This annual report covers the period
1 April 2012 to 31 March 2013

University Hospitals Birmingham NHS
NHS Foundation Trust

Annual Report and Accounts 2012 / 2013

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

University Hospitals Birmingham NHS Foundation Trust
Annual Report and Accounts 2012/2013

Contents

Section 1 – Annual Report

Directors' Report

1. Overview 1
2. Management Commentary 4
3. Financial Review 21

Governance 25

Council of Governors 29

Board of Directors 32

Audit Committee 38

Nominations Committees 41

Membership 42

Staff Survey 45

Regulatory ratings 48

Public Interest Disclosures 51

Section 2 – Remuneration Report 57

Section 3 – Quality Report 63

Section 4 – Consolidated Financial Statements 137

Annual Governance Statement V

This annual report covers the period
1 April 2012 to 31 March 2013

University Hospitals Birmingham NHS
NHS Foundation Trust

Section 1 **Annual Report 2012/2013**

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 Financial Officer: Mike Sexton
Executive Medical Director: Dr David Rosser
Executive Director of Delivery: Tim Jones
Executive Chief Nurse: Kay Fawcett
Executive Chief Operating Officer (interim): Andrew McKirgan (from 10 September 2012)
Executive Director of Strategic Operations: Kevin Bolger (from 10 September 2012)

Non-Executive Directors:

Professor David Bailey
Gurjeet Bains
David Hamlett
Angela Maxwell
David Ritchie
David Waller
Professor Michael Sheppard

1.2 Principal activities of the Trust

University Hospitals Birmingham NHS Foundation Trust (UHB) is recognised as one of the leading hospitals in Europe and has an international reputation for quality of care, informatics/IT, clinical training and research.

UHB provides direct clinical services to over 800,000 patients every year, serving a regional, national and international population. It is a regional centre for cancer, trauma, renal dialysis, burns and plastics and has the largest solid organ transplantation programme in Europe.

UHB employs around 8,000 staff and has successfully transferred its services from two hospitals, a mile and a half apart, into the UK's newest and largest single site hospital. The £545m Queen Elizabeth Hospital Birmingham opened its doors to patients on June 16, 2010, has 1,213 inpatient beds, 32 operating theatres and a 100-bed critical care unit, the largest co-located critical care unit in the world.

UHB is also the home of the UK's first and only National Institute for Health Research Centre for Surgical Reconstruction and Microbiology and the hospital celebrated its first year anniversary as one of the UK's 22 major trauma centres in March 2013.

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 Royal Centre for Defence Medicine's (RCDM) Clinical Unit, hosted by University Hospitals Birmingham NHS Foundation Trust, is the primary receiving unit for all military patients that are injured overseas. In addition to operational casualties UHB accepts non-operational casualties from around the world and routine military referrals from the West Midlands region.

The combined experience of the military and medical staff and the civilian doctors, nurses and allied health professionals working together means RCDM/UHB strive to deliver the best in care in the country. The hospital is at the leading edge in the medical care of trauma injuries and the experience gained by the staff working in this busy acute care environment provides the ideal training required for operations in Afghanistan.

RCDM has approximately 380 uniformed personnel – mainly clinical, but around 50 in the headquarters and some working in academic positions throughout Birmingham.

The majority of military patients will receive their treatment on the military-managed ward at the QEHB. However the over-riding priority is to ensure that the individual receives the most appropriate care and therefore some patients will be based on other wards within QEHB and occasionally other hospitals in Birmingham. Preference will be given to military patients when allocating beds on the military-managed wards, but where there is capacity, civilian patients are also treated on this ward.

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's comprehensive research portfolio builds on a long history of achievement and enhances our long-standing global reputation for the range of healthcare services we deliver.

Our research expertise is widespread: from Burns, Critical Care and Liver Surgery to Renal Medicine, Diabetes and Sexual Health, across a whole range of specialties in between.

Coupled with this extensive knowledge platform is a real push to put research at the core of everything UHB does. In raising awareness among all staff of its extensive research agenda, in turn the Trust aims to engage patients who will benefit from taking part in clinical trials. The diversity of the population it serves allows the Trust to recruit effectively to establish robust trials with valid and timely outcomes to benefit not just its patients but the whole of the NHS.

In November 2011 UHB and the University of Birmingham formed Birmingham Health Partners (BHP) to bring together clinical, scientific, and academic excellence to advance medical research and improve patient outcomes.

By optimising the delivery of translational research the collaboration also acts as a focal point for partnerships with the private sector to accelerate the 'concept to commercialisation' of new developments.

BHP currently hosts the largest Wellcome Clinical Research Facility in the UK, a national research unit in Liver Disease, the largest specialist Cancer Trials Unit in the UK and a National Centre for Trauma Research.

1.4.1 Funding

In July 2012 the Government announced support for the creation of a new world-class clinical research facility co-located within the Trust and University of Birmingham campus as part of the City Deal funding allocation.

The centre, due to open in June 2015, will help progress the very latest scientific research findings from the combined expertise of the University and Trust into enhanced treatments for patients across a range of major health issues including cancer and liver disease.

The Institute will build on Birmingham's excellent track record in clinical trials by

increasing capacity and enabling more patients to be co-located alongside clinicians and researchers. It will also make it easier for both SME and large pharmaceutical and biotechnology firms to work more closely with clinicians and academics, bringing additional investment into the city.

In December 2012 the Trust and its partners were awarded an £800,000 research grant and designated a Healthcare Technology Cooperative (HTC).

The HTC scheme is run by the National Institute for Health Research (NIHR) and provides funding to NHS organisations to act as centres of expertise, developing new concepts which are applicable across the NHS. The funding has been awarded for a four-year period starting in January 2013.

The QEHB Charity continues to support the Trust's research agendas, and has provided pump-priming for a number of research projects that have gone on to receive larger NIHR or Medical Research Council funding as a direct result of the research funded by the charity.

In summary, during the year the Charity funded nearly £0.5m of research grants and infrastructure.

1.4.2 Public engagement

The Trust's extensive and innovative Research and Development portfolio enables it 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 2012/13, UHB has been able to deliver benefits to patients on clinical trials including reduced symptoms, improved survival times and improved quality of life. These include patients with prostate cancer, cancers of the blood, relapsing remitting multiple sclerosis (RRMS) and Hepatitis C Virus (HCV) infection.

In January 2013 the Trust appointed Professor Phil Begg, its first ever Head of Academic Innovation, Research/Education. In March 2013 he established a Public Patient Involvement Research Task and Finish Group to develop a plan to increase the awareness and participation of patients and their relatives in research within the Trust.

The group will build on existing frameworks to raise awareness and increase participation from patients and their families and to disseminate research findings and share innovation.

In January 2013 the Trust supported a PPI event hosted by Theme 1 of the NIHR CLAHRC (Collaborations for Leadership in Applied Health Research and Care) for Birmingham and the Black Country.

The Trust's successful annual Research Showcase in March 2012 will be followed by a bigger and more diverse event in May 2013, with members of the public, patients and staff invited to see how their involvement in research can make a real difference to the healthcare of future generations.

1.4.3 Clinical Trials

The number of patients receiving NHS services provided or sub-contracted by UHB that were recruited during 2012/13 to participate in research approved by a research ethics committee was 8,598.

The number of clinical research projects registered with the Trust's Research and Development (R&D) Team during 2011/12 was 196 and during 2012/13 it was 286. The total number of patients recruited to clinical trials during 2012/13 was 8,598 (2011/12: 6,811).

Through the work of the R&D team the number of new R&D studies registered has increased by 90 and the number of patients recruited has increased by 2,440 since 2011/12. The R&D team will continue to increase recruitment during 2013/14 to ensure that the Trust makes the most of all research opportunities available.

2. Management Commentary

2.1 Trust Development and Performance in 2012/13 and Position at Year End

The Trust has continued to build upon its work to deliver its vision, values, and core purposes during the financial year. This has been achieved through the development and delivery of the Annual Plan for 2012/13 which forms part of the overall Trust's five-year strategy. The main objective of the strategy and plan continues to be the Trust's vision to deliver the best in care.

Each core purpose within the Trust Strategy and 2012/13 Annual Plan 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 of care through the use of 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 2012/13 objectives and has achieved the following:

- **Infection Control:** a 14% reduction in the number of *C. difficile* cases compared to 2011/12
- **Pressure Ulcer Reduction**: at least a 5% reduction in hospital acquired grade 3 and 4 pressure ulcers
- **Dementia Care**: greater than 90% compliance against requirements for screening, assessment, and onward referral for specialist diagnosis for patients with suspected dementia
- **Patient Experience**: a continued improvement in performance in the national Inpatient Survey score and positive responses received in the Trust local patient feedback surveys
- **Quality Priorities**: good progress in relation to three of its five quality improvement priorities: improving patient experience and satisfaction, completeness of observation sets and infection prevention and control. Performance in reducing medication errors and improving venous thromboembolism prevention remained stable during 2012/13
- **Commissioning for Quality and Innovation Indicators (CQUINS)**: successful delivery of the majority of the CQUIN schemes agreed with commissioners
- **Information for Patients and Shared Decision Making**: launch of the myhealth@QEHB system giving patients in long-term care access to much of their clinical information held at the hospital, including their letters and laboratory results. Patients can submit information direct to their consultant, allowing their consultant to instantly see the updates and respond where necessary. They can also store and share files about their health on the system, view and add their own appointments at, and away from, the hospital, as well as receive reminders. Over 1,300 patients have already signed up to use the system
- **Digitisation of Patients Records**: significant

progress in the digitisation of patients medical records enabling real time access to and analysis of clinical data

- **System Automation**: improved quality and efficiency through the automation of services/systems
- **New Technologies**: continued the implementation of advanced technologies for the treatment of cancer such as Cyberknife and Tomotherapy with the first Cyberknife patient due to be treated in July 2013
- **Career Opportunities**: more than 130 unemployed people taking up employment following training offered by the Trust's Learning Hub over the last year. In addition more than 500 training qualifications have been awarded. The Trust has also focussed on providing opportunities to marginalised groups
- **Staff training**: seen significant improvement in mandatory training completion rates with the average completion rate for each indicator increasing by 17% over the last 12 months. More than 1,900 staff received customer care training and 1,800 received training in equality and diversity over the year
- **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 development of the 2012/13 Trust Annual Plan 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 change of government 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 Financial Challenge

The country continues to experience weak economic growth 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 region, 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 QEHB unitary payment ('mortgage' on the new hospital) provides further pressure 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 commissioners and work jointly through the uncertainty while the reform settles.

2.2.2 NHS Regulatory Changes

Following the passing of the Health and Social Care Act, Monitor has now taken on its role as the sector regulator for health with its primary duty being to protect and promote the interests of patients. Monitor continues to have a role in assessing NHS trusts for foundation status and ensuring that existing foundation trusts are well run. In addition Monitor now licenses foundation trusts and UHB was licensed from 1 April 2013. Monitor is also responsible for setting prices for NHS-funded care, promoting integrated care, preventing anti-competitive behaviour and taking action if a provider gets into financial difficulties. This was seen with the placing of Mid Staffordshire NHS Foundation Trust into administration soon after these new powers were introduced.

The Care Quality Commission (CQC) continues to regulate 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. Over the last year the CQC has continued its move to regularly inspecting services from its previous model of self-certification.

2.2.3 NHS Commissioning Context

The structural changes that have taken place over the last year have had a fundamental effect on the relationship between providers of healthcare services, such as UHB, and their commissioners. The Operating Framework for 2012/13 set out the priority areas for the NHS to improve performance over the year. As the former structure of Primary Care Trusts (PCTs) was replaced by first PCT clusters and then Clinical Commissioning Groups, commissioners have found themselves under increasing pressure from the Local Area Teams (initially part of the cluster Strategic Health Authorities which is now NHS England) to apply the contractual levers available to them in the Acute Contract.

This forms part of a trend for greater accountability for quality that results from both the NHS reforms and the outcome of the Francis Inquiry into the Mid Staffordshire NHS Foundation Trust. The Trust has therefore found that it is under greater scrutiny than ever before from Monitor, the Care Quality Commission and commissioners to ensure that standards of quality and performance are maintained and improved.

The Trust maintains a strong relationship with commissioners and over 2012/13 the Joint Clinical Commissioning Group continued to meet to discuss proposals to improve the quality of care through the redesign of pathways.

2.2.4 Urgent Care Models

2012/13 saw the highest levels of emergency activity in recent years. This has been recognised as a national issue. Work is being undertaken regionally to address the rising demand for emergency care across healthcare organisations and ensure that pathways and provision are configured effectively to manage and meet demand and ensure that quality is being maintained. This is a significant challenge for healthcare providers and their partners such as social care. UHB has been required to open additional capacity in both the QEHB and the retained estate in order to meet demand. During 2012/13 the Trust responded to the increased demand by opening inpatient capacity on Ward 620 in the QEHB and on Harborne and Bournville Wards in the retained estate. In addition estates work was completed on wards West 1 and West 2 in preparation for these to be opened, if required. The Trust has taken these steps to reduce the risk of operations being cancelled and delays in the A&E department.

2.2.5 Clinical Quality

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.

In 2012/13 the Trust continued to build on the strong approach to quality improvement by enhancing and expanding the existing systems and processes. UHB has also continued to support its quality agenda and drive innovation through the digitisation of the patient record, development and use of digital decision support systems such as PICS and reporting tools such as HED in order to drive improvements in quality outcomes. The Trust continues to work collaboratively with commissioners to improve identified pathways and effective progress was made to redesign a range of pathways in order to improve the quality of care, patient experience, and efficiency. The Trust's Quality Report is included in Section 3 of this document and provides additional detail on UHB's quality priorities.

In 2013/14, as part of its quality objectives, the Trust is planning to deliver further enhancements to digital systems, develop and implement an external website containing performance against key quality indicators (mystay@QEHB), strengthen governance and assurance processes overall for performance and quality, work with commissioners to improve pathways focussing on pre-operative assessment and discharge, and implement new clinical technologies such as Cyberknife.

2.2.6 Patient Experience

Over 2012/13 the Trust undertook work to strengthen the governance and assurance systems in place to make sure there are high levels of patient experience. Part of this included the delivery of the Trust's Customer Care Strategy which resulted in 1,900 members of staff receiving customer care training. The Mystery Patient programme was also expanded.

As well as delivering metric-based quality outcomes, there is a need to improve the overall patient experience across the NHS. Again UHB has focussed on developing its systems for collating patient feedback information at a local level as well as participating in national patient experience surveys. Improvements in the scores across these surveys were seen, demonstrating that patients are more satisfied with their experience of care at UHB. The Trust further focussed on involvement with decision-making through expanding the roll-out of the myhealth@QEHB initiative.

Work was also undertaken to ensure the Trust is addressing equality and diversity requirements, improving care for hard-to-reach groups working collaboratively with the relevant groups and communities, and incorporating social inequality as part of the Trust's work on Equality and Diversity.

In 2013/14, the Trust will be working to further improve processes for maximising opportunities for patient feedback, assessing and addressing issues highlighted, and sharing good practice. Also, the objectives include a focus on further improving discharge processes, the health and wellbeing of patients, and safeguarding. Work will also continue on meeting equality and diversity requirements of patients.

With regard to patient pathways, there will be a focus on improving streamlining these internally and externally with partners. Resource utilisation will form part of this where performance around theatre and clinic capacity usage will be monitored.

The QEHB 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.

2.2.7 Workforce

The Trust has continued to work to achieve the required standards around attendance, performance, mandatory training, and appraisal 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. The Trust has a track record of attracting new entrants via initiatives such as the Learning Hub and this work will continue.

The automation of workforce systems such as me@QEHB made further progress in 2012/13 with an expansion in its functionality. Innovative solutions have been implemented to support education and training requirements for staff. An example of this is the use of electronic prescribing information to identify practice where further education is required within the junior medical workforce. This has supported the quality agenda around error reduction. Leadership programmes across a range of staff groups also continue to be implemented.

UHB has had an active participation in the Local Education and Training Board (LETB) and Local Education and Training Council (LETC) which has particularly been driven by the significant changes of the educational element to the health reforms.

Going forward in 2013/14, the Trust will further develop automation processes for workforce management including developing a master staff index. The requirement for a system to be in place to meet the General Medical Council (GMC) revalidation requirements for consultant medical staff is a significant project and work has already commenced on this.

Work will continue to deliver a plan in response to funding changes from the introduction of tariffs for clinical education. In addition, the Trust will develop a five-year Workforce Development Strategy in line with the refreshed Trust service development strategy and evolving clinical developments. Staff health and wellbeing and availability of the workforce will also continue to be priorities for the organisation. There will continue to be a focus on quality and profile of educational programmes delivered by UHB while supporting other organisations to deliver their education and training agendas.

2.2.8 Collaboration and Integration

The Trust has continued to work in partnership with other local providers including primary and social care. Strong links with the Trust's commissioners and local GPs are maintained through the Joint Clinical Commissioning Group. Work continues to redesign pathways and over the last year work on avoiding emergency admissions has continued with the expansion of Acute Medical Clinics in the Clinical Decision Unit and their development to also include surgical patients.

2.2.9 Reputation

The Trust has been undertaking work to obtain local, national, and international recognition. It has cemented its local reputation and this has been reflected in the increasing levels of both elective and emergency activity over the last year. At a national level, the Trust is recognised for its work with the military, quality outcomes, and research and development. Internationally, UHB's reputation has grown further, particularly in research with its increased participation in international and European research studies. Its reputation has also grown in the area of education and training with overseas medical staff receiving specialist education in partnership with the Trust.

2.3 Performance against key healthcare targets

The Trust achieved all targets and indicators included in Monitor's Compliance Framework for the full year 2012/13 (with the exception of the target for 95% of patients attending A&E to have a maximum waiting time of four hours) and treated more patients than ever before.

National targets and regulatory requirements	Time Period for 2012/13	2012/13 Performance	2012/13 Target	2011/12 Performance	2011/12 Target
Clostridium difficile (post-48 hour cases)	Apr 2012 – Mar 2013	73	76	85	114
MRSA (post-48 hour cases)	Apr 2012 – Mar 2013	5	5	4	7
62-day wait for first treatment from urgent GP referral: all cancers	Apr 2012 – Mar 2013	86.2%	85%	85.3%	85%
62-day wait for first treatment from consultant screening service referral: all cancers	Apr 2012 – Mar 2013	95.2%	90%	94.7%	90%
31-day wait from diagnosis to first treatment: all cancers	Apr 2012 – Mar 2013	97.2%	96%	97.2%	96%
31-day wait for second or subsequent treatment: surgery	Apr 2012 – Mar 2013	96.8%	94%	98.1%	94%
31-day wait for second or subsequent treatment: anti cancer drug treatments	Apr 2012 – Mar 2013	99.8%	98%	99.7%	98%
31-day wait for second or subsequent treatment: radiotherapy	Apr 2012 – Mar 2013	99.3%	94%	99.9%	94%
Two week wait from referral to date first seen: all cancers	Apr 2012 – Mar 2013	96.3%	93%	98.0%	93%
Two week wait from referral to date first seen: breast symptoms	Apr 2012 – Mar 2013	98.2%	93%	98.6%	93%
18-week maximum wait from point of referral to treatment (admitted patients)	Apr 2012 – Mar 2013	94.9%	90%	95.6%	90%
18-week maximum wait from point of referral to treatment (non-admitted patients)	Apr 2012 – Mar 2013	99.1%	95%	98.3%	95%
18-week maximum wait from point of referral to treatment (incomplete pathways)	Apr 2012 – Mar 2013	95.7%	92%	94.1%	92%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	Apr 2012 – Mar 2013	94.95%	95%	96.1%	95%
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	Apr 2012 – Mar 2013	Certification made	N/A	Certification made	N/A

Numbers of patients treated in 2012/13

Activity Type	2011/12	2012/13	Change
Inpatient Finished Consultant Episodes	118,504	126,309	+6.59%
Outpatient attendances	544,876	585,488	+7.45%
A&E Attendances	87,744	94,666	+7.89%
Total treatments	751,124	806,463	+7.37%

There were no significant changes in the services offered by the Trust over the year 2012/13 therefore the increase in activity seen reflects a genuine growth in activity.

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.

These reports adopt a risk-based approach to reporting to ensure that the consequences of underachievement are highlighted to the Executive Team and Board of Directors as well as the actions that are in place to improve performance. Findings from Care Quality Commission assessments are also reported. The framework provides a good level of assurance and supports effective decision-making. 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 groups report to the Board of Directors and provide additional assurance and effective accountability around clinical quality and the patient experience. See the Trust's Quality Report for further details.

