman	Graham Bunch
Yardley	
Kadeer Arif	
Perry Barr & Sutton Coldfield	
Joan Walker	
Erdington & Hodge Hill	
Monica Quach	

1.3 Staff
Up to 30 June 2010

Dr Tom Gallacher (Medical Class)
Susan Price (Clinical Scientist/Allied Health Professional)
Erica Perkins (Nursing Class)
Barbara Tassa (Nursing Class)
Patrick Moore (Ancillary, Administrative and Other Staff)

1.4 Stakeholder

- Rabbi Margaret Jacobi, appointed by the Birmingham Faith Leaders' Group
- Professor David Cox, appointed by South Birmingham Primary Care Trust (Professor Cox resigned as a Governor on 30 November 2011 and a replacement has not yet been nominated by South Birmingham PCT)
- Professor Edward Peck, appointed by the University of Birmingham
- Vice Admiral Raffaelli, appointed by the Ministry of Defence
- Cllr James Hutchings, appointed by Birmingham City Council
- Ms Ruth Harker, appointed by the South West Area Network of the Secondary Education Sector in Birmingham

The Council of Governors met regularly throughout the year, holding seven meetings in total.

Name of Governor	No. of meetings attended*
Rita Bayley	0 out of 1
Edith Davies	All
Valerie Jones	0 out of 4
Shirley Turner	All
Jamie Gardiner	4 out of 4
Colin McAllister	2 out of 4
Margaret Burdett	All
Kadeer Arif	2 out of 4
Shazad Zaman	0 out of 4
Joan Walker	0 out of 1
Dr John Delamere	All
Monica Quach	0 out of 4
David Spilsbury	All
John Coleman	1 out of 7
Tony Mullins MBE	6 out of 7
Ian Trayer	All
Aprella Fitch	3 out of 3
Graham Bunch	3 out of 3
Valerie Reynolds	2 out of 2
Ian Fairbairn	3 out of 3
Stakeholder Governors	
Cllr James Hutchings	6 out of 7
Prof. David Cox	2 out of 3
Ruth Harker	3 out of 7
Rabbi Margaret Jacobi	3 out of 7
Vice Admiral Raffaelli	5 out of 7
Prof. Edward Peck	0 out of 7
Staff Governors	
Barbara Tassa	3 out of 7
Dr Tom Gallacher	4 out of 7
Patrick Moore	All
Susan Price	2 out of 7
Erica Perkins	4 out of 7

*While a member of the Board of Governors.

1.5 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

1.6 Register of Interests

The Trust's Constitution and Standing Orders of the Council of Governors requires the Trust to maintain a Register of Interests for Governors. Governors are required to declare interests that are relevant and material to the Board. These details are kept up-to-date by an annual review of the Register, during which any changes to interests declared during the preceding 12 months are incorporated. The Register is available to the public on request to the Director of Corporate Affairs, University Hospitals Birmingham NHS Foundation Trust, Trust Headquarters, PO Box 9551, Mindelsohn Way, Edgbaston, B15 2PR.

Board of Directors

1. Overview

Throughout the year, the Board of Directors comprised the Chairman, six Executive and seven Non-Executive Directors.

Professor Michael Sheppard was appointed as Deputy Chairman on 1 October 2011, taking over from Stewart Dobson, and Gurjeet Bains was appointed as Senior Independent Director on 1 October 2011, taking over from Clare Robinson. 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: Dame Julie Moore
Executive Director of Finance: Mike Sexton
Executive Medical Director: Dr 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
David Hamlett
Angela Maxwell
David Ritchie
David Waller
Professor Michael Sheppard

The Non-Executive Directors have all been appointed or re-appointed for terms of three years.

NAME	Date of Appoint-ment/ Latest Renewal	Term	Date of end of term
Sir Albert Bore	1 December 2010	3 years	30 November 2013
Clare Robinson	1 October 2008	3 years	30 September 2011
Stewart Dobson	1 October 2008	3 years	30 September 2011
Prof David Bailey	1 December 2010	3 years	30 November 2013
David Ritchie	1 December 2010	3 years	30 November 2013
Gurjeet Bains	1 December 2011	3 years	30 November 2014
Prof Michael Sheppard	5 December 2010	3 years	4 December 2013
Angela Maxwell	1 July 2009	3 years	30 June 2012
David Hamlett	1 October 2011	3 years	30 September 2014
David Waller	1 October 2011	3 years	30 September 2014

The Board of Directors considers Clare Robinson, Stewart Dobson, Prof David Bailey, David Ritchie, Gurjeet Bains, Angela Maxwell,

David Hamlett and David Waller to be independent. With regard to Clare Robinson and Stewart Dobson, the Board of Directors has given special consideration to the issue of independence, given that Clare Robinson and Stewart Dobson had served as Non-Executive Directors for more than six years. Their term expired in September 2011.

2. Board meetings

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

Directors	No. of meetings attended
Sir Albert Bore	All
Dame Julie Moore	All
Mike Sexton	All
Tim Jones	10
Stewart Dobson	5 out of 5*
Clare Robinson	5 out of 5*
David Ritchie	10
Prof Michael Sheppard	9
Dr David Rosser	All
Prof David Bailey	9
Kay Fawcett	10
Gurjeet Bains	10
Angela Maxwell	10
Kevin Bolger	All
David Hamlett	6 out of 6*
David Waller	3 out of 6*

*While a member of the Board of Directors.

3. The Board of Directors composition

Sir Albert Bore, Chairman

Sir Albert Bore was elected Chairman of the Trust on 1 December 2006 and re-appointed for a further three years on 1 December 2010. 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 Performances Birmingham - responsible for Symphony Hall and the Town Hall, Marketing Birmingham, National Exhibition Centre Limited and Birmingham Technology Ltd, the joint venture company developing and managing Birmingham Science Park Aston.

Dame Julie Moore, Chief Executive

Julie is a graduate nurse who worked in clinical practice before moving into management. She was appointed as an Executive Director of Operations at University Hospital Birmingham (UHB) in 2002, subsequently becoming Chief Executive of UHB in 2006.

Julie was a member of the National Organ Donation Taskforces in 2007 and 2008 and in 2009 was a member of the Nuffield Trust Steering Group on New Frontiers in Efficiency. She is a member of the International Advisory Board of the University of Birmingham Business School, an Independent Member of the Board of the Office for Strategic Co-ordination of Health Research (OSCHR), a member of the MoD/DH Partnership Board overseeing healthcare of military personnel, a member of the Commission on Living Standards undertaken by the Resolution Foundation and a Board Member of Marketing Birmingham, a strategic partnership to drive the inward investment strategy for the city. She is a Fellow of the Royal Society of Arts.

In April 2011 she was asked by the Government to be a member of the NHS Future Forum to lead on the proposals for Education and Training reform and in August asked to lead the follow-up report on the same subject.

Julie was made a Dame Commander of the British Empire in the New Year's Honours 2011.

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. 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 became Deputy Chief Operating Officer and was made Chief Operating Officer in June 2009, responsible for the day-to-day running of the Queen Elizabeth and Selly Oak hospitals. He led the historic, safe and successful operational transition of two hospitals into the UK's largest single site hospital between June 2010 and April 2012. He oversaw the hospital going live as a major trauma centre in March 2012. He is also involved in the Trust's international work.

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. She returned 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 University Hospital Birmingham in 2000 as Head of Nursing. She became Deputy Chief Nurse in 2002. In July 2005 she took up post as Executive Director of Nursing for Derby Hospitals NHS Foundation Trust where she held responsibility for Nursing and Allied Health Professionals, Infection Prevention and Control, Governance and Risk. Kay rejoined the Trust in January 2008, when she was appointed as Executive Chief Nurse, with responsibility for Nursing, Facilities Management, Infection Prevention and Control and Business Continuity.

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. Tim joined UHB in 1995 as an operational manager in General Medicine and Elderly Care. He continued to work in Operations until 2002 when he undertook the role of Head of Service Improvement and led the New Hospital Clinical Redesign Programme. In June 2006 he took up the Board level position of Chief Operating Officer. As COO he chaired the Operational Commissioning Group for the new hospital. In September 2008 he was appointed to the newly created role of Executive Director of Delivery which included executive responsibility for operational commissioning of the new hospital, service improvement, strategy, performance, research, education and organisational development. Tim is also a board member of the National Institute for Health Research (NIHR) Health Service Research Board, Birmingham Science City and MidTech, a health service intellectual property company.

Dr 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 a Divisional Director 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. He also has executive responsibility for IT and Quality.

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 16 years he has held numerous positions including Head of Operational Finance and Business Planning, Director of Operational Finance and Performance and Acting Director of Finance. Mike is also the executive lead for international affairs, commercial development, payroll, service and healthcare contracts, procurement, arts and charities.

Non-Executive Directors

Professor Michael Sheppard, Deputy Chairman

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 and 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.

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 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 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. She was appointed as a Governor for Birmingham Metropolitan College in 2010. She is the board's senior independent Director, the key link between the Board of Directors and the Council of Governors.

David Hamlett

David is a qualified solicitor who has worked at Linklaters & Paines (1978-1983) and then Wragge & Co LLP (1983-Present (Partner 1988)). He has a strong track record as a Birmingham-based lawyer, with the added breadth of working with clients from around the world, and across the commercial and public sectors. David co-leads Wragge's health business, a practice which has developed and grown predominantly as a result of its being

retained by the Department of Health as independent legal advisors to 46 health trusts and Independent Sector Treatment Centres. Wragge's health practice work takes him around the world, including advising in Abu Dhabi and Bahrain on joint partnerships. In addition to his health expertise, David has a strong track record working in defence; another highly regulated and complex sector.

Angela Maxwell OBE

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, 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. In 2010 Angela was awarded an honorary doctorate for business leadership from the University of Birmingham and was made an OBE for services to business. She recently co-launched Vibe Generation, specialists in intellectual property creation and product commercialisation.

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.

David Waller

David is Chairman of Network Group Holdings plc, the public company arm of Pertemps Ltd, one of the UK's largest, recruitment, training and people contracting businesses with a turnover of over £400 million. He is also chairman of Birmingham Chamber of Commerce Group, a director of the National Exhibition Centre (NEC), his own investment company, Delami Investments Ltd, Country People Ltd and Nexus Professional Network Ltd. He is also a director of Millennium Point Trust Ltd, Stream2School Ltd and Event That Ltd. Up until January 2009, David was Senior Partner of PricewaterhouseCoopers' Birmingham Office and PwC Regional Chairman with responsibility for 2,500 professional staff and over £250 million of revenues. He also headed PwC's regional Management Consultancy practice and represented PwC Middle Market interests globally. He was lead partner for several major clients in both the Private and Public Sectors. During his time with PwC he has been actively involved with over 200 clients of all types and sizes.

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, Mindelsohn Way, Edgbaston, 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 until 1 April 2011, when David Ritchie was appointed as Chairman of the Audit Committee. The Committee currently comprises of the following Non-Executive Directors of the Trust: David Ritchie, Prof David Bailey, Gurjeet Bains and David Waller, 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	3 out of 3*
Gurjeet Bains	All
Prof David Bailey	4
David Ritchie	All
Stewart Dobson	3 out of 3*
Prof Michael Sheppard	1 out of 3*
Angela Maxwell	3 out of 3*
David Waller	1 out of 3*

*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 Trust'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 Care Quality 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 Council 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 Council 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 Council of Governors, following a recommendation by the Audit Committee, must be obtained prior to commencement of the work. Neither approval of the Council 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 Council of Governors through the Audit Committee. KPMG LLP's accompanying report on our financial statements is based on its examination conducted in accordance with International Financial Reporting Standards 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 Committees

1. Council of Governors' Nominations Committee for Non-Executive Directors

The Nomination Committee for Non-Executive Directors was amalgamated with the Remuneration Committee for Non-Executive Directors on 22 December 2011, forming the Council of Governors' Remuneration & Nomination Committee for Non-Executive Directors. The Council of Governors' Remuneration & Nomination Committee for Non-Executive Directors is a sub-committee of the Council of Governors responsible, amongst other things, for advising the Council of Governors and making recommendations on the appointment of Non-Executive Directors, including the Chairman of the Trust. Its terms of reference, role and delegated authority have all been agreed by the full Council of Governors. The committee meets on an as-required basis.

The Remuneration & Nomination Committee for Non-Executive Directors comprises the Chairman and five Governors of the Trust. The Chairman chairs the committee, save when the post/remuneration of the Chairman is the subject of business, in which case the committee is chaired by the Governor Vice-Chair.

During the reporting year the membership of the Committee was as follows:

Council of Governors' Nominations Committee (up to 21 December 2011)	Council of Governors' Remuneration and Nominations Committee (from 22 December 2011)
Sir Albert Bore (Chairman)	Sir Albert Bore (Chairman)
Margaret Burdett (Governor Vice-Chair)	Margaret Burdett (Governor Vice-Chair)
Shirley Turner	Edith Davies
Prof Ian Trayer	Aprella Fitch
Erica Perkins	Dr Tom Gallacher
Ruth Harker	Ruth Harker

The Nominations Committee met once during the year and all those Committee members in office at the time attended. The Remuneration and Nominations Committee met twice during the year and all Committee members attended both meetings with the exception of Tom Gallacher and Ruth Harker who each attended one of the two meetings.

During the year, the Committee oversaw the re-appointment of one Non-Executive Director for a further term of three years and the appointment of two new Non-Executive Directors.

2. Nominations Sub-Committee

The Executive Appointments and Remuneration Committee did not appoint a Nominations Sub-Committee during the reporting year.

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 drawn from 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

Constituency	Total at 31/03/10*	%
Public	11,053	48
Patient	4,447	19
Staff	7,633	33
Total Membership	**23,133**	**100**

*Numbers correct up to 31 March 2012

3. Membership Strategy

3.1 Background

University Hospitals Birmingham was a first wave NHS FT in 2004. It launched its much-improved membership programme, which places emphasis on meaningful engagement, at the beginning of April 2009 alongside a high-profile awareness and recruitment campaign.

3.2 Membership development 2010/11

Since re-launching, work has continued to ensure that members are actively engaged.

Activities are aligned to the four membership types; thought, time, energy and support and are communicated with though the Trust in the Future magazine.

Social media tools such as Facebook and Twitter have played an important part in improving the accessibility of both membership information available and Trust news. Some 26 membership items have been posted via Twitter and four dedicated stories on Facebook have been published in the past 12 months.

Members may now get posts (on average three per day) about the Trust directly to their smartphone, or any other device with internet access, as it is released.

Increased awareness around the role of staff governors has been made through a number of Trust publications including 'in the hot seat' questions published in the Trust magazine and staff governors featuring on Trust screensavers. Engagement activities involve staff governors holding drop-in sessions for staff in the hospital's Plaza restaurant and fronting internal awareness campaigns, such as the NHS' Sustainability in Action Day, in their role as staff governor. The staff governor for Admin and Clerical staff was short-listed for the Trust's annual Best in Care Awards for the category 'Member of the Year'.

In November 2011, members' views were sought regarding their preferred methods of communication, in particular in relation to information on the conditions, treatments and services the Trust provides. The survey received over 750 responses and provided a useful insight into how information for patients may be developed and improved going forward, with the emphasis switching to evidencing quality outcomes for patients rather than some of the softer measures of quality ie. food, or car parking.

3.3 Ambassador Programme

In June 2010 the Ambassador Programme was launched to give members who wanted to play a more active role in their community setting, the opportunity to do just that. The programme also offers support to the Membership Office.

In 2011/12 two foundation members made successful bids to become governors after participating in the Ambassador Programme for more than 12 months. The Ambassador Programme provided a positive arena to develop their knowledge of the NHS, the needs of patients and visitors, and the skills to engage with the community effectively about the hospitals.

Since launching the Ambassador Programme in 2010, the Trust has been approached by several NHS trusts interested in adopting a similar programme for enthusiastic members or aspiring governors. In addition the Foundation Trust Network has invited the Trust to share its example of a successful initiative as a best practice case study.

The role of an Ambassador is to:

- Assist in promoting the profile of the Trust by attending local community groups
- Support the distribution of Trust information i.e. leaflets, posters and newsletters
- Assist at and support corporate functions and events such as fun days
- Act as an information resource for patients and the public on membership
- Actively promote to and sign-up new members

At present, the Trust has 11 Ambassadors (up from eight in 2010/11) who are actively involved in promoting the Trust through presenting at community groups, fundraising for the Trust's charity, recruiting new members and giving feedback as 'mystery patients'.

3.4 Membership recruitment 2011/12

From 1 April 2011 1,067 new members were recruited representing an increase of 4.43%. However 2,001 members left the programme due to moving away from the area or having died, resulting in a loss of 934 members.

This loss can in part be attributed to the number of students joining the membership programme in 2009 when significant recruitment activity was undertaken to increase membership. A substantial number of those recruited at that time were undergraduates studying at a number of the city's universities. Similar experience of students through the volunteer programme suggests that due to their transient nature, they tend to leave after 2-3 years once their course has concluded. As a result the emphasis of the Trust's strategy has

been to retain young people going forward, rather than recruiting.

In early March 2011 a recruitment mailing exercise was launched, based on the most successful methodology, to ensure that the 5% growth and replacement of churn was achieved. At the time of the Annual Report going to press, the Trust was confident that these recruitment targets would be met.

3.5 Recruitment and engagement strategy 2012/13

During 2012/13 the Trust aims to replace the annual churn and maintain existing membership numbers to no less than 23,000. With a membership of 23,000, UHB has the fifth highest number of members when comparing foundation trusts. However it is quality, not quantity when it comes to priority with members – evidencing the tangible benefits they bring to patients and staff.

In addition the following methods will be employed as analysis shows that those with an existing relationship with the Trust are more likely to become members:

- Trust publications
- Internal leaflets
- Trust website
- Social media tools
- GP surgeries
- Existing members
- Community groups
- Governors
- Ambassadors
- Health talks
- Drop-in sessions

Emphasis will be put on retention of existing members and further engagement. This will be conducted via:

- The quarterly publication Trust in the Future
- Further development of the Ambassador Programme, ensuring that Ambassadors are involved in appropriate activities and contributing to the recruitment of new members
- Further developing membership content published via social media and the Trust website
- The inclusion of members on appropriate patient groups
- Raising the profile and role of Foundation Members, Ambassadors and Governors within the Trust
- Working with QEHB Charity to increase membership opportunities amongst fundraisers

3.6 Engagement with members Recruitment

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. These sessions are held monthly at the Queen Elizabeth Hospital Birmingham. 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 Membership Office which then steers members to the appropriate Governor/ Director
- Website. Each Governor has their profile and details of the constituency they serve, published on the Trust website
- Trust in the Future magazine – highlights work of Governors and opportunities to be involved in projects/patient experience groups

- Direct email and telephone number to the Membership Office 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
- Governors attend community presentations held in their constituency in relation to the hospital/patients' issues
- Health Talks. Governors attend health talks which are held on a monthly basis for members and the wider community. Evening sessions are held regularly to provide greater access
- news@QEHB – Trust newspaper distributed through the hospital sites
- Social media tools – Twitter, Facebook, Flickr and YouTube
- Regular e-bulletins to members who select to receive them

3.7 Recognition of UHB's Membership Programme

In 2010, the Trust was approached by Monitor to be interviewed as a case study for their report on membership recruitment and engagement. The report was published in July 2011 highlighting the extensive work done at UHB to develop an effective membership strategy.

Monitor's report can be found at: http://www.monitor-nhsft.gov.uk/sites/default/files/Current%20practice%20in%20foundatio...ecruitment%20and%20engagement.pdf

NHS Staff Survey

1. Commentary

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

The Trust has many mechanisms in place to get staff views and opinions including a Chief Executive hotline, e-mail addresses for staff questions to be directly answered, 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.

UHB is committed to keeping staff up-to-date with news and developments through an internal communications programme, as follows:

- Team Brief - staff receive the Chief Executive's core brief every month
- news@QEHB - the Trust's monthly staff magazine, is available throughout the Trust
- intranet@QEHB - the intranet is constantly updated and improved
- In the Loop - staff receive weekly email updates on Trust news and developments
- There is a programme of corporate and local induction and orientation for new starters to improve long-term retention of staff

2. Summary of Performance

Each year the Trust results are compared against other similar NHS trusts and hence the results show a comparison between the acute trusts across the UK (shown below as National Average) in addition to a comparison of UHB's own results from the previous year.

2.1 NHS Staff Survey Response Rate 2011 compared with 2012

	2010		2011		Difference
	UHB	National Average	UHB	National Average	
Response Rate	45%	52%	55%	55%	10% improvement and now meets national average

The staff survey results are presented in the form of 38 key findings. There are two types of key findings:

- Percentage scores
- Scale summary scores between 1 and 5

Areas of improvement from 2010 survey

	2010	2011	Difference
KF16: % of staff receiving health and safety training in the last 12 months	83%	92%	9% increase

Area of deterioration from 2010 survey

	2010	2011	Difference
KF15: Support from immediate managers	3.82	3.61	0.21 scale point deterioration
KF9: % of staff using flexible working options	66%	57%	9% deterioration
KF4: Quality of job design	3.56	3.44	0.12 scale point deterioration
KF32: Staff job satisfaction	3.62	3.49	0.13 scale point deterioration

2011 Top 4 Ranking Scores

These questions were calculated on a scale of 1 to 5, with 1 the minimum score and 5 the maximum score

	2010		2011		Difference
	UHB	National Average	UHB	National Average	
KF16: % of staff receiving health and safety training in last 12 months	83%	80%	92%	81%	9% increase (improvement)

KF10: % of staff feeling there are good opportunities to develop their potential at work	51%	41%	49%	40%	2% decrease (deterioration)
KF34: Staff recommendation of the trust as a place to work or receive treatment	3.81	3.52	3.78	3.50	0.03 scale decrease (deterioration)
KF27: Perceptions of effective action from employer towards violence and harassment	3.73	3.56	3.66	3.58	0.07 scale point decrease (deterioration)

2011 Bottom 4 Ranking Scores

	2010		2011		Difference
	UHB	National Average	UHB	National Average	
KF9: % of staff using flexible working options	66%	63%	57%	61%	9% decrease (deterioration)
KF38: % of staff experiencing discrimination in the last 12 months	15%	13%	17%	13%	2% increase (deterioration)
KF21: % of staff reporting errors, near misses or incidents witnessed in the last month	95%	95%	95%	96%	No change
KF19: % of staff saying hand washing materials always available	62%	67%	60%	66%	2% decrease (deterioration)

3. Areas of concern and action plans

The priorities are as follows:

- Target areas/staff groups where response rates have been lower
- Divisional Action Plans to target their specific problem areas
- Equality & Diversity training to become mandatory
- Availability of hand washing materials
- Prevention of discrimination

Regulatory ratings

1. Explanation of ratings

1.1 Finance Risk Rating

When assessing financial risk for the period 2011/12 Monitor assigned a risk rating using a scorecard which compared key financial metrics. The risk rating is 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 2011/12 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. As there is no longer a separate risk assessment for the provision of mandatory services, this is now incorporated within the governance risk assessment. Monitor therefore considers eight 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
8. Provision of mandatory services

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

2. 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 show the risk ratings for the Trust for Finance and Governance identified in the Annual Plan and the quarterly self-certifications in 2010/11 and 2011/12. Additional detail is provided where risks are declared and have a contribution to the risk ratings.

a. Monitor Risk Ratings in 2010/11

	Annual Plan 2010/11	Q1 2010/11	Q2 2010/11	Q3 2010/11	Q4 2010/11
Financial Risk Rating	3	3	3	3	3
Governance Risk Rating	Amber-Green	Amber-Green	Green	Green	Green
Governance Risks Declared	Cancer - 62 day all Cancer - 62 day screening	Cancer – 62 day all	-	-	-

In 2010/11 the Trust declared a risk in its Annual Plan against the 62-day cancer GP referral and screening targets. In Quarter 1 the Trust's performance was in line with the risks declared as the 62-day GP referral target was underachieved. However due to effective action the Trust met this target for the remaining quarters and for the full year. All other targets and indicators included in Monitor's Compliance Framework for 2010/11 were met for the full year.

b. Monitor Risk Ratings in 2011/12

	Annual Plan 2011/12	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q4 2011/12
Financial Risk Rating	3	3	3	3	3
Governance Risk Rating	Amber-Green	Green	Amber-Green	Green	Green
Governance Risks Declared	MRSA A&E Clinical Quality – Time to Treatment and Reattendance Rate	-	Cancer – 62 day all	-	-

In its Annual Plan for 2011/12 the Trust declared risks to achieving the MRSA target and two of the A&E Clinical Quality indicators. During the year Monitor discontinued the A&E clinical quality indicators therefore these were not considered as part of the Governance Risk Rating after the annual plan return. Due to effective action the Trust performed significantly better than trajectory with only 4 MRSA cases against the full year trajectory of 7. The 62-day cancer was not achieved in Quarter 2 due to the large number of late tertiary referrals received from other trusts over the period. Action was taken to improve performance and this target was met for the remainder of the year. The Trust is currently working with all local trusts and the Pan-Birmingham Cancer Network to establish a system for the reallocation of the breaches of the target resulting from late referrals. All other targets and indicators included in Monitor's Compliance Framework for 2011/12 were met for the full year.

3. Details and actions from any formal interventions

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

Public Interest Disclosures

1. Consultation

The Trust is committed to involving staff in decision-making and keeping them informed of changes and developments across the Trust. It works hard to ensure its staff are aware of the key priorities and issues affecting the Trust - this has been particularly important with the changes to the NHS and financial environment. Our vision and values are at the heart of everything it does and for its staff to 'Deliver the Best in Care' has to mean their involvement in decisions and a commitment from Trust management to meaningfully consult and communicate.

UHB’s range of well-established communication channels includes a monthly team briefing from the Chief Executive and a weekly publication called 'In the Loop'. The Trust magazine, news@QEHB and the corporate induction programme is a valuable source of information for new recruits. The Trust's intranet is also a central source for policies, guidance and online tools. In 2011, the Trust launched a staff portal called me@QEHB. Staff are able to directly access information which affects them individually e.g. payslips, training records, absence records. There is also a section called AskHR which contains frequently asked HR questions, template letters and links to the Trust Policies and Procedures. Nearly 5,700 staff have viewed, and continue, to view the staff portal, which is available 24 hours a day.

The Trust works in partnership with staff representatives to ensure employees' voices are heard. The Trust Partnership Team meets monthly, acting as a valuable consultative forum. The forum includes Executive Directors and management representatives from across all specialities to ensure that the knowledge required to give representatives meaningful information is available. The Group looks at policy and pay issues, in addition to organisational changes, future Trust developments and financial performance. Staff throughout the Trust are encouraged to voice opinions and get involved in developing services to drive continuous improvement.

2. Policies in relation to disabled employees and equal opportunities

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 utilises organisations such as Access to Work and Autism West Midlands for specialist advice to enable disabled staff to continue working at the Trust where possible.

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 Bournville College is provided

for staff who wish to improve upon their literacy and numeracy skills. Support can also be utilised via the Learning Hub at the Trust.

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.

All Trust policies and procedures are equality impact assessed to ensure that they have no adverse impact due to disability (or any of the other protected characteristics as per the Equality Act 2010).

3. Sickness absence

The Trust recorded an annual average sickness absence of 3.94% across all clinical and corporate divisions; this was at 4.28% in 2010. Trust management is working in partnership with Staffside to reduce this to 3% by 2013 and therefore the reduction from the previous year demonstrates our commitment and progress on reaching that target.

4. Cost allocation

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

5. Health and Safety

The staff incident rate for 2011/12 was 205 incidents per 1,000 staff. No Improvement Notices were issued by the Health and Safety Executive (HSE).

Whilst violence and aggression is the highest incident type reported (493), the majority of these (373) related to verbal rather than physical incidents or unintentional assaults. Inoculation injuries, of which there were 267, remain in the top three incident causation categories with impact incidents in third place at 162.

The Trust continues to ensure that action is taken to reduce instances of violence and aggression occurring and to deal appropriately with the perpetrators of such incidents.

Product trials of safety cannula devices have been undertaken and final product selection rolled out in the high risk areas of the Trust. Roll out will be extended Trust wide as existing

stock decreases. Further product trials are planned for the near future including a safety insulin administration device. A specific risk assessment protocol has been developed to assist managers to reduce inoculation incidents; there have been a number of improvements in clinical and operational practice as a result.

Moving and handling incidents are no longer in the top three categories (82), probably attributable to the additional moving and handling equipment that has been made available following the move to the new hospital in conjunction with training in local areas in its use.

The Trust received three visits from the Health and Safety Executive in this 12-month period. The first was in relation to a potential Brucella exposure in the microbiology laboratory. No action was taken against the Trust. A national safety alert was issued by the HSE in relation to this, based on the lessons learned, relating to interdepartmental communication to biological specimens. The second visit was in response to an incident involving a visiting contractor which resulted in a serious head injury. Again no action was taken. The third visit was in relation to a Road Traffic Accident on the Whittall Street Clinic access road bordering the Dental Hospital. No recommendations from the HSE were addressed to the Trust, although the landowners received formal recommendations including improved communication and co-operation between all parties about the use of the access road and clear responsibility for control of access to be determined. No further action was taken.

Staff are informed about health and safety matters through various means, including regular monthly drop-in sessions and a monthly brief for senior managers offering a snapshot of health and safety compliance within their division. These senior managers provide a quarterly progress report to the Trust Health Safety and Environment Committee.

The Trust's Stress at Work policy has been reviewed and is being overseen by the Stress Steering Group. Flu vaccination was made available to all frontline staff as close to their place of work as possible to reduce any disruption to services.

6. Serious untoward incidents – Information Governance

In March 2012 the Trust was informed by a healthcare contractor that they had inadvertently collected items of personal patient information along with items of product performance data they routinely downloaded from (e.g. 2 diagnostic scanners they had provided to the Trust). The Trust was one of a number of NHS organisations where this process had inadvertently taken place and therefore the incident investigation and management was undertaken by the Department of Health (DoH).

The incident has been notified to the Information Commissioners Office (ICO) and the joint view of the DoH and ICO is that the risk of harm to patients is negligible. The data is held in a complex format and is not readily accessible and the contractor has given assurance, independently verified, that the data remains secure, has not been subject to loss, hacking, misuse or theft and will be destroyed on the completion of the investigation.

Other than the above incident, the Trust has had no Information Governance Serious Untoward Incidents involving personal data as reported to the Information Commissioner's Office in 2011/12.

The table following sets out a summary of other personal data related incidents in 2011-12.

Summary of Other Personal Data Related Incidents in 2011/12

Category	Nature of incident	Total
I	Loss/theft of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	3
II	Loss/theft of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	0
V	Other	0

7. Countering fraud and corruption

The Trust has a duty, under the Health and Safety at Work Act 1974 and the Human Rights Act 2000, to provide a safe and secure environment for staff, patients and visitors. As part of this responsibility, regular reviews into security around the Trust are conducted. They are conducted by the NHS accredited Local Security Management Specialist, a post that is required under Secretary of State Directions, and the Trust encourages a pro-security culture amongst its staff. The Trust actively investigates all reported criminal incidents and has a close working relationship with local police officers.

The Trust policy is to apply best practice regarding fraud and corruption and 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. In the year, the local counter-fraud service carried out a staff survey, in line with one used at a number of public and private organisations internationally, and found that in relation to fraud awareness and the building of an anti-fraud culture, and in comparison with others surveyed, the responses from the Trust's staff were overwhelmingly positive.

8. Better Payment Practice Code

	Number	£000
Total bills paid in the year	103,635	259,069
Total bills paid within target	102,287	255,932
Percentage of bills paid within target	98.70%	98.79%

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.

9. The Late Payment of Commercial Debts (Interest) Act 1998

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

10. Management costs

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

University Hospitals Birmingham NHS
NHS Foundation Trust

Section 2 **Remuneration Report 2011/2012**

This annual report covers the period 1 April 2011 to 31 March 2012

Section 2 | Remuneration Report

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 four times in the year. Attendance was as follows:

Directors	No. of meetings attended
Sir Albert Bore	All
Dame Julie Moore	All
Clare Robinson	1 out of 1*
Gurjeet Bains	3
Prof David Bailey	2
David Ritchie	All
Stewart Dobson	1 out of 1*
Prof Michael Sheppard	All
Angela Maxwell	1 out of 4
David Hamlett	2 out of 3*
David Waller	1 out of 3*

*While a member of the Committee

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 2011/12.

3. Pensions

All the executive directors are members of the NHS Pensions Scheme – with the exception of Viv Tsemelis. 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 pages 60 and 61.

4. Salary and Pension Entitlements of Senior Managers

A. Remuneration

Salary entitlements of senior managers

Name and Title	Year Ended 31 March 2012			Year Ended 31 March 2011		
	Salary	Other Re-muneration	Benefits in Kind	Salary	Other Re-muneration	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						
Dame Julie Moore Chief Executive	210-215	0	0	210-215	0	0
Kay Fawcett Executive Chief Nurse	120-125	0	0	125-130	0	0
Dr David Rosser Executive Medical Director	85-90	95-100	0	85-90	95-100	0
Tim Jones Executive Director of Delivery	135-140	0	0	135-140	0	0
Mike Sexton Executive Director of Finance	135-140	0	0	135-140	0	0
Kevin Bolger Executive Chief Operating Officer	130-135	0	0	130-135	0	0
Fiona Alexander Director of Communications	100-105	0	0	100-105	0	0
Morag Jackson New Hospitals Project Director	115-120	0	0	115-120	0	0
David Burbridge Director of Corporate Affairs	100-105	0	0	95-100	0	0
Viv Tsesmelis Director of Partnerships	95-100	0	0	95-100	0	0

NON EXECUTIVE DIRECTORS						
Sir Albert Bore Chairman	50-55	0	0	50-55	0	0
Stewart Dobson	5-10	0	0	15-20	0	0
Angela Maxwell	10-15	0	0	10-15	0	0
David Ritchie	15-20	0	0	10-15	0	0
Clare Robinson	5-10	0	0	15-20	0	0
Gurjeet Bains	10-15	0	0	10-15	0	0
Professor Michael Sheppard	10-15	0	0	10-15	0	0
Professor David Bailey	10-15	0	0	10-15	0	0
David Hamlett (commenced office 01/10/2011)	5-10	0	0	0	0	0
David Waller (commenced office 01/10/2011)	5-10	0	0	0	0	0

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

	Year Ended 31 March 2012	Year Ended 31 March 2011
Band of Highest Paid Director's Total Remuneration (£ '000)	210-215	210-215
Median Total Remuneration	26,215	25,635
Ratio	8.1	8.3

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

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 2012	Total accrued pension related lump sum at age 60 at 31 March 2012	Cash Equiva-lent Transfer Value at 31 March 2011	Cash Equiva-lent Transfer Value at 31 March 2012	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
Dame Julie Moore, Chief Executive	0-2.5	0-2.5	80-85	245-250	1,446	1,610	120	N/A
Mike Sexton, Executive Director of Finance	0-2.5	2.5-5	50-55	160-165	928	1,046	90	N/A
Tim Jones, Executive Director of Delivery	0-2.5	5-7.5	30-35	100-105	440	556	102	N/A
Kay Fawcett, Executive Chief Nurse	0-2.5	0-2.5	50-55	155-160	923	1,024	72	N/A
Kevin Bolger, Executive Chief Operating Officer	0-2.5	0-2.5	45-50	145-150	871	973	75	N/A
Dr David Rosser, Executive Medical Director	0-2.5	0-2.5	50-55	155-160	720	866	124	N/A
David Burbridge, Director of Corporate Affairs	0-2.5	0-2.5	15-20	45-50	236	287	43	N/A
Fiona Alexander, Director of Communications	0-2.5	2.5-5	5-10	20-25	83	118	32	N/A
Morag Jackson, New Hospitals Project Director	7.5-10	20-22.5	40-45	125-130	556	763	190	N/A

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

Details above are provided by the NHS Pensions Agency.

6. Non-Executive Directors' remuneration

Non-Executive Directors' remuneration consists of fees which are set by the Council of Governors. The Council of Governors established a committee, the Council of Governors Remuneration Committee for Non-Executive Directors, amalgamated on 22 December 2011 with the Council of Governors' Nominations Committee for Non-Executive Directors to form the Council of Governors' Remuneration and Nominations Committee for Non-Executive Directors. The role of the Committee is, among other things, to advise the Council of Governors as to the levels of remuneration for the Non-Executive Directors. NED fees are reviewed regularly year with advice taken from independent consultants where appropriate. During the reporting year, the Committee comprised the following:

Council of Governors' Nominations Committee (up to 21 December 2011)	Council of Governors' Remuneration and Nominations Committee (from 22 December 2011)
Sir Albert Bore (Chairman)	Sir Albert Bore (Chairman)
Margaret Burdett (Governor Vice-Chair)	Margaret Burdett (Governor Vice-Chair)
Jamie Gardiner	Edith Davies
Dr Tom Gallacher	Aprella Fitch
James Hutchings	Dr Tom Gallacher
Ian Trayer	Ruth Harker

The Chairman does not attend when the committee considers matters relating to his own remuneration. The Remuneration and Nominations Committee met twice during the year and all Committee members attended both meetings with the exception of Tom Gallacher and Ruth Harker who each attended one of the two meetings.

Julie Moore, Chief Executive

Date: 24 May 2012

University Hospitals Birmingham NHS Foundation Trust

NHS

Section 3 **Quality Report 2011/2012**

This report covers the period 1 April 2011 to 31 March 2012

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Part 1: Chief Executive's Statement

2011/12 has been an exciting year for University Hospitals Birmingham NHS Foundation Trust (UHB) as the remaining services and departments moved into the new Queen Elizabeth Hospital Birmingham (QEHB). The Trust also took over the provision of Reproductive Sexual Health (RSH) and Genito-Urinary Medicine (GUM) from Heart of Birmingham Teaching Primary Care Trust from 1 April 2011.

The past year has also been a challenging one as the Trust has focused on continuously improving the quality of care it delivers in the new QEHB whilst delivering efficiency savings. This is against the backdrop of the wider economic situation and the Quality, Innovation, Productivity and Prevention (QIPP) programme which aims to improve the quality of care across the NHS whilst making £20billion of efficiency savings by 2014-15. The Trust's Vision is "to deliver the best in care" to our patients. Quality in everything we do supports 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 has made very good progress in relation to all six quality improvement priorities for 2011/12 identified in last year's Quality Report: reducing delays in antibiotic delivery; completion of venous thromboembolism (VTE) risk assessments; improving patient experience and satisfaction; completeness of observation sets; reducing medication errors and reducing infection. The Trust has chosen to continue with five of these priorities in 2012/13 to deliver further improvements for our patients.

The Trust's focused approach to quality, based on driving out errors and making small but significant improvements, is driven by innovative and bespoke information systems which allow us to capture and use real-time data in ways which few other UK trusts are able to do. We have expanded our programme of Executive Root Cause Analysis (RCA) meetings over the past year to include a wider range of care omissions which cover all four clinical divisions as well as support services and other areas. Cases are selected for review from a range of sources and include: wards selected for review, missed or delayed drugs, Serious Incidents Requiring Investigation (SIRIs), serious complaints and infection incidents. The Trust will also be including some hospital-acquired grade 3 or 4 pressure ulcers from 2012/13.

A key part of UHB's commitment to quality is being open and honest with our staff, patients and the public, with published information not simply limited to good performance. The Quality web pages provide up to date information on the Trust's performance in relation to quality: http://www.uhb.nhs.uk/quality.htm. A wide range of information was published during 2011/12 including quarterly Quality Report updates, Trust-level patient experience data, performance for specialty level indicators and the A&E Clinical Quality Indicators. The Trust will be using the feedback provided by Members in response to the patient information survey carried out in 2011/12 to drive quality communication strategies over the coming year.

An essential part of driving up quality at UHB continues to be the scrutiny and challenge provided through proper engagement with staff and other stakeholders such as the

Trust Council of Governors, the Birmingham Local Involvement Network and Birmingham and Solihull NHS Cluster. Clinical staff have continued to develop and use a wide range of specialty level quality indicators through the Trust's Quality and Outcomes Research Unit (QuORU), some of which are shown in Part 3 of this report. The Trust will continue to work with local Clinical Commissioning Groups (CCGs) and Birmingham and Solihull NHS Cluster to improve quality and prepare for the new NHS structure led by General Practitioners (GPs) which will come into force in April 2013.

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 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 Board of Directors and Council of Governors have selected patient experience data as the local indicator for review by our external auditors as part of the external assurance of the 2011/12 Quality Report. This indicator has been selected to ensure that UHB provides the same level of rigour to reporting of patient feedback as with other types of information. The Trust's internal auditors will review the performance indicator framework, currently in development, in 2012/13 to ensure that it will enable us to identify and investigate potential performance exceptions for the specialty quality indicators.

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

Finally, 2012/13 will be another challenging year as the Trust aims to deliver further improvements to quality whilst working with local Clinical Commissioning Groups and Birmingham and Solihull NHS Cluster to deliver efficiency savings and prepare for the new NHS structure which will come into force in April 2013.

Dame Julie Moore, 24 May 2012
Chief Executive

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

2.1 Quality Improvement Priorities

2011/12

The Trust's 2010/11 Quality Report set out six priorities for improvement during 2011/12:

Key Priorities:

Priority 1
Time from prescription to administration of first antibiotic dose

Priority 2
Completion of VTE (venous thromboembolism) risk assessments on admission

Priority 3
Improve patient experience and satisfaction

Priority 4
Electronic observation chart – completeness of observation sets (to produce an early warning score)

Ongoing Priorities:

Priority 5: Reducing medication errors (missed doses)

Priority 6: Infection prevention and control

The Trust has made good progress in relation to all six quality improvement priorities during 2011/12 with further improvements identified for 2012/13 as described below.

2012/13

The Board of Directors has chosen to continue with five of these improvement priorities for 2012/13 as follows:

Priority 2: Improving VTE prevention

Priority 3: Improve patient experience and satisfaction

Priority 4: Electronic observation chart – completeness of observation sets (to produce an early warning score)

Priority 5: Reducing medication errors (missed doses)

Priority 6: Infection prevention and control

The improvement priorities for 2012/13 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 2012/13 were then finally approved by the Board of Directors.

The performance for 2011/12 and the rationale for the changes to the priorities are provided in detail below. This report should be read alongside the Trust's Quality Report for 2010/11.

Priority 1: Time from prescription to administration of first antibiotic dose

Background

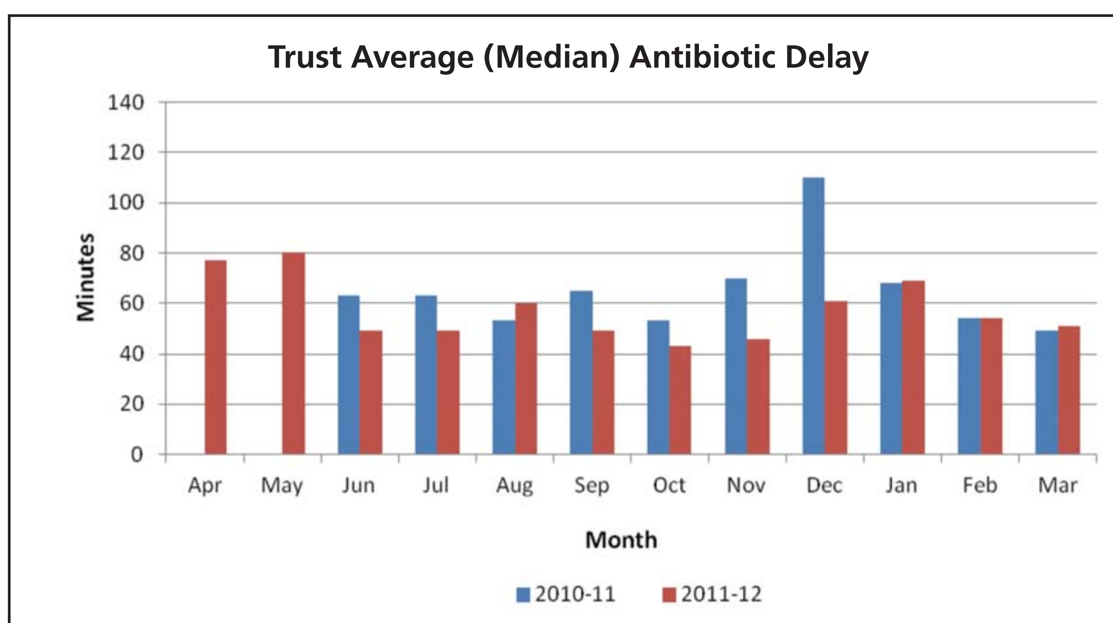
There is evidence within the clinical literature that rapid antibiotic delivery can reduce patient harm and improve outcomes. The recommended time from prescription to administration of first antibiotic dose for certain conditions should ideally be 60 minutes or less.

This indicator focuses on the first prescription of antibiotics for patients identified as having likely infections (based on white blood cell counts) and measures the time delay between the antibiotic prescription being made and the first dose of this drug being given. All courses of antibiotics lasting for three days are included even where they include a discharge prescription.

The Trust has identified clinical exception rules with clinicians and refined the methodology for measuring performance against this indicator. Data has been collected from the Trust's electronic Prescribing Information and Communication System (PICS) for patients admitted with acute illnesses. This does not however include Emergency Department (ED) referrals where prescribing data is not yet captured electronically. The Trust implemented a new electronic information system called Oceano in the Emergency Department in October 2011 to enable better data capture. This is the first step towards implementing the Prescribing and Information Communication System within the ED in the future.

Performance

The graph below shows performance by month for 2010/11 and 2011/12. The Trust has generally performed well against the target time of 60 minutes since June 2011.



Note: Baseline data for this indicator was reported from June 2010 so data is not shown for April and May 2010.

Initiatives implemented in 2011/12:

- An antimicrobial stewardship programme has been developed with local commissions and is led by the trust's Antimicrobial Steering Group. The group has a clear work plan to improve the prescription of antibiotics more generally and includes education for doctors, nurses and pharmacists about the timely provision of antibiotics
- An electronic ward round tool has been developed to monitor prescribing practice and dosing of antibiotics. This tool extracts data on a daily basis from the Prescribing Information and Communication System on all patients treated with antibiotics so they can be reviewed by Microbiology staff to ensure that appropriate and timely treatment is being provided
- The time difference between prescribed antibiotics and administration of first doses forms part of the Medicines Management Clinical Dashboard and is routinely reviewed by clinical teams. In addition, outliers are identified for review at the Executive Care Omissions Root Cause Analysis meetings

Changes to Improvement Priority for 2012/13:

The time from prescription to administration of first antibiotic dose for patients identified as having likely infections remains important but its scope is rather narrow. This is important for all medicines, but a number of new measures are being regularly monitored for particular groups of medicines such as antibiotics, insulin and anti-thrombotic drugs (used to prevent blood clots).

The Trust therefore intends to continue monitoring performance for this indicator but will not be making it an improvement priority for 2012/13. The indicator will be reviewed as soon as the Prescribing and Communication System has been implemented within the Emergency Department and more data becomes available.

Initiatives to be implemented in 2012/13:

- The Antimicrobial Steering Group is going to develop more in-depth reporting from PICS in order to monitor compliance with the antibiotic policy and general usage of antibiotics. This will help prescribers and pharmacy staff to ensure that the right antibiotics are being given to the right patients in the right manner. This will reduce delays due to inappropriate prescribing of non-routine antibiotics which are not widely available in the clinical areas
- Work will continue regarding the implementation of the Prescribing and Communication System into the Emergency Department
- A new Patient Information Leaflet has been developed and standards for providing information to patients regarding antibiotics have been set. The plan is to give this to patients in 2012/13 to encourage them to query any delays or other problems with the administration of their medicines

How progress will be monitored, measured and reported:

- Performance will continue to be measured and monitored at specialty and ward levels using PICS data and the Trust's usual reporting tools
- Progress will be reported in the quarterly Quality Report updates and monitored by the Clinical Quality Monitoring Group following the implementation of PICS in the Emergency Department

Priority 2: Venous thromboembolism (VTE) risk assessment on admission

Background

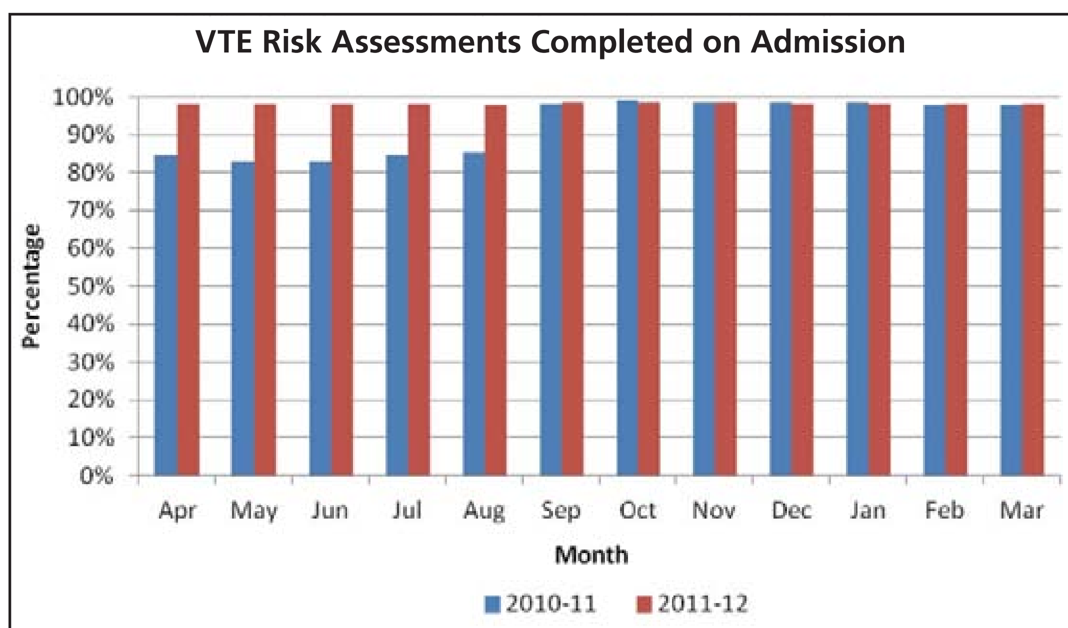
Venous thromboembolism (VTE) is the term used to describe deep vein thrombosis (blood clot occurring in a deep vein, most commonly in the legs) and pulmonary embolism (where such a clot travels in the blood and lodges in the lungs) which can cause considerable harm or death. VTE is associated with periods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

Whilst many 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's electronic VTE risk assessment tool has been revised to reflect the latest guidance from the National Institute for Health and Clinical Excellence (NICE CG92). Ambulatory care (day case) admissions have been included in the electronic risk assessment tool since February 2011 as well as all inpatients.

Performance

The graph shows performance by month for 2010/11 and 2011/12. The Trust has achieved a VTE risk assessment completion rate of at least 98% since September 2010 which is well above the national average of 91%*.



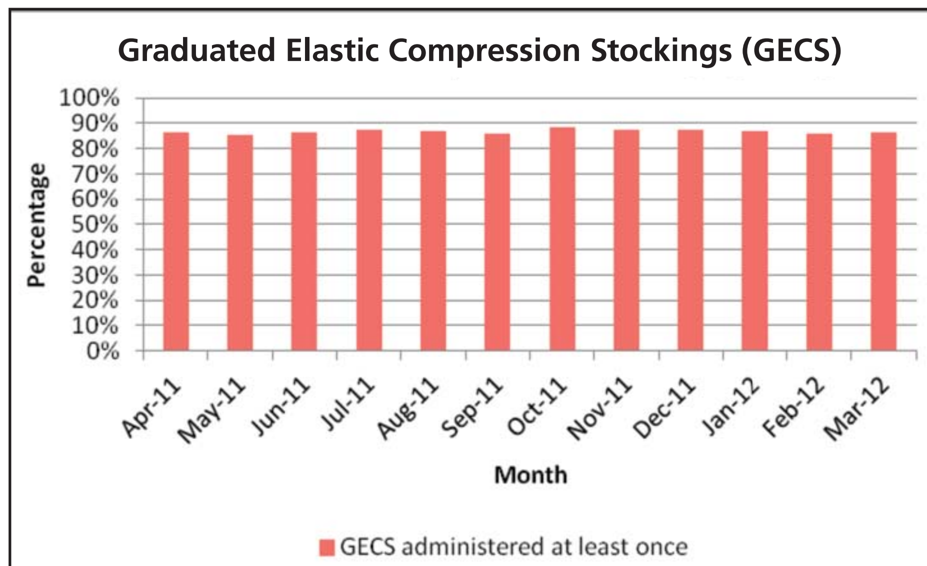
* This is the latest available national average for NHS acute providers published on the Department of Health website (October to December 2011).

Changes to Improvement Priority for 2012/13:

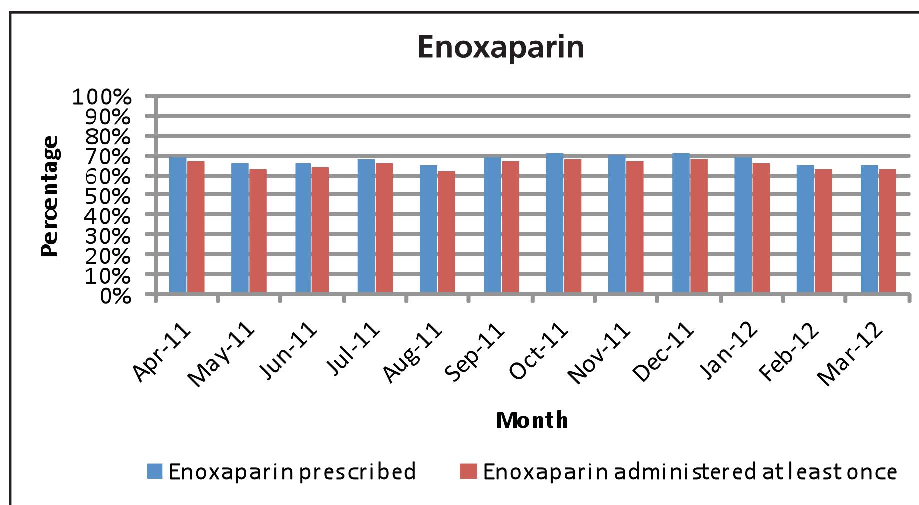
As the Trust has performed consistently highly for completion of VTE risk assessments in 2011/12, the focus of this priority will change to VTE prevention through appropriate administration of preventative (prophylactic) treatment during 2012/13. This includes graduated elastic compression stockings (GECS) and enoxaparin (medication used to reduce the risk of blood clots forming). The Trust will be focusing on improving compliance with the outcomes of completed VTE risk assessments so that a higher percentage of patients receive the preventative treatment they require, particularly pharmacological treatment (Enoxaparin medication).

During 2011/12, the Trust started to regularly monitor whether patients are given VTE prevention treatment, if required, following risk assessment. Performance for individual wards and the Trust overall is now available on the electronic Clinical Dashboard to allow real-time audit of performance by nursing and medical staff.

The table below shows the percentage of graduated elastic compression stockings administered at least once by episode as recorded on the electronic Prescribing and Information Communication System. One patient admission or spell in hospital can comprise a number of different episodes of care. If the outcome of a VTE risk assessment shows that a patient requires GECS, they are automatically prescribed by PICS. It is not always appropriate to administer compression stockings every day for a variety of reasons including patient choice and clinical contraindications such as sore or swollen skin for example. These two categories account for over two-thirds of the stockings not administered.



The table below shows the percentage of patients who required enoxaparin medication following VTE risk assessment and were prescribed it and the percentage who were given it at least once. As with other forms of medication, there can be valid reasons why enoxaparin is not administered such as immediately prior to and after surgery to reduce the risk of bleeding.



Initiatives implemented during 2011/12:

- The Trust's electronic VTE risk assessment tool was revised to take into account the latest NICE guidance
- Electronic VTE risk assessment was implemented within Ambulatory Care during 2011/12
- Review of and modifications made to Ambulatory Care risk assessment tool to enhance clinical utility
- Nurse training on use of compression stockings has been established at induction and through the use of an e-learning package for all nurses to complete to a satisfactory standard

Initiatives to be implemented in 2012/13:

- Modification of PICS tool to remind clinicians to follow the recommendations of VTE risk assessments
- Ongoing programme of education for junior doctors through induction, compulsory teaching sessions and the e-learning anti-coagulation (clot prevention) module which forms part of the SCRIPT (Standard Computerised Revalidation Instrument for Prescribing and Therapeutics) project
- Revise e-learning tool for nursing staff to coincide with the introduction of a new type of graduated elastic compression stocking

How progress will be monitored, measured and reported:

- Performance will continue to be measured using PICS VTE risk assessment data
- 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 3: Improve patient experience and satisfaction

The Trust measures patient experience and satisfaction in a variety of ways, including local and national patient surveys, complaints and compliments.

Performance

Patient Experience Data

Over 23,044 patients responded to the electronic inpatient survey and 618 responded to the discharge survey during 2011/12 providing a wealth of information about their experience. The table below shows the patient experience data collected by UHB during 2010/11 and 2011/12. The survey results show that the Trust has made improvements across a number of areas of patient experience and will continue to focus on delivering improvements, particularly around communication about medication side effects, during the coming year. The Trust's latest National Adult Inpatient Survey and Outpatient Department Survey results are shown in Part 3 of this report.

		Performance					
Question	Answer	2010/11	2011/12	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q4 2011/12
1. Have you been involved as much as you want to be in decisions about your care and treatment?	Yes	73.4%	77.2%	76.6%	77.9%	76.3%	77.8%
	Yes, to some extent	20.9%	17.9%	18.8%	16.5%	18.1%	17.9%
	No	5.8%	5.0%	4.6%	5.5%	5.6%	4.3%
2. Did you find someone on the hospital staff to talk about your worries and fears?	Yes, definitely	60.8%	66.9%	64.0%	66.4%	67.3%	69.6%
	Yes, to some extent	27.5%	22.7%	25.2%	22.1%	22.9%	21.1%
	No	11.8%	10.3%	10.8%	11.5%	9.8%	9.3%
3. Were you given enough privacy when discussing your care and treatment?	Yes, always	87.4%	89.5%	90.0%	89.8%	88.6%	89.7%
	Yes, sometimes	10.6%	8.5%	8.4%	8.1%	9.1%	8.3%
	No	2.0%	2.0%	1.6%	2.1%	2.3%	2.0%
4. Do you think that hospital staff do all they can to help control your pain?	Yes, definitely	80.8%	83.3%	83.9%	83.1%	82.9%	83.2%
	Yes, to some extent	16.0%	14.2%	14.2%	14.1%	14.1%	14.4%
	No	3.1%	2.5%	1.9%	2.8%	2.9%	2.4%
5. Did a member of staff tell you about medication side effects to watch for when you went home?	Yes, completely	60.3%	46.3%	Not enough data*	48.4%	41.0%	46.3%
	Yes, to some extent	12.2%	9.3%		8.3%	12.0%	7.3%
	No	27.5%	44.4%		43.3%	47.0%	46.3%

6. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	Yes	88.9%	72.4%	Not enough data*	70.8%	73.5%	76.1%
	No	11.1%	27.6%		29.2%	26.5%	23.9%
7. Overall how would you rate the hospital food you have received?	Excellent	Data collection for these questions began in April 2011	20.3%	17.7%	20.9%	21.4%	21.3%
	Very good		27.9%	27.9%	29.0%	27.0%	27.6%
	Good		27.2%	29.3%	26.2%	27.3%	25.9%
	Fair		16.5%	16.6%	16.1%	16.8%	16.6%
	Poor		8.1%	8.5%	7.8%	7.5%	8.6%
8. Have you been bothered by noise at night from hospital staff?	No, never		66.2%	65.2%	67.2%	66.1%	66.1%
	Yes, occasionally		28.0%	28.6%	27.2%	28.2%	27.8%
	Yes, often		5.9%	6.2%	5.5%	5.7%	6.0%
9. Sometimes in hospital a member of staff says one thing and another says something quite different. Has this happened to you?	No, never		70.0%	69.0%	70.4%	68.1%	71.9%
	Yes, sometimes		24.3%	25.7%	23.7%	26.2%	22.1%
	Yes, often		5.7%	5.2%	5.9%	5.8%	6.0%

Note on Patient Experience Data

Data for questions 2-4 was collected from June 2010, data for questions 5-6 was collected from August 2010 and data for questions 7-9 was collected from April 2011.