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

2.5 Regulatory Action

The Care Quality Commission inspected the Trust's services in November 2012 against the following outcomes from its Essential Standards of Quality and Safety:

- **Outcome 1**: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run
- **Outcome 4**: People should get safe and appropriate care that meets their needs and supports their rights
- **Outcome 5**: Food and drink should meet people's individual dietary needs
- **Outcome 6**: People should get safe and coordinated care when they move between different services
- **Outcome 9**: People should be given the medicines they need when they need them, and in a safe way
- **Outcome 10**: People should be cared for in safe and accessible surroundings that support their health and welfare
- **Outcome 13**: There should be enough members of staff to keep people safe and meet their health and welfare needs
- **Outcome 16**: Assessing and monitoring the quality of service provision

The services inspected were found to be compliant with all the outcomes considered with the exception of Outcome 16. The CQC judged that the Trust did not meet this standard but that the non-compliance had a minor effect on patients. An action plan was developed and action taken to ensure that the Trust is compliant with the outcome. Confirmation that the Trust was compliant was submitted to the CQC in January 2013 however the CQC has yet to confirm whether or not it judges the Trust to now be compliant.

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 held with NHS South Birmingham and Midlands and East Specialised Commissioning for the provision of services the Trust is required to report its performance against a number of targets in its monthly Service Quality Performance Report.

The Trust achieved all targets for the full year 2012/13 with the following exceptions:

- Total time spent in A&E - % waiting 4 hours or less
- Elective surgery cancelled for non-clinical reasons as % of elective admissions
- Stroke patients spending 90% of length of stay on the stroke unit
- TIA patients scanned and treated within 24 hours

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 and stroke) the Trust has undertaken joint working to identify how performance can be improved across the system. The Trust's commissioners raised formal contract queries in relation to A&E performance and Cardiac Surgery waiting times but in each case the Trust has taken action to the satisfaction of its commissioners and no further contractual action has been taken under the terms of the contract.

2.7 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 one of Birmingham's largest employers. 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 care 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.

2.7.1 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 – have to offer to unemployed people, particularly those living in the most disadvantaged parts of the city. The training projects now in the Learning Hub have enabled almost 1,500 people to gain a job – with 155 trainees gaining employment in 2012/13.

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. A key example of this during 2012/13 was pre-employment training for apprentices on behalf of Birmingham Community Healthcare Trust.

The majority of the Learning Hub's pre-employment training provides induction and placement in a ward, technical or administrative area. Experience shows this is invaluable in gaining unemployed people a job. Recently placements have added to the Building Health programme which provides entry level training for Healthcare Assistants. Some 62 unemployed Learning Hub clients gained a job as a Healthcare Assistant during 2012/13.

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's Inspired programme continues to provide long-term patients with educational and vocational skills and mentoring support whilst being treated. Some 101 patients were provided with information, advice

and guidance during 2012/13. Additionally, the Learning Hub works closely with representative bodies of those with a disability. The Learning Hub has significantly contributed to the Trust's Diversity and Equal Opportunities Strategy.

2012/13 has seen the Learning Hub focus more particularly on the young unemployed (18-24-year-olds). This reflects the very high rates of youth unemployment across Birmingham. UHB was a member of the Birmingham Commission for Youth Unemployment set up by the City Council which reported in early 2013 with substantive recommendations including the establishment of a Birmingham Jobs Fund.

The Learning Hub continued to work successfully during 2012/13 with Health Tec at Harborne Academy to broaden access for young people to the jobs and training healthcare can offer, as well as promote young people's awareness of their own health and wellbeing and active citizenship.

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.

2.7.2 Increasing Prosperity

Adjacent to the University of Birmingham, the new hospital has created one of the largest academic/medical complexes in Europe.

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 are integral to the strategy and priorities of the Birmingham and Solihull Local Enterprise Partnership (which has taken over many of the responsibilities of the former regional development agency, Advantage West Midlands) and the City Council.

The Trust is host to the Wellcome Trust's most successful clinical research facility, the largest transplant programme in Europe, a national Biomedical Research unit in liver disease, the first CRUK cancer centre, the largest specialist cancer trials unit, a national centre for trauma research, the highly successful centre for Clinical Haematology and the Royal Centre for Defence Medicine.

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.

Key outcomes of all of this have been the award by Government under its City Deal initiative of £12.5m, matched by local partners, for the establishment of an institute of Translational Medicine on the Queen Elizabeth Hospital site; and the designation by the City Council of the area centred on the Queen Elizabeth Hospital Birmingham and the University of Birmingham as a Life Sciences Campus – one of six high-growth Economic Zones across the city.

The potential prosperity benefit of this activity and investment to Birmingham and the West Midlands is huge.

The land vacated by the two old hospitals also offers further 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.

2.8 Patient Care

2.8.1 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-focussed 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, help to rest and sleep, being treated with dignity and respect, and given privacy when being treated.

Feedback from the 'Mystery Patient' programme has been used to help develop a set of customer care standards for receptionists. The patients have tested various elements of the services provided and have worked with the ambulatory care unit to test different elements of the patient pathway. A number of changes have been made to enhance the patient experience as a result of the feedback received.

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

2.8.2 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. Initiatives to standardise clinical practice have enabled the Trust to meet the national MRSA objective for 2012/13 and continue to improve performance year on year. In addition, the Trust has met its target for the reduction of cases of Clostridium difficile infection (CDI).

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.

2.8.3 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 Trustwide audit of noise at night was undertaken following national survey results that indicated that this was a problem for patients. The outcome has been the 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.

The comments patients have made about food have also been used to completely change the way meals are prepared and served and our internal surveys have shown an improvement. Every patient menu card has a small survey on the reverse to gain real-time feedback that we respond to.

2.9 Public and Patient Involvement

2.9.1 Patient and Carer Councils

The Trust has 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 Councils hosted a seminar this year to celebrate their achievements over the last year. This included a reflection on the working arrangements for the Councils and the work programmes for the next year. Membership across all Councils has increased with the total number of patient and public representatives now being 50.

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. Some members have also been involved in the Back to the Floor quality visits undertaken by the senior nursing team.

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.

2.9.2 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 facilitating consultation events to gain young people's views on developing facilities and support for young people in the hospital.

2.9.3 Mystery Patient Council

Council members have undertaken several Mystery Patient visits to test 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 restaurant facilities and therapy services this year, but plans to roll out the initiative to other departments and services in 2013/14.

2.9.4 Readership Panel

The group was established six 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 leaflet for patients referred to the Rapid Assessment, Interface and Discharge (RAID) team for mental health
- Revising the information for the hospital

information channel on the bedside televisions in wards

- Leaflet on reducing side effects of Radiotherapy
- Patient information poster – are you at risk of pressure sores?
- Hearing aid leaflets regarding assessment, fitting and aftercare
- Information leaflet on Customer Care Standards

The Panel has also been involved in the review of Trust audit documents, procedures and guidelines including:

- Procedure for the handling of patient's cash, valuables and property
- Guidelines for Urinary Continence Care for adult patients aged 16 or over
- Enhanced Recovery Programme – Recovering from Bowel Surgery
- Patient Experience Audit: Were you involved in decisions about your care?
- Patient Experience Audit: Were you given conflicting information?

2.9.5 Carers' Advisory Group

The group has continued to meet and consists of carers, members of Birmingham Carers' Association, Birmingham City Council communities department, Patient & Carer Council representatives, Governors and staff. The set of Principles for Carers, which were developed last year, have been used to formulate education and information for staff.

An assessment of the impact of this will be undertaken in 2013, and any actions for improvement implemented.

2.9.6 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.

2.9.7 Patient & Carer Consultations

Patient & 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 – Medical education
- Information for relatives of the patient at end of life

2.9.8 Volunteers from the local community

The Trust had around 570 people registered as active volunteers at the end of March 2013. 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:

- 35% male
- 24% black and Asian
- 15% under 30 years old
- 26% over 66 years old
- 13% 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 organised a fundraising event as part of National Volunteer Week, where they

were also involved in promoting and publicising the role of volunteers in the hospital. The Committee have been involved in reviewing the annual awards celebration for long service awards.

Voluntary Services commenced a new buggy service in 2012, to transport patients and visitors from the car park to the hospital main entrance. Over 14,000 individual journeys have been provided in the first 12 months and feedback from patients and visitors has been very positive.

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 the service has been demonstrated through a request from the Department of Health for the Associate Director of Patient Affairs (ADoPA) to continue to be part of the strategic group developing volunteering across health and social care. The AdoPA has also been elected for a second term to a key national role as the Chair for the National Association of Voluntary Services Managers, the organisation that leads volunteering in the NHS.

2.10 Complaints

The Trust received 752 formal complaints in 2012/13, compared with 797 in 2011/12, 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. PALS (Patient Advice & Liaison Service) has also worked hard in collaboration with Trust staff to resolve concerns locally to prevent them turning into formal complaints.

The top 3 main issues raised in complaints were:

- Perception of clinical care and treatment
- Communication and information issues
- Delay/Cancellation of In-patient appointments

The Trust is currently undertaking a thorough review of the Francis Report and its recommendations, including the implications for how it deals with complaints. This review will inform any changes the Trust considers is warranted to its approach to complaints handling and related services.

The Trust takes a number of steps to review learning from complaints and to take action as necessary. Related actions and learning from individual complaints are shared with the complainant in the Trust's written response to the complainant or at the local resolution meeting where appropriate.

Details of all actions/learning from individual complaints are shared in a wider Patient Relations report, which is presented at the relevant Division's Clinical Quality Group meeting. This report provides detailed data around complaints, concerns and compliments, as well as highlighting trends around specific issues and/or wards/departments/ specialties. Trends around staff attitude and communication for particular locations inform bespoke customer care training sessions, which are delivered by the Head of Patient Relations to ward/department staff and include anonymised quotes from actual complaints about the specific ward/department. Complaints and PALS data is also shared in a broader Aggregated Report which is presented to the Audit Committee on a quarterly basis and which also incorporates information from Risk and Legal Services regarding incidents and legal claims.

Complaints and PALS data is also reported monthly to the Care Quality Group as part of the Patient Experience report. A monthly complaints report is also presented at the Chief Executive's Advisory Group.

In addition to the customer care sessions held in response to trends highlighted in reporting noted above, the Head of Patient Relations also undertakes a number of sessions around complaints and customer care as part of existing induction and development programmes across the Trust. Over 1900 Trust staff received some form of customer care training during the year.

Please see the full details surrounding complaints in the Quality Report.

2.11 Stakeholders, Partnerships, Alliances/contractual Arrangements

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

Local Health organisations	
Birmingham and Black Country Area Team (representative of NHS England	Regular meetings between Chairs and CEOs and appropriate directors
	Member of frail elderly programme board
	Membership of working groups such as Urgent Care Review, RAID development etc.
Clinical Commissioning Groups	Within South Birmingham, participating and leading work across a range of specialties on redesigned pathways working in partnership with primary care and community trust as appropriate
	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)
	Formed Clinical Commissioning and Contracting Board with representatives from local CCGs and specialised commissioning representatives. Used to agree commissioning intentions and develop service improvement plans
	Trust's Associate Medical Director is the lead clinician with CCGs 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 CCG teams/ Boards
	Negotiation and implementation of Local Delivery Plan
	Monthly joint meetings with Community Trust to discuss capacity issues in the local health system
Specialised Commissioning Agency	Chief Operating Officer continues to hold regular meetings with the head of the SCA
	Member of major trauma network
Regional Office of NHS England	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
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
	FD 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
	Local operational manager now part of 'Front door working group'
	Trust' Executive Director of Strategic Operations 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
	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 developed
	Working with Business School to Develop MBA Programme
	Progress on ongoing discussions on various agendas are regularly reported to Board of Directors
	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 chaired the Science City Innovative Healthcare Group during 2012/13
	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 its patients on discharge
	Member of BCC commission on Youth unemployment
Skills Funding Agency and Birmingham Employer Board	UHB representation on the Birmingham Employer Board
	Apprentice training funding
JobCentre Plus	Continued effective working through the Learning Hub
	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 has raised substantial funding 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. As a Foundation 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 2012/13

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 2013 and appropriate to NHS Foundation Trusts. This is the fourth set of full year results prepared

in accordance with IFRS accounting policies. The previously reported 2011/12 financial statements have been restated where IFRS has required this; with the date of transition being 1 April 2011, which is the beginning of the comparative period for the year ended 31 March 2013.

There have been no significant amendments to accounting standards in 2012/13 affecting the Trust.

3.2 Financial Performance

Despite the challenging economic climate the Trust has again reported strong financial results for 2012/13. Total income has increased by 9.1% to £640.0m ensuring that the Trust remains amongst the largest Foundation Trusts in the country. Within this the Trust has achieved an operational income and expenditure surplus of £3.7m before impairment costs.

An impairment of (£10.0m) has been recognised in 2012/13 due to a reduction in the value of the new hospital based on the latest external valuation report. This reflects the accounting valuation, which estimates the fair value in operational use rather than an actual economic impairment of the building. Including this the Trust has recorded an overall retained deficit of (£6.3m) for the financial year.

The impairment is a technical adjustment to the accounts, rather than an actual cash payment by the Trust, and therefore the organisation remains financially sound despite the accounting deficit.

The reported 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 2012/13.

Summary income and expenditure – plan v. outturn

The Trust's Summarised Income and Expenditure (£M's)		
	Plan 2012/13	Outturn Position 2012/13
Income	597.6	639.8
Expenditure	-559.4	-593.8
EBITDA	**38.2**	**46.0**
Depreciation	-19.3	-21.1
Donated Asset Revenue	2.8	0.2
Interest receivable	0.8	0.7
Interest Payable	-21.9	-22.0
Corporation Tax	0.0	-0.1
Surplus before impairments	**0.6**	**3.7**
Impairments on Property	0.0	-10.0
Retained Deficit	**0.6**	**-6.3**

The largest component of the Trust's income is the provision of NHS healthcare, accounting for £511.5m (80.0%) of the total. Non-NHS clinical income contributes a further £11.9m (1.8%) and this includes private patients, provision of healthcare to the military and costs recovered from insurers under the Injury Cost Recovery scheme.

Following changes to the Health and Social Care Act 2012 (the 'Act'), Monitor removed the requirement for foundation trusts to limit private patients revenue as a percentage of total revenue from activities. In its place, the Act requires that a foundation trust's principal activity is to deliver goods and services for the purposes of the National Health Service in England. Therefore, this clinical revenue must exceed the total of revenues derived from all other activities ('non-principal purpose revenue').

Revenue derived from NHS clinical activity in England is £504.6m, the remaining £6.9m of NHS healthcare income is from NHS Wales, Scotland and Northern Ireland. Revenue from the NHS in England is 78.8% of the total income and therefore the Trust is significantly ahead of the minimum 50% requirement.

The Trust has a number of other income streams which are not linked directly to patient care. These include education levies which account for £33.1m (5.1%) of the Trust's income in 2012/13 and funding associated with Research and Development (R&D) activities, which totals £28.0m (4.4%). 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 the Non-Medical Education and Training (NMET) levy.

R&D income includes grants from the National Institute of Health Research, including revenue support for the Wellcome Trust Clinical Research Facility and funding for the Birmingham and Black Country Comprehensive Local Research Network, which is hosted by the Trust. The balance of the Trust's income is attributable to services provided to other NHS bodies, trading activities and other miscellaneous items.

The main variances against plan in 2012/13 include additional healthcare income, reflecting growth in emergency admissions, 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 £327.4m, equivalent to 55.1% of total expenditure. Other significant components include £75.9m on drugs (12.8%) and £79.7m on Clinical Supplies and Services (13.4%).

3.4 Capital Expenditure Plan

In 2012/13 the Trust incurred £10.7m of capital expenditure on equipment, new facilities and improvements to existing buildings. This is summarised below:

Category	Capital Invested £ Million
Brought Forward Programmes from 2011/12	**0.3**
IT Replacement, Modernisation, Infrastructure and additional capacity	**1.5**
Trust Buildings	
• Existing Estate	3.9
• New Hospital	0.7
	4.6
Trust Equipment	
• Rolling Replacement	3.4
• New Equipment	0.8
	4.2
TOTAL	**10.6**

The Trust's planned capital expenditure over the next three financial years (2013/14 to 2015/16) totals £44.1m. 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 2012/13 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 £16.8m 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 £3.6m which is no longer subject to a specific limit, as described above the new principal – non principal income legislation applies to total revenue.

3.7 QEHB Charity

The charitable funds for the Trust are administered by QEHB Charity, a separate legal entity from the Trust. In 2012/13 the Trust received grants of £0.8m and donated assets worth £0.2m 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 £180,569 of which £96,696 relates to statutory audit services, and £83,873 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 2012, 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
Chief Executive

Date: 23 May 2013

Governance

4.1 NHS Foundation Trust Code of Governance

In September 2006 Monitor, the independent regulator of foundation trusts, published the NHS Foundation Trust Code of Governance as best practice advice. The 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 2012/13. In its Annual Report, the Trust is required to report on how it applies the main and supporting principles of the Code.

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

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

4.1.1 Application of Principles of the Code

A. The Board of Directors

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

The Trust has a formal scheme of delegation which reserves certain matters to the 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 32, 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 Council of Governors, page 29 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 term of appointment of one non-executive director, Angela Maxwell, expired during the reporting year and, having only served one term, she was re-appointed for a further term of three years by the Council of Governors, on the recommendation of the Council of Governors' Remuneration and Nomination Committee for Non-Executive Directors. Details of the composition of that Committee and its activities are set out on page 41 of the Annual Report. Details of terms of office of the Directors are set out in Board of Directors, page 32, 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 17 of the Annual Report and in Membership, page 42.

4.1.2 Compliance with the Code

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

A.3.2 At least half the board of directors, excluding the chairman, should comprise non-executive directors determined by the board to be independent.

Andrew McKirgan was appointed to the Board of Directors in September 2012, as an Executive Director, making the total number of Directors, excluding the chairman, 14. Only six of the seven non-executive Directors are determined to be independent by the Board, as Professor Michael Sheppard has not been so determined as he is an appointed representative of the Trust's university medical school.

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, the Chairman, Sir Albert Bore, and two of the Non-Executive Directors, David Ritchie and Professor David Bailey have served for more than six years without being subject to annual re-election. Their current terms expire on 30 November 2014.

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.

4.2 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 the reporting year 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 in Section 3 and the Annual Governance Statement in Section 4.

Council of Governors

5.1 Overview

The Trust's Council of Governors was established in July 2004, with 37 representatives.

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.

Subsequently, 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
- 1 public Governors elected from the Rest of England area
- 3 patient Governors elected by Patient members
- 5 staff Governors elected by the following staff groups:
  - Medical
  - Nursing (2)
  - Clinical Professions Allied to Healthcare
  - Corporate and Support Services
- 6 stakeholder Governors appointed by six of its key stakeholders

Elections for 4 public and 1 patient governor seats were held in July 2012. Governors appointed to public and patient seats at these elections were appointed for terms commencing on 13 July 2012 and end on 30 June 2015.

During this year, the Governors have been:

5.1.1 Patient

Shirley Turner
Ian Fairbairn
Aprella Fitch

5.1.2 Public (by Area and Parliamentary Constituency)

Up to 30 June 2012	From 13 July 2012
Northfield	**Northfield**
Margaret Burdett	Sandra Haynes, MBE
Edith Davies	Edith Davies
Selly Oak	**Selly Oak**
Valerie Reynolds	Valerie Reynolds
John Delamere	John Delamere
Hall Green	**Hall Green**
David Spilsbury	David Spilsbury
Tony Mullins MBE	Tony Mullins MBE
Edgbaston	**Edgbaston**
John Coleman	Christine Beal
Ian Trayer	Ian Trayer
Ladywood, Yardley, Perry Barr, Sutton Coldfield, Erdington & Hodge Hill	**Ladywood, Yardley, Perry Barr, Sutton Coldfield, Erdington & Hodge Hill**
Graham Bunch	Graham Bunch
Rest of England Area	**Rest of England Area**
	Vacant (election in progress)

5.1.3 Staff

From 1 July 2010 for terms of three years

Dr Tom Gallacher (Medical Class)
Susan Price (Clinical Professions Allied to Healthcare)
Erica Perkins (Nursing Class)

Barbara Tassa (Nursing Class)
Patrick Moore (Corporate and Support Services)

5.1.4 Stakeholder

- Rabbi Margaret Jacobi, appointed by the Birmingham Faith Leaders' Group
- Jenny Ord, appointed by South Birmingham Primary Care Trust (from July 2012)
- Professor Joanne Duberley, appointed by the University of Birmingham (from June 2012)
- Vice Admiral Raffaelli, appointed by the Ministry of Defence (up to December 2012)
- Air Vice Marshal Paul Evans, appointed by the Ministry of Defence (from January 2013)
- Cllr James Hutchings, appointed by Birmingham City Council (up to June 2012)
- Cllr Elaine Williams, appointed by Birmingham City Council (from June to October 2012)
- Cllr Susan Barnett, appointed by Birmingham City Council (from January 2013)
- Ms Ruth Harker, appointed by the South West Area Network of the Secondary Education Sector in Birmingham (up to July 2012)
- Mr Richard Crookes, appointed by the South West Area Network of the Secondary Education Sector in Birmingham (from January 2013)

The Council of Governors met regularly throughout the year, holding five meetings in total. The Chairman attended all the meetings.

Name of Governor	No. of meetings attended*
Edith Davies	All
Shirley Turner	4
Dr John Delamere	All
David Spilsbury	4
Tony Mullins MBE	4
Ian Trayer	4
Aprella Fitch	4
Graham Bunch	4
Valerie Reynolds	All
Ian Fairbairn	4
Christine Beal	3 out of 4
Margaret Burdett	2 out of 2
John Coleman	0 out of 1
Richard Crookes	1 out of 1
Sandra Haynes	3 out of 4
Stakeholder Governors	
Cllr James Hutchings	1 out of 2
Susan Barnett	1 out of 1
Joanne Duberley	3 out of 4
Ruth Harker	2 out of 2
Rabbi Margaret Jacobi	2
Vice Admiral Raffaelli	1 out of 4
Surg Air Vice Marshal Evans	1 out of 1
Jenni Ord	4 out of 4
Staff Governors	
Barbara Tassa	2
Dr Tom Gallacher	2
Patrick Moore	4
Susan Price	3
Erica Perkins	3

*While a member of the Council of Governors.

5.1.5 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. Care Quality Group

5.1.6 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

6.1 Overview

Up until 10 September 2012, the Board of Directors comprised the Chairman, six Executive and seven Non-Executive Directors. An additional Executive Director was appointed to the Board of Directors on that date.

Throughout the reporting period, Professor Michael Sheppard held the appointment of Deputy Chairman and Gurjeet Bains held the appointment of Senior Independent Director. The Senior Independent Director is available to meet stakeholders on request and to ensure that the Board is aware of member concerns not resolved through existing mechanisms for member communications.

The Board is currently comprised as follows:

Chairman: Sir Albert Bore

Chief Executive: Dame Julie Moore
Chief Financial Officer: Mike Sexton
Executive Medical Director: Dr David Rosser
Executive Director of Delivery: Tim Jones
Executive Chief Nurse: Kay Fawcett
Executive Chief Operating Officer (interim): Andrew McKirgan (from 10 September 2012)
Executive Director of Strategic Operations: Kevin Bolger (from 10 September 2012)

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
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 2012	3 years	30 June 2015
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 Prof David Bailey, David Ritchie, Gurjeet Bains, Angela Maxwell, David Hamlett and David Waller to be independent. In coming to this determination, the Board of Directors has taken into account the following:

With regard to David Waller, the Board of Directors has taken into account that he, together with the Chairman, Sir Albert Bore, is a director of the NEC Group Limited. The

Board does not consider that this affects the determination that David Waller is independent.

With regard to Professor David Bailey and David Ritchie Waller, the Board of Directors has taken into account that they have each served on the board of the Trust for more than six years from the date of their first appointment, as referred to on page 27. The Board does not consider that this affects the determination that either of Professor Bailey or Mr Ritchie is independent.

6.2 Board meetings

The Board met regularly throughout the year, holding 10 meetings in total.

Directors	No. of meetings attended
Sir Albert Bore	All
Dame Julie Moore	9
Mike Sexton	8
Tim Jones	9
David Ritchie	All
Prof Michael Sheppard	9
Dr David Rosser	All
Prof David Bailey	6
Kay Fawcett	9
Gurjeet Bains	9
Angela Maxwell	9
Kevin Bolger	All
David Hamlett	All
David Waller	9
Andrew McKirgan	6 out of 6*

*While a member of the Board of Directors.

6.3 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 became the leader of Birmingham City Council in May 2012, having served in the same role from 1999-2004. He also spearheaded key regeneration projects, including Eastside and the Bullring. Sir Albert 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, Birmingham Airport and Birmingham Technology Ltd, the joint venture company developing and managing Birmingham Science Park Aston. He is also a member of the Greater Birmingham & Solihull Local Enterprise Partnership.

Dame Julie Moore, Chief Executive

Julie is a graduate nurse who worked in clinical practice before moving into management. After a variety of clinical, management and director posts, she was appointed as Chief Executive of University Hospitals Birmingham (UHB) in 2006.

Julie was a member the National Organ Donation Taskforces in 2007 and 2008 and in 2009 of the Nuffield Trust Steering Group on New Frontiers in Efficiency. She is an Independent Member of the Board of the Office for Strategic Co-ordination of Health Research (OSCHR) and a member of the following bodies: the International Advisory Board of the University of Birmingham Business School, the MoD/DH Partnership Board overseeing healthcare of military personnel, the Court of the University of Birmingham, the Faculty Advisory Board of the University of Warwick Medical School and Marketing Birmingham, a strategic partnership to drive the inward investment strategy for the city. She is a founder member and current Chair of the Shelford Group, compromising ten leading academic hospitals in England. 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 was asked to lead the follow up report.

She has spoken at numerous national and international conferences including appearing on the same programme as former US President Bill Clinton in 2012.

Julie was made a Dame Commander of the British Empire in the New Year's Honours 2012. In 2013, she was included in the BBC Radio 4's Woman's Hour's 100 most powerful women in the UK.

Executive Directors

Kevin Bolger, Executive Director of Strategic Operations

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 and in September 2012 was appointed to the new position of Executive Director of Strategic Operations to lead Regional and National service redesign and further develop the Trust's international work.

Kay Fawcett, Executive Chief Nurse

Kay qualified as a Registered Nurse in 1980 and held a series of clinical posts before moving into Nurse Education working as a Clinical Teacher and then Nurse Tutor in Leicestershire and Warwickshire. She returned to clinical work as a Lecturer Practitioner and Emergency Care Manager in 1995. In 1998, Kay became an Operational Nurse Manager at the George Eliot Hospital NHS Trust. She joined University Hospital Birmingham in 2000 as Head of Nursing going on to be Deputy Chief Nurse in 2002. In July 2005 she became Executive Director of Nursing for Derby Hospitals NHS Foundation Trust. Kay rejoined University Hospitals Birmingham in January 2008, as Executive Chief Nurse, with responsibility for Nursing, Facilities Management, Infection Prevention and Control, Patient Relations 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.

Andrew McKirgan, Executive Chief Operating Officer (Interim)

Andrew started his NHS career as a graduate on the NHS Financial Training Scheme in September 1992. Having completed the scheme in December 1995 and qualified as an accountant (CIPFA), Andrew moved into

general management and operations and held a number of posts in the North West of England including Group Manager for Renal Services and General Manager for Women and Children. He moved to UHB in April 2003 as the Deputy Director of Operations for Division 1 and in July 2006 assumed his first Director of Operations role. In 2009 he became Director of Operations, Division 2 and in April 2011 he became Deputy Chief Operating Officer. He was appointed Interim Executive Chief Operating Officer in September 2012.

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, Chief Financial Officer

Mike, who became FD in December 2006, spent five years in the private sector working for the accountancy firm KPMG and had a spell in commissioning at the Regional Specialities Agency (RSA) before joining the Trust in 1995. Over the last 18 years he has held numerous positions including Director of Operational Finance and Performance and Acting Director of Finance. Mike is also the executive lead for international affairs, commercial development, 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 was 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 coach for the National Growth Accelerator programme and for 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 a Director of Pertemps Network Group Holdings Ltd, one of the UK's largest, recruitment, training and outsourcing companies. In addition, he is Chairman of Nexus Professional Network Ltd an organisation that provides accountancy, legal and tax experts to projects and on an interim basis. He holds a number of other company appointments including the Chairmanship of Birmingham Chamber of Commerce Group, Director of the National Exhibition Centre (NEC), Director of MIRA Ltd, Chairman of Delami Investments Ltd and Chairman of Event That Ltd. He is also a trustee of Millennium Point Trust 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 was actively involved with over 200 clients of all types and sizes.

6.4 Directors' Interests

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

Audit Committee

7.1 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 David Ritchie throughout the reporting period. 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.

7.2 Membership of the Committee

The members of the Committee (i.e. all the Non-Executive Directors of the Trust, apart from the Chairman) during 2012/13 were as follows:

Mr David Ritchie (Chair)

Professor David Bailey

Mr David Waller

Ms Gurjeet Bains

The members of the Committee disclosed their interests, which included the following, in the Trust's Register of Interests:

Mr David Ritchie (Chair) – President of Governors of the Queen's Foundation for Ecumenical Theological Education and Trustee of UHB Charities.

Professor David Bailey - Chair, Director and Trustee of the Regional Studies Association

Mr David Waller - Director and part-owner, Pertemps Network Group Limited; Non Executive Director, NEC Group Limited; Executive Director and major shareholder, Nexus Professional Network Ltd; Director, Delami Investments; Non Executive Director - Mira Limited; and Chairman – Eventthat Limited; Chairman - Birmingham Chamber of Commerce & Industry Ltd; Trustee - Millennium Point Trust Ltd; Patron - St Giles Hospice

Ms Gurjeet Bains – Governor – Birmingham Metropolitan College; Chair – Sikh Educational Forum; and Trustee – Sikh Mairi Manch

The Committee's principal support officer throughout the year was the Director of Corporate Affairs. The Director of Finance, Chief Operating Officer, Executive Director of Delivery and Head of Governance, together with representatives of both the External and Internal Auditors, attended the meetings of the Committee as a matter of course. Other directors and officers of the Trust attended meetings of the Committee as and when required.

7.3 Operation of the Committee

7.3.1 Meetings and attendance

The Committee is required to meet at least four times a year. A total of six meetings took place during 2012/13 and were attended as follows:

Directors	No. of meetings attended
Gurjeet Bains	6 out of 6
Prof David Bailey	4 out of 6
David Ritchie	6 out of 6
David Waller	6 out of 6

The quorum for meetings of the Committee is three members. All meetings of the Committee during the period were quorate.

Committee members have received bespoke training by the Good Governance Institute following the governance review in 2012/13. This culminated in the completion of an annual self-assessment of the Committee's performance. An action plan will be developed to address those areas where improvements are considered necessary; the action plan will be monitored during 2013/14.

The Committee has also maintained its practice of agreeing an annual cycle of business which is designed to facilitate forward planning and to assist the Committee in ensuring that all aspects of its terms of reference are being fulfilled.

It was further agreed that, in future, the review of the Board Assurance Framework by the Board of Directors will inform the Audit Committee's agenda and formal reports will be taken to the Board of Directors' meetings following each Audit Committee meeting.

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.

7.4 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.

7.5 Auditors' reporting responsibilities

KPMG LLP, the Trust's 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

8.1 Council of Governors' Remuneration & Nominations 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 13 July 2012)	Council of Governors' Remuneration and Nominations Committee (from 13 July 2012)
Sir Albert Bore (Chairman)	Sir Albert Bore (Chairman)
Margaret Burdett (Governor Vice-Chair)	Dr John Delamere (Governor Vice-Chair)
Edith Davies	Ian Trayer
Aprella Fitch	Ian Fairbairn
Dr Tom Gallacher	Dr Tom Gallacher
Ruth Harker	Richard Crookes (from 1 March 2013)

The Remuneration & Nominations Committee met twice during the year.

Members	No. of meetings attended*
Sir Albert Bore	All
Margaret Burdett	1 out of 1
Edith Davies	1 out of 1
Aprella Fitch	1 out of 1
Dr Tom Gallacher	None
Ruth Harker	1 out of 1
Dr John Delamere	None out of 1
Ian Trayer	1 out of 1
Ian Fairbairn	1 out of 1
Richard Crookes	1 out of 1

*While a member of the Committee.

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

8.2 Nominations Sub-Committee

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

Membership

9.1 Overview

The Trust has four membership constituencies: Public, Rest of England, Patient and Staff 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

Rest of England Constituency

Rest of England members are individuals who:

a. live outside the area of the Trust but within England; and
b. are aged 16 or over; and
c. not eligible to become members of the staff constituency

Patient Constituency

Patient members are individuals who are:

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

(N.B. 1. Following changes to the Constitution approved by the Council 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.)

(N.B. 2. Following changes to the Constitution approved by the Council of Governors in September 2012, a Rest of England member may opt to become a member of the Patient Constituency).

Staff Constituency

The staff constituency is divided into four classes:

a. medical staff
b. nursing staff
c. clinical professions allied to healthcare staff
d. corporate and support services staff

9.2 Membership Overview by Constituency

Constituency	Total at 31/03/13	%
Public	11,116	46.43
Patient	4,251	17.76
Rest of England (public with no catchment)	416	1.74
Staff	8,158	34.08
Total Membership	**23,941**	**100**

*Numbers correct up to 31 March 2013

9.3 Membership Strategy

9.3.1 Background

University Hospital 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.

9.3.2 Membership development 2012/13

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 through the Trust in the Future magazine to all members.

Social media tools such as Facebook and Twitter have played an important part in improving the accessibility of membership information available in the last 12 months. Members may now receive information directly via 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. Engagement activities involve staff governors holding drop-in sessions for staff and fronting internal awareness campaigns in their role as staff governor, such as the Trust's Cycle Safe Campaign, which was launched in September 2012.

The introduction of Membership Week was a new initiative for 2012/13. This enabled the Trust to focus on the value of members and inspire others to join the programme. Information stands, recruitment activity and leaflet distribution was carried out by the Membership Office and Trust Ambassadors during November 2012.

Members continue to play an important role in obtaining patient feedback on services. Information gathered via a survey directed at foundation members contributed significantly towards the creation of myStay@QEHB – a website providing information on the quality of clinical services. Members also took part in a Trust-wide survey on public transport facilities serving the hospital site, which has resulted in improvements to local bus services and timetable information.

Evidence of the contribution members make towards improving the Trust's services can also be seen in the monthly 'You Said, We Did' articles which highlight areas of improvement made by listening to feedback. Examples of this include improving information on travel routes, providing better seating and improving visitor facilities on wards.

9.3.3 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 that. The programme also offers support to the Membership Office.

In November 2012, Ambassadors took part in the first UHB Membership Week aimed at promoting membership to patients and visitors.

Since launching the Ambassador Programme, the Trust has been approached by several NHS trusts interested in adopting a similar programme for enthusiastic members or aspiring governors.

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 and sign-up new members

In 2012/13, the Trust recruited three new Ambassadors who are actively involved in promoting the Trust through presenting at community groups, fundraising for the Queen Elizabeth Hospital Birmingham Charity, recruiting new members and giving feedback as 'mystery shoppers'.

9.3.4 Membership recruitment 2012/13

The Trust achieved its recruitment objectives agreed by the Board of Directors in April 2012. These were to replace the annual churn and maintain existing membership numbers to no less than 23,000. With a membership of 23,000, UHB would be in the top 10 of

foundation trusts with the highest number of members, based on the most recently available figures from 2011/12. The Trust would also ensure that the membership was representative of the constituencies it served.
On 1 April 2013 UHB had a total membership of 23,941, an increase of 808 members (3.5%) on the previous year (23,133 members). During the last 12 months the Trust has also created a Rest of England constituency made up of members of the public who had registered an interest in the Trust but weren't eligible for membership as they were not a patient, a member of staff or lived in one of the public constituencies which correspond to the city's parliamentary wards. There are 416 members in this new constituency.

In January 2013 UHB Membership Week was held, which aimed to raise awareness of membership and encourage existing members and staff to refer a friend or relative. Information stands were held at the Main Entrance where potential members could sign up. Membership Week was promoted to patients and visitors through the hospital's website, social media and publications and to staff via internal communication channels. This activity resulted in 150 new members.

Online communication through e-bulletins, Facebook and Twitter has resulted in a rise in online applications since the campaign began. Further promotion through UHB's communication channels and via volunteers aims to increase the number of people signing up going forward.

9.3.5 Recruitment and engagement strategy for 2013/2014

The Trust will endeavour to replace the annual churn and maintain existing membership numbers to no less than 23,000. It will ensure that the membership is representative. However, the main focus will be evidencing the outputs of the engagement with its members.

9.3.6 Engagement with members

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/patient issues
- Health Talks. Governors attend health talks which are held on a monthly basis for members and 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
- Membership Week – activities held over five days aimed at promoting membership

NHS Staff Survey

10.1 Commentary

UHB is committed to engaging its workforce and recognises 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
- Insight - 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

10.2 Summary of Performance

Each year the Trust's 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.

NHS Staff Survey Response Rate 2012 compared with 2011

2011		2012		Difference
UHB	**National Average**	**UHB**	**National Average**	
55%	55%	48%	48%	7% lower response rate but meets national average

The staff survey results are presented in the form of key findings. The survey was shortened this year so there were 28 key findings in comparison to 38 in 2011.

There are two types of key findings:

- Percentage scores
- Scale summary scores between 1 and 5

Areas of improvement from 2011 survey

	2011	2012	Difference
KF22: % of staff able to contribute to improvements at work	61%	71%	10% increase
KF1: % of staff feeling satisfied with the quality of work and patient care they are able to deliver	76%	86%	10% increase
KF23: Staff job satisfaction	3.52	3.64	0.12 scale point improvement
KF26: % of staff having equality and diversity training in the last 12 months	39%	57%	18% increase
KF24: Staff recommendation of the Trust as a place to work or receive treatment	3.80	3.93	0.13 scale point improvement

Area of deterioration from 2011 survey

	2011	2012	Difference
KF10: % of staff receiving health and safety training in the last 12 months	91%	72%	19% decrease

2012 Top 5 Ranking Scores

	2011		2012		Difference
	UHB	National Average	UHB	National Average	
KF1. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver	76%	74%	86%	78%	10% increase (improvement)
KF11. Percentage of staff suffering work-related stress in last 12 months (lower score better)	27%	29%	29%	37%	2% increase (deterioration)
KF2. Percentage of staff agreeing that their role makes a difference to patients	91%	90%	94%	89%	3% increase (improvement)
KF3. Work pressure felt by staff (lower score better)	3.07	3.12	2.88	3.08	0.29 scale point decrease (improvement)
KF24. Staff recommendation of the trust as a place to work or receive treatment	3.78	3.50	3.93	3.57	0.15 scale point increase (improvement)

2012 Bottom 5 Ranking Scores

	2011		2012		Difference
	UHB	National Average	UHB	National Average	
KF5. Percentage of staff working extra hours (lower score better)	67%	65%	73%	70%	6% increase (deterioration)
KF28. Percentage of staff experiencing discrimination at work in last 12 months (lower score better)	17%	13%	15%	11%	2% decrease (improvement)
KF15. Fairness and effectiveness of incident reporting procedures	3.49	3.46	3.49	3.50	No change
KF10. Percentage of staff receiving health and safety training in last 12 months	91%	81%	72%	74%	19% decrease (deterioration)
KF12. Percentage of staff saying hand washing materials are always available	60%	66%	59%	60%	1% decrease (deterioration)

10.3 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
- Staff group action plans to be developed to target specific issues

Divisional action plans are being agreed at present. The priority areas and action plans discussed will be monitored on a quarterly basis at the Trust's Strategic Delivery group.

10.4 Future priorities and targets

This year the Trust-wide action plan will focus on the following areas:

- Preventing discrimination with a view to reducing further the % of staff experiencing discrimination
- Communication around what constitutes health and safety training
- Targeting particular staff groups around availability of hand washing materials

Regulatory ratings

11.1 Explanation of ratings

11.1.1 Finance Risk Rating

When assessing financial risk for the period 2012/13 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.

11.1.2 Governance Risk Rating

Monitor's assessment of governance risk in 2012/13 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.

11.2 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

11.2.1 Monitor Risk Ratings in 2011/12

	APR 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
Risks declared	MRSA, 2xA&E Clinical Quality				
Targets not achieved		None	Cancer - 62 day all	None	None

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 target 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 and subsequently for the whole of 2012/13. All other targets and indicators included in Monitor's Compliance Framework for 2011/12 were met for the full year.

11.2.2 Monitor Risk Ratings in 2012/13

	APR 2012/13	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	Amber-Red	Amber-Green
Risks declared	*C. diff*				
Targets not achieved		None	*C. diff*	MRSA, *C. diff*, A&E	A&E

In its Annual Plan for 2012/13 the Trust declared a risk to achieving the *C. difficile* trajectory. This was due to the impact of two-stage testing for toxigenic *C. difficile* which commenced at the beginning of April 2012. The Trust was above its year-to-date trajectory for two quarters of the year but continued focus and challenge throughout the year contributed to year-end performance being below trajectory.
In Quarter 3 the Trust was above its trajectory for MRSA however as the total number of cases was below Monitor's de minimis limit this did not contribute to the Trust's governance risk rating for that quarter. Work

continued throughout the year to improve the management of invasive devices and ensure the optimal management of all patients with MRSA colonisation and the Trust has not had a further case of MRSA since November 2012 resulting in the Trust being in line with its trajectory by the end of Quarter 4.

Over Quarters 3 and 4 the Trust experienced unprecedented demand for its emergency services. Over this period the Trust had a total number of Emergency Department attendances that was 7% higher than the same period in 2011/12. In addition the Trust had an increase in GP admissions of 36.9%. It was not possible to predict this level of increase in demand when the Trust's annual risk assessment was undertaken. The increased demand directly contributed to the non achievement of the A&E 4 hour wait target over those two quarters. In response to these pressures the Trust has opened additional bed capacity and introduced acute medical and surgical clinics together with an Older Person's Assessment and Liaison Service to avoid admissions. The Trust has a proven track record in the delivery of the A&E target year-on-year and is confident that the steps taken and those planned will support the delivery of the 95% target in future.

All other targets and indicators included in Monitor's Compliance Framework for 2012/13 were met for the full year.

11.3 Details and actions from any formal interventions

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

Public Interest Disclosures

12.1 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 online 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.