Initiatives implemented in 2011/12:

- Following an audit of noise at night, involving all inpatient areas of the Trust, a set of good practice guidelines for staff and for patients were introduced. These were developed in collaboration with members of the Trust Patient and Carer Councils
- Satisfaction with food has been monitored by use of a survey on the back of the patient menu card. These results have been benchmarked against the results of the last National Patient Survey and put the Trust in the top 20% of NHS Trusts. Information from the survey system has been used to highlight improvements at individual ward level
- The Patient Experience Champion Programme was launched and currently has 219 champions registered which include Patient and Carer Council representatives. An education programme for champions commenced in the Autumn and has evaluated well. The programme will continue to recruit new champions and is supported by future planned education days
- On-line patient experience surveys were developed and tested by members of the Patient & Carer Councils. They went live on our website in March 2012, giving patients another method to provide feedback on the care and services provided
- A Patient and Carer Council for Mystery Shoppers was established in June 2011, and a programme of Mystery Shopper visits commenced in July 2011, which have evaluated well. Members have worked with the Customer Care Facilitator to develop standards for Receptionists. The shoppers have undertaken benchmarking visits to Reception areas, and will repeat the visits following implementation of the standards
- Following feedback from carers, a set of Principles to Support Carers were developed by the Carers Advisory Group which included Patient and Carer Council members, a Governor and representatives of Birmingham Carers Association. The principles were launched in February 2012 and will form the basis of an educational programme for staff to improve the experience of carers. This Trust won an award for this work at the 2011 National Patient Experience Network Awards
- A patient experience questionnaire has been introduced in the Emergency Department to gain feedback from patients. The responses are fed into the Trust electronic system, which will allow performance to be viewed by staff on the Clinical Dashboard

Changes to Improvement Priority for 2012/13:

The Trust has chosen to continue with the same questions in 2012/13 to deliver further improvements plus one new local question:

- Do you think that the ward staff do all they can to help you rest and sleep at night?

The Trust will also start monitoring performance for the friends and family question during 2012/13:

- How likely is that you would recommend this service to your friends and family?

As in previous years, the questions were selected by the Trust's Care Quality Group which has Governor representation and then approved by the Board of Directors. These questions will also form part of the national Commissioning for Quality and Innovation (CQUIN) patient experience indicator for 2012/13.

Initiatives to be implemented in 2012/13:

- The Patient Experience Champion Programme will be expanded to include outpatient areas, imaging and non-clinical support services
- The Mystery Shopping programme will be extended to include monitoring of the Trust switchboard and restaurant services
- The Friends and Family question (net promoter) will be included in all patient surveys

- A method of gaining feedback from outpatients prior to leaving the department will be developed
- The Complaints Department and Patient Advice and Liaison Service (PALS) will be integrated to improve efficiency in dealing with concerns from patients and relatives
- In response to feedback from patients, an electric golf buggy will be implemented to transport patients and visitors with mobility difficulties from the car park to the hospital entrance

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
- Feedback will be provided by members of the Patient and Carer Councils as part of the Adopt a Ward / Department visits and via the Mystery Shopper visits
- Regular patient experience reports will be provided to the Care Quality Group and to the Board of Directors
- Progress will also be reported via a quarterly Quality report update published on the Trust quality web pages

Complaints

The number of complaints received in 2011/12 was 797, which represents a reduction of more than 5% compared to the previous year. In 2011/12 the rate of inpatient complaints stabilised compared to 2010/11. The increase in the rate and number of inpatient complaints received in 2010/11 compared to the previous year reflected the overall increase in complaints which was expected as a result of the move to the new hospital. This mirrored the experience of other trusts following significant hospital moves.

	2008/09	2009/10	2010/11	2011/12
Total number of complaints	609	643	840	797

Top 3 subjects of complaints	2008/09	2009/10	2010/11	2011/12
Clinical treatment	254	272	390	373
Outpatient appointment delay/cancellation	97	109	116	100
Attitude of staff			88	
Inpatient appointment delay/cancellation				81
Communication and information	69	76		

Ratio of complaints to activity		2008/09	2009/10	2010/11	2011/12
Inpatients	FCEs*	121,653	124,589	123,139	118,504
	Complaints	294	277	444	434
	Rate per 100 FCEs	**0.24**	**0.22**	**0.36**	**0.37**
Outpatients	Appointments**	454,514	499,981	517,516	544,876
	Complaints	263	309	312	289
	Rate per 100 appointments	**0.06**	**0.06**	**0.06**	**0.05**
A&E	Attendances	83,051	82,632	82,925	87,744
	Complaints	52	57	84	72
	Rate per 100 attendances	**0.06**	**0.07**	**0.10**	**0.08**

* FCE = Finished Consultant Episode – which denotes the time spent by a patient under the continuous care of a consultant.
** Outpatients activity data relates to fulfilled appointments only and also includes Therapies (Physiotherapy, Podiatry, Dietetics, Speech and Language Therapy and Occupational Therapy). Outpatient activity data increased during 2011/12 as UHB took over the provision of Reproductive Sexual Health (RSH) and Genito-Urinary Medicine (GUM) services from Heart of Birmingham Teaching Primary Care Trust from 1 April 2011.

Learning from complaints

The table below provides examples of how the Trust has responded to complaints where, serious issues have been raised or where we have received a number of complaints about the same or similar issues or same location.

Theme	Area of Concern	Action taken	Outcome
Attitude of staff	Attitude of some members of Trust staff on occasion.	Appointed Customer Care Facilitator in January 2011. Customer Care training sessions delivered to over 2000 staff in 2011/12.	Number and ratio of complaints received highlighting staff attitude reduced in 2011/12 compared to 2010/11.
Outpatient appointment delay/ cancellation	Delays in Cardiology Outpatient clinic.	Review identified underlying issues causing the delays. Changes made to clinic booking process.	Clinic delays reduced and no further complaints received about these issues after changes made.
Clinical Treatment/ Communication	Care, treatment and attitude on a surgical ward.	Following an Executive Governance Visit carried out by the Trust and complaints received, the following actions were implemented: Complainant invited to talk directly with ward staff about their experience, team-based care introduced and communication sheet at the end of every patient's bed prompting patient/relatives to talk to staff about concerns.	Complaints about this ward have reduced and the ward's performance in key areas has improved, evidenced by data on the Trust's Clinical Dashboard.

Theme	Area of Concern	Action taken	Outcome
Inpatient appointment delay/ cancellation	Cancellation of operations at weekends at short notice due to theatre staff not being available.	A positive check was introduced to confirm that all necessary staff were available prior to theatre slots being released.	No further complaints were received about this specific issue since the change was implemented.

The Trust takes a number of steps to review learning from complaints and to take action as necessary. Complaints are reported monthly to the Care Quality Group as part of the wider Patient Experience report. A monthly complaints report is also presented at the Chief Executive's Advisory Group. Each quarter, a detailed analysis of complaints is presented to the Trust's Audit Committee. Selected complaints form part of the Executive Root Cause Analysis sessions into omissions in care and, where trends are identified; trust-wide actions are implemented to prevent recurrence.

Serious Complaints

The Trust uses a risk matrix to assess the seriousness of every complaint on receipt. Those deemed most serious, which score either 4 or 5 for consequence on a 5 point scale, are highlighted separately across the Trust. Serious complaints are reported to the Board via the Audit Committee, to the PCT, to the Chief Executive's Advisory Group and to the Divisional Management Teams at their Divisional Clinical Quality Group meetings. It is the Divisional Management Team's responsibility to ensure that following investigation of the complaint, appropriate actions are put in place to ensure learning takes place and every effort is made to prevent a recurrence of the situation or issue which triggered the complaint being considered 'serious'.

Independent reviews

As for 2010/11, a total of 16 cases were referred to the Parliamentary and Health Service Ombudsman in 2011/12 for independent investigation at the request of the complainant. The Ombudsman determined that no further investigation was required in 8 of the cases whilst the Trust is still awaiting the outcome for 6 cases. The Ombudsman suspended the investigation for one case pending the outcome of an inquest by HM Coroner. The final case was referred back to the Trust for further investigation and satisfactory local resolution.

The Ombudsman partially upheld one complaint during 2011/12 which was originally received by the Trust in January 2009 and subsequently received by the Ombudsman for investigation in September 2010. Since the time of the original complaint, the Trust has revised and improved its complaints handling procedures to provide a better service to complainants.

Compliments

Compliments are recorded by the Patient Advice and Liaison Service (PALS) on behalf of the Trust. PALS receive some compliments directly from patients and carers; others are forwarded to PALS by staff after being received in wards and departments throughout the Trust.

The majority of compliments are received in writing – by letter, card, email or feedback leaflet, the rest are received verbally via telephone or face to face.

With robust systems now in place for capturing positive feedback the number of recorded compliments continues to increase. Positive feedback is shared with staff and patients to promote and celebrate good practice as well as to boost staff morale.

Compliment Subcategories	2008/09	2009/10	2010/11	2011/12
Nursing care	11	92	310	605
Friendliness of staff	26	76	306	492
Treatment received	142	130	251	300
Medical care	9	21	122	391
Efficiency of service	8	37	47	124
Information provided	1	3	17	16
Facilities	11	4	9	18
Other	3	4	54	20
Totals:	**211**	**367**	**1,116**	**1,966**

Examples of compliments received during 2011/12:

Date Received	Compliment (Anonymised)
April 2011	I will remember the great gift I have been given now my life has endless possibilities. Thank you for your care, compassion & professional conduct. Its appreciated.
May 2011	The treatment and service received was outstanding. From the receptionist, to the nurse in charge…to the final surgeon and theatre staff they were all very attentive efficient and caring. He received first class treatment from start to finish, many thanks to all concerned.
July 2011	Thanking staff for amazing standard of care, support, understanding, dedication and professionalism.
Aug 2011	The care he received was excellent, he felt all his needs were met and staff treated him with respect and dignity.
Oct 2011	Thank you for all the wonderful care and attention given to me on Ward X when I was treated with breathing problems. Everyone I came in contact with gave me 100% when it came to care and nursing skills; everyone was so friendly and made me feel welcome.

Nov 2011	To all the doctors & nurses, thanks for all the dedicated services that you've shown to my son may your hard work be rewarded as you carry on, kindness is a gift that people are always grateful to receive thank you so much.
Nov 2011	From the moment I stepped into the hospital, to moment I left I could not have received better care anywhere and would like to thank all the staff from the doctors, nurses. I compare the QE to a 5 star hotel.
Dec 2011	We would like to express our heartfelt thank and appreciation for all the help and support that you all provided for our mother. We know that she felt very safe and happy in your care and this made her last weeks in your care and this made her last weeks easier for all of us to bear. She told us how much she liked you all and that you made her laugh. Thank you from all of us for treating our mother with such kindness and dignity
Jan 2012	Thanking all staff and those behind the scenes who helped deliver my….. treatment over the past years. The QEHB is clearly the place to be! Much impressed and appreciate the highly professional, calm and sensitive approach of all staff.
March 2012	First class treatment, our heartfelt gratitude for the wonderful way you cared for me.

Feedback received through the NHS Choices and Patient Opinion websites

The Trust has a system in place to routinely monitor feedback posted on two external websites; NHS Choices and Patient Opinion. Feedback is forwarded to the relevant service/department manager for information and action. A response is posted to each comment received acknowledging the comment and providing generic information when appropriate. The response also promotes the Patient Advice and Liaison Service (PALS) as a mechanism for obtaining a more personalised response, or to ensure a thorough investigation into any concerns raised. The number of comments posted on each of these two websites continues to be extremely low in comparison to other methods of feedback received.

Priority 4: Electronic observation chart – completeness of observation sets (to produce an early warning score)

Background

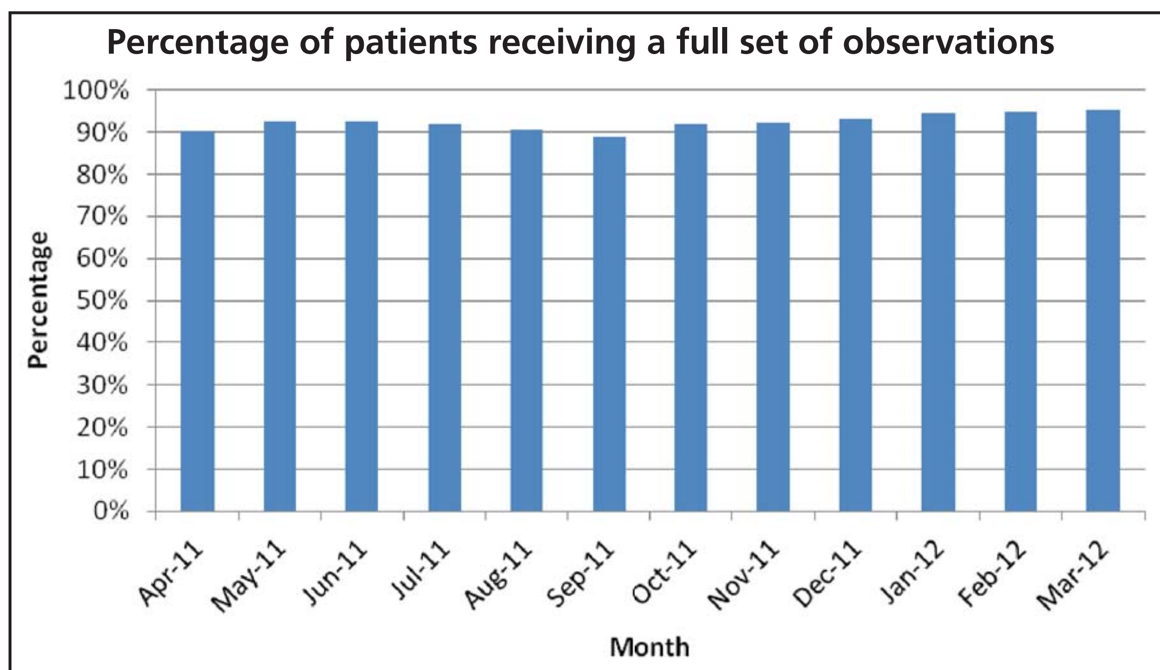
The Trust started to implement an electronic observation chart during 2010/11 within the Prescribing Information and Communication System (PICS) to record patient observations: temperature, blood pressure, oxygen saturation score, respiratory rate, pulse rate and level of consciousness.

When nursing staff carry out patient observations, it is important that they complete the full set of observations. This is because the electronic tool enables an early warning score called the SEWS (Standardised Early Warning System) score to be triggered automatically if a patient's condition starts to deteriorate. This allows patients to receive appropriate clinical treatment as soon as possible. This indicator measures the percentage of patients who receive at least one full set of observations in a 24-hour period.

The Trust completed the roll out of the electronic observation chart to the remaining wards during 2011/12 so all inpatient wards are now recording patient observations electronically. The four Critical Care areas have very different requirements for recording observations compared to the inpatient wards so do not currently record these on the standard electronic observation chart in PICS. There is a plan to develop a specific and detailed electronic observation chart for Critical Care in the future.

Performance in 2011/12

The Trust's baseline performance was 79% for 2010/11 for the wards which were using the electronic observation chart in PICS. The Trust was aiming for at least 91% of all observation sets to be complete for those wards already live and at least 75% to be complete for the remaining wards by the end of quarter 4 2011/12. The Trust has improved performance significantly during 2011/12 with 95.4% of all inpatients receiving at least one full set of observations in March 2012:



Initiatives implemented in 2011/12:

- The roll out of the electronic observation chart to all remaining inpatient general acute beds was completed
- This indicator was added to the Clinical Dashboard to enable clinical staff to monitor and benchmark performance against other similar wards
- A dedicated Task and Finish Group was set up to monitor and resolves issues around non-completion of observations

Changes to Improvement Priority for 2012/13:

The Trust is now aiming for at least 98% of all observation sets to be complete for all inpatient wards by the end of 2012/13.

Initiatives to be implemented in 2012/13:

- Next phase roll-out plan being developed to include other areas such as Dialysis Unit, Coronary Care and Endoscopy
- Analysis of data to find out where missing or incomplete observations are occurring to identify reasons for this and implement mitigating actions
- Identification of areas that have high levels of agency/bank staff to understand whether this may impact on performance for this indicator
- Identify and address any training requirements
- Development of central training record for all types of Prescribing and Information Communication System (PICS) training

How progress will be monitored, measured and reported:

- Progress will be monitored at ward, specialty and Trust levels through the Clinical Dashboard and other reporting tools
- Performance will continue to be measured using PICS data from the electronic observation charts
- Progress will be reported monthly to the Clinical Quality Monitoring Group and the Board of Directors in the performance report. In addition, performance will be publicly reported publicly through the quarterly Quality Report updates on the Trust's website

Ongoing Priorities

Priority 5: Reducing errors (with a particular focus on medication errors)

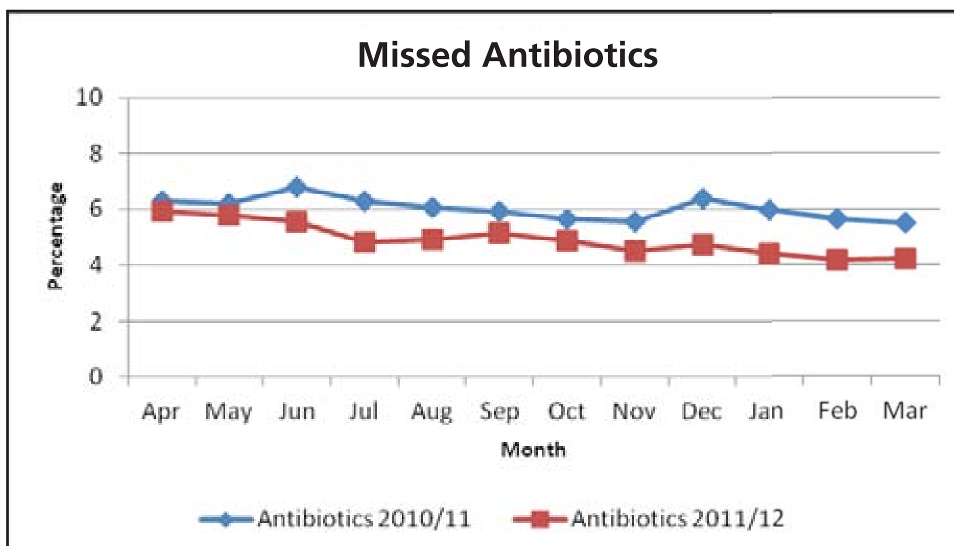
Background

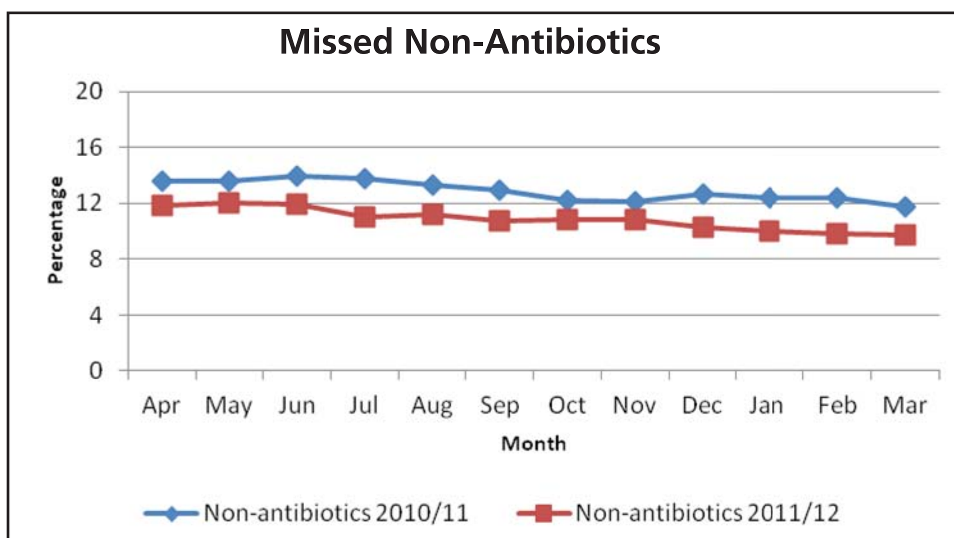
Since April 2009, the Trust has focused on reducing the percentage of drug doses prescribed but not recorded as administered (omitted) to patients on the Prescribing Information and Communication System.

The most significant improvements occurred when the Trust began reporting missed doses data on the Clinical Dashboard in August 2009 and the Executive root cause analysis (RCA) meetings were introduced at the end of March 2010.

Performance

The graphs show that the Trust has made further reductions in the percentage of omitted antibiotic and non-antibiotic drug doses during 2011/12, although the rate of decline has now slowed as expected. UHB is aiming to make further reductions during 2011/12, particularly for non-antibiotics. It is however important to remember that some drug doses are appropriately missed due to the patient's condition at the time. The Trust is therefore evaluating the target reductions in 2011/12 to ensure they are appropriate in the absence of any national agreement on what constitutes an expected level of drug omissions.





Initiatives implemented during 2011/12:

- Targets for reducing omitted antibiotics and non-antibiotics were reviewed in 2011/12 to ensure they remained challenging on the Clinical Dashboard, in the absence of any national agreement on an acceptable omitted dose rate
- Monthly Executive Care Omissions Root Cause Analysis (RCA) meetings were expanded during 2011/12, covering a wide range of omitted/delayed drugs and associated medication issues, with greater input from Pharmacy and other support services
- The Trust has focused on improving the consistency of prescribing practice, particularly amongst junior doctors, through the Junior Doctor Monitoring Tool and dedicated Consultant support

Changes to Improvement Priority for 2012/13:

The Trust will again be reviewing the reduction targets for antibiotics and non-antibiotics to drive further improvements in 2011/12, with a greater focus on reducing avoidable non-antibiotic missed doses through appropriate prescribing and administration.

Initiatives to be implemented in 2012/13:

- Themes from the omitted/delayed drug cases which were reviewed at Executive Care Omissions RCA meetings during 2011/12 will be reviewed to ensure that the learning is shared and implemented across the Trust
- Focused education programmes for specific conditions such as Diabetes will be provided to medical and nursing staff to improve performance in insulin management across the Trust for example
- Enhanced monitoring of prescribing practice, particularly by new cohorts of junior doctors, will be implemented alongside additional Consultant support to review performance and share learning

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 6: Infection prevention and control

Performance in 2011/12

The Trust ended the year under the agreed national trajectories for *C. difficile* infection and MRSA bacteraemia. This has been achieved through a continued focus on improving clinical management of patients with identified or suspected infection. In addition, the Trust commenced mandatory reporting for Staphylococcus aureus (MSSA) bacteraemias and Escherichia coli (E. coli) bacteraemia and introduced an extensive surveillance programme to support ongoing clinical improvement across the organisation.

Time Period/Infection Type	2008/09	2009/10	2010/11	2011/12
C. diffcile infection (post-48 hour cases)	357 (526)	178 (348)	145 (164)	85 (114)
MRSA bloodstream infections	35 (48)	13 (30)	11 (11)	4* (7)

* One further case has been reported on the Health Care Associated Infections (HCAI) capture database however following a local PCT expert panel review it was agreed that it would not be attributed to UHB.

Initiatives implemented in 2011/12:

- The Trust commenced mandatory reporting for meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemias and *Escherichia coli* (E. coli) bacteraemia in accordance with the Department of Health requirements
- The Trust has convened a multi-disciplinary Task and Finish Group chaired by the Deputy Medical Director to support a reduction in surgical site infection. The group has focused on reviewing current practices that may influence the development of post-operative surgical site infection
- The Trust is developing an electronic solution within PICS to enable better data capture and surveillance urinary catheter usage and subsequent urinary tract infections
- The Trust has implemented a new 'closed system' for blood collection across the organisation which has been shown to reduce the incidence of contamination
- The Trust places great emphasis on the good management of all invasive devices and is developing an electronic solution to enable surveillance of all vascular invasive devices and any subsequent infections associated with them
- All infection incidents are subject to investigation using root cause analysis and there is an established programme of Executive review at the Executive RCA meetings

Changes to Improvement Priority for 2012/13:

While much of this work will continue in the coming year, the agreed trajectories for MRSA and CDI in 2012/13 are very challenging and will require innovative management to maintain the momentum of improvement.

Initiatives to be implemented in 2012/13:

- Implement a two-stage laboratory diagnostic test for the detection of toxigenic *Clostridium difficile* in line with the latest Department of Health guidance on CDI testing
- Maintain improvements in patient safety through a robust Infection Prevention and Control surveillance programme. This will include all alert organisms, surgical site infection, urinary catheter associated infection, incidence of blood culture contamination and the identification

and management of multi-drug resistant microorganisms

- Undertake monthly prevalence audit of urinary tract infections as part of the nationally agreed CQUIN (Commissioning for Quality and Innovation) indicator
- Continue to minimise the risk from healthcare associated infections to patients through better management of invasive devices

How progress will be monitored, measured and reported:

- The number of cases of MRSA bacteraemia and *C. difficile* infection will be submitted monthly to the Health Protection Agency and measured against the 2012/13 trajectories
- Performance will be monitored daily via the Clinical Dashboard. Performance data will be discussed monthly at the Board of Directors, Chief Executive's Advisory Group and Infection Prevention and Control Committee meetings
- All MRSA bacteraemias and CDI deaths will be reported as serious incidents requiring investigation (SIRIs) to Birmingham and Solihull NHS Cluster and Solihull Cluster
- Root cause analysis will continue to be undertaken for all MRSA bacteraemias and CDI cases
- Progress against the Trust Infection Prevention & Control delivery plan will be submitted quarterly to the Board of Directors and shared with Commissioners

2.2 Statements of assurance from the Board of Directors

2.2.1 Information on the review of services

During 2011/12 the University Hospitals Birmingham NHS Foundation Trust* provided and/or sub-contracted 63 NHS services.

The Trust has reviewed all the data available to them on the quality of care in 63 of these NHS services**.

The income generated by the NHS services reviewed in 2011/12 represents 100% per cent of the total income generated from the provision of NHS services by the Trust for 2011/12.

In line with the Transforming Community Services Programme, the Trust took over responsibility for the provision of Reproductive Sexual Health (RSH) and Genito-Urinary Medicine (GUM) from Heart of Birmingham Teaching Primary Care Trust as of 1 April 2011.

* 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 2011/12, 47 national clinical audits and 3 national confidential enquiries covered NHS services that UHB provides.

During that period UHB participated in 74% 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 2011/12 are as follows: (see tables over the page)

The national clinical audits and national confidential enquiries that UHB participated in during 2011/12 are as follows: (see tables below)

The national clinical audits and national confidential enquiries that UHB participated in, and for which data collection was completed during 2011/12, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (See tables below).

Audit type	Audit UHB eligible to participate in	UHB participation 2011-12	Percentage of required number of cases submitted
Part of the National Clinical Audit and Patient Outcomes Programme	IBD (Inflammatory Bowel Disease) Audit	Yes	62.5%
	IBD - Biologics Audit	Yes	N/A no required case target
	IBD – inpatient Experience Questionnaire	Yes	N/A no required case target
	Oesophago-gastric (stomach) Cancer	Yes	Data will be submitted by the October 2012 deadline.
	Bowel cancer (NBOCAP)	Yes	100%
	Adult cardiac surgery	Yes	100%
	Heart failure	Yes	126.3% (submitted more than the required number of cases)
	Adult cardiac interventions (e.g., angioplasty)	Yes	100%
	Myocardial Infarction (MINAP)	Yes	N/A no required case target
	Cardiac rhythm management (Pacing / Implantable Defibrillators)	Yes	100%
	Congenital heart disease (children and adults) / Paediatric cardiac surgery	Yes	100%
	Carotid Endarterectomy Audit	Yes	42%
	National Lung Cancer Audit	Yes	100%
	National Diabetes Audit	Yes	32%
	National Diabetes Inpatient Audit (NaDIA)	Yes	N/A no required case target
	Pain Database Audit	Yes	N/A organisational questionnaire completed only
	National Audit of Continence Care (pilot)	Yes	0% - Audit form not appropriate for an acute trust

Audit type	Audit UHB eligible to participate in	UHB participation 2011-12	Percentage of required number of cases submitted
	Head and Neck Cancer (DAHNO)	Yes	100%
	Hip Fracture Database	Yes	100%
	SINAP	No	N/A

Audit type	Audit UHB eligible to participate in	UHB participation 2011-12	Percentage of required number of cases submitted
Not part of the National Clinical Audit and Patient Outcomes Programme	Renal Registry – Renal Replacement Therapy	N/A	N/A. Deadline for 2011/12 data submission not yet known.
	UK Transplant registry: 1. Cardiothoracic	Yes	100%
	UK Transplant registry: 2. Liver	Yes	100%
	UK Transplant registry: 3. Kidney	Yes	100%
	National Vascular Database (NVD) Abdominal Aortic Aneurysm – AAA	Yes	19%
	National Vascular Database (NVD) Amputation	Yes	N/A no required case target
	National Vascular Database (NVD) Infrainguinal Bypass Surgery - IIB	Yes	N/A no required case target
	National Vascular Database (NVD) AAA Turn down audit	No	0%
	National Vascular Database (NVD) AAA – Mortality	Yes but not accredited.	100%
	National Cardiac Arrest Audit	No	N/A
	ICNARC - Adult Critical Care Case Mix Programme	Yes	100%

Audit type	Audit UHB eligible to participate in	UHB participation 2011-12	Percentage of required number of cases submitted
	National Elective Surgery Patient Reported Outcome Measures (PROMS): Groin hernia	Yes	April-11 to Sept-11 Pre-operative questionnaire participation by patients: 3%* Post-operative questionnaire participation by patients: Not available due to low number of responses*
	National Elective Surgery Patient Reported Outcome Measures (PROMS): Varicose Veins	Yes	April-11 to Sept-11 Pre-operative questionnaire participation by patients: Not available due to low number of responses* Post-operative questionnaire participation by patients: Not available due to low number of responses*
	Potential Donor Audit	Yes	100%
	BTS Adult Asthma	Yes	600% (submitted more than the required number of cases)
	BTS Emergency Oxygen	Yes	N/A - no required case target
	BTS Pleural Procedures	Yes	317% (submitted more than the required number of cases)
	BTS Adult Community Acquired Pneumonia	No	N/A
	BTS Non-Invasive Ventilation	Yes	147% (submitted more than the required number of cases)
	BTS Bronchiectasis	Yes	350% (submitted more than the required number of cases)
	CEM Sepsis	No	N/A
	CEM Pain in Children	No	N/A
	Parkinson's Audit	Yes	100%
	Severe Trauma - TARN (Trauma Audit and Research Network)	Yes	100%
	NASH National Audit of Seizure Management in Hospitals	No	N/A

Audit type	Audit UHB eligible to participate in	UHB participation 2011-12	Percentage of required number of cases submitted
	National Care of the Dying Audit Hospitals	No	N/A
	National Health Promotion in Hospitals Audit (NHPH)	No	N/A

* Data is only available on the Information Centre website until September 2011. The Trust focused on raising the pre-operative response rate during the second half of 2011/12 so an improvement is expected once the full year data is finally published.