12.2 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 Trust has taken positive action under the equality Act 2010 to facilitate employment for some disadvantaged groups. Working initially with Autism West Midlands and latterly Action for Blindness the Trust is utilising periods of work experience to 'level the playing field' during selection to enable managers to draw upon their experience of the applicant and provide an alternative source of information where an interview alone might disadvantage the applicant. To date we have employed 3 new members of staff via this route and provided work experience for a number of others who are not yet job ready.

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).

12.3 Sickness absence

The Trust recorded an annual average sickness absence of 3.9% across all clinical and corporate divisions in 2012/13; 3.96 % in 2011/12 this was at 4.28% in 2010/11. Trust management is working in partnership with Staffside to reduce this to 3% by 2014 and therefore the reduction from the previous years demonstrates our commitment and progress on reaching that target.

From May 2013 staff will also be able to access the new health and wellbeing portal which covers over 20 topic areas for advice on guidance, from bereavement to exercise and weight loss. It also importantly enables staff to refer themselves to the staff access physiotherapy service. In April 2013 a pilot study to evaluate the effectiveness of Mindfulness Stress reduction was commenced with the overall aim to assess its effectiveness in reducing stress, sickness absence and to build a more resilient workforce. Our hope is to become a more mindful employer.

12.4 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.

12.5 Health and Safety

The staff incident rate for 2012/13 was 186 incidents per 1,000 staff; this is down from 205 last year. No Improvement Notices were issued by the Health and Safety Executive (HSE).

Whilst violence and aggression is the highest incident type reported (483), the majority of these (218) related to verbal rather than physical incidents or unintentional assaults. Inoculation injuries, of which there were 294, remain in the top three incident causation categories with falls incidents in third place at 147.

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.

Following product trials last year a new safety cannula has been launched across the Trust. Daniel Healthcare have conducted an audit of sharps boxes in the Trust, and any areas of concern are being prioritised. The Trust has introduced a new phlebotomy trolley; this has an appropriate sharps box bracket attached. The Trust has run a 'safety product day' so staff and management were able to assess different safety needle products. There is an ongoing evaluation of sharps across the Trust and further product trials are planned. 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. The evaluation, implementation and monitoring of safety devices is monitored quarterly by the Sharps Advisory Group.

There were 90 Moving and Handling incidents. The Trust continues to provide equipment and training for all staff. The Trust has introduced a new transfer aid to increase mobility and support for patients as well as increase staff safety.

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 the Trust and specific divisions. These senior managers provide a quarterly progress report to the Trust's Health Safety and Environment Committee.

The Trust's Stress at Work policy and procedure has been approved; application of the policy 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.

12.6 Serious untoward incidents – Information Governance

The Trust has had no Information Governance Serious Untoward Incidents involving personal data that required reporting to the Information Commissioner's Office in 2012/13.

The table below sets out a summary of other personal data related incidents in 2012-13.

Summary of Other Personal Data Related Incidents in 2012/13

Category	Nature of incident	Total
I	Loss/theft of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0
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	3
V	Other	0

12.7 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 along with pro-active crime reduction initiatives to reduce the opportunities for crime to occur, examples are a virtually stolen scheme, where stickers are placed on items left lying around which could be stolen, and a targeted check of all cycles and the security locks to ensure that quality locks are in use, any that are found to be of poor quality are offered quality locks at subsidised rates from the Trust. These are overseen by the NHS accredited Local Security Management Specialist, a post that is required under Secretary of State Directions, 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.

12.8 Better Payment Practice Code

	Number	£000
Total bills paid in the year	100,761	288,794
Total bills paid within target	99,632	287,323
Percentage of bills paid within target	98.88%	99.49%

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.

12.9 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.

12.10 Management costs

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

12.11 Off-payroll engagements

As part of the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, departments and their arm's length bodies, including Foundation Trusts, must publish information in relation to the number of off-payroll engagements – at a cost of over £58,200 per annum.

Off-payroll engagements at a cost of over £58,200 per annum	Number
(a) No. in place on 31 January 2012	3
Of which:	
No. that have since come onto the payroll	1
No. that continue without contractual clauses allowing the Trust to seek assurance as to their tax obligations	2
Total	**3**
(b) No. of new engagements *	1
No. for whom assurance has not yet been requested or received	1
No. of new engagements which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	-
Total	**1**

* New engagements are defined as worth £220 per day for more than 6 months, equivalent to a rate of £58,200 per annum.

This annual report covers the period
1 April 2012 to 31 March 2013

University Hospitals Birmingham NHS
NHS Foundation Trust

Section 2 **Remuneration Report 2012-13**

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 2012/13.

3. Pensions

All the executive directors are members of the NHS Pensions Scheme – with the exception of Dame Julie Moore and Viv Tsesmelis. Under

this scheme, members are entitled to a pension based on their service and final pensionable salary subject to HM Revenue and Customs' limits. The scheme also provides life assurance cover of twice the annual salary. The normal pension age for directors is 60. None of the Non-Executive Directors are members of the schemes. Details of the benefits for executive directors are given in the tables provided on page 61.

4. Salary and Pension Entitlements of Senior Managers

A. Remuneration

Salary entitlements of senior managers

Name and Title	Year Ended 31 March 2013			Year Ended 31 March 2012		
	Salary	Other Remuneration	Benefits in Kind	Salary	Other Remuneration	Benefits in Kind
	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100
SENIOR MANAGERS						
Dame Julie Moore Chief Executive	230-235	0	0	210-215	0	0
Kay Fawcett Executive Chief Nurse	120-125	0	0	120-125	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 Chief Financial Officer	135-140	0	0	135-140	0	0
Kevin Bolger Executive Director Strategic Operations *	135-140	0	0	130-135	0	0
Andrew McKirgan, Acting Chief Operating Officer (commenced office 01/09/2012) *	70-75	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	100-105	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 (left office 30/09/2011)	0	0	0	5-10	0	0

Angela Maxwell	10-15	0	0	10-15	0	0
David Ritchie	15-20	0	0	15-20	0	0
Clare Robinson (left office 30/09/2011)	0	0	0	5-10	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)	10-15	0	0	5-10	0	0
David Waller (commenced office 01/10/2011)	10-15	0	0	5-10	0	0

*Kevin Bolger held the post of Chief Operating Officer up to 09/09/2012, where upon he was appointed to the new role of Executive Director of Strategic Operations. Andrew McKirgan was appointed to the post of Chief Operating Officer (Interim) on 10/09/2012.

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 2013	Year Ended 31 March 2012
Band of Highest Paid Director's Total Remuneration (£ '000)	230-235	210-215
Median Total Remuneration	26,742	26,215
Ratio	8.7	8.1

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.

The remuneration of the highest paid director – the Chief Executive, Dame Julie Moore has increased by £22,163 from the previous year in lieu of her exit from the NHS Pension Scheme. The benefit to the Trust in reduced employer pension contributions (14%) means that the Trust has made an overall saving from this change in arrangements.

In addition, the Trust's governors and directors incur expenses in association with activities that they undertake that support the objectives of the Trust.

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 2013	Total accrued pension related lump sum at age 60 at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	Cash Equivalent Transfer Value at 31 March 2013	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000	To nearest £100
Mike Sexton, Chief Financial Officer	0-2.5	0-2.5	55-60	165-170	1,046	1,138	37	N/A
Tim Jones, Executive Director of Delivery	0-2.5	2.5-5	35-40	110-115	556	627	42	N/A
Kay Fawcett, Executive Chief Nurse	0-2.5	0-2.5	50-55	160-165	1,024	1,084	7	N/A
Kevin Bolger, Executive Director Strategic Operations	0-2.5	2.5-5	50-55	160-165	973	1,084	61	N/A
Dr David Rosser, Executive Medical Director	0-2.5	0-2.5	50-55	160-165	866	927	15	N/A
David Burbridge, Director of Corporate Affairs	0-2.5	2.5-5	15-20	55-60	287	333	31	N/A
Fiona Alexander, Director of Communications	0-2.5	2.5-5	5-10	25-30	118	141	17	N/A
Morag Jackson, New Hospitals Project Director	0-2.5	0-2.5	40-45	130-135	763	811	9	N/A
Andrew McKirgan, Acting Chief Operating Officer	2.5-5	7.5-10	25-30	85-90	339	453	54	N/A

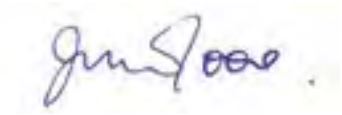
As Non-Executive members do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive members.

Details above are provided by the NHS Pensions Agency.

5. 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 with advice taken from independent consultants where appropriate. Details of membership and attendance of the Committee are set out on page 41.

The Chairman does not attend when the committee considers matters relating to his own remuneration.



Dame Julie Moore, Chief Executive
Date: 23 May 2013

This annual report covers the period
1 April 2012 to 31 March 2013

University Hospitals Birmingham NHS
NHS Foundation Trust

Section 3 **Quality Report 2012/2013**

Contents

Part 1:	**Chief Executive's Statement**	**66**
Part 2:	**Priorities for improvement and statements of assurance from the Board of Directors**	**68**
Priority 1:	Improving VTE (venous thromboembolism) prevention	90
Priority 2:	Improve patient experience and satisfaction	73
Priority 3:	Electronic observation chart – completeness of observation sets (to produce an early warning score)	81
Priority 4:	Reducing medication errors (missed doses)	83
Priority 5:	Infection prevention and control	86
Priority 6:	Improving patient safety through barcoded patient wristbands	88
2.2	Statements of assurance from the Board of Directors	89
2.3	Performance against national core set of quality indicators	97
Part 3:	**Other information**	**98**
3.1	Overview of quality of care provided during 2012/13	98
3.2	Performance against national targets and indicators included in the Monitor Compliance Framework	108
3.3	Mortality	109
3.4	Accident and Emergency Department Survey	112
3.5	Staff Survey	112
3.6	Specialty quality indicators	115
3.7	myhealth@QEHB	118
3.8	mystay@QEHB	118
3.9	Glossary of Terms	119
Appendix A:	**Performance against national core set of quality indicators**	**122**
Annex 1:	**Statements from stakeholders**	**129**
Annex 2:	**Statement of directors' responsibilities in respect of the quality report**	**132**
Independent Auditor's Report on the Annual Quality Report		**133**

Part 1: Chief Executive's Statement

University Hospitals Birmingham NHS Foundation Trust (UHB) has continued to focus on delivering high quality care and treatment to patients in the new Queen Elizabeth Hospital Birmingham during 2012/13. This has proved challenging due to increasing numbers of emergency patients coming to the new hospital and the need to deliver efficiency savings in line with the national Quality, Innovation, Productivity and Prevention (QIPP) programme.

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. The Trust's Core Purposes – Clinical Quality, Patient Experience, Workforce and Research and Innovation – provide the framework for the Trust's robust approach to managing quality.

UHB has made very good progress in relation to three of the five quality improvement priorities for 2012/13 identified in last year's Quality Report: improving patient experience and satisfaction, completeness of observation sets and infection prevention and control. Following the significant reductions in medication errors (missed doses) achieved in previous years, performance has stabilised in 2012/13. Performance has also remained stable for improving venous thromboembolism prevention through timely prescription of enoxaparin medication. The Trust has therefore chosen to continue with all of these priorities in 2013/14 and has set stretching improvement targets where possible. UHB has also selected a new quality improvement priority for 2013/14 around improving patient safety through barcoded wristbands.

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 revised our 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, infection incidents and incomplete observations.

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 has implemented some additional data quality checks for this year's Quality Report in response to the recommendations of the *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* by Robert Francis QC published in February 2013.

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. During 2012/13, the Trust has developed a new website called mystay@QEHB in response to feedback from Trust

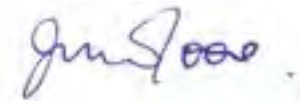
Members about the type of information they would like to receive before they come into hospital. Quality information will be published monthly showing how each inpatient specialty is performing for a range of indicators: infection rates, medication given, observations, clinical assessments and patient feedback. The new website will be launched during 2013/14.

An essential part of improving quality at UHB continues to be the scrutiny and challenge provided through proper engagement with staff and other stakeholders. These include the Trust's Council of Governors, General Practitioners (GPs), local Clinical Commissioning Groups (CCGs) and Birmingham Local Involvement Network (Healthwatch Birmingham from 1 April 2013). 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's internal and external auditors also provide an additional level of scrutiny for key aspects of the Quality Report. For example, our internal auditors reviewed the Trust's process for identifying changes in performance for the specialty quality indicators to ensure it was fit for purpose before implementation. The Trust's external auditors have reviewed both the content of the 2012/13 Quality Report and tested data quality for a limited number of indicators, in line with the Monitor guidance for external assurance. The report provided by our external auditors is included at the end of the Quality Report.

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, 2013/14 will be a challenging year as the new structure of the National Health Service led by clinicians came into force on 1 April 2013 in England. The Trust will continue working with commissioners and other healthcare providers to deliver further improvements to quality in the context of increasing demand and the wider economic challenges.



Dame Julie Moore, 30 May 2013
Chief Executive

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

2.1 Quality Improvement Priorities

2012/13

The Trust's 2011/12 Quality Report set out five priorities for improvement during 2012/13:

Priority 1
Improving VTE (venous thromboembolism) prevention

Priority 2
Improve patient experience and satisfaction

Priority 3
Electronic observation chart – completeness of observation sets (to produce an early warning score)

Priority 4
Reducing medication errors (missed doses)

Priority 5
Infection prevention and control

The Trust has made good progress in relation to three of these quality improvement priorities: improving patient experience and satisfaction, completeness of observation sets and infection prevention and control. Following the significant improvements made in reducing medication errors (missed doses) in previous years, performance has stabilised in 2012/13. The Trust therefore intends to keep this as an improvement priority in 2013/14 and shift the focus to reducing non-antibiotic missed doses. Improving venous thromboembolism prevention has proved very challenging with performance remaining stable during 2012/13. The Trust has set an improvement target for 2013/14 and will be focusing on improving prescription timeliness.

2013/14

The Board of Directors has chosen to continue with the same five improvement priorities for 2013/14 plus a new one as follows:

Priority 1
Improving VTE prevention

Priority 2
Improve patient experience and satisfaction

Priority 3
Electronic observation chart – completeness of observation sets (to produce an early warning score)

Priority 4
Reducing medication errors (missed doses)

Priority 5
Infection prevention and control

Priority 6
Improving patient safety through barcoded wristbands

The improvement priorities for 2013/14 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 various Trust groups including the Council of Governors, Care Quality Group and the Trust Partnership Team. These were also shared and discussed with interested parties outside the Trust including the Trust's lead Clinical Commissioning Group (CCG) – Birmingham

and Cross-City CCG – and the Birmingham Local Involvement Network (LINk) group. 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 2013/14 were then finally approved by the Board of Directors.

The performance for 2012/13 and the rationale for any changes to the priorities are provided in detail below. This report should be read alongside the Trust's Quality Report for 2011/12.

Priority 1: Improving VTE prevention

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 (PICS) since June 2008 for all inpatient admissions. The tool provides tailored advice regarding preventative treatment based on the assessed risk.

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 Trust has performed consistently highly for completion of VTE risk assessments and therefore chose to focus on improving compliance with the outcomes of completed VTE risk assessments in 2012/13. This means improving VTE prevention through appropriate administration of preventative (prophylactic) treatment. Preventative treatments include graduated elastic compression stockings (GECS) and/or enoxaparin (medication used to reduce the risk of blood clots forming).

Performance

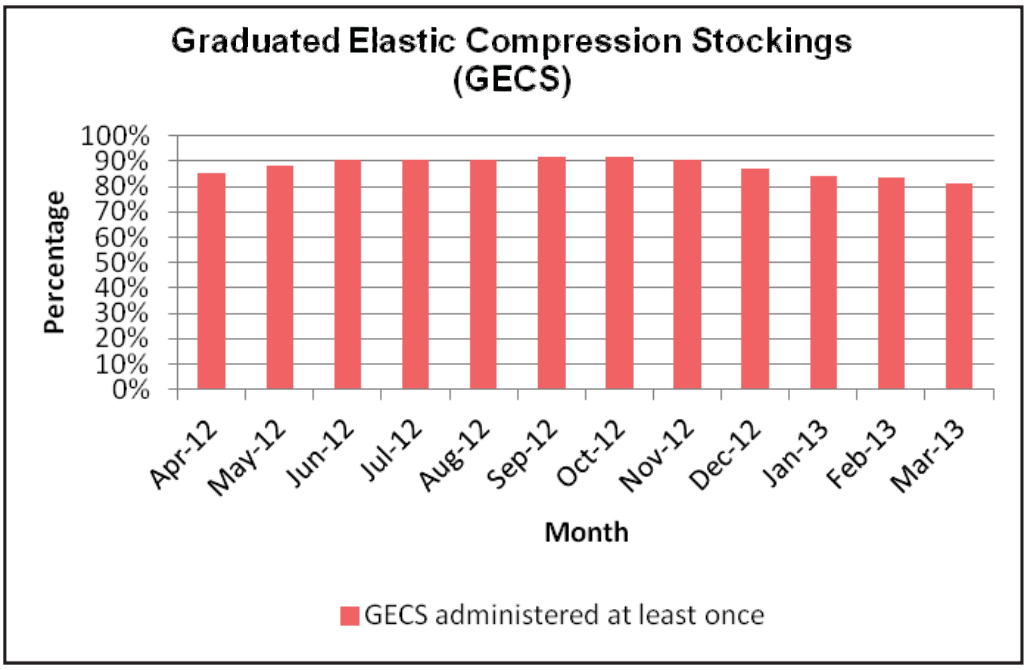
VTE Risk Assessment Completion

The Trust has achieved a VTE risk assessment completion rate of at least 98% since September 2010 and over 99% since June 2012. This is well above the national average of 94.2% for NHS acute providers as published on the Department of Health website (October-December 2012).

VTE Prevention – Graduated Elastic Compression Stockings

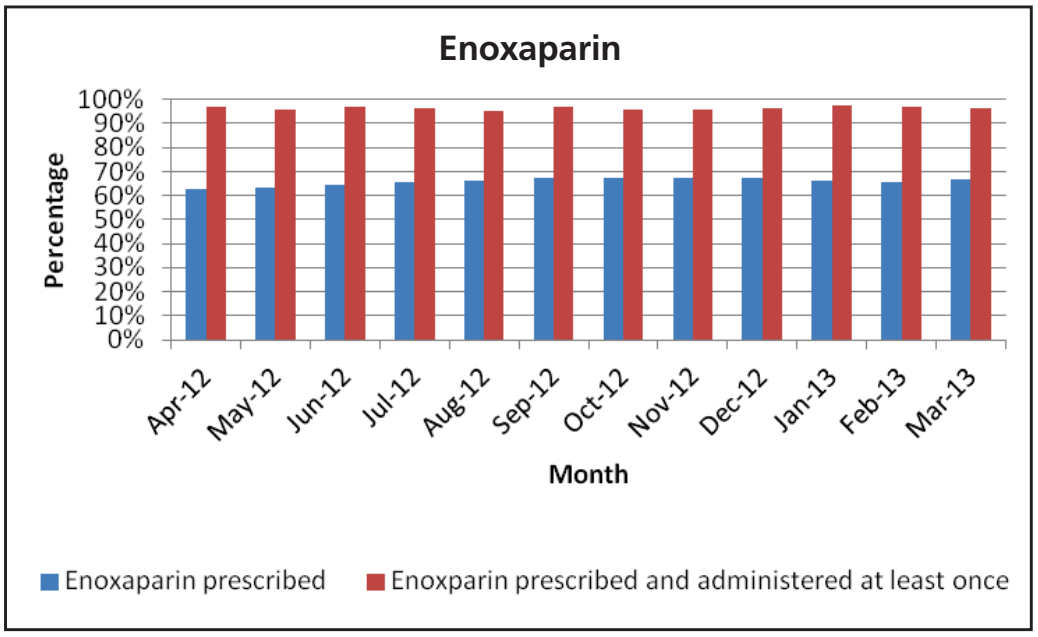
The graph below shows the percentage of graduated elastic compression stockings administered at least once by episode as recorded on the electronic Prescribing and Information Communication System. Overall, 87.9% of graduated elastic compression stockings were administered at least once per episode during 2012/13.

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.



VTE Prevention – Enoxaparin Medication

The graph below shows the percentage of patients who required enoxaparin medication following VTE risk assessment and were prescribed it and of those, the percentage who were given it at least once. Overall, 65.9% of patients who required enoxaparin following VTE risk assessment were prescribed it in 2012/13. Of the patients who were prescribed enoxaparin, 96.4% 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.



Changes to Improvement Priority for 2013/14:

The Trust will focus on maintaining performance for administration of graduated elastic compression stockings and improving performance for enoxaparin prescription.

The aim is for 80% of patients who require enoxaparin following VTE risk assessment to have it prescribed by the end of 2013/14. The Trust will continue to monitor administration of enoxaparin medication to ensure it remains high.

Initiatives implemented during 2012/13:

- A change was made to the Prescribing Information and Communication System 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
- The e-learning tool for nursing staff was revised to coincide with the introduction of a new type of graduated elastic compression stocking
- The Trust implemented regular junior doctor monitoring clinics in quarter 4 2012/13 with dedicated Consultant support to review prescribing practice and share learning. These clinics are enabling changes to be made to the Prescribing Information and Communication System to help medical staff and additional targeted training to be provided as required

Initiatives to be implemented in 2013/14:

- Regular junior doctor monitoring clinics will continue during 2013/14 with a particular focus on improving timeliness of enoxaparin prescription for those patients who require it following VTE risk assessment
- Enoxaparin prescription will be reviewed at specialty level so that best practice can be shared and implemented
- The findings from root cause analysis (thorough investigation) of cases where patients developed VTE during their stay in hospital or within 3 months after discharge will be regularly reviewed. This will enable any improvements to be implemented as soon as possible where required

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 continue to 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 2: 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

During 2012/13, 23,950 patient responses were received for the electronic inpatient survey and 946 responded to the discharge survey providing a wealth of information about their experience. The table below shows the patient experience data collected by UHB for the past three financial years. The survey results show that the Trust has made improvements across all areas of patient experience in 2012/13 except for question 9 around medication side effects which the Trust will focus on trying to improve in 2012/13 and will continue to focus on delivering improvements, particularly around communication during the coming year. The Trust's latest National Adult Inpatient Survey results are shown in Part 3 of this report.

Question	Answer	2010/11	2011/12	2012/13
1. Were you involved as much as you wanted to be in decisions about your care and treatment?	Yes	73.4%	77.20%	81.30%
	Yes to some extent	20.9%	17.90%	15.18%
	No	5.8%	5.00%	3.52%
2. Did you find someone on the hospital staff to talk to about your worries and fears?	Yes, definitely	60.8%	66.90%	74.32%
	Yes, to some extent	27.5%	22.70%	18.18%
	No	11.8%	10.30%	7.50%
3. Were you given enough privacy when discussing your condition or treatment?	Yes, always	87.4%	89.50%	91.35%
	Yes, sometimes	10.6%	8.50%	6.93%
	No	2.0%	2.00%	1.72%
4. Do you think that the ward staff do all they can to help you rest and sleep at night?	Yes, definitely	Data collection started from April 2012		80.03%
	Yes, to some extent			17.38%
	No			2.58%
5. Do you think the hospital staff do all they can to help control your pain?	Yes, definitely	80.8%	83.30%	85.37%
	Yes, to some extent	16.0%	14.20%	12.61%
	No	3.1%	2.50%	2.02%

6. Have you been bothered by noise at night from hospital staff?	No, never	Data collection for these questions began in April 2011	66.20%	71.33%
	Yes, occasionally		28.00%	23.87%
	Yes, often		5.90%	4.81%
7. Overall how would you rate the hospital food you have received?	Excellent		20.30%	21.85%
	Very Good		27.90%	28.51%
	Good		27.20%	26.11%
	Fair		16.50%	15.91%
	Poor		8.10%	7.62%
8. Sometimes in hospital a member of staff says one thing and another says something quite different. Has this happened to you?	No, never		70.00%	74.30%
	Yes, sometimes		24.30%	20.77%
	Yes, often		5.70%	4.93%
9. Did a member of staff tell you about medication side effects to watch for when you went home? (Discharge survey)	Yes, completely	60.3%	46.30%	41.26%
	Yes, to some extent	12.2%	9.30%	22.39%
	No	27.5%	44.40%	36.35%
10. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital? (Discharge survey)	Yes	88.9%	72.40%	78.95%
	No	11.1%	27.60%	21.05%

The Trust has continued to raise awareness in all of the areas covered by the questions above. The need to provide a conducive environment for rest and sleep for inpatients has been communicated to staff. As a result there has been an improvement in the percentage of patients who answered positively to the question 'Do you think that the ward staff do all they can to help you rest and sleep at night?' Communication has also been an area that the Trust has concentrated on, and improvements have been achieved in all of the related areas, resulting in an increase in positive responses from patients.

Friends and Family Question

The Trust has monitored performance for the Friends and Family Test question throughout 2012/13:

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

This question was introduced in all acute trusts covered by the Midlands and East Strategic Health Authority (SHA) area. Patients were asked this question from 24 hours before and up to 48 hours after discharge from hospital and could choose from six different responses as follows:

- Extremely likely?
- Likely?
- Neither likely or unlikely?
- Unlikely?
- Not at all?
- Don't know?

Only those patients who pick 'extremely likely' were classed as promoters, 'likely' responses were classed as passive and all the rest were classed as detractors. The Net Promoter Score is calculated by subtracting the detractors from the promoters and then dividing by the number of responses. The passive responses are excluded from the calculation. It is important to note that patients may not realise that only 'extremely likely' responses are classed as promoters.

The table below shows the Trust's responses and scores for April 2012-March 2013. The response rates and scores have improved during the year.

	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Patient Discharges	3876	3945	6168	5121	5172	6341	5391	5278	5869	4287	4776	5538
Number of Responses	533	437	1144	959	1148	1100	1129	1090	1128	1032	1391	1387
Response Percentage	**13.75%**	**11.08%**	**18.55%**	**18.73%**	**22.20%**	**17.35%**	**20.94%**	**20.65%**	**19.22%**	**24.07%**	**27.62%**	**25.05%**
Promoter	361	282	801	667	835	774	852	786	850	787	975	1070
Passive	129	106	255	228	243	248	186	220	215	204	276	252
Detractor	43	49	88	64	70	78	91	84	63	41	68	65
Score	**59.66**	**53.32**	**62.33**	**62.88**	**66.64**	**63.27**	**67.40**	**64.40**	**69.77**	**72.29**	**68.76**	**72.46**

Initiatives implemented in 2012/13:

- The Patient Experience Champion Programme was expanded and now includes outpatient areas, imaging and non-clinical support services. The number of Champions has increased by 59 to 278. Education programmes have continued throughout the year increasing awareness of the importance of gathering feedback from patients and carers and using it to make improvements to the patient and carer experience
- The Mystery Shopping programme was extended to include monitoring of the Trust switchboard and restaurant services. Mystery Shopper Visits and testing were also undertaken for the main therapies department and for the therapies switchboard. Improvements have been implemented as a result of the visits, e.g. better signage in the restaurant, menu displayed at the entrance and additional checkout cash till during peak times. The Mystery Patient Council members have also been involved in the development of Customer Care Standards
- The Friends and Family question (net promoter) has been included in all patient surveys and provides an overview response from patients
- A pilot postal survey was developed for patients attending the outpatients department. The pilot was successful and so the survey was implemented in Quarter 4. Surveys are now sent to 500 patients each month
- The Complaints Department and Patient Advice and Liaison Service (PALS) have been integrated to improve efficiency in dealing with concerns from patients and relatives
- In response to feedback from patients, an electric golf buggy was introduced in April 2012 to transport patients and visitors with mobility difficulties from the car park to the hospital entrance. 14,000 individual patient and visitor journeys were recorded for the year to 31st March 2013. The buggy has been extremely well received by patients and visitors

Improvement Priority for 2013/14:

The Trust has chosen to continue with the same questions in 2012/13 to deliver further improvements. 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.

Initiatives to be implemented in 2013/14:

- The new Department of Health Friends and Family Test question will be implemented from 1st April 2013 on the inpatient bedside survey and for patients attending the Emergency Department
- An in depth audit of patients around involvement in decisions about their care and being given conflicting information will be completed. An audit of staff perception into these two areas will also be part of the audit
- Introduction of volunteer Dining Companions to support nutrition and hydration for patients
- An audit of the experience of carers will be undertaken
- A method of gaining feedback from patients attending for outpatient chemotherapy will be developed

How progress will be monitored, measured and reported:

- Feedback rates and responses will continue to be measured and communicated via the Clinical Dashboard.
- Regular patient experience reports will be provided to the Care Quality Group and to the Board of Directors
- 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.
- 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 2012/13 was 752, which represents a reduction of more than 5% compared to 2011/12.

In 2012/13, the Trust has treated more inpatients, outpatients and Emergency Department attenders than in previous years. There has been a reduction in the number and ratio of complaints received about inpatients and outpatients with a slight increase in the number and ratio of complaints received about the Emergency Department.

	2009/10	2010/11	2011/12	2012/13
Total number of complaints	643	840	797	752

Most common subjects of complaint	2009/10	2010/11	2011/12	2012/13
Clinical treatment	272	390	373	357
Outpatient appointment delay/cancellation	109	116	100	54
Attitude of staff	61	88	63	63
Inpatient appointment delay/cancellation	17	46	81	78
Communication and information	76	63	64	79

Ratio of complaints to activity		2009/10	2010/11	2011/12	2012/13
Inpatients	FCEs*	124,589	123,139	118,504	126,309
	Complaints	277	444	434	428
	Rate per 100 FCEs	**0.22**	**0.36**	**0.37**	**0.34**
Outpatients	Appointments**	499,981	517,516	544,876	585,488
	Complaints	309	312	289	214
	Rate per 100 appointments	**0.06**	**0.06**	**0.05**	**0.04**
A&E	Attendances	82,632	82,925	87,744	94,662
	Complaints	57	84	72	110
	Rate per 100 attendances	**0.07**	**0.10**	**0.08**	**0.12**

* 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)

Learning from complaints

The table below provides some examples of actions taken during 2012/13 in response to themes or trends in complaints received about UHB:

Theme	Area of Concern	Action taken	Outcome
Communication	How staff communicate with patients, their relatives, visitors and other colleagues	Bespoke customer care training sessions continue to be provided to staff by the Head of Patient Relations. Anonymised examples of real complaints are used about the ward or Department involved. A Communication Skills Training and Development Review Task and Finish Group has been set up to review existing communication skills training and plan future training.	Initial meeting held involving relevant staff. A report will be produced with an action plan by quarter 1 2013/14.
Delays receiving discharge medication	Patients ready for discharge having to wait for discharge medication before they can leave the hospital	Significant changes have been made to the way the Pharmacy Department operates. Turnaround times for discharge medication have significantly reduced across the Trust.	Reduction in the number of complaints about discharge medication delays.
Outpatient appointment delays	Delays in Ear, Nose and Throat Outpatient clinic.	A review identified the underlying issues causing the delays. Changes have been made to clinic booking process.	No further complaints received about these issues since changes made.

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 Relations report. A monthly complaints report is also presented at the Chief Executive's Advisory Group. A detailed analysis of complaints, PALS (Patient Advice and Liaison Service) contacts, incidents and legal claims is presented to the Trust's Audit Committee quarterly. Some of the more serious complaints as selected for review by the Executive Care Omissions Root Cause Analysis meetings.

Serious complaints

The Trust assesses the seriousness of every complaint on receipt. Serious complaints are reported 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 serious complaint.

Complaints referred to the Parliamentary and Health Service Ombudsman (PHSO)

The Trust aims to resolve all complaints at a local level. This may involve telephone calls, written responses, meetings or a combination of all of these. All complainants are given information about the Parliamentary and Health Service Ombudsman service when their

complaint is first acknowledged and again when a response is sent to them. Complainants can refer their complaint to the Parliamentary and Health Service Ombudsman if they feel it has not been handled or resolved satisfactorily by the Trust. The role of the Parliamentary and Health Service Ombudsman is to assess the original complaint and responses provided by the Trust to determine whether an independent review of the complaint and its handling is required. The number of complaints referred to the Parliamentary and Health Service Ombudsman relating to UHB during the past two financial years was low. The Ombudsman chose to investigate half of those referred and only upheld (either partially or fully) a very small number.

PHSO Involvement	2011/12	2012/13
Cases referred to the PHSO by complainant for investigation	16	16
Cases which did not require further investigation as determined by the PHSO	8	9
Cases which were referred back to the Trust for further local resolution	1	2
Cases where the outcome of the initial review is not yet known	6	5
Cases suspended pending the outcome of an HM Coroner's Inquest	1	0
Cases which were partially upheld following review by the PHSO	1	1
Cases which were fully upheld following review by the PHSO	0	1

Compliments

Compliments are recorded by the Patient Advice and Liaison Service (PALS), and also by the Patient Experience Team on behalf of the Trust. PALS record any compliments they receive directly from patients and carers. The Patient Experience Team collate and record compliments received via all other sources. This includes those sent to the Chief Executive's office, the patient experience email address, the Trust website and those sent directly to wards and departments. Where compliments are included in complaints they are also extracted and logged as such.

The majority of compliments are received in writing – by letter, card, email, website contact or trust feedback leaflet, the rest are received verbally via telephone or face to face. Positive feedback is shared with staff and patients to promote and celebrate good practice as well as to boost staff morale.

The Trust received a high number of compliments in 2012/13 although slightly fewer than 2011/12. The Patient Experience team will continue to provide support and guidance to divisional staff around the collation and recording of compliments received directly to wards and departments. In addition, they will be scoping additional methods of capturing positive feedback received.

Compliment Subcategories	2009/10	2010/11	2011/12	2012/13
Nursing care	92	310	605	356
Friendliness of staff	76	306	492	205
Treatment received	130	251	300	766
Medical care	21	122	391	92
Other	4	54	20	37
Efficiency of service	37	47	124	150
Information provided	3	17	16	10

Facilities	4	9	18	24
Totals:	**367**	**1116**	**1966**	**1640**

Examples of compliments received during 2012/13:

Date received	Compliment
May 2012	I had exceptional attention from Auxiliary Nurse X In my mind he epitomised nursing to its highest degree, he attended to my needs with care and compassion at tall times and his dedication to his job was of the highest standard.
May 2012	Consultant was very helpful and explained everything in great detail. he made me feel relaxed, he made time to listen and comment on my concerns.
June 2012	Saw by Dr immediately, warm friendly smiling woman. Treated courteously and professional, explained in detail. Appt made for 3 months. Left 3 mins after our appt, excellent service.
July 2012	We appreciate all that you did giving him dignity you bought sunshine into our lives.
July 2012	I was nervous when I booked in to Clinic, the care was outstanding. A big thank you to everyone.
Aug 2012	I could not have wished for better, kinder, more helpful treatment from every single member of the team.
Sept 2012	I stayed with the Short Stay Unit….having had surgery on my spine. A fantastic team of people who made a daunting time more bearable. Many thanks to all involved, from the surgical/nursing team to the cleaners who were all so professional and courteous. Warmest thanks.
Oct 2012	His chances were not very good but with the excellent care he received he is now back at work and doing really well. Thank you so very much. Take care and keep up the good work
Dec 2012	An excellent, friendly, respectful and efficient service provided from reception onwards. Facilities were spotless.
Jan 2013	We, I owe so much to the Queen Elizabeth Hospital and I cannot fault the treatment and support we both received from the staff ….. in those last three weeks. X died amongst friends and they offered me endless support, especially in the last week of her life when I was staying overnight in a bed beside her.
March 2013	I would just like to say a massive thank you for the wonderful support and service that my mom received at your hospital……from the moment we were put in touch with your hospital the service was fantastic.

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. Whilst there has been an increase in the number of comments posted on each of these two websites the numbers continue to be extremely low in comparison to other methods of feedback received.

Priority 3: Electronic observation chart – completeness of observation sets (to produce an early warning score)

Background

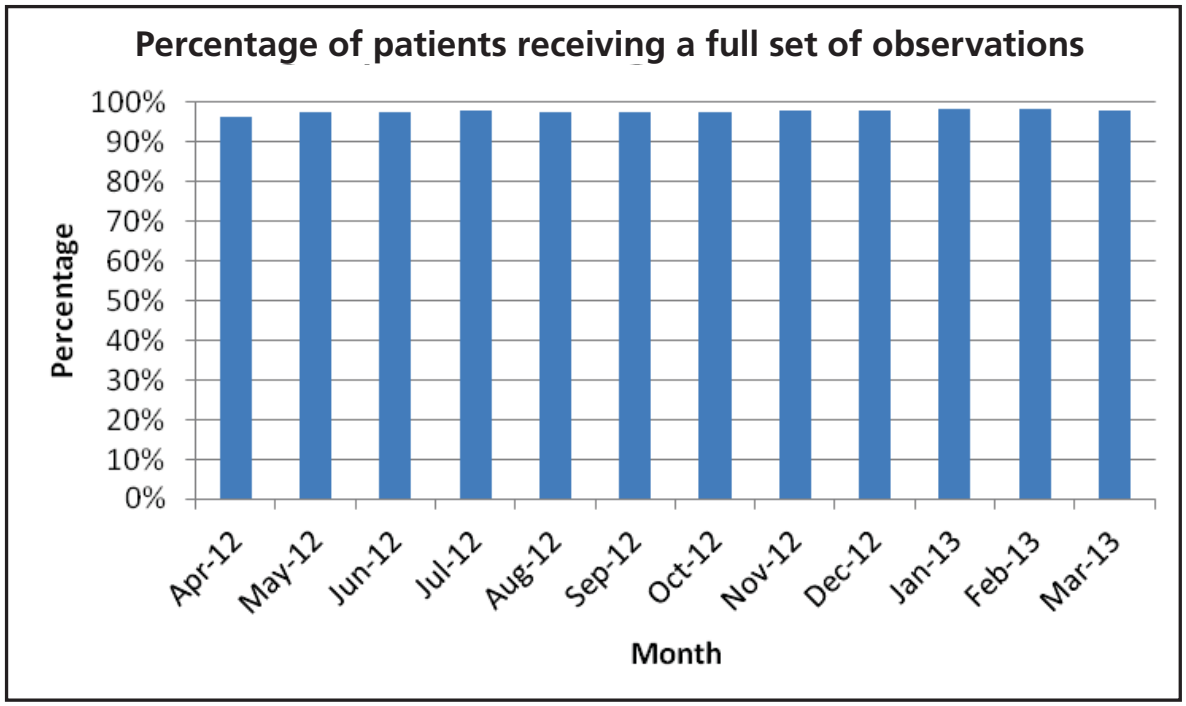
The Trust started to implement an electronic observation chart during 2010/11 within the Prescribing Information and Communication System (PICS) to record patient observations: temperature, blood pressure, oxygen saturation score, respiratory rate, pulse rate and level of consciousness.

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

The Trust has improved performance during 2012/13 with an overall completion rate of 97.7% compared to 93.7% for 2011/12, which is slightly below the Trust target of 98.0%. The vast majority of the Trust's wards now perform at over 98.0% for observation completion.



Initiatives implemented in 2012/13:

- Electronic recording of observations was implemented on the Coronary Care Unit and for inpatients on the Dialysis Unit
- Performance for completeness of observations has been monitored at ward level and on the Clinical Dashboard. Wards performing below the 98% target have been reviewed at the Executive Care Omissions Root Cause Analysis meetings to identify where improvements could be made
- Training delivered to staff by the Prescribing and Information Communication System (PICS) training team is now centrally recorded

Changes to Improvement Priority for 2013/14:

The Trust is now aiming for all wards to achieve at least 98% for completion of observations by the end of 2013/14.

Initiatives to be implemented in 2013/14:

- The few wards which are still performing slightly below the 98.0% target will be reviewed at the Executive Care Omissions Root Cause Analysis meetings to identify where improvements need to be made
- Performance for observation completion by specialty will start to be published for patients and the public each month. This will form part of the new mystay@QEHB website which is explained further in part 3 of this report

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. Performance will continue to be publicly reported through the quarterly Quality Report updates on the Trust's website
- Specialty-level performance will start to be reported publicly each month on the new mystay@QEHB website

Priority 4: Reducing medication errors (missed doses)

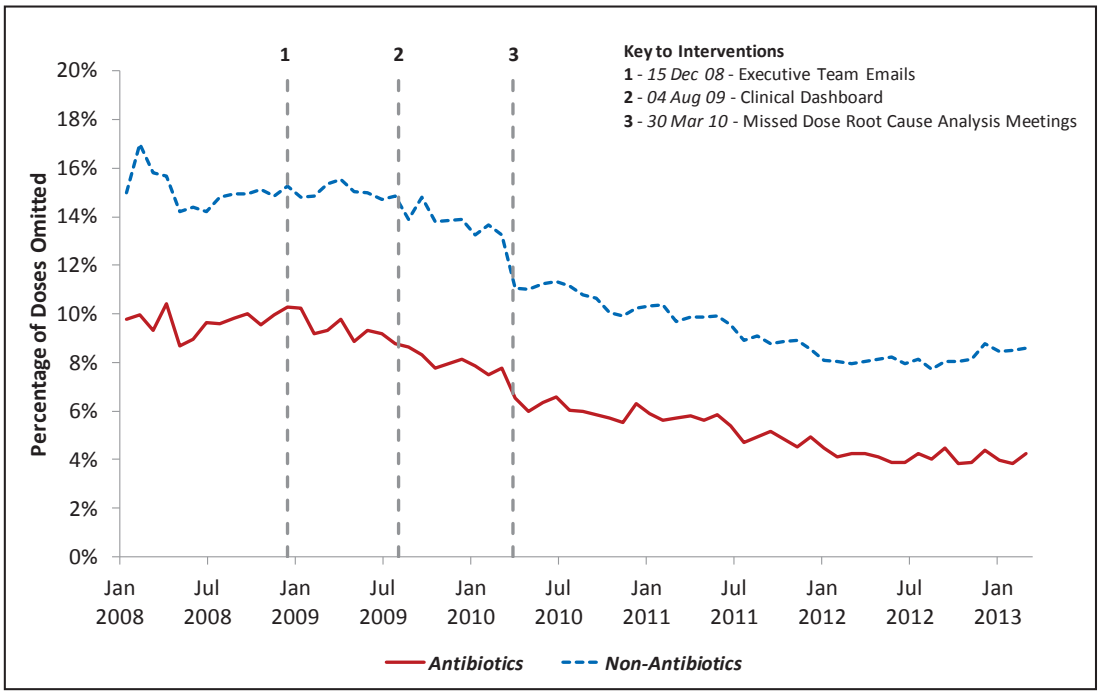
Background

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.