National Confidential Enquiries

National Confidential Enquiries	UHB participation 2011/12	Percentage of required number of cases submitted
Bariatric Surgery	Yes	N/A
Cardiac Arrest Procedures	Yes	100%
Peri-operative Care	Yes	100%

Percentages given are the latest available figures.

The reports of 32 national clinical audits were reviewed by the provider in 2011/12 and UHB intends to take the following actions to improve the quality of healthcare provided:

Improvement measures will include:

- Education and knowledge
- Undertaking additional local clinical audit
- Review or development of care plans, guidance and procedures
- Continued review of data quality and use of data for benchmarking purposes
- Review or development of patient information leaflets

The Trust will also be focusing on improving the pre-operative questionnaire response rate for the National Patient Reported Outcome Measures for groin hernia and varicose vein procedures during 2012/13. This should in turn help to improve the post-operative questionnaire response rate.

A list of examples of specific actions for individual national clinical audits can be viewed on the Quality web pages: http://www.uhb.nhs.uk/quality.htm

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 hand hygiene. A total of 712 clinical audits were registered with UHB's clinical audit team as having commenced or been completed at UHB during 2011-12.

The reports of 231 local clinical audits were reviewed by the provider in 2011/12 and UHB intends to take the following actions to improve the quality of healthcare provided:

Measures include:

- reviewing or developing new protocols or guidelines for staff
- arranging training or education sessions in order to increase staff awareness of required standards
- employing new staff
- drafting research and development proposals
- multidisciplinary collaborative working
- developing new data capture tools

This figure indicates that the results of 231 clinical audits were reported 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

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 Information on 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 6158.

The table below shows the number of clinical research projects registered with the Trust's Research and Development (R&D) Team during 2010/11 and 2011/12. The number of studies which were abandoned is also shown for completeness. The main reason for studies being abandoned is that not enough patients were recruited due to the study criteria or patients choosing not to get involved.

Reporting Period	2010/11	2011/12
Total number of projects registered with R&D	181	164
Out of the total number of projects registered, the number of studies which were abandoned	13	15 + 1 declined by UHB
Trust total patient recruitment	7300	6158

The provisional number of studies registered with Research & Development and Trust total patient recruitment for 2011/12 show reductions compared to 2010/11. The reductions are due to:

- national difficulties in recording studies and patient recruitment in the new National Institute for Health Research (NIHR) IT system; and
- and the closure of certain high recruiting studies – low intensity Band 2 observational studies – at the end of 2010/11

Total patient recruitment is however likely to increase once the final number for 2011/12 is known. The R&D team continues to regularly monitor the number of new R&D studies registered and patient recruitment to ensure that the Trust makes the most of all research opportunities available in 2012/13.

The table below shows the number of projects registered in 2011/12 split by discipline:

Projects registered during this period by discipline	Registered	Abandoned
Cancer Oncology:24; Haematology:11; Imaging:1; Neurosurgery:1; Respiratory Medicine:1; Radiotherapy: 1; Dermatology:1; Histopathology: 2; Liver Medicine:1; Neuropsychology:1; GI Surgery:2; GI Medicine:1; No Objection Studies: 3	50	5 + 1 declined
Heart and Vascular Disease Cardiology:12; Cardiac Surgery:1; Endocrinology:2; Renal Medicine:2; Anaesthetics:1; Rheumatology:1; Imaging:2; GI Surgery:1; Diabetes:1; Respiratory Medicine:2; No Objection Studies:2	27	2
Inflammation and Infection Critical Care:1; Nursing:1; ENT:1; Burns & Plastics: 4; Anaesthetics:1; Rheumatology:5; Microbiology:2; Respiratory Medicine:1; Liver Medicine:10; Neurology:2; Dermatology:1; Renal Medicine:2; Urinary Medicine:1; Imaging:1; GI Surgery:1; Haematology:1; GI Medicine:3; Ophthalmology:2; No Objection Studies:2	42	4
Molecular & Genetic Basis for Disease Nursing:1; Endocrinology:4; Renal:1; Diabetes:4; ENT:1; Oncology:1; Haematology:2; GI Medicine:1; Respiratory Medicine:1; Genito-Urinary Medicine:1; Liver Medicine:1; Anaesthetics:1; Ophthalmology:1; No Objection Studies 3	23	2
Neurosciences and Aging Neurology:6; Endocrinology:2; Therapy Services:1; ENT:2; GI Medicine:1; Stroke Services:1; Neurosurgery:1; Geriatric Medicine:1	15	2
Transplantation Renal Medicine:3; Haematology:1; Liver Medicine:2; No Objection Studies:1	7	0
Total	164	15 + 1 declined

Patient Benefits of Research

The Trust's extensive and innovative Research & Development portfolio enables us to have access to new medicines earlier as part of clinical trials which can provide hope for patients for whom conventional treatments might have failed. During 2011/12, UHB has been able to deliver benefits to patients on clinical trials including reduced symptoms, improved survival times and improved quality of life for example. These include patients with prostate cancer, cancers of the blood, relapsing remitting multiple sclerosis (RRMS) and Hepatitis C Virus (HCV) infection.

2.2.4 Information on the use of the Commissioning for Quality and Innovation (CQUIN) payment framework

A proportion of UHB income in 2011/12 was conditional upon achieving quality improvement and innovation goals agreed between UHB and Birmingham and Solihull NHS Cluster, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2011/12 and for the following 12 month period are available online at http://www.uhb.nhs.uk/quality.htm.

The amount of UHB income in 2011/12 which was conditional upon achieving quality improvement and innovation goals was £6.76m* and the Trust received £XXm** in payment.

* This figure has been arrived at as a percentage of the healthcare income which will be included within the Trust's 2011/12 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 the final position has been reconciled with the Healthcare Commissioning Services (HCS).

** Final payment will be subject to verification with Birmingham and Solihull NHS Cluster and West Midlands Specialised Commissioning Team for 2011/12.

2.2.5 Information relating to registration with the Care Quality Commission (CQC) 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: the provider conditions that the regulated activities UHB has registered for may only be undertaken at Queen Elizabeth Medical Centre and Selly Oak Hospital.

Following the final moves into the new Queen Elizabeth Hospital Birmingham, the Trust has applied to remove the Selly Oak Hospital location from its CQC registration. Only one outpatient service remains at Selly Oak Hospital and so the site no longer meets the CQC's definition of a 'location'.

The Care Quality Commission has not taken enforcement action against UHB during 2011/12.

UHB has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2011/12: Dignity and Nutrition Inspection (6 April 2011) and Emergency Department Inspection (30 December 2011).

UHB intends to take the following actions to address the conclusions or requirements reported by the CQC:

The random Dignity and Nutrition Inspection undertaken by the CQC found that the Queen Elizabeth Hospital Birmingham (QEHB) was meeting both of the essential standards of quality and safety that were reviewed: Outcome 1 – respecting and involving people who use services and Outcome 5 – meeting nutritional needs. In order to maintain compliance the CQC proposed some improvements in relation to Outcome 5. UHB submitted an action plan to the CQC setting out a number of actions: changing menu options; undertaking ongoing patient meal surveys; procurement of adapted cutlery, plate guards and non slip mats for patient use; liaising with the supplier to make changes to food offered; making changes to the way food is served; and auditing and taking action to improve documentation.

The Emergency Department Inspection at QEHB was undertaken in response to concerns relating to two outcomes: Outcome 04 - Care and welfare of people who use services and Outcome 13 – Staffing. The CQC found that overall the essential standards were being met and therefore no actions were required by UHB.

UHB has made the following progress by 31 March 2012 in taking such action: all actions are now complete. The findings from each of these inspections can be viewed in full on the

Care Quality Commission website: http://www.cqc.org.uk/directory/RRK02

2.2.6 Information on the quality of data

UHB submitted records during 2011/12 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: 97.5% for admitted patient care; 98.2% for outpatient care; and 94.1% 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.

UHB Information Governance Assessment Report overall score for 2011/12 was 77% and was graded green (satisfactory).

UHB was subject to the Payment by Results clinical coding audit during 2011/12 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 [8.0%]
- Secondary Diagnoses Incorrect [15.5%]
- Primary Procedures Incorrect [16.1%]
- Secondary Procedures Incorrect [9.0%]

The results should not be extrapolated further than the actual sample audited. The following services were reviewed within the sample: Cardiology and a random sample covering all specialties.

The reduction in performance compared to the last audit which was carried out in 2009/10 is mainly due to:

- the appropriateness of national guidelines on the coding of ablation procedures which is being followed up with the Information Centre
- some but not all comorbidities being coded

UHB will be taking the following actions to improve data quality:

- Accreditation of the collaborative West Midlands Clinical Coding Academy by the National Classifications Service to create a local centre of excellence for clinical coding training, stabilise the local clinical coding workforce and help develop appropriate fit for purpose national standards for clinical coding practice
- Increasing clinician engagement by piloting the electronic use of clinical terminology (Snomed) by clinicians to automatically generate accurate clinical coding for Payment by Results
- Review of the Data Quality Policy to incorporate learning from 2011/12 initiatives and development of the Data Quality Specialist Role to support its implementation
- Maintaining Level 2 compliance with the Information Governance Toolkit Data Quality Initiatives and working towards Level 3 compliance

Part 3: Other information

3.1 Overview of quality of care provided during 2011/12

The tables below show the Trust's latest performance for 2011/12 and the last two financial years 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 previous Quality Reports to enable patients and the public to understand 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 for 2011/12 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 is monitored and challenged during the year by the Clinical Quality Monitoring Group and the Board of Directors.

3.2 Performance of Trust against selected indicators

Patient safety indicators

Indicator	2009/10	2010/11	2011/12	Peer Group Average (where available)
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	0.33	0.14	0.08
Time period	2009/10	2010/11	April 2011-Jan 2012	April 2011-Jan 2012
Data source	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)
Peer group				Acute trusts in West Midlands SHA
1(b). MRSA: Patients with MRSA infection/10,000 bed days (aged >15, excluding Obstetrics Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	0.43	0.33	0.14	0.09
Time period	2009/10	2010/11	April 2011-Jan 2012	April 2011-Jan 2012
Data source	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)
Peer group				Acute trusts in West Midlands SHA

Indicator	2009/10	2010/11	2011/12	Peer Group Average (where available)
2(a). *C. difficile*: Patients with *C. difficile* infection/100,000 bed days (includes all bed days from all specialties) Lower rate indicates better performance	53.43	43.33	26.61	28.72
Time period	2009/10	2010/11	April 2011-Jan 2012	April 2011-Jan 2012
Data source	Trust C.diff data reported to HPA, HES data (bed days)	Trust C.diff data reported to HPA, HES data (bed days)	Trust C.diff data reported to HPA, HES data (bed days)	Trust C.diff data reported to HPA, HES data (bed days)
Peer group				Acute trusts in West Midlands SHA
2(b). *C. difficile*: Patients with *C. difficile* infection/100,000 bed days (aged >15, excluding Obstetrics Gynaecology and elective Orthopaedics) Lower rate indicates better performance	55.09	43.34	26.61	33.85
Time period	2009/10	2010/11	April 2011-Jan 2012	April 2011-Jan 2012
Data source	Trust C.diff data reported to HPA, HES data (bed days)	Trust C.diff data reported to HPA, HES data (bed days)	Trust C.diff data reported to HPA, HES data (bed days)	Trust C.diff data reported to HPA, HES data (bed days)
Peer group				Acute trusts in West Midlands SHA

Indicator	2009/10	2010/11	2011/12	Peer Group Average (where available)
3(a) Patient safety incidents (reporting rate per 100 admissions) Higher rate indicates better reporting	9.7	11.3	11.3	6.6
Time period	2009/10	2010/11	2011/12	April-Sept 2011
Data source	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	Based on data from NPSA NRLS report
Peer group				Acute teaching organisations
3(b) Never Events Lower number indicates better performance	0	2	1 (see explanatory note below table)	Not available
Time period	2009/10	2010/11	2011/12	
Data source		Datix (incident data)	Datix (incident data)	
Peer Group				

Indicator	2009/10	2010/11	2011/12	Peer Group Average (where available)
4(a) Percentage of patient safety incidents which are no harm incidents Higher % indicates better performance	89.9%	81.3%	70.4%	70.8%
Time period	2009/10	2010/11	2011/12	April-Sept 2011
Data source	Datix (incident data)	Datix (incident data)	Datix (incident data)	Based on data from NPSA NRLS report
Peer group				Acute teaching organisations
4(b) Percentage of patient safety incidents resulting in severe harm or death Lower % indicates better performance	Not available	Not available	0.98%	0.68%
Time period			April-Sept 2011	April-Sept 2011
Data source			Based on data from NPSA NRLS report	Based on data from NPSA NRLS report
Peer group				Acute teaching organisations

Notes on patient safety indicators

1(a), 1(b), 2(a), 2(b): The data shown for 2009/10 differs to that shown in previous Quality Reports. This is due to a change in the method and data source used to calculate bed days. The data for *c.difficile* infection has been calculated using 100,000 bed days rather than 1,000 used previously, in line with DH guidance.

3(a): The data shown for 2009/10 differs to that shown in previous Quality Reports. This is due to a change in the method of calculation which uses admissions data rather than episodes; an admission is classed as the first episode of care.

3(b): The Trust reported one never event during 2011/12. The incident was recorded as 'retained foreign object post-operation' and related to a swab being left inside a patient during surgery at the Queen Elizabeth Hospital Birmingham. The swab was subsequently removed and the patient suffered no ill-effects as a result.

4(a): The data shown for 2009/10 differs to that shown in previous Quality Reports. This is due to a change in the method of calculation which now includes near miss as well as no harm incidents. The reduction in the percentage of no harm incidents in 2010/11 and 2011/12 is largely due to the reporting of all grades of pressure ulcer as harm incidents from April 2010 and a reduction in the number of (no harm) incidents relating to missing medical records following the introduction of the electronic Clinical Portal in Outpatients.

Clinical effectiveness indicators

Indicator	2009/10	2010/11	2011/12	Peer Group Average (where available)
5(a). Readmissions within 30 days: Readmission rate (Medical and surgical specialties - elective and emergency admissions aged >15) % Lower % indicates better performance	5.62%	6.22%	4.82%	4.92%
Time period	2009/10	2010/11	April-Dec 2011	April-Dec 2011
Data source	HES data	HES data	HES data	HES data
Peer group				University hospitals
5(b). Readmissions within 30 days: Readmission rate (all specialties) % Lower % indicates better performance	5.61%	6.20%	4.80%	4.02%
Time period	2009/10	2010/11	April-Dec 2011	April-Dec 2011
Data source	HES data	HES data	HES data	
Peer group				University hospitals

Indicator	2009/10	2010/11	2011/12	Peer Group Average (where available)
6. Falls (incidents reported as % of elective and emergency admissions) Lower % indicates better performance	2.0%	2.5%	2.6%	Not available
Time period	2009/10	2010/11	April-Dec 2011	
Data source	Datix (incident data), Trust admissions data	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%	100%	100%	99.3%
Time period	2009/10	2010/11	April 2011-Feb 2012	2009
Data source	Trust PICS data	Trust PICS data	Trust PICS data	Cleveland Clinic website
Peer group				Cleveland Clinic, Ohio, U.S.A.

Indicator	2009/10	2010/11	2011/12	Peer Group Average (where available)
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%	92.6%	93.1%	98.0% NB This data is for all surgery patients with heart conditions who were on betablockers and is based on a sample of cases.
Time period	2009/10	2010/11	April 2011-Feb 2012	2010/11
Data source	Trust PICS data	Trust PICS data	Trust PICS data	Cleveland Clinic website
Peer group				Cleveland Clinic, Ohio, U.S.A.

Notes on clinical effectiveness indicators

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.

5(a), 5(b): The methodology for emergency readmissions has been revised. The data shown relates to patients who are readmitted within 30 days of being discharged from UHB to any provider in England, including private sector providers. In line with guidance from the Department of Health, the new methodology also includes patients who were originally admitted as daycases (for a planned procedure) and regular daycases (e.g., patients attending dialysis):
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125490.pdf The new methodology cannot be applied to 2008/09 data due to a change in the national grouping of diagnosis codes. The data is now presented for 100,000 bed days rather than 1,000 bed days.

6: The admissions data includes daycase patients as well as all elective and emergency admissions. The increases in 2011/12 and 2010/11 are due to a higher number of falls being reported as a result of increased awareness.

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.

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.

3.2.3 Patient experience indicators

Patient survey question	2010/11	2011/12	Comparison with other NHS trusts in England (2011/12)
9. Overall were you treated with respect and dignity	**8.8**	**9.1**	**About the same**
Time period & data source	2010, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission	2011, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission	2011, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission
10. Involvement in decisions about care and treatment	**6.9**	**7.4**	**About the same**
Time period & data source	2010, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission	2011, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission	2011, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission
11. Did staff do all they could to control pain	**7.9**	**8.0**	**About the same**
Time period & data source	2010, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission	2011, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission	2011, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission
12. Cleanliness of room or ward	**8.9**	**9.2**	**About the same**
Time period & data source	2010, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission	2011, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission	2011, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission
13. Overall rating of care	**7.8**	**8.1**	**About the same**
Time period & data source	2010, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission	2011, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission	2011, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission

Notes on patient experience measures:
9-13: The style of the survey reports produced by the Care Quality Commission for individual trusts has changed from previous years. The new style benchmark report uses the same scoring system as before but presents the data as a score out of 10; the higher the score for each question, the better the Trust is performing. Performance for 2010 has been recalculated to enable comparison with 2011 but not for previous years which are therefore not included in the table above.

3.3 Performance against key national priorities

National targets and regulatory requirements	Time Period for 2011/12	2009/10 Target	2009/10 Performance	2010/11 Target	2010/11 Performance	2011/12 Target	2011/12 Performance
Clostridium difficile (post-48 hour cases)	Apr 2011 – Mar 2012	348	178	164	145	114	85
MRSA (post-48 hour cases)	Apr 2011 – Mar 2012	30	13	11	11	7	4
62-day wait for first treatment from urgent GP referral: all cancers	Apr 2011 – Mar 2012	85%	85.4%	85%	86.5%	85%	85.2%
62-day wait for first treatment from consultant screening service referral: all cancers	Apr 2011 – Mar 2012	90%	92.6%	90%	93.9%	90%	94.7%
31-day wait from diagnosis to first treatment: all cancers	Apr 2011 – Mar 2012	96%	97.4%	96%	98.6%	96%	97.3%
31-day wait for second or subsequent treatment: surgery	Apr 2011 – Mar 2012	94%	96.6%	94%	97.9%	94%	98.1%
31-day wait for second or subsequent treatment: anti cancer drug treatments	Apr 2011 – Mar 2012	98%	99.1%	98%	99.9%	98%	99.7%
31-day wait for second or subsequent treatment: radiotherapy	Apr 2011 – Mar 2012	Target introduced in January 2011		94%	100% (Jan – Mar 2011)	94%	99.9%
Two week wait from referral to date first seen: all cancers	Apr 2011 – Mar 2012	93%	94.6%	93%	96.0%	93%	98.2%
Two week wait from referral to date first seen: breast symptoms	Apr 2011 – Mar 2012	93%	98.6% (Jan – Mar 2010)	93%	98.4%	93%	98.6%

National targets and regulatory requirements	Time Period for 2011/12	2009/10 Target	2009/10 Performance	2010/11 Target	2010/11 Performance	2011/12 Target	2011/12 Performance
18-week maximum wait from point of referral to treatment (admitted patients)	Apr 2011 – Mar 2012	90%	95.4%	Not a target from July 2010	95.6%	Not a target from July 2010	95.6%
Crude average of monthly 95th centile Referral to treatment waiting times (admitted patients)	Apr 2011 – Mar 2012	Target introduced in July 2010		23.0 weeks	17.6 weeks	23.0 weeks	17.8 weeks
18-week maximum wait from point of referral to treatment (non-admitted patients)	Apr 2011 – Mar 2012	95%	98.5%	Not a target from July 2010	98.7%	Not a target from July 2010	98.3%
Crude average of monthly 95th centile Referral to treatment waiting times (non-admitted patients)	Apr 2011 – Mar 2012	Target introduced in July 2010		18.3 weeks	15.2 weeks	18.3 weeks	15.0 weeks
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	Apr 2011 – Mar 2012	98%	98.5%	95% from July 2010	97.6%	95%	96.1%
A&E: Total time in A&E (95th percentile)	Apr 2011 – Mar 2012	Target introduced in July 2010		240 mins from July 2010	240 mins	240 mins	240 mins
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	Apr 2011 – Mar 2012	N/A	Certification made	N/A	Certification made	N/A	Certification made

3.4 Mortality

The Trust continues to monitor mortality as close to real-time as possible with senior managers receiving daily emails detailing mortality information and on a longer term comparative basis via the Trust's Clinical Quality Monitoring Group. Any anomalies or unexpected deaths are promptly investigated with thorough clinical engagement.

UHB did not receive any formal mortality outlier notifications from the Care Quality Commission during 2011/12. The Trust has not included comparative information due to concerns about the validity of single measures used to compare trusts.

Summary Hospital-level Mortality Indicator (SHMI)

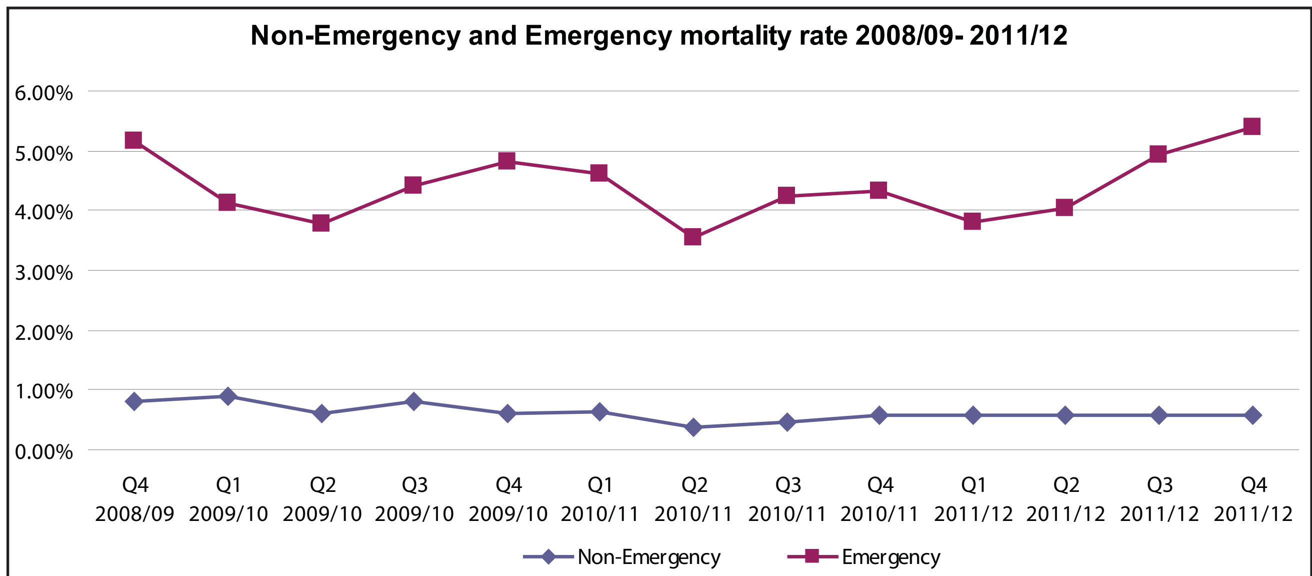
In October 2011, the NHS Information Centre published data for the Summary Hospital-level Mortality Indicator. This is the new national hospital mortality indicator which replaces previous measures such as the Hospital Standardised Mortality Ratio (HSMR). The SHMI is a ratio of observed deaths in a trust over a period time divided by the expected number based on the characteristics of the patients treated by the trust. A key difference between the SHMI and previous measures is that it includes deaths which occur within 30 days of discharge, including those which occur outside hospital.

The new indicator should be interpreted with caution as no single measure can be used to identify whether hospitals are providing good or poor quality care. An average hospital will have a SHMI around 100; a SHMI greater than 100 implies more deaths occurred than predicted by the model. A higher than expected SHMI should be used as a trigger for further investigation. The NHS Information Centre will publish updated SHMI data on a quarterly basis and is expected to make refinements to the way the indicator is calculated over time.

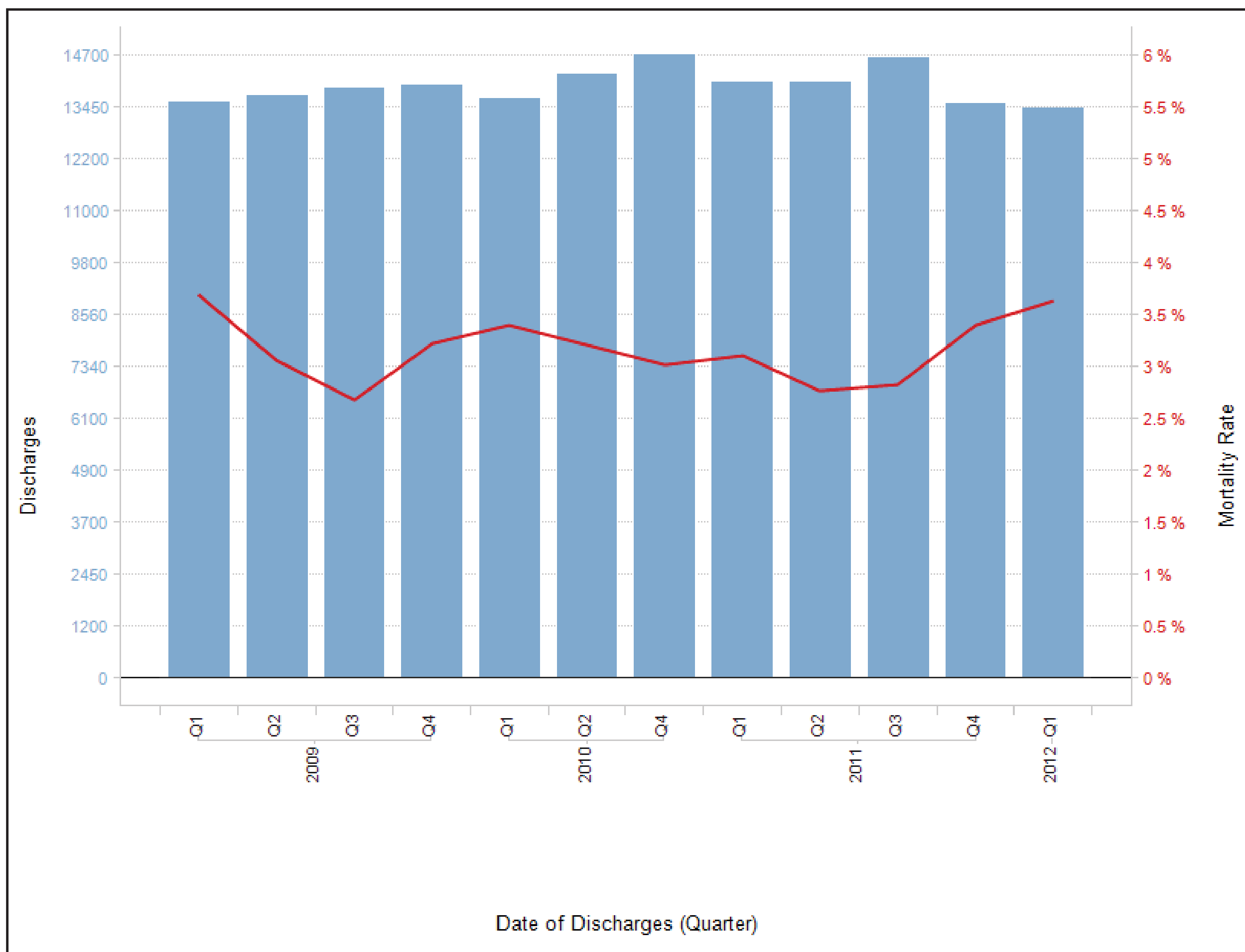
The Trust's latest published SHMI is 100.16 for the period October 2010-September 2011 which is within the expected range (band 2). Although the SHMI has superseded the Hospital Standardised Mortality Ratio and the Trust has concerns about its validity, it is included here for completeness. UHB's overall 1 year HSMR value is 107.2 for 2010-11 which is within the expected range and the latest period available.