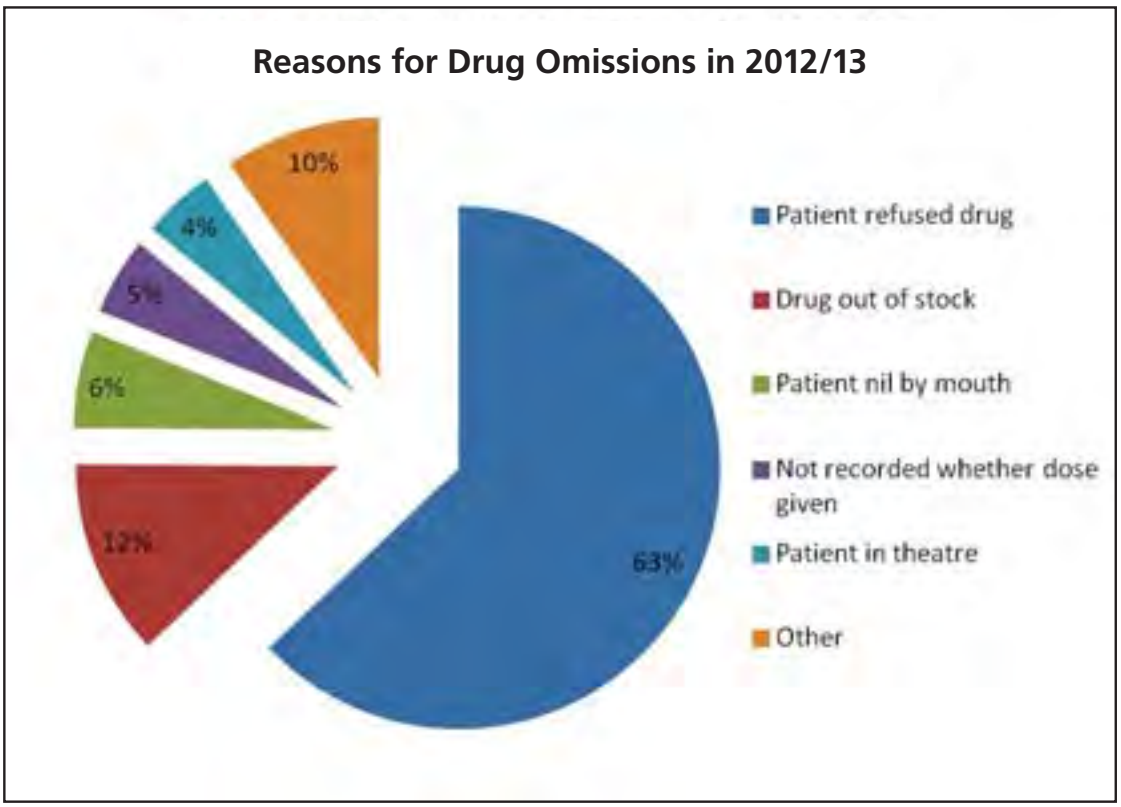
Performance

The graph below shows that missed antibiotic and non-antibiotic doses have stabilised during 2012/13 following the significant reductions made in previous years. It is however important to remember that some drug doses are appropriately missed due to the patient's condition at the time. Antibiotic missed doses performance remains strong but there is further work to be done to reduce non-antibiotic missed doses.



The pie chart below shows the main categories of reasons recorded for doses missed in 2012/13.

One of the main reasons recorded for doses being missed was due to patients refusing their medication. Certain medications such as pain-relieving (e.g., paracetamol), anti-sickness and other symptomatic treatments tend to be regularly prescribed in case patients require it. This can result in a lot of missed doses due to patient refusals. The Trust has greatly improved stock availability with nursing staff expected to go to adjacent wards or other areas should the medication they require be out of stock on their ward. It is therefore disappointing to see 12% recorded as being out of stock. The Trust will be focusing on reducing patient refusals, improving stock availability and ensuring all doses are appropriately recorded as given or not. There are a number of other reasons recorded for drug omissions included in the 'Other' category such as patient unable to take medication due to vomiting or drowsiness.



Initiatives implemented during 2012/13:

- Missed doses and other medication issues have been reviewed at the Executive Care Omissions RCA meetings with learning shared and implemented as required
- A Diabetes education programme has been implemented to help medical and nursing staff to improve insulin management across the Trust
- The Trust implemented regular junior doctor monitoring clinics in quarter 4 2012/13 with dedicated Consultant support to review prescribing practice and share learning. These clinics are enabling changes to be made to the Prescribing Information and Communication System to help medical staff and additional targeted training to be provided as required

Changes to Improvement Priority for 2013/14:

The Trust has chosen to focus on maintaining performance for missed antibiotics and reducing non-antibiotic missed doses in the absence of a national consensus on what constitutes an expected level of drug omissions. The Trust is aiming for a 20% reduction in missed non-antibiotic doses by the end of 2013/14.

Initiatives to be implemented in 2013/14:

- Patient refusal rates for missed doses will be reviewed at nurse level to ensure all our clinical staff do their best to encourage patients to take the medication they need
- The Trust will be looking to increase the percentage of symptomatic medications such as paracetamol prescribed on a PRN (pro re nata – as required) basis to reduce patient refusals
- Performance for missed doses by specialty will start to be published for patients and the public each month. This will form part of the new mystay@QEHB website which is explained further in part 3 of this report

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
- Missed 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 be publicly reported in the quarterly Quality Report updates published on the Trust's quality web pages. Furthermore, performance for missed doses by specialty will be provided to patients and the public each month on the new mystay@QEHB website

Priority 5: Infection prevention and control

Performance

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 completed the first year of mandatory reporting for *Staphylococcus aureus* (MSSA) bacteraemia and *Escherichia coli* (E. coli) bacteraemia and introduced surveillance on urethral catheters and urinary tract infections as part of the national Safety Thermometer CQUIN.

Time Period/ Infection Type	2009/10	2010/11	2011/12	2012/13
***C. difficile* infection (post-48 hour cases)**	178 (348)	145 (164)	85 (114)	73 (76)
MRSA bloodstream infections	13 (30)	11 (11)	4 (7)	5 (5)

Initiatives implemented in 2012/13:

- In April, the Trust introduced a two stage test for the identification of Toxigenic *C. difficile* in line with the Department of Health Guidelines. This approach has improved the accuracy of *C. difficile* detection and diagnosis
- The Trust has implemented surveillance of surgical site infection. The group has reviewed current practices that may influence the development of post-operative surgical site infection and is now undertaking audit in specific specialties
- The Trust has developed a new audit tool for antimicrobial prescribing. This will enhance education, prescribing practice and support the antimicrobial stewardship programme
- The Trust has implemented enhanced laboratory surveillance for the detection of multi-drug resistant Gram negative microorganisms

Changes to Improvement Priority for 2013/14:

In 2013/14 there will be a change to the national approach for the reporting and investigation of MRSA bacteraemia. There will be zero tolerance towards avoidable MRSA bacteraemia and there will be the introduction of a Post Infection Review (PIR) tool which will replace the current root cause analysis tool. The agreed objective for CDI requires a further reduction and this will present a significant challenge to maintain the momentum of improvement.

Initiatives to be implemented in 2013/14:

- Maintain improvements in patient safety through a robust Infection Prevention and Control surveillance programme. This will include all alert organisms, surgical site infection, and urinary catheter associated infection, incidence of blood culture contamination and the identification and management of multi-drug resistant microorganisms
- Continue 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 2013/14 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 bacteraemia and CDI deaths will be reported as serious incidents requiring investigation (SIRIs) to Birmingham Cross City Clinical Commissioning Group
- Post infection review and root cause analysis will continue to be undertaken for all MRSA bacteraemia and CDI cases
- Progress against the Trust Infection Prevention and Control delivery plan will be submitted quarterly to the Board of Directors and shared with Commissioners

Priority 6: Improving patient safety through barcoded wristbands

Background

The Trust takes correct patient identification very seriously as patients with similar names and/or dates of birth can often be on the same ward at the same time. The main risks associated with patient identification include identifying the wrong patient and/or the wrong patient record which the introduction of barcoded wristbands will help to reduce.

Patients currently have their identity confirmed on admission and are then given a printed wristband. The printed wristband includes a patient's first and last names, date of birth, hospital number and NHS number. Patients are asked to verbally confirm their name and other details are correct before medication is given or they go for a procedure to ensure that the correct patient is identified.

The Trust plans to improve patient safety by implementing barcoded patient wristbands in addition to the processes currently used to check patient identity for medication administration. This will mean that patients will be asked to verbally confirm their details and their wristband will be scanned before they are given their medication during a drug round. Scanning a barcoded patient wristband will automatically open the correct patient's drug chart in the Trust's Prescribing Information and Communication System (PICS).

The Trust is aiming to implement barcoded wristbands for all inpatients for medication administration by the end of 2013/14. The plan is to use barcoded wristbands to improve patient safety in other areas in the future such as when ordering scans or blood tests for patients.

Initiatives to be implemented in 2013/14:

- An implementation sub-group will be established to oversee the implementation of barcoded wristbands. This sub-group will report to the Trust's Electronic Patient Record (EPR) Executive Group and to the Clinical Quality Monitoring Group chaired by the Executive Medical Director
- An implementation plan will be developed which will clarify the staff training requirements and staff roles
- The IT hardware requirements will be reviewed at ward level to ensure that enough barcode scanning equipment is ordered for staff to use
- A mechanism to monitor ward compliance with the use of barcoded wristbands to improve patient safety will be developed

How progress will be monitored, measured and reported:

- Progress will monitored and measured through the implementation sub-group and reported to the Clinical Quality Monitoring Group
- Ward compliance with the use of barcoded wristbands will be monitored following implementation
- Progress will be publicly reported in the quarterly Quality Report updates published on the Trust's quality web pages

2.2 Statements of assurance from the Board of Directors

2.2.1 Information on the review of services

During 2012/13 the University Hospitals Birmingham NHS Foundation Trust* provided and/or sub-contracted 63 relevant health services.

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

The income generated by the relevant health services reviewed in 2012/13 represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2012/13.

* 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.

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 2012/13, 40 national clinical audits and 4 national confidential enquiries covered relevant health services that UHB provides.

During 2012/13 UHB participated in 90% 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 2012/13 are as follows: (see table below)

The national clinical audits and national confidential enquiries that UHB participated in during 2012/13 are as follows: (see table below)

The national clinical audits and national confidential enquiries that UHB participated in, and for which data collection was completed during 2012/13, 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.

Audit type	Audit UHB eligible to participate in	UHB participation 2012-13	Percentage of required number of cases submitted
Part of the National Clinical Audit and Patient Outcomes Programme	Inflammatory bowel disease (IBD)	Yes	30%. Current participation level. Data collection finishes December 2013.
	Oesophago-gastric (stomach) Cancer	Yes	Data is being reviewed and will be submitted by the 1st October 2013 deadline.
	Bowel cancer (NBOCAP)	Yes	Data is being reviewed and will be submitted by the 1st October 2013 deadline.
	Adult cardiac surgery	Yes	100%
	Heart failure	Yes	73%. Heart Failure cases as identified by UHB and not HES data.
	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	67%. Current participation level. Data will be submitted up to the June 2013 deadline.
	Carotid Endarterectomy Audit	Yes	82%.
	National Vascular Database (NVD) Abdominal Aortic Aneurysm – AAA	Yes	100%
	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 Lung Cancer Audit	Yes	100% (submitted more than requested)
	National Audit of Dementia	Yes	100%
	National Diabetes Audit	Yes	N/A no required case target
	National Diabetes Inpatient Audit (NaDIA)	154	N/A no required case target
	Pain Database Audit	No	N/A
	Head and Neck Cancer (DAHNO)	Yes	100%
	Hip Fracture Database	Yes	100%
	SSNAP	Yes	N/A no required case target

Audit type	Audit UHB eligible to participate in	UHB participation 2012-13	Percentage of required number of cases submitted
Not part of the National Clinical Audit and Patient Outcomes Programme	Renal Registry – Renal Replacement Therapy	Yes	100%
	UK NHSBT UK Transplant registry: 1. Cardiothoracic	Yes	100%
	UK NHSBT UK Transplant registry: 2. Kidney	Yes	100%
	National Cardiac Arrest Audit	No	N/A
	ICNARC - Adult Critical Care Case Mix Programme	Yes	100%
	PROMs – Patient Reported Outcome Measures (Groin hernias and varicose veins only as UHB does not do hip or knee replacement surgery)	Yes	21.1% (Pre-operative questionnaire completion for groin hernias and varicose veins as published on the Health and Social Care Information Centre website). Data covers April to Sept 2012. Participation in PROMs by patients is voluntary.
	Potential Donor Audit	Yes	100%
	National Review of Asthma Deaths	Yes	100%
	BTS Adult Asthma	Yes	100% (Minimum 5, submitted 56)
	BTS Emergency Oxygen	Yes	N/A - no required case target
	BTS Adult Community Acquired Pneumonia	Yes	100% (Minimum 5, submitted 90)
	BTS Non-Invasive Ventilation	Yes	N/A - no required case target
	BTS Bronchiectasis	Yes	100% (Minimum 5, submitted 61)
	CEM Fractured Neck of Femur (#NOF)	Yes	100%
	CEM Feverish Children	Yes	100% (50 required cases, 24 maximum cases eligible for participation at UHB and all submitted)
	CEM Renal Colic	No	N/A
	Parkinson's Audit	Yes	100%
	Severe Trauma - TARN (Trauma Audit and Research Network)	Yes	100%
	National Joint Registry	Yes	100%
	National Comparative Audit of Blood Transfusion	Yes	100%

National Confidential Enquiries (NCEPOD)

National Confidential Enquiries (NCEPOD)	UHB participation 2012-13	Percentage of required number of cases submitted
Bariatric Surgery	No applicable patients	N/A
Cardiac Arrest Procedures	Yes	100%
Alcohol Related Liver Disease	Yes	100%
Subarachnoid Haemorrhage	Yes	100%

Percentages given are latest available figures.

The reports of 26 national clinical audits were reviewed by the provider in 2012/13 and UHB intends to take the following actions to improve the quality of healthcare provided: (see separate clinical audit appendix available 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 784 clinical audits were registered with UHB's clinical audit team as having commenced or been completed at UHB during 2012/13.

The reports of 259 local clinical audits were reviewed by the provider in 2012/13 and UHB intends to take the following actions to improve the quality of healthcare provided:

This figure indicates that the results of 259 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 These include measures such as: updating patient information; reviewing or developing new protocols or guidelines for staff; arranging training or education sessions in order to increase staff awareness of required standards; making changes to staff roles; implementing new care plans or assessment tools for patients; and purchasing equipment.

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 8598.

The table below shows the number of clinical research projects registered with the Trust's Research and Development (R&D) Team during 2011/12 and 2012/13. 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	2011/12	2012/13
Total number of projects registered with R&D	196	286
Out of the total number of projects registered, the number of studies which were abandoned	33	27
Trust total patient recruitment	6811	8598

Through the work of the R&D team the number of new R&D studies registered has increased by 90 and the number of patients recruited has increased by 2440 since 2011/12. The R&D team will continue to increase recruitment during 2013/14 to ensure that the Trust makes the most of all research opportunities available.

The table below shows the number of projects registered in 2012/13 split by specialty:

Projects registered during this period by Specialty	Registered
Anaesthetics	5
Audiology	2
Burns & Plastics	7
Cardiac Medicine	1
Cardiac Surgery	3
Cardiology	10
Clinical Immunology	2
Critical Care	3
Dermatology	8
Diabetes	7
Elderly Care	1
Endocrinology	21
ENT	8
General Surgery	2
Genito-Urinary Medicine	4
GI Medicine	4
GI Surgery	4
Haematology	24
HIV	1
Imaging	1
ITU	2
Liver Medicine	27
Liver Surgery	1
Maxillofacial	1
Microbiology	2
Neurology	20
Neuro-psychology	2
Neuroradiology	1
Neurosurgery	6
Nursing	1
Oncology	40
Ophthalmology	6
Palliative Care	1
Physiotherapy	1
Renal Medicine	21
Renal Surgery	2
Respiratory Medicine	10
Rheumatology	14
Stroke Services	4
Trauma	3
Urology	2
Vascular Surgery	1
Total	286

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 2012/13, 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 2012/13 was conditional upon achieving quality improvement and innovation goals agreed between UHB and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2012/13 and for the following 12 month period are available online at http://www.uhb.nhs.uk/quality.htm.

The amount of UHB income in 2012/13 which was conditional upon achieving quality improvement and innovation goals was £11.6m*. The Trust received £6,225,982m in payment in 2011/12. Final payment for 2012/13 will not be known until June 2013.

* This figure has been arrived at as a percentage of the healthcare income which will be included within the Trust's 2012/13 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).

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.

The Care Quality Commission has not taken enforcement action against UHB during 2012/13. The CQC inspects most hospitals annually. All scheduled inspections are unannounced and focus on a minimum of five national standards.

UHB has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2012/13 (see table below). UHB intends to take the following action to address the conclusions or requirements reported by the Care Quality Commission (see table below). UHB has made the following progress by 31 March 2013 in taking such action (see table below).

UHB also received an unannounced visit from Birmingham Cross City Clinical Commissioning Group during 2012/13. The findings and actions being taken are summarised in the table below. In addition, the Trust has a policy for handling external agency visits, inspections, accreditations and peer review assessments. This ensures external recommendations are monitored and actions identified and addressed. In 2012/13, there were 36 external visits to the Trust.

Date	Regulatory body	Type of inspection	Outcome	Actions taken
October 2012	Care Quality Commission	Unannounced inspection of Core Essential Standards	Met 7 of the 9 standards inspected. Inspectors requested the Trust to take action in respect of Outcome 16: Assessing and monitoring the quality of service provision. CQC judged that this had a minor impact on people using the service. .	UHB submitted an action plan to CQC setting out plans to improve the implementation and compliance with the WHO Surgical Safety checklist. Actions included putting in place robust clinical audit with an escalation process for non compliance UHB has demonstrated improvement in both implementation and compliance which has been monitored by the Board of Directors and Commissioners UHB has supplied compliance information against the action plan to the CQC and requested a review of the data to confirm compliance with Outcome 16. The CQC has confirmed receipt of this information.
February 2013	Birmingham Cross City Clinical Commissioning Group (CCG)	Unannounced visit - Review compliance with quality standards	The CCG visited the Emergency Department, Clinical Decision Unit and two wards. A report sharing comments regarding areas of good practice and any areas of concern or risk was received by UHB.	The report has been reviewed by UHB and a response drafted that addresses the concerns or risks that were raised. The Executive Chief Nurse has received the final report and has submitted an action plan for consideration by Birmingham Cross City CCG.
March 2013	Care Quality Commission	Announced visit – Review of UHB application of Mental Health Act (MHA)	The visit reviewed the application of the MHA, not a review of compliance against standards. Informal feedback from the visiting inspectors indicated that the systems in place provided a more than adequate application of the MHA. The CQC is currently drafting a report for UHB to review.	A work programme is currently in place, reviewed by the Mental Health Group, chaired by the Executive Chief Nurse. Any additional requirements will be developed after UHB has received the final report and added to the work programme.

2.2.6 Information on the quality of data

UHB submitted records during 2012/13 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:
97.8% for admitted patient care;
98.4% for outpatient care; and
93.6% 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 2012/13 was 80% and was graded green (satisfactory).

UHB was subject to the Payment by Results clinical coding audit during 2012/13 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:

	Diagnoses Incorrect		Procedures Incorrect	
	Primary	Secondary	Primary	Secondary
Kidney and Urinary Tract Infections	4.0%	13.5%	0.0%	4.8%
Haematological Procedures and Disorders	3.0%	8.7%	1.0%	13.5%
Vascular Procedures and Disorders	8.7%	8.5%	15.0%	20.0%

	Investigation Codes Incorrect	Treatment Codes Incorrect
Emergency Department	16.9%	13.3%

The results should not be extrapolated further than the actual sample audited. The following four areas were reviewed within the sample: Kidney and Urinary Tract Infections, Haematological Procedures and Disorders, Vascular Procedures and Disorders and the Emergency Department.