The graph on the following page shows the Trust's non-emergency and emergency mortality rates by quarter for the last three financial years. The Trust is generally treating more elderly patients and patients with complex conditions. Emergency mortality has increased slightly during quarters 3 and 4 2011/12 which is mainly due to the introduction of the Ambulatory Care Clinics in the second half of 2011/12.

Emergency admissions to a hospital include very sick patients as well as those who require a short period of treatment before being discharged (short stay patients). Over the past year, UHB has changed its model of care so that many of the patients who require only a short period of treatment are seen in a clinic setting rather than being admitted to hospital which is better for patients. The Trust has therefore seen a reduction in the number of emergency admissions and treated a higher proportion of sicker patients which have both impacted upon the emergency mortality rate.



The graph below shows the Trust's crude mortality rate against activity (patient discharges) by quarter for the past three calendar years. The graph again shows the slight increase during the final two quarters of 2011/12 (quarter 4 2011 and quarter 1 2012 on the graph) as explained above.



3.5 Performance against national core set of quality indicators

A national core set of quality indicators has been jointly proposed by the Department of Health and Monitor for inclusion in trusts' Quality Reports from 2012/13. The Trust has included performance in relation to some of these in this year's report, where the data is available for 2011/12, including readmissions, patient safety incidents and mortality. UHB will take part in the consultation over inclusion of these indicators from 2012/13 to ensure that the methodologies are consistent with other national requirements where possible. The Trust plans to include a detailed section on these in next year's Quality Report.

Further details of the proposed set of quality indicators can be found on the Department of Health website:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132727.pdf

3.6 Outpatient Department Survey

The Trust performed very well in the 2011 Outpatient Department Survey. The results are based on responses from 423 patients which represents a response rate of 50% compared to 53% for all trusts. The table provides a summary of the survey results grouped into categories:

Performance	Number of Questions	Percentage of Questions
Best performing 20% of trusts	13	33.3%
Intermediate 60% of trusts	22	56.4%
Worst performing 20% of trusts	4	10.2%

The Trust has developed an action plan in response to the survey results and will be focusing on making improvements in the following areas:

- Information provided to patients before and after their Outpatient appointments
- Communication of clinic delays
- Access to patient clinic letters through roll-out of MyHealth@QEHB (see further information provided in section 3.11 below)

The Trust's Outpatient Department Survey 2011 detailed benchmark report can be accessed from the Care Quality Commission website:
http://www.nhssurveys.org/Filestore/documents/OP11_RRK.pdf

3.7 Staff Survey

The Trust's Staff Survey results for 2011 show that performance was average or better for 31 (82%) of the 38 survey questions and below average for 7 (18%) questions. The results are based on responses from 449 staff which represents an improved response rate of 55% compared to 45% last year. The results for the Staff Survey questions which most closely relate to quality of care are shown in the table below. The Trust will be aiming to improve performance for those questions which were below average, including staff reporting of errors, near misses or incidents and the availability of hand washing materials across the Trust.

Staff survey question	2009/10	2010/11	2011/12	Comparison with other NHS trusts 2011/12
1. Percentage feeling satisfied with the quality of work and patient care they are able to deliver	83%	79%	76%	Above (better than) average
Time period & data source	Trust's 2009 Staff Survey Report, Care Quality Commission	Trust's 2010 Staff Survey Report, Care Quality Commission	Trust's 2011 Staff Survey Report, Care Quality Commission	
2. Percentage agreeing their role makes a difference to patients	93%	93%	91%	Above (better than) average
Time period & data source	Trust's 2009 Staff Survey Report, Care Quality Commission	Trust's 2010 Staff Survey Report, Care Quality Commission	Trust's 2011 Staff Survey Report, Care Quality Commission	
3. Staff recommendation of the trust as a place to work or receive treatment	3.79	3.81	3.78	Highest (best) 20%
Time period & data source	Trust's 2009 Staff Survey Report, Care Quality Commission	Trust's 2010 Staff Survey Report, Care Quality Commission	Trust's 2011 Staff Survey Report, Care Quality Commission	
4. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	95%	96%	95%	Below (worse than) average

Time period & data source	Trust's 2009 Staff Survey Report, Care Quality Commission	Trust's 2010 Staff Survey Report, Care Quality Commission	Trust's 2011 Staff Survey Report, Care Quality Commission	
5. Percentage of staff saying hand washing materials are always available	71%	63%	60%	Below (worse than) average
Time period & data source	Trust's 2009 Staff Survey Report, Care Quality Commission	Trust's 2010 Staff Survey Report, Care Quality Commission	Trust's 2011 Staff Survey Report, Care Quality Commission	

Notes on staff survey

3. Possible scores range from 1 to 5, with a higher score indicating better performance.

3.8 Specialty Quality Indicators

The Trust's Quality and Outcomes Research Unit (QuORU) was set up in September 2009. The unit has linked a wide range of information systems together to enable different aspects of patient care, experience and outcomes to be measured and monitored. Performance for a wide selection of the quality indicators developed by clinicians, Health Informatics and the Quality and Outcomes Research Unit was included in the Trust's 2009/10 and 2010/11 Quality Reports.

During 2011/12, the unit has continued to provide support to clinical staff in the development of innovative quality indicators with a greater focus on research. The Trust has expanded the web-based tool which enables clinical staff to track performance on a monthly basis and emails are now automatically sent out to clinical and managerial teams if performance deteriorates. The tool allows clinical staff to drill down to patient level data to facilitate validation, audit and research activity. In addition, the Trust has further expanded the number of specialty quality indicator web pages during 2011/12 to enable patients and the public to track performance. These pages include graphs showing performance and explanatory text which are updated regularly.

The Trust's clinical and management teams have improved performance for 42% of the indicators during 2011/2 with support from the Quality and Informatics teams. Performance for 44% has stayed about the same and performance for 14% has deteriorated during 2011/12. Table 1 shows the performance for those specialty quality indicators where the most notable improvements have been made during 2011/12. The data has been checked by the appropriate clinical staff to ensure it accurately reflects the quality of care provided. Benchmarking data has been included where possible.

Table 2 shows performance for some of the indicators where performance has deteriorated during 2011/12. Performance for the remaining indicators can be viewed on the Quality web pages: http://www.uhb.nhs.uk/quality.htm. The goals for all indicators are being reviewed by the clinicians involved to ensure they are both challenging and realistic for 2012/13. The Trust's Informatics and Quality teams are currently developing a performance indicator framework based on a statistical model which will highlight potentially significant changes in performance and any unusual patterns in the data. The framework will be used from quarter 2 2012/13 to provide a more rigorous approach to quality improvement and to direct attention to those indicators where performance is proving most challenging to improve such as the heart failure indicators.

Table 1

Specialty	Indicator	Goal	Percentage Apr 09-Mar 10	Percentage Apr 10-Mar 11	Percentage Apr 11-Mar 12	Numerator Apr 11- Mar 12	Denominator Apr 11-Mar 12	Data Sources	Benchmarking (where available)
Anaesthetics	Post operative Nausea & Vomiting - Percentage of high risk patients who did not require anti-sickness medication after their operation		66.7%	69.8%	62.3%	1,512	2,427	Lorenzo PICS	
Emergency Department (ED)	Percentage of CT head scans performed within 1 hour of arrival in ED		28.2%	28.2%	29.5%	844	2,861	Oceano CRIS	
	Percentage of CT head scans performed within 1-2 hours of arrival in ED		26.9%	27.7%	34.5%	988	2,861	Oceano CRIS	
	Percentage of CT head scans performed within 2-3 hours of arrival in ED		22.8%	25.0%	22.6%	646	2,861	Oceano CRIS	
	Percentage of CT head scans performed in more than 3 hours of arrival in ED		22.0%	19.1%	13.4%	383	2,861	Oceano CRIS	
Maxillofacial Surgery	Percentage of emergency admissions with fractured mandible who have surgery same day or the next day	90%	70.1%	78.7%	91.9%	181	197	Lorenzo	
Neurosurgery	Percentage of emergency sub-arachnoid haemorrhage patients who had surgery or coiling within 2 days - including cases where intervention was deferred, for medical reasons.	90% within 2 days	72.0%	73.1%	91.5%	130	142	Lorenzo	

Renal Medicine	Percentage of patients on haemodialysis programme with a urea reduction ratio (URR) of >65%	90%						MARS	Data from 62 UK dialysis centres in 2009 reported in the renal registry report of 2009 show that 83% of reported patients achieve a URR ≥ 65% (centre range 46%–95%).
	All patients on haemodialysis		89.7%	89.2%	93.0%				
	Patients who have been on haemodialysis for 90 days or more		90.0%	89.5%	93.7%				
Respiratory	Percentage of asthmatic patients discharged on inhaled steroids	95%	87.8%	88.9%	92.7%	190	205	PICS	
Rheumatology	An indication of continuity of care - percentage of patients who saw the same person at least 3 times out of 5 previous visits	60%	Not measured	71.2%	75.6%	524	693	Clinical Portal	
Trauma & Orthopaedics	Percentage of patients who had surgery within 48 hours of admission for fractured neck of femur (fractured hip)	90%	64.6%	77.9%	86.1%*	297	345	Lorenzo Galaxy	
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%	53.2%	46.1%	60.2%	71	118	Lorenzo PICS	

*Performance for quarter 4 (January-March) 2011/12 was 91.7%.

Table 2

Specialty	Indicator	Goal	Percentage Apr 09-Mar 10	Percentage Apr 10-Mar 11	Percentage Apr 11-Mar 12	Numerator Apr 11-Mar 12	Denominator Apr 11-Mar 12	Data Sources	Benchmarking
Elderly Care	Percentage of elderly care patients discharged to their normal place of residence	95%	83.9%	82.2%	75.3%	1,769	2,348	Lorenzo	
Heart Failure	Percentage of heart failure patients discharged on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)	93%	69.7%	66.0%	60.7%	181	298	Heart Failure database PICS	
Heart Failure	Percentage of patients with a primary diagnosis of acute heart failure who had an echocardiogram (ECHO) prior to discharge	100%	79.2%	77.4%	73.2%	218	298	Heart Failure database PICS	
Imaging	Proportion of outpatients who have report turnaround time of less than 5 days for CT scan		79.3%	76.3%	71.5%	12,767	17,846	CRIS	
Palliative Care	Percentage of patients with palliative care diagnosis code who are receiving regular analgesic background pain medications (Morphine Sulphate Tablets (MST), Zomorph, Fentanyl, Oxycontin) should also be prescribed with breakthrough analgesia (e.g.oramorph,oxynorm)	100%	91.6%	90.9%	88.5%	307	347	Somerset, PICS	

Pathology	Turnaround times Urine - 90% within 48 hours	90% within 48 hours	88.2%	89.1%	86.1%	30,318	35,218	Laboratory database	
Pharmacy	Dispensing error rate (nationally these are measured as number of errors per 100,000 dispensed items)		11.15	16.01	25.55	77	301,400	Pharmacy database, Datix	
Therapy Services	90% of In-patient referrals are responded to by each of the Therapy Services on the same day	90% on same day	96.3%	92.5%	82.4%	22,178	26,928	Therapy database	
Therapy Services	95% of In-patient referrals are responded to by each of the Therapy Services within two working days of the patient being identified to the service.	95% within two working days	98.8%	95.5%	92.9%	25,015	26,928	Therapy database	

Notes on data sources:

Cleveland Clinic and US data = published on Cleveland Clinic website
Clinical Portal = Trust's bespoke Electronic Patient Record
CRIS = Radiology database
Galaxy = Theatres database
Lorenzo = Patient administration system
MARS = Renal database
Oceano = Emergency Department patient administration system
PICS = Prescribing Information and Communication System
Somerset = Cancer database

3.9 Quality Web Pages

The Trust first launched the Quality web pages on its website in November 2009 to provide patients and the public with up to date information on quality of care: http://www.uhb.nhs.uk/quality.htm

The information was expanded during 2011/12 and now includes:

- Quality Reports: this includes the Trust's annual Quality Reports plus quarterly progress reports
- A&E Clinical Quality Indicators: graphs showing performance and explanatory text which are updated at the end of each month
- Patient Experience Data: graphs showing Trust-level, electronic patient experience data collected locally through bedside televisions and telephone surveys.
- Specialty Quality Indicators: graphs showing performance and explanatory text for specialty quality indicators which are updated monthly

A patient information survey went out to Trust members in the Autumn edition of 'Trust in the Future' to find out what types and formats of information patients want before they come into hospital. The results from over 700 responses received have been analysed and will be used by the Communications, Informatics and Quality teams to drive website developments and quality communication strategies in 2012-13. Further information and specialty quality indicator pages are likely to be added during 2012/13.

3.10 Healthcare Evaluation Data (HED) Tool

The Trust developed the interactive healthcare evaluation data (HED) tool during 2009/10 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 national Hospital Episode Statistics (HES) data and incorporates advanced methodologies which account for casemix and other variables, incorporate all care delivered and include anonymised patient level data.

Over the past year, new methodologies and datasets have been included including the Summary Level Hospital Mortality Indicator (SHMI) and Death Certificate data from the Office of National Statistics (ONS). The HED tool now enables both comparison of care in distinct areas as well as more innovative overviews of performance for a range of acute care indicators monitored across the NHS as a whole.

3.11 myhealth@QEHB

myhealth@QEHB is a web-based system that provides patients with chronic health conditions with high-quality information and support to allow informed choice and shared decision-making. A secure, prototype version of the system has been successfully piloted by Liver Medicine patients since 2010, under the supervision of a Consultant. MyHealth@QEHB provides patients with access to key parts of their clinical information held by the Trust including clinical letters, medications and laboratory results. Patients can also update the system with their own healthcare information such as results/readings taken at their local hospital, GP surgery or via home monitoring equipment, and they will soon have the option to share and incorporate this into their QEHB health record.

The system enables patients to create their own support networks of patients with similar chronic conditions and to access reliable information on their condition. Early feedback suggests the innovative system gives patients more control over their care and improves their experience, particularly those who have complex conditions and undergo regular tests. Further development of the system is currently underway in preparation for its implementation in a number of other clinical specialties during 2012/13.

3.12 Glossary of Terms

Abdominal aortic aneurysm	This occurs when the large blood vessel that supplies blood to the abdomen, pelvis, and legs becomes abnormally large or balloons outward and can rupture if left untreated
Ablation	Cardiology procedure carried out to control or correct an abnormal heart rhythm
ACE	Angiotensin converting enzyme inhibitors
Acinetobacter	Acinetobacter is an environmental organism which can cause infection in susceptible patients such as those who are immuno-suppressed or seriously ill due to other causes
Ambulatory Care	Hospital admissions of less than 23 hours
Angioplasty	A coronary angioplasty operation is carried out to treat angina or heart attack by relieving blockages or narrowing of the arteries
Antiemetics	Anti-sickness medication
Bariatric surgery	Bariatric surgical procedures are an option for treating severe obesity which focus on reducing intake or absorption of calories
Bed days	Unit used to calculate the availability and use of beds over time
Biologics	Class of drugs used to treat Crohn's disease
Bronchiectasis	A lung condition which causes a persistent cough and an excess amount of sputum (phlegm) due to abnormal widening of the bronchial tubes (airways)
BTS	British Thoracic Society
CABG	Coronary artery bypass graft procedure
Carotid Endarterectomy	A surgical procedure used to prevent stroke by correcting narrowing in the common carotid artery
CCG	Clinical Commissioning Group
CDI	*C. difficile* infection
CEM	College of Emergency Medicine
Cleveland Clinic	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.
Clinical Portal	Trust's bespoke electronic patient record
Congenital	Condition present at birth
COPD	Chronic obstructive pulmonary disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation payment framework
CRIS	Radiology database
CT	Computerised tomography scan. It uses X-rays and a computer to create detailed images of the inside of the body
DAHNO	National Head and Neck Cancer Audit
Datix	Database used to record incident reporting data
Daycase	Admission to hospital for planned procedure where patient does not stay overnight
DNAs	Patients who did not attend their appointments

ECHO	Echocardiogram
E. coli	Escherichia coli
ED	Emergency Department (previously called Accident and Emergency Department)
ENT	Ear, Nose and Throat
Foundation Trust	Not-for-profit, public benefit corporations which are part of the NHS and were created to devolve more decision-making from central government to local organisations and communities
Galaxy	Theatres database
GECS	Graduated elastic compression stockings
GI	Gastro-intestinal
GP	General Practitioner
GUM	Genito-urinary Medicine
HCS	Healthcare Commissioning Services
HCV	Hepatitis C infection
HED	Trust's Healthcare Evaluation Data tool
HES	Hospital Episode Statistics
HPA	Health Protection Agency
IBD	Inflammatory Bowel Disease
ICNARC	Intensive Care National Audit & Research Centre
Infrainguinal Bypass Surgery	Bypass procedure carried out to improve blood flow in the lower limbs
IT	Information Technology
ITU	Intensive Care Unit
LINk	Local Involvement Network
Lorenzo	Patient administration system
LUCADA	Lung cancer audit
Mandible	Lower jaw bone
MARS	Renal database
Median	Data is ranked in order and then the middle value is selected
MINAP	Myocardial Ischaemia National Audit Project
Monitor	Independent regulator of NHS Foundation Trusts
MRSA	Meticillin-resistant Staphylococcus aureus
MSSA	Meticillin-sensitive Staphylococcus aureus
NASH	National Audit of Seizure Management in Hospitals
NBOCAP	National Bowel Cancer Audit Programme
NCAA	National Cardiac Arrest Audit
NCG	National Commissioning Group
Neck of femur	Hip
NIHR	National Institute for Health Research
NHPH	National Health Promotion in Hospitals Audit
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence

NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning System
NVD	National Vascular Database
Oceano	Emergency Department patient management system
Oesophago-gastric	Stomach
PALS	Patient Advice and Liaison Service
Peri-operative	Period of time prior to, during, and immediately after surgery
PICS	Prescribing Information and Communication System (PICS)
PROMS	Patient reported outcome measures
QEHB	Queen Elizabeth Hospital Birmingham
QIPP	Quality, Innovation, Productivity and Prevention programme
QuORU	Trust's Quality and Outcomes Research Unit
R&D	Research and Development
RCA	Root cause analysis
Readmissions	Patients who are readmitted to hospital after being discharged from hospital within the last 30 days
RRMS	Relapsing Remitting Multiple Sclerosis
RSH	Reproductive Sexual Health
SCRIPT	Standard Computerised Revalidation Instrument for Prescribing and Therapeutics (e-learning tool)
SEWS	Standardised Early Warning System
SHA	Strategic Health Authority
SHMI	Summary hospital mortality indicator
SINAP	Stroke Improvement National Audit Programme
SIRI	Serious incident requiring investigation
SNOMED CT	System for coding and recording clinical data
Somerset	Cancer database
Sub-arachnoid haemorrhage	Bleed in the brain (stroke) often caused by rupture of an aneurysm (bulge in blood vessel due to weakness in vessel wall)
SUS	Secondary Uses Service
TARN	Trauma Audit and Research Network
TURP	Transurethral resection of the prostate is an operation where part of the prostate is cut away to stop it pressing on the tube (urethra) that carries urine out through the penis
UHB	University Hospitals Birmingham NHS Foundation Trust
Urea reduction ratio	Used to measure how effective a haemodialysis treatment is by testing the levels of urea in the blood before and after treatment to show how much has been removed
VTE	Venous thromboembolism

Annex 1: Statements from stakeholders

The Trust has shared its 2011/12 Quality Report with the commissioning Primary Care Trust, Birmingham & Solihull NHS Cluster, the Birmingham Local Involvement Network (LINk) UHB Action Group and Birmingham City Council Overview and Scrutiny Committee.

Birmingham & Solihull NHS Cluster and the Birmingham LINk UHB Action Group have reviewed the Trust's Quality Report for 2011/12 and provided the statements below. Birmingham City Council Overview and Scrutiny Committee has chosen not to provide a statement.

Statement provided by Birmingham and Solihull NHS Cluster:

University Hospital Birmingham NHS Foundation Trust

Statement of Assurance from Birmingham & Solihull NHS Cluster May 2012

This statement from Birmingham and Solihull NHS Cluster as the lead commissioner for University Hospital Birmingham NHS Foundation Trust has been developed in consultation with key leads within the cluster (including shadow clinical commissioning groups). The Quality Report for 2011/12 has been reviewed in line with Department of Health guidance and Monitor's requirements. We can confirm that to the best of our knowledge this Quality Report is a fair and accurate reflection of the Trusts performance against the relevant indicators and thresholds in the Quality Framework set by Monitor for all Foundation trusts.

This is a comprehensive 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 throughout all services provided and through all of the strategic developments inclusive of safety, patient experience and clinical effectiveness. It is positive that the Quality Account includes a range of feedback from different sources in relation to patient experience and examples of how this feedback has led to quality improvements and initiatives.

The report clearly defines progress against the Trusts six quality improvement priorities for 2011/12.

Birmingham & Solihull NHS Cluster has an on-going quality assurance process with the Trust which includes monthly contract meetings and quality reviews. These monitoring mechanisms provide the commissioners with a good understanding of the issues facing the Trust and the internal systems and processes that are in place to provide assurance. Given the significant challenges that lie ahead across the health economy and the new developments in commissioning we welcome the continuing engagement with University Hospitals Birmingham Foundation Trust to deliver the quality agenda.

During 2011/12 commissioners have undertaken a themed review of the management of pressure ulcers. This demonstrated collaborative working between commissioner and provider and an action plan is being monitored jointly. It is positive to note that during 2012/13 the Executive root cause analysis reviews will include the reports arising from grade 3 and 4 hospital acquired pressure ulcers. This will support the clusters ambition of eliminating grade 3 and 4 hospital avoidable pressure ulcers.

In addition, the Trust proactively engages with the commissioning infection prevention

team and collaborates and supports the health economies ambition of zero tolerance of avoidable healthcare acquired infections. The cluster welcomes UHBFT programme of surgical site infection surveillance and the use of electronic data systems to support early warning of infection associated with indwelling lines and devices.

UHBFT places significant emphasis on its safety agenda and as such it is unfortunate that UHBFT experienced one never event during the year 2011/2012. This was reported within the defined timescale to commissioners and full investigation of this incident has taken place with commissioners receiving a robust and detailed action plan.

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. Commissioners acknowledge 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 the Trust's achievements throughout 2011/12 and has set clear priorities for quality improvement in 2012/13.

Denise McLellan
Chief Executive
NHS Birmingham & Solihull Cluster.

Statement provided by Birmingham LINk:

The Trust has acted promptly and appropriately on new initiatives from NICE, feedback from the CQC and Ombudsman with regard to the quality of care and has been proactive in introducing new initiatives which will drive up the quality of patient care and the experience of service users and their meaningful others.

The LINk has been impressed with the freedom of access given by the trust and its openness and transparency. The Trust has co-operated well with the LINk and has continued to develop the relationship between the two parties.

The Trust has also demonstrated its commitment to recording patient experience through a variety of different channels and the LINk would encourage the Trust to maintain the excellent progress made in accumulating and evaluating this data.

Annex 2: Statement of directors' responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 as amended to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011-12;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2011 to June 2012
    - Papers relating to Quality reported to the Board over the period April 2011 to June 2012
    - Feedback from the commissioners dated 23/05/2012
    - Feedback from governors dated 27/03/2012
    - Feedback from LINks dated 24/05/2012
    - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 03/05/2012;
    - The 2011 national patient surveys: Adult Inpatient Survey 24/04/2012, Outpatient Department Survey 14/02/2012
    - The 2011 national staff survey March 2012
    - The Head of Internal Audit's annual opinion over the trust's control environment dated 03/05/2012
    - CQC quality and risk profiles dated 02/04/2012
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

24 May 2012 Date .... Chairman

24 May 2012 Date .... Chief Executive

Independent Auditor's Report to the Council of Governors of University Hospitals Birmingham NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of **University Hospitals Birmingham NHS Foundation Trust** to perform an independent assurance engagement in respect of **University Hospitals Birmingham NHS Foundation Trust's** Quality Report for the year ended 31 March 2012 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Clostridium difficile – all cases of Clostridium Difficile positive diarrhoea in patients aged two years or over that are attributed to the Trust; and
- 62 Day cancer waits – the percentage of patients treated within 62 days of referral from GP.

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified below; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports.*

We read the Quality Report and considered whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual*, and considered the implications for our report if we became aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the sources specified below:

The sources with which we shall be required to form a conclusion as to the consistency of the Quality Report are limited to:

- Board minutes for the period April 2011 to May 2012;
- Papers relating to Quality reported to the Board over the period April 2011 to May 2012;
- Feedback from the Commissioners dated 23 May 2012;
- Feedback from LINKs dated 24 May 2012;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 3 May 2012;
- The latest national and local patient survey, dated April 2012;
- The national staff survey dated March 2012;
- Care Quality Commission quality and risk profiles dated 2 April 2012; and

- The Head of Internal Audit's annual opinion over the Trust's control environment dated 3 May 2012.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents. We refer to those sources, (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of **University Hospitals Birmingham NHS Foundation Trust** as a body, to assist the Council of Governors in reporting **University Hospitals Birmingham NHS Foundation Trust's** quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2012, to enable the Council of Governors to demonstrate that is has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and **University Hospitals Birmingham NHS Foundation Trust** for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – "Assurance Engagements other than Audits or Reviews of Historical Financial Information" issued by the International Auditing and Assurance Standards Board ("ISAE 3000"). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Testing key management controls;
- Analytical procedures;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report; and
- Reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts/organisations/entities. In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by **University Hospitals Birmingham NHS Foundation Trust.**

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2012:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified above; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports.*

KPMG LLP

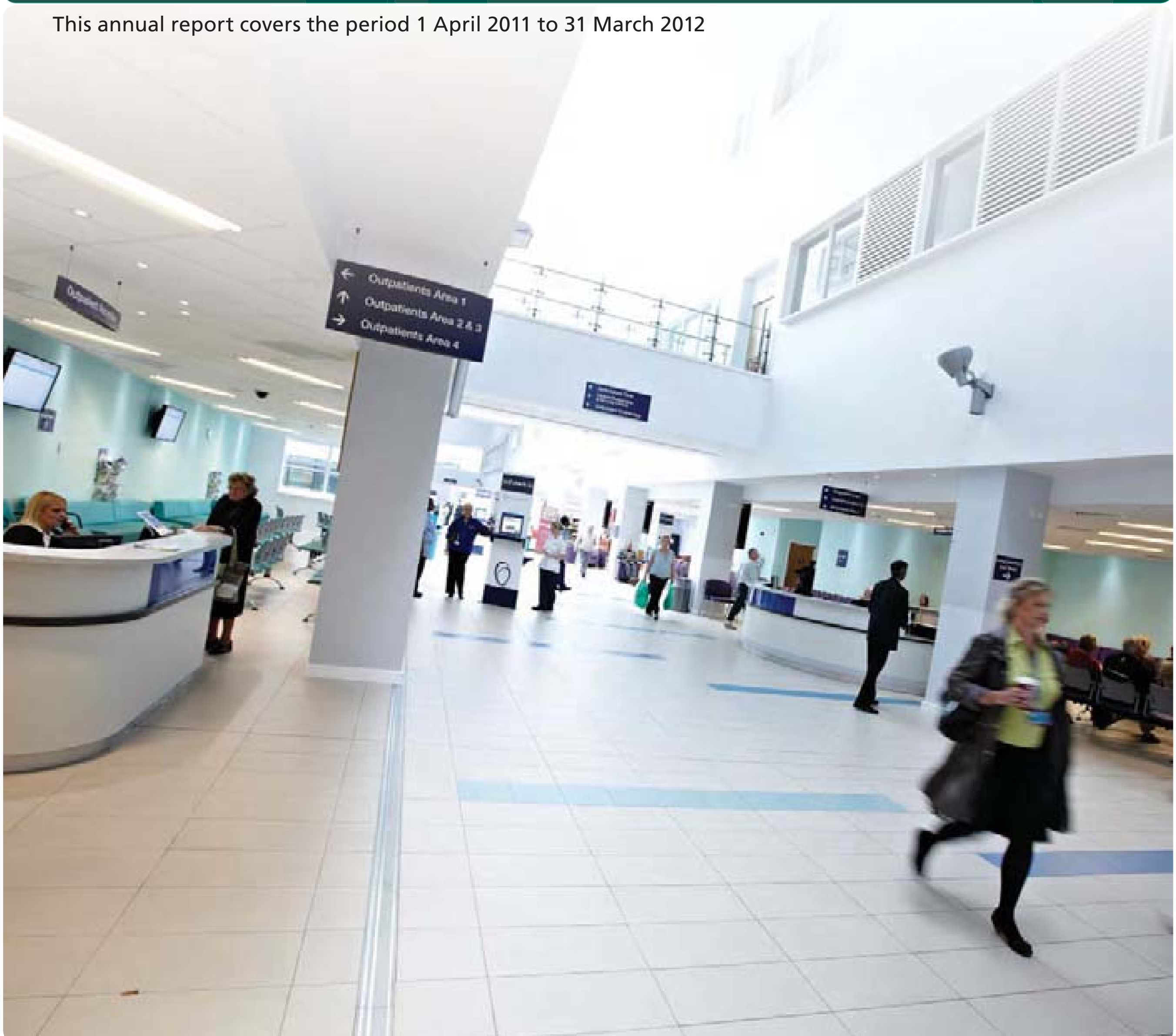
KPMG LLP, Statutory Auditor

Birmingham, 20 June 2012

University Hospitals Birmingham NHS Foundation Trust

Section 4 Consolidated Financial Statements 2011/12

This annual report covers the period 1 April 2011 to 31 March 2012



University Hospitals Birmingham NHS Foundation Trust - Consolidated Financial Statements 2011/12

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Foreword to the Financial Statements

University Hospitals Birmingham NHS Foundation Trust

These financial statements for the year ended 31 March 2012 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.

Dame Julie Moore, 24 May 2012
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 NHS Foundation Trust Accounting Officer 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.

Dame Julie Moore, 24 May 2012
Chief Executive

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

We have audited the consolidated financial statements of the University Hospitals Birmingham NHS Foundation Trust Group for the year ended 31 March 2012 on pages I to LXIV. These financial statements have been prepared under applicable law and the accounting policies set out in the Statement of Accounting Policies.

This report is made solely to the Council of Governors of University Hospitals Birmingham NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the accounting officer and the auditor

As described more fully in the Statement of Accounting Officer's Responsibilities on page ii the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed, the reasonableness of significant accounting estimates made by the accounting officer and the overall presentation of the financial statements. In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the University Hospitals Birmingham NHS Foundation Trust Group as at 31 March 2012 and of the Group's income and expenditure for the year then ended; and

- have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2011/12.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report where under the Audit Code for NHS Foundation Trusts we are required to report to you if, in our opinion, the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We are not required to assess, nor have we assessed, whether all risks and controls have been addressed by the Annual Governance Statement or that risks are satisfactorily addressed by internal controls.

Certificate

We certify that we have completed the audit of the accounts of the University Hospitals Birmingham NHS Foundation Trust Group in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Jon Gorrie for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
One Showhill
Snow Hill Queensway
Birmingham

25 May 2012

Annual Governance Statement

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 (the "Trust") policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the 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 the 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 the Trust for the year ended 31 March 2012 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. Deloittes (Internal Auditors) and KPMG (External Auditors) attend the Audit Committee meetings. Both the Board of Directors and the Audit Committee receive reports that relate to 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 ('Procedure for the Assessment of Risks 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 and the Chief Nurse's Root Cause Analysis of Clinical Care Meeting that report to the Board of Directors, and locally at department and ward level. Identified groups of Senior staff are trained in Root Cause Analysis (RCA), which is carried out on all Serious Incidents requiring investigation. Learning from RCA 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 The Board of Directors approved the Trust's Risk Management Strategy and Risk Management Policy, (next review date is December 2014), which clearly defines 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 Board 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 1 against the NHSLA Risk Management Standards for Trusts (RMS) in February 2012 and the next assessment at level 2 is in February 2013.

4.5 Quality Governance Arrangements and Compliance with CQC registration

4.5.1 The Clinical Governance Team (CGT) is responsible for liaising with manager leads for all parts of the CQC standards to review compliance using position statements initially completed in January 2010. This process was completed again with Executive Director sign off in January 2012 and will be scheduled as part of the Compliance Framework for every quarter, as in the 'Procedure for Monitoring and Assuring Compliance against the Care Quality Commission (CQC) Essential Standards' . The aim of this process is to ensure that any non-compliance against the standards is reported to the Board of Directors and action plans are produced to resolve compliance issues identified.

4.5.2 The CGT prompts manager leads to provide evidence to support their position statements, where required. The CGT reviews the quality of the evidence and ensures that any moderate or major concerns regarding compliance are raised with the relevant Director in line with the approved procedure. The Director will then be responsible for reviewing the issue raised and making the decision to report to the Board of Directors where necessary.

4.5.3 The Clinical Governance team (CGT) is responsible for liaising with manager leads for all parts of the CQC standards to review compliance. The aim of this process is to ensure that any non-compliance against the standards is reported to the Board of Directors and action plans are produced to resolve compliance issues identified.

4.5.4 The CGT prompts manager leads to provide evidence to support their position statements, where required. The CGT reviews the quality of the evidence and ensures that any moderate or major

concerns regarding compliance are raised with the relevant Director in line with the approved procedure. The Director will then be responsible for reviewing the issue raised and making the decision to report to the Board of Directors where necessary.

4.5.5 Where necessary, the CGT will liaise with leads to formulate action plans to achieve compliance and ensure the relevant Director is made aware of and approves the plans. The CGT will monitor that action plans are completed when the proposed completion date is reached.

4.5.6 The Planning and Performance team compile a monthly performance report for the Board, including compliance against CQC standards. The CGT liaise with Planning and Performance to either confirm that no areas of concern have been identified against the standards, or, in conjunction with the relevant lead Director, will ensure a report is made on any non compliance against the standards. The information that is presented to the CGT is also checked by the Clinical Quality Monitoring Group to ensure it is accurate.

4.5.7 The Director of Corporate Affairs' Governance Group will provide assurance on the monitoring process by reviewing a sample of the standards and reporting to the Audit Committee. Where any major concerns about compliance are identified, this will be reported to the Board of Directors as part of the Planning and Performance report.

4.6 Risk identification and evaluation

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

4.6.2 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.

4.6.3 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.

4.6.4 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

4.6.5 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. This process is audited on a quarterly basis

and reported to the Audit Committee, any non compliance is addressed with the appropriate Divisional Management Team. 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.

4.6.6 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.

4.7 Risk Control

4.7.1 Clinical risks are reported 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.

4.7.2 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.

4.7.3 The Trust completed the Information Governance Toolkit assessment for 2011/12 and achieved a score of 77%, achieving Level 2 or above for all the requirements, which is satisfactory.

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

4.7.5 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.

4.7.6 The Trust requires all clinical and non-clinical incidents, including near misses, to be formally reported. Members of staff involved or witnessing such an incident are responsible for ensuring that the incident is reported in compliance with this policy and associated procedural documents.

4.7.7 When an incident occurs and there is a remaining risk, all practical and reasonable steps are taken to prevent re-occurrence. The line manager is responsible for the provision of primary support for staff involved in the incident and this is made available immediately. Any incidents which are considered to be 'serious' by the Risk Management Advisor are escalated to an appropriate Executive Director who decides whether the incident should be treated as a Serious Incident Requiring an Investigation (SIRI). All SIRIs must be investigated using the Root Cause Analysis (RCA) methodology.

4.7.8 All SIRIs are reported and managed in accordance with the national framework.

4.7.9 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.

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

4.7.11 The financial risks associated with the new hospital project are 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 Board.

4.7.12 The Board Assurance Framework contains strategic level risks that may impact on the achievement of the Trust's overarching Strategic Priorities for 2012/2013. These are linked to the Annual Plan and the Care Quality Commission's Essential Standards; the risks will be reviewed by the Audit Committee, who provides assurance to the Board of Directors. This process ensures that the Board is informed about the most serious risks faced by the Trust.

4.7.13 Changes in the regulatory framework for FTs resulting from the change in government presents 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.

4.8 Infection Prevention and Control

4.8.1 Infection control is a high priority 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.

4.8.2 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.

4.8.3 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 throughout 2011/12. 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.

4.8.4 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.

4.8.5 All Serious Incident Requiring an Investigation (SIRI). are reported to the Commissioners at the Birmingham Cluster, including MRSA bacteraemia and C difficile deaths.

4.8.6 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 Council of Governors of the Trust, represented on the Care Quality Group, receives regular reports on care quality, infection control and the new hospital project.

4.8.7 The Trust is fully compliant with the registration requirements of the Care Quality Commission.

4.8.8 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.

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

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

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

5.1 The Trust's Financial Plan for 2011/12 was approved by the Board of Directors in April 2011. Achievement of the financial plan relied on delivery of cash releasing efficiency savings of around £19m during the financial year. This has been accomplished through the establishment of a 4.0% 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 reported to the Board of Directors via the monthly Finance and Activity Performance Report.

5.2 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.

5.3 During 2011/12 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 day case rates.

5.4 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.

6. Annual Quality Report

6.1 The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. 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.

6.2 "The content of the Trust's Quality Report for 2011/12 builds on the 2010/11 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."

6.3 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.

6.4 The quality improvement priorities and metrics identified in the Quality Report form part of the Trust's Annual Plan objectives for 2011/12 and 2012/13. 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.

7. Review of effectiveness

7.1 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, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me.

7.2 My review is also informed by comments made by the External Auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, 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.

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

a) 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;

b) 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;

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

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

e) Quarterly reports from the Clinical governance support unit regarding national and local audit

7.4 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 generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk." The Internal Auditor has made two Priority 1 recommendations in respect of the Trust's SAGE finance system, leading it to give 'limited' assurance around the Trust's disaster recovery/business continuity arrangements, and password security and access control. Proposals have been agreed by the Trust to address the business continuity and disaster recovery planning issues that might arise in the event of a failure of the SAGE system and this is a key area of focus for management and the Audit Committee. Whilst there are a number of compensating measures that mitigate against the access control weaknesses, the Trust will ensure that access security is tightened as a key aspect of the control environment.

7.5 During 2010/11, both the Trust's external auditors and internal auditors have reviewed 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.

8. Conclusion

8.1 With the exception of the issue identified by the Internal Auditors regarding the SAGE finance system referred to above, 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.

Dame Julie Moore, 24 May 2012
Chief Executive

Consolidated statement of comprehensive income

	Notes	Before non-recurring costs	Material non-recurring costs	Year Ended 31 March 2012 Total	Before non-recurring costs	Material non-recurring costs	Restated Year Ended 31 March 2011 Total
		£000	£000	£000	£000	£000	£000
Revenue	3 - 4	586,640	-	586,640	536,515	-	536,515
Operating expenses	5	(567,969)	(33,510)	(601,479)	(524,934)	(250,055)	(774,989)
Operating surplus		18,671	(33,510)	(14,839)	11,581	(250,055)	(238,474)
Finance costs							
Finance income	10	738	-	738	358	-	358
Finance expense	10	(19,531)	-	(19,531)	(10,497)	-	(10,497)
Net finance expense		(18,793)	-	(18,793)	(10,139)	-	(10,139)
Surplus / (deficit) before taxation		(122)	(33,510)	(33,632)	1,442	(250,055)	(248,613)
Taxation		(10)	-	(10)	-	-	-
Surplus / (deficit) after taxation		(132)	(33,510)	(33,642)	1,442	(250,055)	(248,613)
PDC Dividends payable	11	-	-	-	(231)	-	(231)
Retained surplus / (deficit) for the year		(132)	(33,510)	(33,642)	1,211	(250,055)	(248,844)
Other comprehensive income							
Revaluation gains / (losses) on property, plant and equipment				3,637			(3,623)
Total comprehensive income / (expense) for the year				(30,005)			(252,467)

All income and expenditure is derived from continuing operations.

The prior year has been restated to reflect the revised HM Treasury applications of IAS 18 and IAS 20 to donated and granted non-current assets, as detailed in accounting policy notes 1.8 and 1.9 respectively. The financial statements have been restated with effect from 1 April 2010 - see notes 4 and 24 to the financial statements on pages XXXIII and L respectively for details of the restatement to revenue.

Material non-recurring costs are associated with the relocation of healthcare services to the new 'Queen Elizabeth Hospital Birmingham' PFI hospital and the consequent decommissioning of the Selly Oak hospital site.

The notes on pages XVII to LXIII are an integral part of these financial statements.

Consolidated statement of financial position

	Notes	Group 31 March 2012 £000	Group Restated * 31 March 2011 £000	Trust 31 March 2012 £000	Trust Restated * 31 March 2011 £000
Assets					
Non-current assets					
Intangible assets	13	**806**	993	**806**	993
Property, plant and equipment	14	**513,279**	436,983	**513,187**	436,983
Trade and other receivables	20	**2,922**	2,864	**2,922**	2,864
Other assets	21	**213**	254	**213**	254
		517,220	441,094	**517,128**	441,094
Current assets					
Inventories	19	**13,056**	12,790	**12,247**	12,790
Trade and other receivables	20	**35,964**	53,909	**38,040**	53,909
Other current assets	21	**41**	41	**41**	41
Cash and cash equivalents	22	**67,696**	62,009	**66,728**	62,009
		116,757	128,749	**117,056**	128,749
Total assets		**633,977**	569,843	**634,184**	569,843
Liabilities					
Current liabilities					
Trade and other payables	23	**(78,140)**	(71,677)	**(78,356)**	(71,677)
Borrowings	25	**(12,254)**	(10,935)	**(12,254)**	(10,935)
Provisions	29	**(2,420)**	(2,354)	**(2,420)**	(2,354)
Other liabilities	24	**(23,858)**	(26,598)	**(23,858)**	(26,598)
		(116,672)	(111,564)	**(116,888)**	(111,564)
Total assets less current liabilities		**517,305**	458,279	**517,296**	458,279
Non-current liabilities					
Borrowings	25	**(545,877)**	(447,934)	**(545,877)**	(447,934)
Provisions	29	**(1,645)**	(1,700)	**(1,645)**	(1,700)
Other liabilities	24	**(29,837)**	(38,694)	**(29,837)**	(38,694)
		(577,359)	(488,328)	**(577,359)**	(488,328)
Total liabilities		**(694,031)**	(599,892)	**(694,247)**	(599,892)
Net assets / (liabilities)		**(60,054)**	(30,049)	**(60,063)**	(30,049)
Taxpayers' equity					
Public dividend capital		**171,012**	171,012	**171,012**	171,012
Revaluation reserve		**108,389**	104,043	**108,389**	104,043
Income and expenditure reserve		**(339,455)**	(305,104)	**(339,464)**	(305,104)
Total taxpayers' equity		**(60,054)**	(30,049)	**(60,063)**	(30,049)

* The prior year has been restated to reflect the revised HM Treasury applications of IAS 18 and IAS 20 to donated and granted non-current assets, as detailed in accounting policy notes 1.8 and 1.9 respectively. The financial statements have been restated with effect from 1 April 2010 - see notes 4 and 24 to the financial statements on pages XXXIII and L respectively for details of the restatement to revenue.

The financial statements on pages XIII to LXIII were approved by the Board of Directors on 24 May 2012 and were signed on its behalf by:

Dame Julie Moore, Chief Executive

Consolidated statement of changes in taxpayers' equity

Group	Public Dividend Capital	Revaluation Reserve	Donated Asset Reserve	Income and Expenditure Reserve	**Total**
	£000	£000	£000	£000	**£000**
Balance at 1 April 2010	171,012	109,052	7,735	(68,368)	**219,431**
Adoption of revised interpretation of IAS 18 *	-	106	(7,735)	7,629	**-**
Adoption of revised interpretation of IAS 20 *	-	-	-	2,987	**2,987**
Balance at 1 April 2010 as restated	171,012	109,158	-	(57,752)	**222,418**
Deficit for the year	-	-	-	(248,844)	**(248,844)**
Transfers in respect of assets disposed of	-	(1,492)	-	1,492	**-**
Revaluation gains / (losses)	-	(3,623)	-	-	**(3,623)**
Total comprehensive income for the year	-	(5,115)	-	(247,352)	**(252,467)**
Balance at 31 March 2011 as restated	171,012	104,043	-	(305,104)	**(30,049)**
Deficit for the year				(33,642)	**(33,642)**
Transfers in respect of assets disposed of		(10)		10	**-**
Transfers between reserves		719		(719)	**-**
Revaluation gains / (losses)		3,637		-	**3,637**
Total comprehensive income for the year	-	4,346	-	(34,351)	**(30,005)**
Balance at 31 March 2012	**171,012**	**108,389**	**-**	**(339,455)**	**(60,054)**

Trust	Public Dividend Capital	Revaluation Reserve	Donated Asset Reserve	Income and Expenditure Reserve	**Total**
	£000	£000	£000	£000	**£000**
Balance at 1 April 2010	171,012	109,052	7,735	(68,368)	**219,431**
Adoption of revised interpretation of IAS 18 *	-	106	(7,735)	7,629	**-**
Adoption of revised interpretation of IAS 20 *	-	-	-	2,987	**2,987**
Balance at 1 April 2010 as restated	171,012	109,158	-	(57,752)	**222,418**
Deficit for the year	-	-	-	(248,844)	**(248,844)**
Transfers in respect of assets disposed of	-	(1,492)	-	1,492	**-**
Revaluation gains / (losses)	-	(3,623)	-	-	**(3,623)**
Total comprehensive income for the year	-	(5,115)	-	(247,352)	**(252,467)**
Balance at 31 March 2011 as restated	171,012	104,043	-	(305,104)	**(30,049)**
Deficit for the year				(33,651)	**(33,651)**
Transfers in respect of assets disposed of		(10)		10	**-**
Transfers between reserves		719		(719)	**-**
Revaluation gains / (losses)		3,637		-	**3,637**
Total comprehensive income for the year	-	4,346	-	(34,360)	**(30,014)**
Balance at 31 March 2012	**171,012**	**108,389**	**-**	**(339,464)**	**(60,063)**

* The prior year has been restated to reflect the revised HM Treasury applications of IAS 18 and IAS 20 to donated and granted non-current assets, as detailed in accounting policy notes 1.8 and 1.9 respectively.

Consolidated statement of cash flows for the year ended 31 March 2012

	Notes	Year Ended 31 March 2012 £000	Restated * Year Ended 31 March 2011 £000
Cash flows from operating activities			
Operating surplus for the year before non-recurring items		**18,671**	11,581
Non-recurring items		**(33,510)**	(250,055)
Operating surplus for the year		**(14,839)**	(238,474)
Depreciation and amortisation		**20,105**	16,534
Impairments		**31,695**	243,557
Loss on disposal of property, plant and equipment		**-**	-
(Increase) / decrease in inventories		**(266)**	(1,939)
(Increase) / decrease in trade and other receivables		**17,940**	(16,499)
(Increase) / decrease in other assets		**41**	40
Increase / (decrease) in trade and other payables		**6,814**	6,233
Increase / (decrease) in other liabilities		**(11,597)**	13,122
Increase / (decrease) in provisions		**(29)**	(930)
Net cash generated from operating activities		**49,864**	21,644
Cash flows from investing activities			
Interest received		**685**	354
Payments to acquire property, plant and equipment		**(14,124)**	(29,848)
Receipts from sale of property, plant and equipment		**-**	-
Payments to acquire intangible assets		**(181)**	(281)
Net cash used in investing activities		**(13,620)**	(29,775)
Cash flows from financing activities			
Capital element of finance lease obligations		**(7)**	(68)
Interest element of finance lease obligations		**-**	(4)
Capital element of PFI obligations		**(10,928)**	(15,541)
Interest element of PFI obligations		**(19,491)**	(10,449)
PDC dividends received / (paid)		**(131)**	(88)
Net cash used in financing activities		**(30,557)**	(26,150)
Net increase / (decrease) in cash and cash equivalents		**5,687**	(34,281)
Cash and cash equivalents at 1 April		**62,009**	96,290
Cash and cash equivalents at 31 March	22	**67,696**	62,009

* 2010/11 figures have been restated to reflect the revised HM Treasury applications of IAS 18 and IAS 20 to donated and granted non-current assets, as detailed in accounting policy notes 1.8 and 1.9 respectively.

Notes to the Financial Statements

1. Accounting policies

General information

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 2011/12 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 ('FReM') 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.

Basis of preparation and statement of compliance

These financial statements have been prepared in accordance with applicable International Financial Reporting Standards (IFRS) and International Finance Reporting Interpretation Committee (IFRIC) interpretations, issued by the International Accounting Standard Board (IASB), as adopted for use in the European Union effective at 31 March 2012, and appropriate to this Foundation Trust as noted above.

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.

Basis of consolidation

The Group financial statements consolidate the financial statements of the Trust and all of its subsidiary undertakings made up to 31 March 2012, together with the Group's share of the results of joint ventures and associates up to the 31 March 2012. The income, expenses, assets, liabilities, equity and reserves of the subsidiaries have been consolidated into the Trust's financial statements and group financial statements have been prepared.

A subsidiary is an entity controlled by the Trust. Control exists when the Company has the power, directly or indirectly, to govern the financial and operating policies of the entity so as to derive benefits from its activities. A joint venture is an entity in which the Group holds a long-term interest and which is jointly controlled by the Group and one or more other venturers under a contractual arrangement. An associate is an entity, being neither a subsidiary nor a joint venture, in which the Group holds a long-term interest and where the Group has a significant influence. The results of joint ventures and associates are accounted for using the equity method of accounting. Any subsidiary undertakings, joint ventures or associates sold or acquired during the year are included up to, or from, the dates of change of control.

All intra-group transactions, balances, income and expenses are eliminated on consolidation. Adjustments are made to eliminate the profit or loss arising on transactions with joint ventures and associates to the extent of the Group's interest in the entity. Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK GAAP) then amounts are adjusted during consolidation where the differences are material, however there are no such differences at the reporting date. In accordance with the NHS Foundation Trust Annual Reporting Manual a separate income and cash flow statement for the parent (the Trust) has not been presented.

1.2 Revenue recognition

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). A 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.

The 2011/12 HM Treasury Financial Reporting Manual has made two changes that effect the reporting of revenue: the accounting of revenue in respect of donated assets and government granted assets are now disclosed in accordance with IAS 18 'Revenue' and IAS 20 'Accounting for Government Grants' respectively. See accounting policy notes 1.8 and 1.9 respectively for detailed explanations of the changes.

1.3 Expenditure on employee benefits

Short term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from 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.

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.

In order that the defined obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal acturial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) 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. The last formal actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes have been suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public services pensions, and while future scheme terms are developed as part of the reforms to public service pension provision. Employer and employee contribution rates are currently being determined under the new scheme design.

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. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data are accepted as providing suitably robust figures for financial reporting purposes. However, as the interval since the last formal valuation now exceeds four years, the valuation of the scheme liabilty as at 31 March 2012, is based on detailed membership data as at 31 March 2010 updated to 31 March 2012 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

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:

"The NHS Pension Scheme provides 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".

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. From 2001-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

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.

1.4 Expenditure on other goods and services

Recurring items

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.

Non-recurring items

Non-recurring items are those items that are unusual because of their size, nature or incidence. The Trust's management consider

that these items should be separately identified within their relevant operating expenses category to enable a full understanding of the Trust's results.

1.5 Property, plant and equipment

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.

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.

After recognition of the asset, property is carried at fair value using the 'Revaluation model' set out in IAS 16, in accordance with HM Treasury's Finance Reporting Manual. Property used for the Trust's services or for administrative purposes is carried at a revalued amount, being its fair value as determined 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 measured as follows:

- Land and non specialised buildings - existing use value
- Specialised buildings - depreciated replacement cost

Valuations are carried out by a professionally qualified valuer in accordance with the Royal Institute of Chartered Surveyors (RICS) Valuation Standards, 7th Edition. The District Valuation Service has carried out the valuation of the Trust's property as at the reporting date. Where depreciated replacement cost has been used, the valuer has had regard to RICS Valuation Information Paper No. 10 'The Depreciated Replacement Cost (DRC) Method of Valuation for Financial Reporting', as supplemented by Treasury guidance. HM Treasury require the measurement of 'DRC' using the 'Modern Equivalent Asset' (MEA) estimation technique, see accounting policy 1.28 for details.

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.

Equipment and fixtures are carried at cost less accumulated depreciation and any accumulated impairment losses, as this is not considered to be materially different from the fair value of assets which have low values or short economic useful lives.

Revaluation

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income. Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is 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. These intangible assets are stated at cost less accumulated amortisation and impairment losses. Amortisation is charged to the Statement of Comprehensive Income on a straight line basis.

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.

In accordance with the NHS Foundation Trust Annual Reporting Manual, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when,

and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of other impairments are treated as revaluation gains.

1.8 Donated assets

The 2011/12 HM Treasury Financial Reporting Manual has removed the previous exemption to IAS 18 'Revenue' applicable to donated non-current assets. Donated assets continue to be capitalised at their fair value on receipt, but there is no longer a matching credit to the donated asset reserve. The revenue is recognised in full in the reporting year the asset is received, unless the donor imposes a condition that the future economic benefits embodied in the donation are to be consumed in a manner specified by the donor. In which case the donation would be deferred within liabilities carried forward to future years to the extent that the condition has not yet been met. Donated assets continue to be valued, depreciated and impaired as described for purchased assets. These changes to revenue and reserves are treated as prior period adjustments and are detailed in note 4 to the financial statements on page XXXIII and the Statement of Changes in Taxpayers' Equity on page 15 respectively.

1.9 Government grants

The 2011/12 HM Treasury Financial Reporting Manual requires the accounting for government and other granted assets to follow IAS 20 with the following interpretations: the option to deduct the grant from the carrying value of the asset is not permitted and revenue is recognised when the foundation trust becomes entitled to the grant, unless the grantor imposes a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the grantor. In which case the grant would be deferred within liabilities carried forward to future years to the extent that the condition has not yet been met. Granted assets continue to be capitalised at their fair value upon receipt and are valued, depreciated and impaired as described for purchased assets. These changes to revenue, other liabilities and reserves are detailed in notes 4 and 24 to the financial statements on pages XXXIII and L respectively and the Statement of Changes in Taxpayers' Equity on page XV.

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.

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.

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

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 PFI asset recognised is the 'Queen Elizabeth Hospital Birmingham' as detailed in note 28.1 to the financial statements on page LIV. The services received under the contract are recorded as operating expenses.

Valuation

The PFI assets are recognised as property, plant and equipment, when they come into use, in accordance with the HM Treasury interpretation of IFRIC 12. The assets are measured initially at fair value in accordance with the principles of IAS 17, HM Treasury guidance for PFI assets is the construction cost and capitalised fees incurred as at financial close, disclosed in the PFI contract. 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, as detailed in accounting policy note 1.5 'Property, plant and equipment - valuation'. For specialised buildings this is depreciated replacement cost.

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.

The PFI lease obligations due at the reporting date are detailed in note 28.1 to the financial statements on page LIV.

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 expense 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 recognised under the relevant finance costs heading within note 10 to the financial statements on page XXXIX.

The fair value of services received in the year is recognised under the relevant operating expenses headings within note 5 to the financial statements on page XXXIV.

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.

The lifecycle prepayment recognised at the reporting date is detailed in note 20 to the financial statements on page XLVII.

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.

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.

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

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.

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'.

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.

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'.

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.

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 borrowings and position against its prudential borrowing limit are respectively disclosed in notes 25 and 26 to the financial statements on page LII. The Trust has not utilised any loan or working capital facility, borrowing as at the reporting date consists of obligations under finance leases and the 'Queen Elizabeth Hospital Birmingham' Private Finance Initiative contract.

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 probable 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, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.8% in real terms.

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 29 to the financial statements on page LVI, but is not recognised in the Trust's financial statements.

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 30 to the financial statements on page LVII, 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.

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 30 to the financial statements on page LVII where an inflow of economic benefits is probable.

1.21 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) net cash balances held with the Government Banking Services (GBS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the pre-audit version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.22 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 future scope of corporation tax in respect of activities where income is received from a non public sector source. With regards to the Trust's trading commercial subsidiaires the standard corporation tax leglisation applies, see note 12 to the financial statements on page XL.

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 2012. 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 critical accounting judgements and key sources of estimation uncertainty that have a significant effect on the amounts recognised in the financial statements are detailed below:

Modern equivalent asset valuation of property

As detailed in accounting policy note 1.5 'Property, plant and equipment - valuation', the District Valuation Service provided the Trust with a valuation of the land and building assets (estimated fair value and remaining useful life). The significant estimation being the specialised building - depreciated replacement value, using modern equivalent asset methodology, of the new PFI hospital (the 'Queen Elizabeth Hospital Birmingham'). This valuation, based on estimates provided by a suitably qualified professional in accordance with HM Treasury guidance, leads to a significant reduction in the reported fair value of the new PFI hospital; see note 14.2 to the financial statements on page XLIV for details. Future revaluations of the Trust's property may result in further material changes to the carrying values of non-current assets.

Provisions

Provisions have been made for probable legal and constructive obligations of uncertain timing or amount as at the reporting date. These are based on estimates using relevant and reliable information as is available at the time the financial statements are prepared. 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 carrying amounts of the Trust's provisions are detailed in note 29 to the financial statements on page LVI.

1.29 Accounting standards, interpretations and amendments adopted in the year ended 31 March 2012

The following new, revised and amended standards and interpretations have been adopted in the reporting year and have affected the amounts reported in these financial statements or have resulted in a change in presentation or disclosure.

On the 1st April 2011 the Trust acquired part of the Community Sexual Health service for the city of Birmingham, which was previously a division of Heart of Birmingham Teaching PCT and not a separate legal entity. The HM Treasury Financial Reporting Manual requires the use of merger accounting for these transactions as they are considered to be 'machinery of government change'. Such transactions fall outside the 'Group Reconstruction' provisions of IFRS 3 'Business Combinations' (as interpreted by the FReM) and as a result are then excluded from the scope of that standard. There is no IFRS standard that otherwise deals with accounting for group reconstructions, and as such the FReM has followed the IAS 8 hierarchy to the selection of accounting policies and adopted merger accounting principles similar to those in FRS 6 (UK GAAP).

HM Treasury have adopted a one year exemption from the full application of merger accounting for 'Transforming Community Services' transactions, to all bodies in the Department of Health resource accounting boundary. This exemption removes the requirement to modify prior year comparatives. The reporting year's financial transactions of the Community Sexual Health service are fully incorporated within the financial statements of the Trust, the prior year comparatives do not reflect this merger.

In addition to the above, all other new, revised and amended standards and interpretations, which are mandatory as at the reporting date, have been adopted in the year. None have had a material impact on the Trust's financial statements.