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

- Following successful Accreditation of the West Midlands National Classifications Service Clinical Coding Academy, UHB will continue to drive forward the strategy of the Academy to further improve training and clinical coding across the West Midlands
- Implementing the PbR Data Assurance Programme Action Plan developed as a result of the 2012/13 PbR audit
- Working through a robust programme of internal audit, which is undertaken by the Trust's own Accredited Auditor
- Ensuring compliance with the Information Governance Toolkit Initiatives is maintained at Level 2, whilst continuing to facilitate process reviews to work toward Level 3 compliance
- Continuing to participate in process reviews, such as bed capacity management and real time rostering, to ensure that data quality is embedded within the organisational culture of the Trust
- Continuing to regularly review the Data Quality Policy

2.3 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 data source for all the indicators is the Health and Social Care Information Centre (HSCIC) which has only published data for part of 2012/13 for some of the indicators. The Trust's performance for the applicable quality indicators is shown in Appendix A for the latest time periods available. Further information about these indicators can be found on the HSCIC website: www.hscic.gov.uk

Part 3: Other Information

3.1 Overview of quality of care provided during 2012/13

The tables below show the Trust's latest performance for 2012/13 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 2011/12 Quality Report 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 2012/13 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.

Patient safety indicators

Indicator	2010/11	2011/12	2012/13	Peer Group Average (where available)
1(a). MRSA: Patients with MRSA infection/100,000 bed days (includes all bed days from all specialties) *Lower rate indicates better performance*	**3.26**	**1.50**	**1.70**	**0.78**
Time period	2010/11	2011/12	April 2012-Jan 2013	April 2012-Jan 2013
Data source(s)	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/100,000 bed days (aged >15, excluding Obstetrics Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	**3.29**	**1.51**	**1.72**	**0.96**
Time period	2010/11	2011/12	April 2012-Jan 2013	April 2012-Jan 2013
Data source(s)	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	2010/11	2011/12	2012/13	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*	**43.33**	**25.44**	**22.16**	**17.70**
Time period	2010/11	2011/12	April 2012-Jan 2013	April 2012-Jan 2013
Data source(s)	Trust CDI data reported to HPA, HES data (bed days)	Trust CDI data reported to HPA, HES data (bed days)	Trust CDI data reported to HPA, HES data (bed days)	Trust CDI 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*	**43.62**	**25.60**	**22.30**	**21.68**
Time period	2010/11	2011/12	April 2012-Jan 2013	April 2012-Jan 2013
Data source(s)	Trust CDI data reported to HPA, HES data (bed days)	Trust CDI data reported to HPA, HES data (bed days)	Trust CDI data reported to HPA, HES data (bed days)	Trust CDI data reported to HPA, HES data (bed days)
Peer group				Acute trusts in West Midlands SHA

Indicator	2010/11	2011/12	2012/13	Peer Group Average (where available)
3(a) Patient safety incidents (reporting rate per 100 admissions) *Higher rate indicates better reporting*	**9.1**	**9.3**	**10.4**	*Not yet published*
Time period	2010/11	2011/12	2012/13	
Data source(s)	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	
Peer group				
3(b) Never Events *Lower number indicates better performance*	**2**	**1** (see explanatory note below table)	**0**	*Not yet published*
Time period	2010/11	2011/12	2012/13	
Data source(s)	Datix (incident data)	Datix (incident data)	Datix (incident data)	
Peer group				
4(a) Percentage of patient safety incidents which are no harm incidents *Higher % indicates better performance*	**81.3%**	**70.4%**	**64.4%**	*Not yet published*
Time period	2010/11	2011/12	2012/13	
Data source(s)	Datix (incident data)	Datix (incident data)	Datix (incident data)	
Peer group				

Indicator	2010/11	2011/12	2012/13	Peer Group Average (where available)
4(b) Percentage of patient safety incidents reported to the National Reporting and Learning System (NRLS) resulting in severe harm or death *Lower % indicates better performance*	**0.52%**	**1.06%**	**0.27%**	*Not available*
Time period	2010/11	2011/12	2012/13	
Data source(s)	Datix (patient safety incidents reported to the NRLS)	Datix (patient safety incidents reported to the NRLS)	Datix (patient safety incidents reported to the NRLS)	
Peer group				
4(c) Number of patient safety incidents reported to the National Reporting and Learning System (NRLS)	**9,295**	**8,514**	**9,536**	*Not yet published*
Time period	2010/11	2011/12	2012/13	
Data source(s)	Datix (patient safety incidents reported to the NRLS)	Datix (patient safety incidents reported to the NRLS)	Datix (patient safety incidents reported to the NRLS)	
Peer group				

Notes on patient safety indicators

1(a), 1(b), 2(a), 2(b): The data for MRSA and *C.difficile* infection has been calculated using 100,000 bed days in line with DH guidance. The data for previous years has therefore been recalculated so differs from the 2011/12 Quality Report.

3(a): The admissions data has been changed to include dialysis patients from 2012/13 as these are also classed as admissions. The data for 2010/11 and 2011/12 has been recalculated to aid comparison and therefore differs from that shown in the Trust's 2011/12 Quality Account.

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 reduction in the percentage of no harm incidents in 2011/12 and 2012/13 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.

4(b): The methodology for this indicator has changed in line with the guidance published by Monitor on the external assurance requirements for the 2012/13 Quality Reports (revised guidance published 26 April 2013). The new methodology is being included for the first time, is reliant on staff reporting all incidents and includes an element of local clinical judgement as to whether an incident resulted in severe harm or death.

The denominator (incident) data for this indicator only includes those incidents which are classed as patient safety incidents and were reported to the National Reporting and Learning System (NRLS). Data for previous years has therefore been recalculated to aid comparison and differs to that shown in the 2011/12 Quality Report. The percentage of incidents classed as severe harm or death in 2012/13 is lower than previous years as pressure ulcers are no longer included in the severe harm category as per NRLS guidance.

4(c): The number of incidents shown only includes those classed as patient safety incidents and reported to the National Reporting and Learning System.

Clinical effectiveness indicators

Indicator	2010/11	2011/12	2012/13	Peer Group Average (where available)
5(a). Emergency readmissions within 30 days (Medical and surgical specialties - elective and emergency admissions aged >15) % *Lower % indicates better performance*	**6.16%**	**5.19%**	**4.48%**	**5.19%**
Time period	2010/11	2011/12	April-November 2012	April-November 2012
Data source(s)	HES data	HES data	HES data	HES data
Peer group				University hospitals
5(b). Emergency readmissions within 30 days (all specialties) % *Lower % indicates better performance*	**6.15%**	**5.17%**	**4.46%**	**4.16%**
Time period	2010/11	2011/12	April-November 2012	April-November 2012
Data source(s)	HES data	HES data	HES data	HES data
Peer group				University hospitals

Indicator	2010/11	2011/12	2012/13	Peer Group Average (where available)
5(c). Emergency readmissions within 28 days of discharge % *Lower % indicates better performance*	**9.29%**	**9.50%**	**9.90%**	*Not available*
Time period	2010/11	2011/12	2012/13	
Data source(s)	Lorenzo	Lorenzo	Lorenzo	
Peer group				
6. Falls (incidents reported as % of patient episodes) *Lower % indicates better performance*	**2.1%**	**2.2%**	**2.2%**	*Not available*
Time period	2010/11	2011/12	2012/13	
Data source(s)	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	
Peer group				
7. Percentage of stroke patients (infarction) on aspirin, clopidogrel or warfarin *Higher % indicates better performance*	**100%**	**100%**	**99.6%**	*Not available*
Time period	2010/11	2011/12	2012/13	
Data source(s)	Trust PICS data	Trust PICS data	Trust PICS data	
Peer group				

Indicator	2010/11	2011/12	2012/13	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*	**92.6%**	**93.6%**	**96.4%**	*Not available*
Time period	2010/11	2011/12	2012/13	
Data source(s)	Trust PICS data	Trust PICS data	Trust PICS data	
Peer group				

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 data shown relates to patients who are readmitted as emergencies to any provider within England, including private sector providers) within 30 days of being discharged from UHB. 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). Data shown for previous years may vary slightly due to changes in published Hospital Episode Statistics (HES) data.

5(c): The data shown relates to patients who are readmitted to UHB as emergencies within 28 days of being discharged from UHB. This is in line with the guidance published by Monitor on the external assurance requirements for the 2012/13 Quality Reports (revised guidance published 26 April 2013).

6: One patient admission or spell in hospital can comprise a number of different episodes of care. The first episode will start from admission to hospital under the admitting Consultant. A new episode of care will be initiated when the responsibility for the patient is transferred to another Consultant. Data shown for previous years may vary slightly due to changes in published Hospital Episode Statistics (HES) data.

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.

Patient experience indicators

The results of the 2012 National Inpatient Survey reported that out of the 70 questions reported, the Trust was better than other Trusts in eight of the questions and worse than other Trusts for one question. It was about the same for the remainder of the questions. However, there was an increased positive score for 69% of the questions, of which five were a statistically significant improvement.

Patient survey question	2010/11	2011/12	Comparison with other NHS trusts in England (2011/12)	2012/13	Comparison with other NHS trusts in England (2012/13)
9. Overall were you treated with respect and dignity	**8.8**	**9.1**	**About the same**	**8.9**	**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	2012, Trust's Survey of Adult Inpatients 2012 Report, Care Quality Commission	2012, Trust's Survey of Adult Inpatients 2012 Report, Care Quality Commission
10. Involvement in decisions about care and treatment	**6.9**	**7.4**	**About the same**	**7.5**	**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	2012, Trust's Survey of Adult Inpatients 2012 Report, Care Quality Commission	2012, Trust's Survey of Adult Inpatients 2012 Report, Care Quality Commission
11. Did staff do all they could to control pain	**7.9**	**8.0**	**About the same**	**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	2012, Trust's Survey of Adult Inpatients 2012 Report, Care Quality Commission	2012, Trust's Survey of Adult Inpatients 2012 Report, Care Quality Commission

12. Cleanliness of room or ward	**8.9**	**9.2**	**About the same**	**9.3**	**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	2012, Trust's Survey of Adult Inpatients 2012 Report, Care Quality Commission	2012, Trust's Survey of Adult Inpatients 2012 Report, Care Quality Commission
13. Overall rating of care	**7.8**	**8.1**	**About the same**	**8.2***	**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	2012, Trust's Survey of Adult Inpatients 2012 Report, Care Quality Commission	2012, Trust's Survey of Adult Inpatients 2012 Report, Care Quality Commission

*The rating for this question has changed this year to a ten point scale and so is not comparable to previous years.

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.

11 Performance against national targets and indicators included in the Monitor Compliance Framework

National targets and regulatory requirements	Time Period for 2012/13	2012/13 Performance	2012/13 Target	2011/12 Performance	2011/12 Target
Clostridium difficile (post-48 hour cases)	Apr 2012 – Mar 2013	73	76	85	114
MRSA (post-48 hour cases)	Apr 2012 – Mar 2013	5	5	4	7
62-day wait for first treatment from urgent GP referral: all cancers	Apr 2012 – Mar 2013	86.2%	85%	85.3%	85%
62-day wait for first treatment from consultant screening service referral: all cancers	Apr 2012 – Mar 2013	95.2%	90%	94.7%	90%
31-day wait from diagnosis to first treatment: all cancers	Apr 2012 – Mar 2013	97.2%	96%	97.2%	96%
31-day wait for second or subsequent treatment: surgery	Apr 2012 – Mar 2013	96.8%	94%	98.1%	94%
31-day wait for second or subsequent treatment: anti cancer drug treatments	Apr 2012 – Mar 2013	99.8%	98%	99.7%	98%
31-day wait for second or subsequent treatment: radiotherapy	Apr 2012 – Mar 2013	99.3%	94%	99.9%	94%
Two week wait from referral to date first seen: all cancers	Apr 2012 – Mar 2013	96.3%	93%	98.0%	93%
Two week wait from referral to date first seen: breast symptoms	Apr 2012 – Mar 2013	98.2%	93%	98.6%	93%
18-week maximum wait from point of referral to treatment (admitted patients)	Apr 2012 – Mar 2013	94.9%	90%	95.6%	90%
18-week maximum wait from point of referral to treatment (non-admitted patients)	Apr 2012 – Mar 2013	99.1%	95%	98.3%	95%
18-week maximum wait from point of referral to treatment (incomplete pathways)	Apr 2012 – Mar 2013	95.7%	92%	94.1%	92%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	Apr 2012 – Mar 2013	94.95%	95%	96.1%	95%
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	Apr 2012 – Mar 2013	Certification made	N/A	Certification made	N/A

3.3 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 received a letter from the Care Quality Commission in November 2012 regarding a mortality outlier notification from 2011/12. The original mortality outlier notification related to pneumonia (Complex Elderly with a Respiratory System Primary Diagnosis) and was fully investigated by the Trust. There were no concerns identified.

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[1]. An average hospital will have a SHMI around 100; a SHMI greater than 100 implies more deaths occurred than predicted by the model but may still be within the control limits. A SHMI above the control limits should be used as a trigger for further investigation. The 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 SHMI is 103.42 for the period April-December 2012 which is within tolerance. The latest SHMI value for the Trust which is available on the Health and Social Care Information Centre website is 106.44 for the period October 2011-September 2012. This is within tolerance.

The Trust has concerns about the validity of the Hospital Standardised Mortality Ratio which has been superseded by the SHMI but it is included here for completeness. UHB's HSMR value is 111.92 for the period April 2012-January 2013 as calculated by the Trust's Health Informatics team. The validity and appropriateness of the HSMR methodology used to calculate the expected range has however been the subject of much national debate and is largely discredited[2][3]. The Trust is continuing to robustly monitor mortality in a variety of ways as detailed above.

Crude Mortality

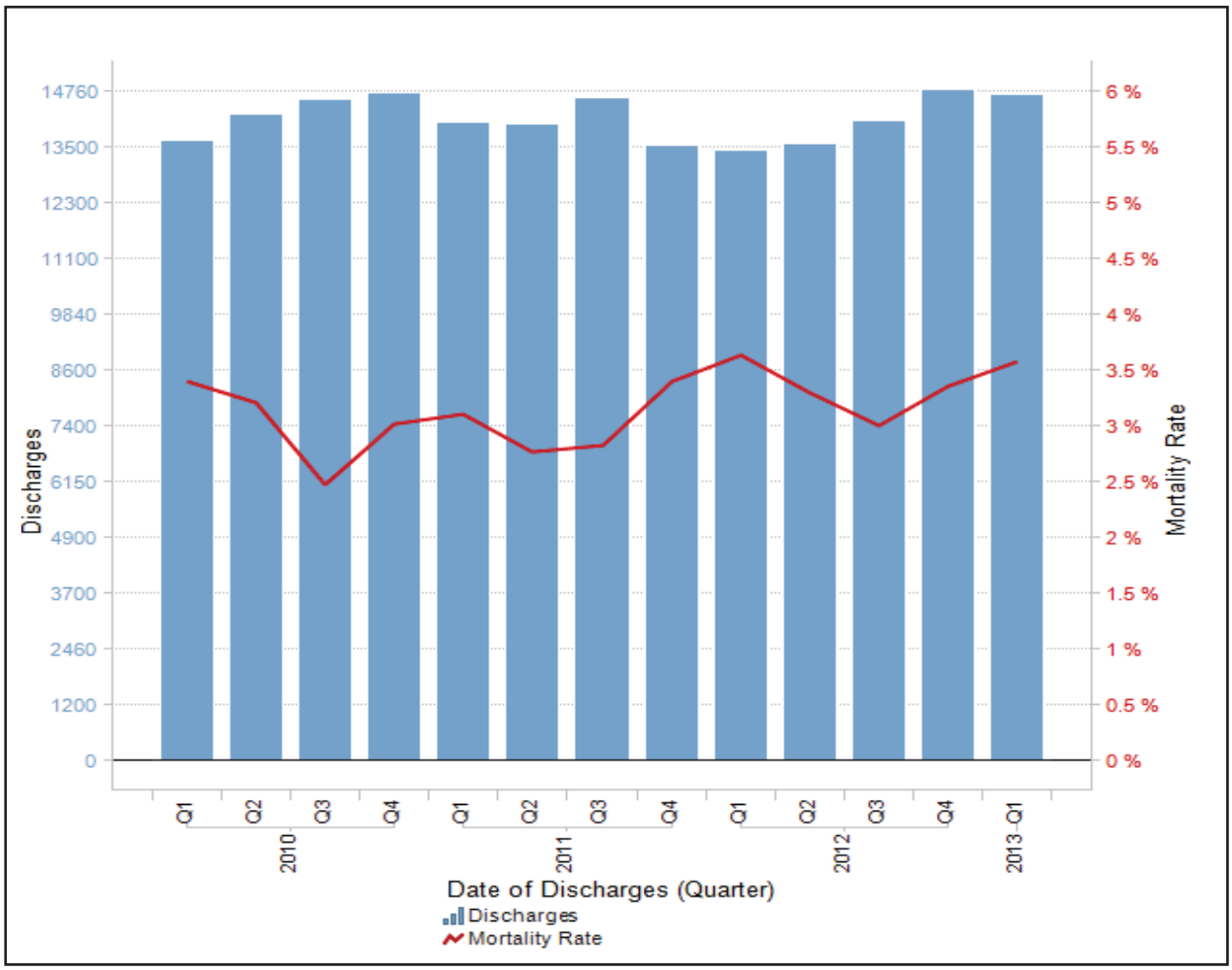
The first graph below shows the Trust's overall crude mortality rate against activity (patient discharges) by quarter for the past three calendar years. The second graph shows the Trust's crude mortality rates for emergency and non-emergency (planned) patients.

The crude mortality rate is calculated by dividing the total number of deaths by the total number of patients discharged from hospital in any given time period. The crude mortality rate does not take into account complexity, case mix (types of patients) or seasonal variation.

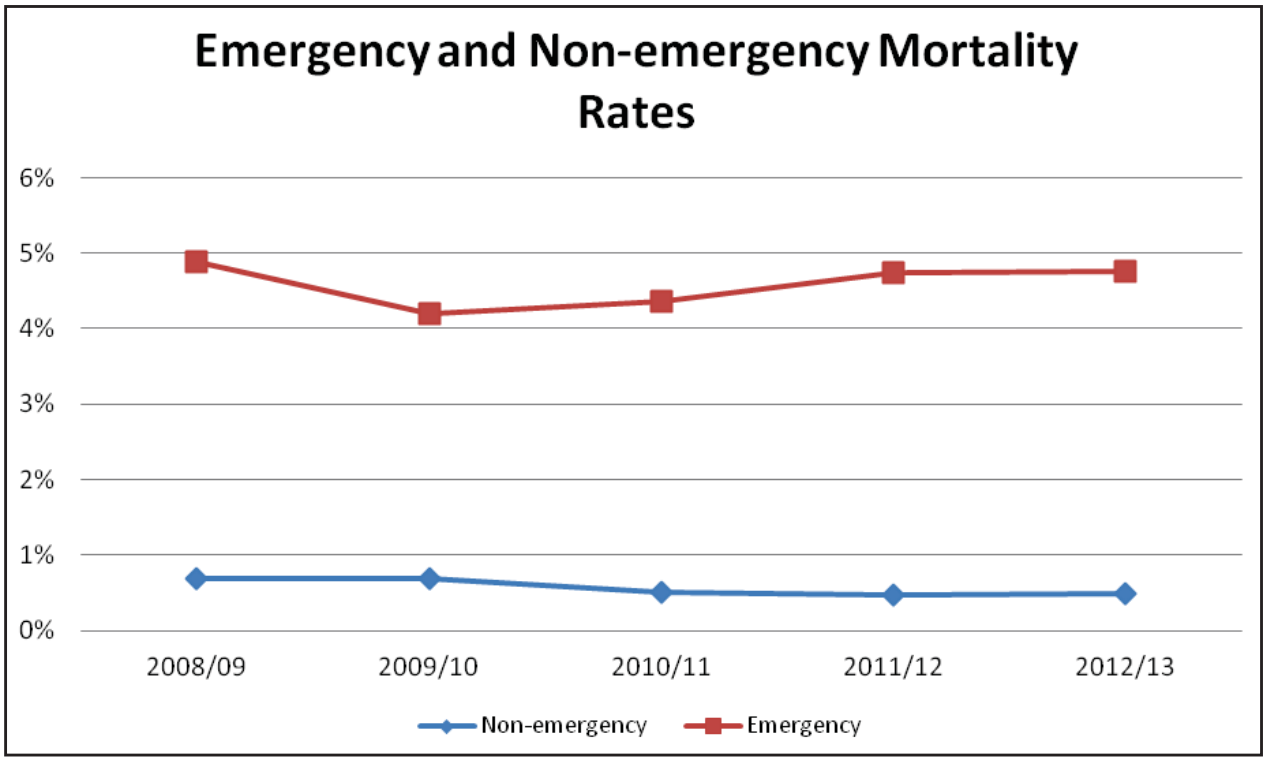
[1] Freemantle N, Richardson M, Wood J, Ray D, Khosla S, Sun P, Pagano, D. Can we update the Summary Hospital Mortality Index (SHMI) to make a useful measure of the quality of hospital care? An observational study. BMJ Open. 31 January 2013.
[2] Hogan H, Healey F, Neale G, Thomson R, Vincent C, Black, N. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review. BMJ Quality & Safety. Online First. 7 July 2012.
[2] Lilford R, Mohammed M, Spiegelhalter D, Thomson R. Use and misuse of process and outcome data in managing performance of acute and medical care: Avoiding institutional stigma. The Lancet. 3 April 2004.