1.30 Accounting standards, interpretations and amendments to published standards not yet adopted

The following standards, interpretations and amendments have been issued by the IASB for future reporting periods and are not yet adopted by the European Union:

- Annual Improvements to IFRSs 2011 (effective 1 April 2012)
- IAS 1 'Presentation of Financial Statements' - other comprehensive income (effective 1 April 2012)
- IAS 12 'Income Taxes' - deferred tax: recovery of underlying assets (effective 1 April 2012)
- IFRS 7 'Financial Instruments' - transfers of financial assets (effective 1 April 2012)
- IFRS 9 'Financial Instruments' - recognition and measurement (effective 1 April 2013)
- IFRS 10 'Consolidated Financial Statements' - (effective 1 April 2013)
- IFRS 11 'Joint Arrangements' - (effective 1 April 2013)
- IFRS 12 'Disclosure of Interests in Other Entities' - (effective 1 April 2013)

- IFRS 13 'Fair Value Measurement' - (effective 1 April 2013)
- IAS 27 'Consolidated and Separate Financial Statements' - amended by IFRS 9 (effective 1 April 2013)
- IAS 28 'Investments in Associates' - amended by IFRS 9 (effective 1 April 2013)

The Trust does not consider that these or any other standards, amendments or interpretations issued by the IASB, but not yet adopted by the European Union, will have a material impact on the financial statements.

2. Segmental Analysis

The analysis by business segment is presented in accordance with IFRS 8 Operating segments, on the basis of those segments whose operating results are regularly reviewed by the Board (the Chief Operating Decision Maker as defined by IFRS 8), as follows:

Healthcare services -

NHS Healthcare is the core activity of the Trust - the 'mandatory services requirement' as set out in the Trust's Terms of Authorisation issued by Monitor and defined by legalisation. This activity is primarily the provision of NHS healthcare, either to patients and charged to the relevant NHS commissioning body, or where healthcare related services are provided to other organisations by contractual agreements. Healthcare services also includes the hosting of the Royal Centre for Defence Medicine (Ministry of Defence) and the treatment of private patients.

Revenue from activities (medical treatment of patients) is analysed by activity type in note 3 to the financial statements on page XXXII. Other operating revenue is analysed in note 4 to the financial statements on page XXXIII and materially consists of revenues from healthcare research and development, medical education and related support services to other organisations. Revenue is predominately from HM Government and related party transactions are analysed in note 32 to the financial statements on page LVII, where individual customers within the public sector are considered material. The proportion of total revenue receivable from whole HM Government is 95.3% (2010/11 - 93.6%).

The healthcare and related support services as described are all provided directly by the Trust, which is a public benefit corporation. These services have been aggregated into a single operating segment because they have similar economic characteristics: the nature of the services they offer are the same (the provision of healthcare), they have similar customers (public and private sector healthcare organisations) and have the same regulators (Monitor, Care Quality Commission and the Department of Health). The overlapping activities and interrelation between direct healthcare services and supporting medical research and education so suggests that aggregation is applicable. However, one healthcare support service is provided by a separate trading company:

Commercial pharmaceutical dispensary -

The company 'Pharmacy@QEHB' Limited is a wholly owned subsidiary of the Trust and provides an Outpatient Dispensary service. As a trading company, subject to an additional legal and regulatory regime (over and above that of the Trust), this activity is considered to be a separate business segment whose individual operating results are reviewed by the Trust Board (the Chief Operating Decision Maker).

A significant proportion of the company's revenue is inter segment trading with the Trust which is eliminated upon the consolidation of these group financial statements. The monthly performance report to the Chief Operating Decision Maker reports financial summary information in the format of the table overleaf.

Year ended 31 March 2012	Healthcare services £000	Commercial dispensary £000	Inter-Group Eliminations £000	Total £000
Total segment revenue	586,806	4,715	(4,881)	586,640
Total segment expenditure	(568,171)	(4,679)	4,881	(567,969)
Operating surplus	**18,635**	**36**	**-**	**18,671**
Net financing	(18,776)	(17)	-	(18,793)
PDC dividends payable	-	-	-	-
Taxation	-	(10)	-	(10)
Retained surplus - before non-recurring items	**(141)**	**9**	**-**	**(132)**
Non-recurring items	(33,510)	-	-	(33,510)
Retained surplus / (deficit)	**(33,651)**	**9**	**-**	**(33,642)**
Reportable Segment assets	634,184	2,909		637,093
Eliminations			(3,116)	(3,116)
Total assets	**634,184**	**2,909**	**(3,116)**	**633,977**
Reportable Segment liabilities	(694,247)	(2,900)		(697,147)
Eliminations			3,116	3,116
Total liabilities	**(694,247)**	**(2,900)**	**3,116**	**(694,031)**
Net assets	**(60,063)**	**9**	**-**	**(60,054)**

Year ended 31 March 2011	Healthcare services £000	Commercial dispensary £000	Inter-Group Eliminations £000	Total £000
Total segment revenue	536,515	-	-	536,515
Total segment expenditure	(524,934)	-	-	(524,934)
Operating surplus	**11,581**	**-**	**-**	**11,581**
Net financing	(10,139)	-	-	(10,139)
PDC dividends payable	(231)	-	-	(231)
Taxation	-	-	-	-
Retained surplus - before non-recurring items	**1,211**	**-**	**-**	**1,211**
Non-recurring items	(250,055)	-	-	(250,055)
Retained surplus / (deficit)	**(248,844)**	**-**	**-**	**(248,844)**
Reportable Segment assets	569,843	32		569,875
Eliminations			(32)	(32)
Total assets	**569,843**	**32**	**(32)**	**569,843**
Reportable Segment liabilities	(599,892)	(32)		(599,924)
Eliminations			32	32
Total liabilities	**(599,892)**	**(32)**	**32**	**(599,892)**
Net assets	**(30,049)**	**-**	**-**	**(30,049)**

The company 'Pharmacy@QEHB Limited' commenced trading on 4 July 2011 and hence there is no revenue or expenditure in the prior reporting year.

All activities are based in the UK.

3. Revenue from Activities

	Year Ended 31 March 2012	Year Ended 31 March 2011
	£000	£000
Foundation Trusts	**95**	120
NHS Trusts	**428**	326
Strategic Health Authorities	**19,654**	15,031
Primary Care Trusts	**430,066**	395,601
NHS Scotland, Wales and Northern Ireland	**4,577**	3,690
Private Patients	**2,701**	2,989
NHS Injury Cost Recovery scheme	**2,580**	2,813
Ministry of Defence	**8,980**	10,736
	469,081	431,306

Healthcare activity income from the Ministry of Defence of £8,980,000 relates to the Trust contract with the Royal Centre for Defence Medicine (2010/11 - £10,736,000).

NHS Injury Cost Recovery scheme income, received from commercial insurance providers, is subject to a provision for impairment of receivables of 10.5% to reflect expected rates of collection.

With the exception of private patient, NHS Injury Cost Recovery scheme and Ministry of Defence income, all of the above revenue from clinical activities arises from mandatory NHS services as set out in the Trust's Terms of Authorisation from Monitor.

On the 1st April 2011 the Trust acquired part of the Community Sexual Health service for the city of Birmingham, which was previously a division of Heart of Birmingham Teaching PCT. The use of merger accounting for these transactions is detailed in accounting note 1.29 including an HM Treasury adopted exemption from disclosing prior year figures. The reporting year disclosure for healthcare activity income from Primary Care Trusts includes £8,420,000 relating to this community service, but the prior year comparatives exclude the equivalent revenue of £7,816,000 recorded by Heart of Birmingham PCT.

3.1 Private Patients

	Financial Year 2011/12	Base Year 2002/03
	£000	£000
Private patients	**2,701**	2,773
Total patient related revenue	**469,081**	225,193
Proportion (as percentage)	**0.58%**	1.23%

The Trust's Terms of Authorisation contain a private patient income cap (limit) of 1.23% of income earned from activities. This cap is based on actual results for reporting year 2002/03 as disclosed above and defined in section 44 of the National Health Service Act 2006. The private patient cap has not been breached.

4. Other Operating Revenue

	Year Ended 31 March 2012	Restated Year Ended 31 March 2011
	£000	£000
Research and development	**25,933**	21,430
Education and training	**32,681**	34,694
Charitable and other contributions to expenditure	**3,334**	3,027
Non-patient care services to other bodies	**11,501**	10,970
Other revenue	**44,110**	35,088
	117,559	105,209

Other revenue includes PFI related income of £11,000,000 (2010/11 - £nil); rental income of £1,993,000 (2010/11 - £1,216,000) due to the leasing of new hospital facilities by the University of Birmingham and Ministry of Defence; £4,150,000 from Clinical Excellence Awards (2010/11 - £4,174,000); recharges of £4,184,000 to the Ministry of Defence to fund the training expenditure of Nurses along with catering and car parking costs associated with the military contract (2010/11 - £2,422,000); £1,579,000 from the National Quality Assurance Service (2010/11 - £2,082,000); and funding of £3,345,000 (2010/11 - £2,441,000) for the organ retrieval service.

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

The revised HM Treasury application of IAS 18 'Revenue' and IAS 20 'Accounting for Government granted assets' to donated and granted non-current assets respectively, at the reporting date, has resulted in the following changes to the 2010/11 disclosure of other operating revenue. There are no longer any transfers from donated asset reserves or granted asset deferred income balances as these no longer exist, due to no conditions or restrictions of use being in force upon any applicable Trust asset at the reporting date. The fair value of the donated or granted asset is recognised as revenue in the reporting year the Trust becomes entitled to the economic benefit, subject to any conditions of use, as detailed in accounting policy notes 1.8 and 1.9 respectively.

	£000
Charitable and other contributions to expenditure	
Reporting year 2010/11 as previously reported	1,420
Adoption of revised HM Treasury interpretation of IAS 18	1,607
Reporting year 2010/11 as restated	**3,027**
Transfers from the donated asset reserve	
Reporting year 2010/11 as previously reported	704
Adoption of revised HM Treasury interpretation of IAS 18	(704)
Reporting year 2010/11 as restated	**-**
Other revenue	
Reporting year 2010/11 as previously reported	35,181
Adoption of revised HM Treasury interpretation of IAS 20	(93)
Reporting year 2010/11 as restated	**35,088**
Movements in 2010/11 recognised in other comprehensive income	810

5. Operating Expenses

	Before non-recurring costs	Material non-recurring costs	Year Ended 31 March 2012 Total	Before non-recurring costs	Material non-recurring costs	Year Ended 31 March 2011 Total
	£000	**£000**	**£000**	£000	£000	£000
Services from Foundation Trusts	**3,102**		**3,102**	2,321	-	2,321
Services from other NHS Trusts	**6,041**		**6,041**	5,238	13	5,251
Services from PCTs	**362**		**362**	1,402	-	1,402
Services from other NHS bodies	**403**		**403**	-	-	-
Purchase of healthcare from non NHS bodies	**10,801**		**10,801**	10,271	94	10,365
Directors' costs	**1,693**		**1,693**	1,672	-	1,672
Non executive directors' costs	**166**		**166**	164	-	164
Staff costs	**304,416**	**1,621**	**306,037**	288,405	2,366	290,771
Supplies and services - clinical	**135,726**	**188**	**135,914**	123,163	783	123,946
Supplies and services - general	**7,197**	**153**	**7,350**	6,542	245	6,787
Consultancy services	**2,711**	**112**	**2,823**	4,903	705	5,608
Establishment	**4,628**	**58**	**4,686**	4,540	131	4,671
Transport	**1,016**	**320**	**1,336**	893	539	1,432
Premises	**18,570**	**802**	**19,372**	20,585	2,098	22,683
Provision for Impairment of Receivables	**(204)**		**(204)**	640	-	640
Depreciation on property, plant and equipment	**19,737**		**19,737**	16,223	-	16,223
Amortisation on intangible assets	**368**		**368**	311	-	311
Impairments of property, plant and equipment	**2,504**	**29,191**	**31,695**	612	242,945	243,557
Loss on Disposal of property, plant and equipment	**-**		**-**	-	-	-
Audit services - statutory audit	**96**		**96**	93	-	93
Other auditors remuneration - taxation services	**27**		**27**	40	-	40
Other auditors remuneration - corporate finance	**13**		**13**			
Clinical negligence	**3,492**		**3,492**	3,392	-	3,392
Other	**45,104**	**1,065**	**46,169**	33,524	136	33,660
	567,969	**33,510**	**601,479**	524,934	250,055	774,989

Other expenditure includes £22,470,000 (2010/11 - £12,222,000) in relation to payments to the Trust's PFI partner for services provided; Research Grants distributed to other West Midlands NHS organisations of £11,828,000 (2010/11 - £10,998,000) due to the Trust acting as host body for the Comprehensive Local Research Network; Training, Courses and Conference fees of £4,753,000 (2010/11 - £3,145,000) and fees payable to Deloitte LLP with regard to internal audit and counter fraud services of £136,000 (2010/11 - £132,000).

Non-recurring items are detailed in note 5.1 to the financial statements on page XXXV.

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

On the 1st April 2011 the Trust acquired part of the Community Sexual Health service for the city of Birmingham, which was previously a division of Heart of Birmingham Teaching PCT. The use of merger accounting for these transactions is detailed in accounting note 1.29 including an HM Treasury adopted exemption from disclosing prior year figures. The reporting year disclosure for operating expenses includes £9,172,000 relating to this community service, but the prior year comparatives exclude the equivalent expenditure of £9,207,000 recorded by Heart of Birmingham PCT.

5.1 Material non-recurring costs

	Year Ended 31 March 2012	Year Ended 31 March 2011
	Total	Total
	£000	£000
Non-recurring operating expenses:		
Transition costs relating to relocation to the new PFI hospital (a)	**4,319**	7,110
Impairment of property - new PFI hospital (b)	**29,191**	242,945
	33,510	250,055

(a) Non-recurring costs associated with the relocation of healthcare services to the new 'Queen Elizabeth Hospital Birmingham' PFI hospital and the consequent decommissioning of the Selly Oak hospital site. The timetable of moves to the new hospital is disclosed in note 28.1 to the financial statements on page LIV. Details of the transition costs by expense type are disclosed in note 5 to the financial statements on page XXXIV.

(b) Further disclosure of the impairment of the new 'Queen Elizabeth' PFI hospital, resulting from the difference between the PFI contracted cost and the fair value in operational use as at the reporting date, is given in note 14.2 to the financial statements on page XLIV.

6. Operating leases

6.1 As lessee

Payments recognised as an expense	**Year Ended 31 March 2012**	Year Ended 31 March 2011
	£000	£000
Minimum lease payments	**1,098**	1,100

Total future minimum lease payments	**Year Ended 31 March 2012**	Year Ended 31 March 2011
	£000	£000
Payable:		
Not later than one year	**1,039**	1,177
Between one and five years	**1,277**	1,921
After 5 years	**1,857**	1,917
Total	**4,173**	5,015

6.2 As lessor

Rental revenue	**Year Ended 31 March 2012**	Year Ended 31 March 2011
	£000	£000
Rents recognised as income in the period	**2,182**	1,523

Total future minimum lease payments	**Year Ended 31 March 2012**	Year Ended 31 March 2011
	£000	£000
Receivable:		
Not later than one year	**1,875**	1,910
Between one and five years	**4,355**	5,567
After 5 years	**5,328**	5,419
Total	**11,558**	12,896

7. Employee costs and numbers

7.1 Employee costs *

	Year Ended 31 March 2012			Year Ended 31 March 2011		
		Permanently	Other		Permanently	Other
	Total	Employed		Total	Employed	
	£000	£000	£000	£000	£000	£000
Short term employee benefits - salaries and wages	**246,693**	**229,537**	**17,156**	237,358	221,104	16,254
Short term employee benefits - social security costs	**20,174**	**20,174**		18,481	18,481	-
Post employment benefits - employer contributions to NHS pension scheme	**26,915**	**26,915**		25,421	25,421	-
Termination benefits	**129**	**129**		359	359	-
Agency/contract staff	**13,948**		**13,948**	17,390	-	17,390
	307,859	**276,755**	**31,104**	299,009	265,365	33,644

7.2 Average number of persons employed *

	Year Ended 31 March 2012			Year Ended 31 March 2011		
		Permanently	Other		Permanently	Other
	Total	Employed		Total	Employed	
Medical and dental	**982**	**925**	**57**	907	842	65
Administration and estates	**1,463**	**1,463**		1,468	1,468	-
Healthcare assistants and other support staff	**540**	**540**		564	564	-
Nursing, midwifery and health visiting staff	**2,666**	**2,666**		2,389	2,389	-
Scientific, therapeutic and technical staff	**1,050**	**1,050**		1,134	1,134	-
Bank and agency staff	**201**		**201**	268	-	268
	6,902	**6,644**	**258**	6,730	6,397	333

* On the 1st April 2011 the Trust acquired part of the Community Sexual Health service for the city of Birmingham, which was previously a division of Heart of Birmingham Teaching PCT. The use of merger accounting for these transactions is detailed in accounting note 1.29 including an HM Treasury adopted exemption from disclosing prior year figures. The reporting year disclosures above include employee costs of £6,282,000 due to the 136 staff employed by this community service, but the prior year comparatives exclude the equivalent employee costs of £6,009,000 due to the 149 staff employed by Heart of Birmingham PCT.

7.3 Key management compensation

	Year Ended 31 March 2012	Year Ended 31 March 2011
	£000	£000
Salaries and short term benefits	**1,355**	1,351
Social Security Costs	**165**	154
Employer contributions to NHSPA	**173**	167
	1,693	1,672

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.

7.4 Staff exit packages

	Compulsory redundancies		Other agreed departures		Total termination packages	
	Number	Cost £'000	Number	Cost £'000	Number	Cost £'000
Termination benefit by band - Year Ended 31 March 2012						
< £10,000	2	7	-	-	2	7
£10,000 - £25,000	1	23	-	-	1	23
£25,000 - £50,000	1	29	-	-	1	29
	4	59	-	-	4	59
Termination benefit by band - Year Ended 31 March 2011						
< £10,000	9	33	-	-	9	33
£10,000 - £25,000	3	48	-	-	3	48
£25,000 - £50,000	1	35	-	-	1	35
£50,000 - £100,000	2	133	-	-	2	133
> £100,000	1	110			1	110
	16	359	-	-	16	359

There were no termination benefits paid or due in the reporting year to key management personnel, who are defined to be the Board of Directors of the Trust (2010/11 - £nil).

8. Retirements due to ill-health

During the year to 31 March 2012 there were 11 early retirements from the Trust agreed on the grounds of ill-health (2010/11 - 9). The estimated additional pension liabilities of these ill-health retirements will be £837,548 (2010/11 - £483,904). The cost of these ill-health retirements will be borne by the NHS Pensions Agency.

9. Better payment practice code

9.1 Measure of compliance

	Year Ended 31 March 2012		Year Ended 31 March 2011	
	Number	**£000**	Number	£000
Trade				
Total trade bills paid in the year	**103,635**	**259,069**	104,393	234,740
Total trade bills paid within target	**102,287**	**255,932**	103,156	232,928
Percentage of trade bills paid within target	**98.70%**	**98.79%**	98.82%	99.23%
NHS				
Total NHS bills paid in the year	**7,088**	**174,041**	4,937	90,237
Total NHS bills paid within target	**6,751**	**169,670**	4,688	85,495
Percentage of NHS bills paid within target	**95.25%**	**97.49%**	94.96%	94.74%

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 and costs

	Year Ended 31 March 2012	Year Ended 31 March 2011
	£000	£000
Financing income		
Interest receivable	**738**	358
	738	358
Financing costs		
Interest on obligations under PFI contracts	**(19,491)**	(10,449)
Interest on obligations under finance leases	**-**	(4)
Other financing charges	**(40)**	(44)
	(19,531)	(10,497)
Net finance expense	**(18,793)**	(10,139)

11. Public dividend capital dividends

Public dividend capital ('PDC') dividends paid and due to the Department of Health amounted to £nil (2010/11 - £231,000). PDC dividends are calculated as a percentage (3.5%) of average net relevant assets. The Trust has negative taxpayers' equity as at the current and prior reporting dates hence there is no PDC dividend to pay.

12. Taxation

The activities of the subsidiary company Pharmacy@QEHB Limited have given rise to a corporation tax liability recognised in the Income Statement of £10,000 (2010/11 - £nil). The activities of the Trust do not incur corporation tax.

13. Intangible assets

Group	**Computer software - purchased**	**Licences and trademarks**	**Intangible assets under construction**	**Total**
	£000	**£000**	**£000**	**£000**
Cost				
At 1 April 2010	1,219	164	270	1,653
Additions	196	85	-	281
Reclassifications	255	15	(270)	-
At 31 March 2011	**1,670**	**264**	**-**	**1,934**
Additions	61	120		181
Reclassifications				-
At 31 March 2012	**1,731**	**384**	**-**	**2,115**
Amortisation				
At 1 April 2010	559	71	-	630
Charged for the year	271	40	-	311
At 31 March 2011	**830**	**111**	**-**	**941**
Charged for the year	303	65	-	368
At 31 March 2012	**1,133**	**176**	**-**	**1,309**
Net book value				
At 31 March 2012	**598**	**208**	**-**	**806**
At 31 March 2011	840	153	-	993
At 1 April 2010	660	93	270	1,023

A separate schedule for the Trust's intangible assets has not been produced as the subsidiaries' have no intangible assets.

All intangible assets of the Group have been purchased and none have been donated, funded by government grant or internally generated.

The valuation basis is described in accounting policy note 1.6. There is no active market for the Group's intangible assets and there is no revaluation reserve.

The estimated useful economic lives of the Group's intangible assets range from two to five years and each asset is being amortised over this period, as described in accounting policy note 1.7.

14. Property, plant and equipment - 2011/12

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost									
At 31 March 2011	68,875	322,251	1,298	1,165	82,548	90	14,109	4,594	494,930
Additions purchased	-	112,242		393	8,196	11	800	135	121,777
Additions donated	-	-	-	100	2,184	-	-	30	2,314
Reclassifications	-	603	-	(1,378)	99	-	646	30	-
Impairments charged to operating expenses	-	(30,783)	-	(141)	(771)	-	-	-	(31,695)
Impairments charged to revaluation reserve	-	-	-	-	-	-	-	-	-
Revaluation surpluses	-	3,508	129	-	-	-	-	-	3,637
Disposals other than by sale	-	-	-	-	(846)	(90)	-	-	(936)
At 31 March 2012	**68,875**	**407,821**	**1,427**	**139**	**91,410**	**11**	**15,555**	**4,789**	**590,027**
Depreciation									
At 31 March 2011	-	4,469	-	-	41,842	90	7,495	4,051	57,947
Provided during the year	-	8,961	80	-	8,144	-	2,359	193	19,737
Revaluation surpluses	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	(846)	(90)	-	-	(936)
At 31 March 2012	**-**	**13,430**	**80**	**-**	**49,140**	**-**	**9,854**	**4,244**	**76,748**
Net book value									
Owned	26,125	47,923	1,321	33	37,807	11	5,701	507	119,428
Donated	-	6,579	26	106	4,463	-	-	38	11,212
Private Finance Initiative	-	339,889	-	-	-	-	-	-	339,889
Finance Lease	42,750	-	-	-	-	-	-	-	42,750
At 31 March 2012	**68,875**	**394,391**	**1,347**	**139**	**42,270**	**11**	**5,701**	**545**	**513,279**

Group	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
Analysis of property, plant and equipment									
Net book value									
Protected assets	42,750	384,903	-	-	-	-	-	-	427,653
Unprotected assets	26,125	9,488	1,347	139	42,270	11	5,701	545	85,626
At 31 March 2012	**68,875**	**394,391**	**1,347**	**139**	**42,270**	**11**	**5,701**	**545**	**513,279**

Condition 9 of the Trust's Terms of Authorisation defines protected assets as "Property needed for the purposes of providing any of the mandatory goods and services". This comprises NHS healthcare and related education and training services, such properties cannot be sold without the prior approval of Monitor.

A separate schedule for the Trust's tangible assets has not been produced as the subsidiaries' tangible assets represent just £92k (31 March 2011 - £32,000) of the net book value held by the Group.

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost									
At 1 April 2010	72,500	59,050	1,348	3,381	69,082	119	12,497	5,165	223,142
Prior period adjustment *	-	4	-	(270)	(319)	(29)	(15)	(212)	(841)
At 1 April 2010 as restated	**72,500**	**59,054**	**1,348**	**3,111**	**68,763**	**90**	**12,482**	**4,953**	**222,301**
Additions purchased	-	479,652	-	561	15,825	-	1,184	143	497,365
Additions donated	-	-	-	5	1,602	-	-	-	1,607
Reclassifications	-	1,694	-	(2,512)	372	-	443	3	-
Transferred in from other non-financial assets **	-	30,963	-	-	-	-	-	-	30,963
Impairments charged to operating expenses	-	(243,557)	-	-	-	-	-	-	(243,557)
Impairments charged to revaluation reserve	(3,625)	(695)	-	-	-	-	-	-	(4,320)
Revaluation surpluses	-	(4,860)	(50)	-	-	-	-	-	(4,910)
Disposals other than by sale	-	-	-	-	(4,014)	-	-	(505)	(4,519)
At 31 March 2011	**68,875**	**322,251**	**1,298**	**1,165**	**82,548**	**90**	**14,109**	**4,594**	**494,930**

Group	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
Depreciation									
At 1 April 2010	-	3,485	-	-	38,356	119	5,813	4,648	52,421
Prior period adjustment *	-	4	-	-	(319)	(29)	(15)	(212)	(571)
At 1 April 2010 as restated	**-**	**3,489**	**-**	**-**	**38,037**	**90**	**5,798**	**4,436**	**51,850**
Provided during the year	-	6,499	88	-	7,819	-	1,697	120	16,223
Revaluation surpluses	-	(5,519)	(88)	-	-	-	-	-	(5,607)
Disposals other than by sale	-	-	-	-	(4,014)	-	-	(505)	(4,519)
At 31 March 2011	**-**	**4,469**	**-**	**-**	**41,842**	**90**	**7,495**	**4,051**	**57,947**
Net book value									
Owned	26,125	49,132	1,272	1,159	37,474	-	6,614	531	122,307
Donated	-	5,389	26	6	3,226	-	-	12	8,659
Private Finance Initiative	-	263,261	-	-	-	-	-	-	263,261
Finance Lease	42,750	-	-	-	6	-	-	-	42,756
At 31 March 2011	**68,875**	**317,782**	**1,298**	**1,165**	**40,706**	**-**	**6,614**	**543**	**436,983**
Analysis of property, plant and equipment									
Net book value									
Protected assets	42,750	309,096	-	-	-	-	-	-	351,846
Unprotected assets	26,125	8,686	1,298	1,165	40,706	-	6,614	543	85,137
At 31 March 2011	**68,875**	**317,782**	**1,298**	**1,165**	**40,706**	**-**	**6,614**	**543**	**436,983**

* The prior period adjustment includes £270,000 of additions in 2009/10 classified as property, plant and equipment, now reclassified as intangible software and licences. See note 13 to the financial statements on page XL.

** Due to the opening of the Queen Elizabeth Hospital Birmingham and its subsequent recognition as an asset on 15 June 2010, £30,963,000 of construction work carried out prior to this date on the new PFI hospital was reclassified as property, plant and equipment from other non-financial assets.

14.1 Estimated useful economic lives

The estimated useful economic lives of the Group's property, plant and equipment are as follows with each asset being depreciated over this period, as described in accounting policy note 1.7.

	Minimum life Years	Maximum life Years
Buildings (excluding dwellings)	10	50
Dwellings	15	30
Plant and Machinery	5	15
Information technology	2	5
Furniture and fittings	5	10

14.2 Valuation at the reporting date

The land, buildings and dwellings were valued at the reporting date by an independent valuer, the District Valuation Service 'DVS'. The purpose of this exercise being to determine a fair value for Trust property, as detailed in accounting policy notes 1.5 'Property, plant and equipment - valuation' and 1.28 'Critical accounting judgements and key sources of estimation uncertainty'.

The revaluation exercise resulted in a net impairment being charged to operating expenses, within the consolidated statement of comprehensive income.

Impairments of property, plant and equipment	**Year Ended 31 March 2012 £000**
Impairments charged to consolidated statement of comprehensive income	
Queen Elizabeth Hospital - new PFI facility	**29,191**
Trust owned property	**2,504**
	31,695

During the year the Trust opened the final phase of the new 'Queen Elizabeth Hospital Birmingham' PFI hospital, which gave rise to an impairment resulting from the difference between the cost directly attributable to the construction (including interest charges and fees) and the fair value in operational use, as measured at 31 March 2012. The impairment is disclosed in non-recurring operating expenses within the Income Statement, see note 5 to the financial statements on page XXXIV.

The impairment to Trust owned property charged to operating expenses arose from the difference between the cost attributable to construction of assets and the fair value of the assets in operational use, as measured at the reporting date and exceeding the available revaluation reserve balance to offset this charge.

The surpluses and deficits upon the revaluation exercise resulted in the following gains and losses being charged to the revaluation reserve, see the Statement of Changes in Taxpayers' Equity on page XV of the financial statements.

Revaluation gains / (losses) on property, plant and equipment	31 March 2012	31 March 2011
Group	**£000**	£000
Surpluses / (deficits) due to revaluation of property recognised in other comprehensive income		
Land	**-**	(3,625)
Buildings	**3,508**	(36)
Dwellings	**129**	38
	3,637	(3,623)

The revaluation gains and losses on property, plant and equipment for the Group are the same as for the Trust.

14.3 Assets held under finance leases and PFI arrangements

Group	PFI assets	Assets held under finance leases	Total
	£000	**£000**	**£000**
Cost			
At 1 April 2010	-	45,238	45,238
Additions	478,544	-	478,544
Impairments to revaluation reserve	-	(2,250)	(2,250)
Transferred in from other non-financial assets	30,963	-	30,963
Impairments to operating expenses	(242,945)	-	(242,945)
At 31 March 2011	**266,562**	**42,988**	**309,550**
Additions	111,812	-	111,812
Impairments to revaluation reserve	-	-	-
Impairments to operating expenses	(29,191)	-	(29,191)
At 31 March 2012	**349,183**	**42,988**	**392,171**
Depreciation			
At 1 April 2010	-	168	168
Charged for the year	3,301	64	3,365
At 31 March 2011	**3,301**	**232**	**3,533**
Charged for the year	5,993	6	5,999
At 31 March 2012	**9,294**	**238**	**9,532**
Net book value			
At 31 March 2012	**339,889**	**42,750**	**382,639**
At 31 March 2011	263,261	42,756	306,017
At 1 April 2010	-	45,070	45,070

The Private Finance Initiative asset is the new Queen Elizabeth Hospital Birmingham as detailed in note 28.1 to the financial statements on page LIV. The impairment is detailed in note 14.2 to the financial statements on page XLIV.

A separate schedule for the Trust's finance lease and PFI assets has not been produced as the subsidiaries' have no assets classified as such.

15. Capital commitments

Commitments under capital expenditure contracts at the end of the period, not otherwise included in these financial statements, were £1,318,000 (31 March 2011 - £7,018,000). This amount relates entirely to property, plant and equipment, there are nil contracted capital commitments for intangible assets.

16. Subsidiaries and investments

The Trust's principal subsidiary undertakings and investments as included in the consolidation as at the reporting date are set out below. The reporting date of the financial statements for the subsidiaries is the same as for these group financial statements - 31 March 2012.

Pharmacy@QEHB Limited

The company is registered in the UK, company no. 07547768, with a share capital comprising one share of £1 owned by the Trust. The company commenced trading on the 4 July 2011 as an Outpatients Dispensary service in the new 'Queen Elizabeth Hospital Birmingham' and a significant proportion of the company's revenue is inter group trading with the Trust which is eliminated upon the consolidation of these group financial statements, see note 2 to the financial statements on page XXX.

Birmingham Systems (Healthcare) Limited

The company is registered in the UK, company no. 7136767, with a share capital comprising one share of £1 owned by the Trust. The company is dormant and has not yet traded, there are nil assets and liabilities to consolidate into the Trust's financial statements.

Investments

The Trust has one investment comprising a 12% shareholding in a company 'Sapere Systems Limited', registered in the UK, company no. 7171338, the Trust's shareholding purchased for £12. This company is dormant and has not yet traded, therefore the investment is recognised in the Trust's statement of financial position at cost.

17. Mergers

On the 1st April 2011 the Trust acquired part of the Community Sexual Health service for the city of Birmingham, which was previously a division of Heart of Birmingham Teaching PCT and not a separate legal entity. The HM Treasury Financial Reporting Manual requires the use of merger accounting for these transactions as they are considered to be 'machinery of government change', see accounting note 1.29 for details. Due to the partial exemption from applying merger accounting to restate the prior year, only the reporting year's financial statements include the transactions of the Community Sexual Health service from the 1 April 2011.

Disclosed within the financial statements for the reporting year, the community service earned revenue of £9,375,000 and incurred expenditure of £9,172,000 resulting in a surplus of £203,000. Due to the exemption described above, the prior year comparatives do not include the equivalent transactions disclosed in the financial statements of Heart of Birmingham PCT: revenue earned of £9,207,000 and expenditure incurred of £9,207,000 resulting in a breakeven position for 2010/11.

No consideration was paid by the Trust for the transfer of the Community Sexual Health service and no assets or liabilities have been transferred as at the reporting date.

18. Non-current assets held for sale

The Trust has no non-current assets held for sale (31 March 2011 - £nil).

19. Inventories

	Group		Trust	
	31 March 2012	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
Raw materials	**13,050**	12,787	**12,241**	12,787
Finished goods	**6**	3	**6**	3
	13,056	12,790	**12,247**	12,790

Inventories carried at fair value less costs to sell where such value is lower than cost are nil (31 March 2011 - £nil).

The Trust expensed £130,869,000 of inventories during the year (2010/11 - £122,025,000). The Trust charged £20,000 to operating expenses in the year due to write-downs of obsolete inventories (2010/11 - £13,000).

20. Trade and other receivables

Current	Group		Trust	
	31 March 2012	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
NHS receivables	**20,173**	34,953	**20,173**	34,953
Receivables with other related parties	**3,358**	10,096	**3,358**	10,096
Commercial trade receivables	**2,852**	3,475	**5,211**	3,475
Provision for impaired receivables	**(1,247)**	(2,263)	**(1,247)**	(2,263)
PFI prepayments - lifecycle replacements	**1,496**	14	**1,496**	14
Prepayments	**2,911**	2,164	**2,911**	2,164
Accrued income	**597**	1,061	**597**	1,061
Other receivables	**5,824**	4,409	**5,541**	4,409
PDC receivable		-		-
	35,964	53,909	**38,040**	53,909

Non current	Group		Trust	
	31 March 2012	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
Provision for impaired receivables	**(343)**	(304)	**(343)**	(304)
Other receivables	**3,265**	3,168	**3,265**	3,168
	2,922	2,864	**2,922**	2,864

NHS receivables consist of balances owed by NHS bodies in England, receivables with other related parties consist of balances owed by other HM Government organisations. Related party transactions are detailed in note 32 to the financial statements on page LVII.

Included within trade and other receivables of both Group and Trust are balances with a carrying amount of £10,679,000 (31 March 2011: £12,692,000) which are past due at the reporting date but for which no specific provision has been made as they are considered to be recoverable based on previous trading history.

Aged analysis of past due but not impaired receivables	Group		Trust	
	31 March 2012	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
Not past due date	**28,207**	44,081	**30,283**	44,081
By up to three months	**3,255**	5,257	**3,255**	5,257
By three to six months	**705**	1,218	**705**	1,218
By more than six months	**6,719**	6,217	**6,719**	6,217
	38,886	56,773	**40,962**	56,773

Provision for impaired receivables	Group		Trust	
	31 March 2012	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
Balance at 1 April	**2,567**	1,975	**2,567**	1,975
Increase in provision	**945**	1,327	**945**	1,327
Amounts utilised	**(773)**	(48)	**(773)**	(48)
Unused amounts reversed	**(1,149)**	(687)	**(1,149)**	(687)
	1,590	2,567	**1,590**	2,567

Aged analysis of impaired receivables	Group		Trust	
	31 March 2012	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
By up to three months	**387**	41	**387**	41
By three to six months	**-**	270	**-**	270
By more than six months	**1,203**	2,256	**1,203**	2,256
	1,590	2,567	**1,590**	2,567

21. Other non financial assets

Current	Group		Trust	
	31 March 2012	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
PFI deferred assets - bullet payment	**41**	41	**41**	41

Non current	Group		Trust	
	31 March 2012	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
PFI deferred assets - bullet payment	**213**	254	**213**	254

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 7 years of the contract.

22. Cash and cash equivalents

	Group		Trust	
	31 March 2012	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
Cash and cash equivalents	**67,696**	62,009	**66,728**	62,009
Made up of				
Cash with Government Banking Service	**689**	61,109	**689**	61,109
Commercial banks and cash in hand	**67,007**	900	**66,039**	900
Current investments	**-**	-	**-**	-
Cash and cash equivalents as in statement of financial position	**67,696**	62,009	**66,728**	62,009
Bank overdraft - Government Banking Service	**-**	-	**-**	-
Bank overdraft - Commercial banks	**-**	-	**-**	-
Cash and cash equivalents as in statement of cash flows	**67,696**	62,009	**66,728**	62,009

23. Trade and other payables

Current	Group		Trust	
	31 March 2012	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
NHS payables	**7,016**	9,194	**7,016**	9,194
Amounts due to other related parties	**3,638**	3,440	**3,638**	3,440
Commercial trade payables	**18,413**	18,293	**18,413**	18,293
Trade payables - capital	**1,054**	1,284	**1,052**	1,284
Taxes payable	**6,880**	6,340	**6,874**	6,340
Corporation tax payable	**10**	-	**-**	-
Other payables	**1,521**	1,308	**1,521**	1,308
Accruals	**39,583**	31,592	**39,817**	31,592
Receipts in advance	**25**	95	**25**	95
PDC payable	**-**	131	**-**	131
	78,140	71,677	**78,356**	71,677

NHS payables consist of balances owed to NHS bodies in England, amounts due to other related parties consist of balances owed to other HM Government organisations. Related party transactions are detailed in note 32 to the financial statements on page LVII. Included within amounts due to other related parties are NHS pension contributions of £3,406,000 (31 March 2011: £3,218,000).

The prior year comparative figures are restated due to the reclassification from Provisions to Accruals of the annual leave entitlement earned but not taken by employees at the reporting date of £1,258,000 (31 March 2011: £926,000). See note 29 to the financial statements on page LVI.

Non current trade and other payables are nil (31 March 2011 - £nil).

Corporation tax payable arises from the trading activites of the subsidiary Pharmacy@QEHB Limited.

24. Other liabilities

Current	Group		Trust	
		Restated		Restated
	31 March 2012	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
Deferred income	**23,858**	26,598	**23,858**	26,598
Deferred government grant	**-**	-	**-**	-
	23,858	26,598	**23,858**	26,598

Non current	Group		Trust	
		Restated		Restated
	31 March 2012	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
Deferred income	**29,837**	38,694	**29,837**	38,694
Deferred government grant	-	-	**-**	-
	29,837	38,694	**29,837**	38,694

The revised HM Treasury application of IAS 20 'Accounting for Government granted assets' to granted non-current assets, at the reporting date, has resulted in the following changes to the disclosure of other liabilities. There are no longer any transfers from granted asset deferred income balances as these no longer exist, due to no conditions or restrictions of use being in force upon any granted Trust asset at the reporting date. The fair value of the granted asset is recognised as revenue in the reporting year the Trust becomes entitled to the economic benefit, subject to any conditions of use, as detailed in accounting policy note 1.9.

Group and Trust	Current	Non current
	£000	**£000**
Deferred income		
At 1 April 2010 as previously reported	27,423	25,040
Adoption of revised HM Treasury interpretation of IAS 20	(293)	-
At 1 April 2010 as restated	**27,130**	**25,040**
At 31 March 2011 as previously reported	26,815	38,694
Adoption of revised HM Treasury interpretation of IAS 20	(217)	-
At 31 March 2011 as restated	**26,598**	**38,694**
Deferred government grant		
At 1 April 2010 as previously reported	46	2,648
Adoption of revised HM Treasury interpretation of IAS 20	(46)	(2,648)
At 1 April 2010 as restated	**-**	**-**
At 31 March 2011 as previously reported	46	2,631
Adoption of revised HM Treasury interpretation of IAS 20	(46)	(2,631)
At 31 March 2011 as restated	**-**	**-**

25. Borrowings

Group and Trust	Current		Non current	
	31 March 2012	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
Obligations under finance leases	**-**	7	**-**	-
Obligations under Private Finance Initiative contracts	**12,254**	10,928	**545,877**	447,934
	12,254	10,935	**545,877**	447,934

The Private Finance Initiative obligation relates to the new Queen Elizabeth Hospital Birmingham as detailed in note 28.1 to the financial statements on page LIV.

26. Prudential borrowing limit

	31 March 2012	31 March 2011
	£000	£000
Total long term borrowing limit set by Monitor	**564,500**	561,100
Working capital facility agreed by Monitor	**30,000**	20,000
	594,500	581,100
Long term borrowing at 1st April	**458,869**	75
Net actual borrowing / (repayment) in year - long term	**99,262**	458,794
Long term borrowing at 31st March	**558,131**	458,869
Working capital borrowing at 31st March	**-**	-

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 four 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.

The long term borrowing limit set by Monitor is due to the new private finance initiative contract and the actual net borrowing is the non-current PFI obligation at the reporting date.

The ratio tests used to determine the maximum long term borrowing limit and the Trust's performance against them is set out below.

As the Trust has a PFI scheme it is measured against Monitor's Tier 2 limits:

	Tier 2 Limits	**31 March 2012**	31 March 2011
Minimum dividend cover	> 1.0	**n/a**	76.9
Minimum interest cover	> 2.0	**2.3**	2.8
Minimum debt service cover	> 1.5	**1.4**	1.5
Maximum debt service to revenue	< 10%	**4.80%**	3.50%

The 'minimum debt service cover' ratio is marginally outside the Tier 2 limit however, this is in line with the 2011/12 financial reporting year plan submitted to Monitor.

27. Finance lease obligations (other than PFI)

	Minimum lease payments		**Present value of minimum lease payments**	
Group and Trust	**31 March 2012**	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
Gross lease liabilities	-	7	-	6
Of which liabilities are due:				
Not later than one year	-	7	-	6
Later than one year, not later than five years	-	-	-	-
Later than five years	-	-	-	-
Net finance charges allocated to future periods	-	-	-	-
Net lease liabilities	-	7	-	6
Not later than one year	-	7	-	6
Later than one year, not later than five years	-	-	-	-
Later than five years	-	-	-	-

28. Private finance initiative contracts

28.1 PFI schemes on-statement of financial position

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 was to deliver a modern, state of the art acute hospital facility on the QE site which is now fully operational as at the reporting date. This is part of a wider PFI deal between the Trust, Birmingham & Solihull Mental Health Trust and a consortium led by Consort Healthcare (Birmingham) Limited. The ownership of the consortium entity is as follows:

Balfour Beatty Infrastructure Investments Ltd (40%), HSBC Infrastructure Fund (30%) and Royal Bank of Scotland Investments Ltd (30%).

The contracted value of the new PFI hospital is £584,600,000 (of which £484,889,000 is capital and £99,711,000 are fees and finance costs incurred prior to 15 June 2010). The 'Queen Elizabeth Hospital Birmingham' was handed over in three phases:

- phase 1 on 15 June 2010 and phase 2 on 17 November 2010 were delivered on schedule and were complete as at the prior reporting date.
- phase 3 on 11 October 2011 was delivered on schedule and is complete as at the reporting date.

As at the reporting date there were 161 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.

Total obligations for on-statement of financial position PFI contracts due:

Group and Trust	**31 March 2012**	31 March 2011
	£000	£000
Gross PFI liabilities	**937,828**	856,059
Of which liabilities are due:		
Not later than one year	**30,668**	28,429
Later than one year, not later than five years	**118,430**	119,646
Later than five years	**788,730**	707,984
Net finance charges allocated to future periods	**(379,697)**	(397,197)
Net PFI liabilities	**558,131**	458,862
Not later than one year	**12,254**	10,929
Later than one year, not later than five years	**48,771**	48,378
Later than five years	**497,106**	399,555

The PFI obligation above is only that part of the unitary payment allocated to the finance lease rental, ie the annual finance expense and capital repayment of lease liability over the contract term. This apportionment of the unitary payment is described in accounting policy note 1.11 and the total unitary payment commitment, including annual service expense and lifecycle replacement is disclosed overleaf.

The annual unitary payment for the reported year of £43,893,000 (2010/11 - £25,934,000) reflects the phased opening of the new PFI hospital. The Trust will be committed to the full unitary payment upon final handover and will then be committed till the contract expires on 14 August 2046, at which time the building will revert to the ownership of the Trust. The unitary payment is subject to change based on movements in the Retail Prices Index.

The Trust is committed to making the following payments for on-statement of financial position PFI commitments during the next reporting year and until the contract expires:

Total obligations for on-statement of financial position PFI contracts due:

Group and Trust	Unitary payments		Present value of unitary payments	
	31 March 2012	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
Of which commitments are due:				
Not later than one year	**48,799**	44,013	**48,799**	44,013
Between one and five years	**194,660**	188,162	**178,751**	172,783
After 5 years	**1,432,408**	1,428,539	**772,348**	759,143
Total PFI commitments	**1,675,867**	1,660,714	**999,898**	975,939

Annual service expense for on-statement of financial position PFI contracts due:

Group and Trust	Unitary payments		Present value of unitary payments	
	31 March 2012	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
Of which commitments are due:				
Not later than one year	**12,968**	11,797	**12,968**	11,797
Between one and five years	**55,197**	50,608	**50,632**	46,471
After 5 years	**629,143**	386,714	**318,421**	205,174
Total PFI commitments	**697,308**	449,119	**382,021**	263,442

The Trust has the rights to use the Queen Elizabeth Hospital Birmingham for the length of the Project Agreement and has the rights to expect provision of the range of allied and clinical support services, including facilities management and lifecycle maintenance. In addition, the Trust has the rights to possible deductions from the unitary payment due to the non availability of the infrastructure or under performance regarding the services provided. At the end of the Project Agreement the assets will transfer back to the Trust's ownership.

28.2 PFI schemes off-statement of financial position

The Trust does not have any PFI schemes which are deemed to be off-statement of financial position at the period end.

29. Provisions

Group and Trust	Current		Non current	
	31 March 2012	Restated 31 March 2011	31 March 2012	31 March 2011
	£000	£000	£000	£000
Pensions relating to other staff	**34**	33	111	134
Legal claims	**1,512**	1,259	1,534	1,566
Other	**874**	1,062	-	-
	2,420	2,354	1,645	1,700

	Pensions relating to former directors	Pensions relating to other staff	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2011 - restated	-	167	2,825	1,062	4,054
Arising during the year	-	9	481	291	781
Used during the year	-	(35)	(180)	(145)	(360)
Reversed unused	-	-	(116)	(334)	(450)
Unwinding of discount	-	4	36	-	40
At 31 March 2012	**-**	**145**	**3,046**	**874**	**4,065**
Expected timing of cash flows:					
Within one year	-	34	1,512	874	2,420
Between one and five years	-	88	358	-	446
After five years	-	23	1,176	-	1,199

The provisions included under 'legal claims' are for personal injury pensions £1,631,000 (31 March 2011: £1,653,000), employers and public liability £365,000 (31 March 2011: £355,000) and other claims notified by the Trust's solicitors £1,050,000 (31 March 2011: £893,000). 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 £145,000 (31 March 2011: £167,000), 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 amounts in respect of NHS pay agreements £735,000 (31 March 2011: £986,000).

The prior year comparative figures are restated due to the reclassification from Provisions to Accruals of the annual leave entitlement earned but not taken by employees at the reporting date. At the prior year reporting date (31 March 2011) this amounted to £926,000; see note 23 to the financial statements on page L.

Provisions within the annual accounts of the NHS Litigation Authority at 31 March 2012 include £20,678,000 in respect of clinical negligence liabilities of the Trust (31 March 2011: £20,022,000).

30. Contingencies

There are £146,000 of contingent liabilities at 31 March 2012 which relate to amounts notified by the NHSLA for potential employer and public liability claims over and above the amounts provided for in note 29 to the financial statements on page LVI (31 March 2011: £144,000). There are no contingent assets at the reporting date (31 March 2011: £nil).

31. Events after the reporting period

The Trust does not have any events after the reporting date.

32. 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 has taken advantage of the partial exemption provided by IAS 24 'Related Party Disclosures', where the Government of the United Kingdom is considered to have ultimate control over the Trust and all other related party entities in the public sector.

The Trust considers other NHS Foundation Trusts to be related parties, as they and the Trust are under the common performance management of Monitor - part of the NHS in England. During the year the Trust contracted with certain other Foundation Trusts for the provision of clinical and non clinical support services.

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 of the NHS in England to which the Department is regarded as the parent organisation.

The Trust has had a number of material transactions with other Government Departments and local Government bodies.

These entities are listed below with a disclosure of the total balances owed and owing as at the reporting date and total transactions for the reporting year with the Trust:

Group and Trust	Receivables £'000	Payables £'000	Revenue £'000	Expenditure £'000
NHS in England				
Birmingham East and North PCT	2,769	(4)	163,812	(53)
South Birmingham PCT	1,510	-	136,025	-
West Midlands SHA	57	-	32,751	(8)
Heart of Birmingham Teaching PCT	661	(418)	28,872	(520)
Worcestershire PCT	563	-	20,739	(6)
Sandwell PCT	1,291	(94)	15,928	(130)
South Staffordshire PCT	501	-	11,078	-
Solihull PCT	538	-	9,629	-
Dudley PCT	449	-	9,123	-
Warwickshire PCT	488	-	6,138	-
Walsall PCT	638	-	7,238	-
Herefordshire PCT	1,089	-	4,507	(5)
Shropshire PCT	704	-	3,526	-
Wolverhampton PCT	2	(1)	3,614	-
Coventry PCT	-	(870)	2,168	(1)
London SHA (National Commissioning Group)	962	-	20,455	-
Birmingham Women's FT	1,648	(422)	7,082	(937)
The Royal Orthopaedic Hospital FT	228	(197)	2,572	(745)
Birmingham Children's Hospital FT	697	(611)	1,033	(3,881)
Sandwell and West Birmingham NHS Trust	558	(327)	847	(1,609)
Birmingham Community Healthcare NHS Trust	657	(377)	2,272	(479)
Birmingham and Solihull Mental Health FT	64	(280)	171	(1,615)
Heart of England FT	183	(574)	913	(2,736)
Department of Health	8	(272)	20,928	(2,163)
NHS Business Services Authority	-	-	-	-
NHS Blood and Transplant Agency	15	(1,041)	3,287	(8,274)
West Midlands Ambulance Service NHS Trust	-	(68)	25	(4,437)
NHS Litigation Authority	-	-	-	(3,492)
Other	3,893	(1,460)	23,682	(3,871)
	20,173	(7,016)	538,415	(34,962)
Other related parties - Whole of Government Accounts				
Ministry of Defence	1,812	-	15,886	(2,120)
NHS Wales	1,223	(16)	5,244	(74)
NHS Pension Scheme	-	(3,406)	-	(27,019)
Birmingham City Council	181	(195)	128	(4,536)
HMRC			1,220	(20,174)
Other	142	(21)	255	(83)
	3,358	(3,638)	22,733	(54,006)

Not included within Other Related Parties, are other receivables of £2,378,000 due to VAT refunds owed by and trade payables of £6,880,000 due to social security taxes owed to HMRC at the reporting date. VAT and employee payroll taxes are not considered as trading with HM Government related parties, the £20,174,000 of expenditure with HMRC is the employer NI contribution only.

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 2012 has resulted in a net income to the Trust of £2,110,314.

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 2011/12, was also a non-executive director of the Trust.

The financial statements of the parent (the Trust) are presented together with the consolidated financial statements and any transactions or balances between group entities have been eliminated on consolidation. The board members of Pharmacy@QEHB Ltd include the following directors from the Trust: Mike Sexton as chair, David Burbridge as company secretary and Kevin Bolger as a non-executive.

Pharmacy@QEHB Ltd does not have any transactions with any NHS or other Government entity except those with its parent, the Trust and HMRC (payroll and social security taxes). The Trust's receivables includes £2,876,000 (31 March 2011 - £nil) owed by the subsidiary and the Trust's payables includes £240,000 (31 March 2011 - £nil) owed to the subsidiary.

33. Financial instruments and related disclosures

The fair value of a financial instrument is the price at which an asset could be exchanged, or a liability settled, between knowledgeable, willing parties in an arms-length transaction. All the financial instruments of the Trust are initially measured at fair value on recognition and subsequently at amortised cost. The following table is a categorisation of the carrying amounts and the fair values of the Trust's financial assets and financial liabilities:

Carrying values by category of financial instruments		Group		Trust	
		31 March 2012	31 March 2011	**31 March 2012**	31 March 2011
	Notes	**£000**	£000	**£000**	£000
Current financial assets					
Cash and cash equivalents	1	**67,696**	62,009	**66,728**	62,009
Loans and receivables:					
Trade and receivables	1	**31,557**	51,731	**33,633**	51,731
		99,253	113,740	**100,361**	113,740
Non-current financial assets					
Loans and receivables:					
Trade and receivables	1	**2,922**	2,864	**2,922**	2,864
		2,922	2,864	**2,922**	2,864
Total financial assets		**102,175**	116,604	**103,283**	116,604
Current financial liabilities					
Financial liabilities:					
Finance leases	2	**-**	7	**-**	7
Private Finance Initiative contracts	2	**12,254**	10,928	**12,254**	10,928
Trade and other payables	1	**71,225**	64,185	**71,457**	64,185
Provisions under contract	1	**3,545**	3,150	**3,545**	3,150
		87,024	78,270	**87,256**	78,270
Non-current financial liabilities					
Financial liabilities:					
Finance leases	2	**-**	-	**-**	-
Private Finance Initiative contracts	2	**545,877**	447,934	**545,877**	447,934
Provisions under contract	1	**3**	10	**3**	10
		545,880	447,944	**545,880**	447,944
Total financial liabilities		**632,904**	526,214	**633,136**	526,214
Net financial assets / (liabilities)		**(530,729)**	(409,610)	**(529,853)**	(409,610)

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

(1) Fair values of cash, trade receivables, trade payables and provisions under contract are assumed to approximate to cost due to the short-term maturity of the instruments.

(2) Fair values of borrowings - finances leases and private finance initiative contracts, are carried at amortised cost. Fair values are estimated by discounting expected future contractual cash flows using interest rates implicit in the contracts. The maturity profile of both finance lease and private finance initiative contract liabilities are disclosed in notes 27 and 28.1 to the financial statements on pages LIII and LIV respectively.

The financial assets and financial liabilities of cash and cash equivalents, finance leases and private finance initiative contracts all equate to the amounts disclosed on the statement of financial position and supporting notes to the financial statements. Trade receivables, trade payables and provisions include non-financial assets and liabilities not disclosed in the table above. The reconciling amounts are as follows:

- Trade receivables includes prepayments which are not a financial instrument, see note 20 to the financial statements on page XLVII.
- Trade payables includes receipts in advance and PDC payable which are not financial instruments, see note 23 to the financial statements on page L.

- Provisions includes liabilities incurred under legislation, rather than by contract - early retirements due to ill health or injury. These are not considered by HM Treasury to fit the definition of a financial instrument, see note 29 to the financial statements on page LVI.

Risk management policies

The Trust's activities expose it to a variety of financial risks, though due to their nature the degree of the exposure to financial risk is substantially reduced in comparison to that faced by business entities. The financial risks are mainly credit and inflation risk, with limited exposure to market risks (currency and interest rates) and to liquidity risk.

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. The main responsibilities of the Trust's treasury operation are to:

- Ensure adequate liquidity for the Trust,
- Invest surplus cash, and
- Manage the clearing bank operations of the Trust.

(i) Credit risk

As a consequence 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 exposed to a degree of customer credit risk, but substantially less than that faced by business entities. In the current financial environment where PCT's must manage increasing healthcare demand and affordability within fixed budgets, the Trust regularly reviews the level of actual and contracted activity with the PCT's to ensure that any income at risk is discussed and resolved at a high level at the earliest opportunity available.

As a majority of the Trust's income comes from contracts with other public sector bodies, see note 2 to the financial statements on page XXX, there is limited exposure to credit risk from individuals and commercial entities. The maximum exposures to trade and other receivables as at the reporting date, are disclosed in note 20 to the financial statements on page XLVII. The Trust mitigates its exposure to credit risk through regular review of receivables due and by calculating a bad debt provision.

In accordance with the Trust's treasury policy, the Trust's cash is held in current accounts at UK banks only. There are no cash or cash equivalent investments held, the result being to minimise the counter party credit risk associated with holding cash at financial institutions.

(ii) Inflation risk

The Trust's has exposure to annual price increases of medical supplies and services (pharmaceuticals, medical equipment and agency staff) arising from its core healthcare activities. The Trust mitigates this risk through, for example, transferring the risk to suppliers by contract tendering and negotiating fixed purchase costs (including prices set by nationally agreed frameworks across the NHS) or reducing external agency staff costs via operation of the Trust's own employee 'staff bank'.

The unitary payment of the new 'Queen Elizabeth Hospital Birmingham' private finance initiative contract is subject to change based on movements in the Retail Prices Index (RPI), as disclosed in note 28.1 to the financial statements on page LIV. For the reporting year the relevant RPI index was 231.3 (annualised

rate of 5.5%) fixed at February 2011. The sensitivity of the Trust's retained surplus and taxpayers equity to changes in this RPI inflation rate are set out in the following table:

RPI sensitivity analysis	Year Ended 31 March 2012		Year Ended 31 March 2011	
	£000	**£000**	**£000**	**£000**
	+1.0%	**-1.0%**	+1.0%	-1.0%
Retained surplus / (deficit)	**(417)**	**419**	(317)	318
Taxpayers' equity	**(417)**	**419**	(317)	318

(iii) Market risk

The Trust has limited exposure to market risk for both interest rate and currency risk

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 nor investments and all Trust cash is held in Sterling at UK banks: Barclays bank and the Government Banking Service 'GBS'. The Trust therefore has minimal exposure to currency rate fluctuations.

Interest rate risk - other than cash balances, the Trust's financial assets and all of its financial liabilities carry nil or fixed rates of interest. Cash balances at UK banks earn interest linked to the Bank of England base rate. The Trust therefore has minimal exposure to interest rate fluctuations.

(iv) 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 ensures that it has sufficient cash or committed loan facilities to meet all its commitments when they fall due. This is achieved by the Trust's compliance with the Prudential Borrowing Code made by Monitor, the Independent Regulator of NHS Foundation Trusts, detailed in note 26 to the financial statements on page LII. The Trust is not, therefore, exposed to significant liquidity risks.

(v) Capital management risk

The Trust's capital is 'Public Dividend Capital' (PDC) wholly owned and controlled by the Department of Health, there is no other equity. The 3.5% cost of capital - the 'PDC dividend' is disclosed in note 11 to the financial statements on page XL. Therefore, the Trust does not manage its own capital. Liquidity risk and the funding of the Trust's activities are described above.

34. Third Party Assets

The Trust held £2,963 of cash at 31 March 2012 (31 March 2011: £2,963) which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

35. Losses and Special Payments

There were 2,311 cases of losses and special payments (2010/11 - 2,389 cases) totalling £377,120 (2010/11 - £236,000) 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.

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: David Bennett (Chairman) Dated: 31 March 2012

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' (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 Annual Governance Statement 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: David Bennett (Chairman)   Dated: 31 March 2012