The Trust's overall crude mortality rate is slightly higher for 2012/13 (3.42%) compared to 2011/12 (3.24%). This is due to an increase in the number of emergency admissions and a corresponding reduction in the number of non-emergency admissions. UHB became a Level 1 Major Trauma Centre from April 2012 and is therefore treating more complex and seriously ill patients compared to previous years. The Trust is also treating patients who only require a short period of treatment in a clinic setting rather than admitting them to hospital. This means that the patients who are now being admitted tend to be sicker and require more complex treatment which has had a small impact on the emergency mortality rate.

Overall Crude Mortality Graph



Crude Emergency and Non-emergency Mortality Graph



3.4 Accident and Emergency Department Survey

The Trust performed very well in the 2012 Accident and Emergency Department Survey. The results are based on responses from 255 patients which represents a response rate of 31% compared to 38% for all trusts. Out of the 45 questions included in the report UHB scored better than other NHS Trusts for 8 questions including information, communication, involvement in decision making, cleanliness and provision of food and drinks. The Trust scored the same as other NHS Trusts for the remaining 37 questions, but did not score worse for any questions.

The table provides a summary of the survey results grouped into categories:

Performance	Number of Questions	Percentage of Questions
Better than other Trusts	8	17.7%
About the same as other Trusts	37	82.3%
Worse than other Trusts	0	0%

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

- Waiting times
- Privacy at the reception
- Pain control
- Availability of food and drink
- Communication regarding worries and fears and discussion of condition
- Information given on discharge from the department

The Trust's Accident and Emergency Department Survey 2012 detailed benchmark report can be accessed from the Care Quality Commission website: http://www.nhssurveys.org/Filestore/AE2012/benchmarks/AE12_RRK.pdf

3.5 Staff Survey

The Trust's Staff Survey results for 2012 show that performance was average or better for 26 (93%) of the 28 survey questions and below average for 2 (7%) questions. The results are based on responses from 397 staff which represents a decrease in response rate from 55% last year to 48% this year. However, despite the decrease, this response rate is inkeeping with the national average for acute trusts. The results for the Staff Survey questions which most closely relate to quality of care are shown in the table below. These results are pleasing as in the 2011 survey the scores for staff reporting errors, near misses or incidents witnessed in the last month and staff saying hand washing materials are always available fell within the below average bracket. In these two areas this year, although the scores remain consistent with last year, the Trust is now ranked above average, and average respectively. The Trust will be aiming to continue to improve performance for these questions.

Staff survey question	2009/10	2010/11	2011/12	2012/13	Comparison with other NHS trusts 2012/13
1. Percentage feeling satisfied with the quality of work and patient care they are able to deliver	**83%**	**79%**	**76%**	**86%**	**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	Trust's 2012 Staff Survey Report, Department of Health	
2. Percentage agreeing their role makes a difference to patients	**93%**	**93%**	**91%**	**94%**	**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	Trust's 2012 Staff Survey Report, Department of Health	
3. Staff recommendation of the trust as a place to work or receive treatment	**3.79**	**3.81**	**3.78**	**3.93**	**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	Trust's 2012 Staff Survey Report, Department of Health	

4. Percentage of staff reporting errors, near misses or incidents witnessed in the last month Time period & data source	**95%** Trust's 2009 Staff Survey Report, Care Quality Commission	**96%** Trust's 2010 Staff Survey Report, Care Quality Commission	**95%** Trust's 2011 Staff Survey Report, Care Quality Commission	**92%** Trust's 2012 Staff Survey Report, Department of Health	**Above (better than) average**
5. Percentage of staff saying hand washing materials are always available Time period & data source	**71%** Trust's 2009 Staff Survey Report, Care Quality Commission	**63%** Trust's 2010 Staff Survey Report, Care Quality Commission	**60%** Trust's 2011 Staff Survey Report, Care Quality Commission	**59%** Trust's 2012 Staff Survey Report, Department of Health	**Average**

Notes on staff survey

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

3.6 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. The unit continues to provide support to clinical staff in the development of innovative quality indicators with a focus on research. In August 2012, the Trust implemented a framework based on a statistical model for handling potentially significant changes in performance and identifying any unusual patterns in the data. The framework has been used by the Quality and Informatics teams to provide a more rigorous approach to quality improvement and to direct attention to those indicators which may require improvement.

Performance for a wide selection of the quality indicators developed by clinicians, Health Informatics and the Quality and Outcomes Research Unit has been included the Trust's annual Quality Reports. The selection included for 2012/13 includes 80 indicators covering the majority of clinical specialties and performance for the past three financial years is included in a separate appendix on the Quality web pages: http://www.uhb.nhs.uk/quality.htm

The Trust's clinical and management teams have improved performance for 25% of the indicators during 2012/13 with support from the Quality and Informatics teams. Performance for 66% has stayed about the same and performance for 9% has deteriorated during 2012/13. The vast majority of the 80 indicators have a goal; 52% of those with a goal met them in 2012/13. Table 1 shows the performance for those specialty quality indicators where the most notable improvements have been made during 2012/13. The data has been checked by the appropriate clinical staff to ensure it accurately reflects the quality of care provided.

Table 2 shows performance for some of the indicators where performance has deteriorated during 2012/13. 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 2013/14.

Table 1

Specialty	Indicator	Goal	Percentage Apr 10 - Mar 11	Percentage Apr 11 - Mar 12	Numerator Apr 12 - Mar 13	Denominator Apr 12 - Mar 13	Percentage Apr 12 - Mar 13	Data Sources
Dementia	Percentage of patients with Dementia who had at least 3 out of the following 4 medications prescribed to be taken as required during their stay in hospital: analgesics, sedation to reduce agitation, anti-emetics (anti-sickness medication) and anti-secretory medication	>90%	61.2%	68.6%	92	124	74.2%	Lorenzo PICS
Heart Failure	Patients with a primary diagnosis of acute heart failure who had an echocardiogram (ECHO) within 3 months prior to discharge	100%	50.0%	52.6%	295	520	56.7%	Lorenzo PICS PRISM
Anaesthetics	Post-operative nausea and vomiting: All high risk patients (Ear, Nose and Throat, General Surgery and Laparoscopic Surgery) should be prescribed with antiemetics (anti-sickness medication) so they can be given promptly after the operation if they need them	No goal currently	80.4%	79.1%	2089	2410	86.7%	Lorenzo PICS
Anaesthetics	Post-operative nausea and vomiting: Percentage of high risk patients who did not require anti-sickness medication after their operation	No goal currently	69.8%	62.3%	1664	2410	69.0%	Lorenzo PICS
Imaging	Proportion of Inpatients who have report turnaround time of less than or equal to 2 days for MRI	>85%	77.2%	80.1%	3167	3682	86.0%	CRIS
Imaging	Proportion of Outpatients who have report turnaround time of less than or equal to 5 days for MRI	>75%	44.4%	44.7%	8716	15747	55.4%	CRIS
Therapy Services	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%	95.5%	92.9%	36230	37588	96.4%	Therapy database
Palliative care	Percentage of palliative care patients on the end of life pathway who were prescribed at least 3 out of the following 4 medications to be taken as required - injectible analgesics, injectible sedatives, anti-sickness and anti-secretory medication.	100%	85.6%	83.5%	310	345	89.9%	Lorenzo, PICS
Rheumatology	Continuity of care - Rheumatology outpatients who saw the same clinician at least 3 times out of their 6 most recent visits	>65%	n/a	63.7%	1372	1951	70.3%	Clinical Portal
Colorectal Surgery*	Clexane medication after elective colorectal surgery (excluding day cases)	>95%	83.0%	83.4%	269	309	87.1%	Lorenzo, PICS

* The list of operations included has been refined for this indicator so the percentages shown for previous years have slightly changed.

Table 2

Specialty	Indicator	Goal	Percentage Apr 10 - Mar 11	Percentage Apr 11 - Mar 12	Numerator Apr 12 - Mar 13	Denominator Apr 12 - Mar 13	Percentage Apr 12 - Mar 13	Data Sources
Upper Gastro-intestinal Medicine	Emergency patients admitted with gall stone diseases who had an ultrasound within 24 hours of admission	>90%	60.3%	58.9%	133	262	50.8%	Lorenzo, PICS
Upper Gastro-intestinal Medicine	Emergency patients admitted with gall stone diseases who had bilirubin tested	100%	98.4%	97.1%	245	262	93.5%	Lorenzo, PICS
Imaging	Proportion of Outpatients who have report turnaround time of less than or equal to 5 days for CT	>85%	82.4%	78.1%	11684	16470	70.9%	CRIS
Pathology	Turnaround time: Urine within 48 hours	>90%	89.1%	86.3%	36719	44804	82.0%	Telepath
Radiotherapy*	Patients should commence treatment (first dose of radiotherapy) within 14 calendar days from CT scan. Note: Some of the patients not treated within the target timeframe had chosen to delay their treatment.	>85%	82.8%	81.7%	2273	3188	71.3%	Mosaiq
Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - Emergency readmissions within 28 days	No goal currently	4.0%	3.0%	18	213	8.5%	PATS 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%	73.1%	91.5%	107	131	81.7%	Lorenzo

*Data up to 31 February only.

3.7 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.

3.8 mystay@QEHB

During 2012/13, the Trust has developed a new website for patients and the public called mystay@QEHB in response to feedback from Trust Members about the types of information they would like to receive. The purpose of mystay@QEHB is to provide patients and the public with more information about the care and treatment they are likely to receive before they come into hospital.

Quality information will be published monthly showing how each inpatient specialty is performing for the following indicators:

- Infection rates
- Medication given
- Observations
- Clinical assessments
- Patient feedback

Patients will be told about the new website at their Outpatient appointments and encouraged to look at how each specialty is performing. The proposed site has been positively reviewed by Trust Members and will be launched during 2013/14 subject to approval by the Board of Directors.

3.9 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.
Acute Trust	An NHS hospital trust that provides secondary health services within the English National Health Service
Angioplasty	A coronary angioplasty operation is carried out to treat angina or heart attack by relieving blockages or narrowing of the arteries
Anti-emetics	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
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
Clinical Portal	Trust's bespoke electronic patient record
Congenital	Condition present at birth
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
E. coli	*Escherichia coli*
ED	Emergency Department (previously called Accident and Emergency Department)
ECG	Electrocardiography

ENT	Ear, Nose and Throat
EPR	Electronic Patient Record
FCE	Finished Consultant Episode – denotes the time spent by a patient under the continuous care of a Consultant
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
HCS	Healthcare Commissioning Services
HCV	Hepatitis C infection
HED	Trust's Healthcare Evaluation Data tool
HES	Hospital Episode Statistics
HPA	Health Protection Agency
HSCIC	Health and Social Care Information Centre
HSMR	Hospital Standardised Mortality Ratio
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
MHA	Mental Health Act
MINAP	Myocardial Ischaemia National Audit Project
Monitor	Independent regulator of NHS Foundation Trusts
MRSA	Meticillin-resistant Staphylococcus aureus
MSSA	Meticillin-sensitive Staphylococcus aureus
Myocardial Infarction	Heart attack
NaDIA	National Diabetes Inpatient Audit
NBOCAP	National Bowel Cancer Audit Programme
NCAA	National Cardiac Arrest Audit
NCEPOD	National Confidential Enquiry into Patient Outcome and Death - a national review of deaths usually concentrating on a particular condition or procedure

Neck of femur	Hip
NHS	National Health Service
NHSBT	National Health Service Blood and Transplant
NVD	National Vascular Database
PALS	Patient Advice and Liaison Service
PATS	Patient Analysis and Tracking System (Cardiac Surgery database)
PbR	Payment by Results
Peri-operative	Period of time prior to, during, and immediately after surgery
PHSO	Parliamentary and Health Service Ombudsman
PICS	Prescribing Information and Communication System
PIR	Post Infection Review tool
PRISM	System which holds Cardiology test results e.g., echocardiograms and ECGs (electrocardiography)
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
Renal colic	Type of abdominal pain commonly caused by kidney stones
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
SIRI	Serious incident requiring investigation
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)
SSNAP	Sentinel Stroke National Audit Programme
TARN	Trauma Audit and Research Network
UHB	University Hospitals Birmingham NHS Foundation Trust
VTE	Venous thromboembolism
WHO	World Health Organisation

Appendix A: Performance against national core set of quality indicators

The Trust's performance against the national set of quality indicators jointly proposed by the Department of Health and Monitor is shown in the tables below. There are eight indicators which are applicable to acute trusts. The data source for all the indicators is the Health and Social Care Information Centre (HSCIC) which has only published data for part of 2012/13 for some of the indicators. Data for the latest two time periods is therefore included for each indicator and is displayed in the same format as the HSCIC. National comparative data is included where available. Further information about these indicators can be found on the HSCIC website: www.hscic.gov.uk

1. Mortality

Mortality	UHB Previous period	UHB Current Period	National Current Period	National Best Performance	National Worst Performance	Comment
	April 2011 - March 2012	July 2011 - June 2012	July 2011 - June 2012	July 2011 - June 2012	July 2011 - June 2012	
(a) Summary Hospital-level Mortality Indicator (SHMI) value	1.0079	1.0600	-	0.7108	1.2559	The Trust considers that this data is as described for the following reasons as this is the latest available on the HSCIC website. The Trust intends to take the following actions to improve the indicator and percentage in (a) and (b), and so the quality of services, by continuing with the technical approach UHB takes to improving quality detailed in this report. The Trust does not specifically try to reduce mortality as such but has robust processes in place, using more recent data, for monitoring mortality as detailed in Part 3 of this report. It is important to note that palliative care coding has no effect on the SHMI.
(a) SHMI banding	2	2	-	1	3	
(b) Percentage of patient deaths with palliative care coded at diagnosis or specialty level	14.5	14.4	-	0.3	46.3	

2. Patient Reported Outcome Measures (PROMs) – Average Health Gain

	UHB Previous period	UHB Current Period	National (England)	National Best (Providers)	National Worst (Providers)	Comment
	April 2009 - March 2010	April 2010 - March 2011	April 2010 - March 2011	April 2010 - March 2011	April 2010 - March 2011	
Groin hernia surgery (Average health gain)	0.071	0.109	0.085	0.156	-0.020	The Trust considers that the outcome scores are as described for the following reasons as these are the latest available on the HSCIC website. UHB is performing better than the national average health gain for both groin hernias and varicose veins. The Trust intends to take the following actions to improve these outcome scores, and so the quality of its services, by continuing to focus on improving participation rates for the pre-operative questionnaires which we have control over. Participation is shown in Part 2 as part of the audit section of this report.
Varicose vein surgery (Average health gain)	0.148	-	0.091	0.155	-0.007	
Hip replacement surgery	Not applicable to UHB					
Knee replacement surgery	Not applicable to UHB					

3. Readmissions to hospital within 28 days

	UHB Previous period	UHB Current Period	National (England)	National Best (Acute teaching providers)	National Worst (Acute teaching providers)	Comment
	April 2009 - March 2010	April 2010 - March 2011	April 2010 - March 2011	April 2010 - March 2011	April 2010 - March 2011	
Patients aged 0-15 readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust (Standardised percentage)	-	-	10.15	7.08	12.39	The Trust considers that these percentages are as described for the following reasons as these are the latest available on the HSCIC website. UHB is however unable to comment on whether it is correct as it is not clear how the data has been calculated. The Trust intends to take the following actions to improve these outcome scores, and so the quality of its services, by continuing to review readmissions which are similar to the original admission on a quarterly basis. UHB monitors performance for readmissions using more recent Hospital Episode Statistics (HES) data as shown in Part 3 of this report.
Patients aged 16+ readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust (Standardised percentage)	11.61	11.60	11.42	10.70	13.31	

4. Responsiveness to the personal needs of patients

	UHB Previous period	UHB Current Period	National Current Period	National Best Performance	National Worst Performance	Comment
	April 2010 - March 2011	April 2011 - March 2012	April 2011 - March 2012	April 2011 - March 2012	April 2011- March 2012	
Responsiveness to personal needs – average weighted score of 5 questions from the National Inpatient Survey (Score out of 100)	67.9	71.1	67.4	85.0	56.5	The Trust considers that this data is as described for the following reasons as it is the latest available on the HSCIC website. It is pleasing to note that UHB continues to improve patient experience in the National Inpatient Survey. The Trust intends to take the following actions to improve this data, and so the quality of its services, by continuing to collect real-time feedback from our patients as part of our local patient survey. The Board of Directors has again selected improving patient experience and satisfaction as a Trust-wide quality improvement priority for 2013/14 (see Part 2 of this report for further details).

5. Staff who would recommend the trust as a provider of care to their family and friends

	UHB Previous period	UHB Current Period	National (Average score for 4th quartile)	National Best Performance	National Worst Performance	Comment
	2011	2012	2012	2012	2012	
Staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends Performance shown is the average score for the 4th (top) quartile based on staff who agreed or strongly agreed.	75.28	75.39	81.86	94.20	35.34	The Trust considers that this percentage is as described for the following reasons as UHB is in the 4th (top) quartile for this staff survey question. UHB achieved the highest score of all non-specialist acute trusts in the West Midlands. The Trust intends to take the following actions to improve this percentage, and so the quality of its services, by trying to maintain performance for this survey question.

6. Venous thromboembolism (VTE) risk assessment

	UHB Previous period	UHB Current Period	National Current Period	National Best Performance	National Worst Performance	Comment
	Q2 2012-13	Q3 2012-13	Q3 2012-13	Q3 2012-13	Q3 2012-13	
Percentage of admitted patients risk-assessed for VTE	99.5%	99.4%	94.2%	100.0%	84.6%	The Trust considers that this percentage is as described for the following reasons as UHB has consistently performed above the national average for the past two years. The Trust intends to take the following actions to improve this percentage, and so the quality of its services, by continuing to ensure our patients are risk assessed for venous thromembolism (VTE) on admission and improving VTE prevention as detailed for *Priority 1: Improving VTE prevention* in this report.

7. *C. difficile* infection

	UHB Previous period	UHB Current Period	National (England)	National Best Performance	National Worst Performance	Comment
	2010/11	2011/12	2011/12	2011/12	2011/12	
C. difficile infection rate per 100,000 bed-days (patients aged 2 or over)	43.2	25.3	21.8	0	51.6	The Trust considers that this rate is as described for the following reasons as it is the latest available on the HSCIC website. The Trust intends to take the following actions to improve this rate, and so the quality of its services, by continuing to reduce *C. difficile* infection through the measures outlined for *Priority 5: Infection prevention and control* in this report.

8. Incidents

	UHB Previous period	UHB Current Period	National (Acute teaching providers)	National Highest (Acute teaching providers)	National Lowest (Acute teaching providers)	Comment
	Apr 2011 - Sept 2011	Oct 2011 – Mar 2012	Oct 2011 - Mar 2012	Oct 2011 - Mar 2012	Oct 2011 - Mar 2012	
Incident reporting rate per 100 admissions	9.22	10.37	-	7.55	0.94	The Trust considers that this number and/or rate is as described for the following reasons as the data is the latest available on the HSCIC website. UHB is however unable to comment on whether it is correct as it is not clear how the numerator (incidents) and denominator (admissions) data has been calculated. The Trust intends to take the following actions to improve this number and/or rate and so the quality of its services, by continuing to have a high incident reporting rate. UHB is consistently in the highest 25% of reporting trusts. The Trust routinely monitors incident reporting rates and the percentage of incidents which result in severe harm or death as shown in Part 3 of this report.
Number of patient safety incidents that resulted in severe harm or death	39	74	-	144	0	
Rate of patient safety incidents that resulted in severe harm or death (per 100 admissions)	0.09	0.17	-	0.18	0.00	

Annex 1: Statements from stakeholders

The Trust has shared its 2012/13 Quality Report with Birmingham Cross City Clinical Commissioning Group, Healthwatch Birmingham and Birmingham Health & Social Care Overview and Scrutiny Committee.

Birmingham Cross City Clinical Commissioning Group, Healthwatch Birmingham and Birmingham Health & Social Care Overview and Scrutiny Committee have reviewed the Trust's Quality Report for 2012/13 and provided the statements below.

Statement provided by Birmingham Cross City Clinical Commissioning Group

University Hospitals Birmingham NHS Foundation Trust
Quality Account 2012/13

Statement of assurance from Birmingham CrossCity CCG May 2013

Birmingham CrossCity CCG as the lead commissioner for the University Hospital Birmingham NHS Foundation Trust welcomes the opportunity to provide this statement for the Trust's Quality Account 2012/13. The Quality Account has been reviewed in accordance with the Department of Health guidance and Monitor's requirements. The statement has been developed in consultation with neighbouring CCGs and the Area Team for NHS England.

With responsibility for the quality of services it commissions from the Trust, the CCG as a newly formed commissioning organisation over the past year has developed challenging but constructive relationships with the Trust's clinicians and managers, reviewing performance through monthly Clinical Quality Review Group meetings and addressing any issues around the quality and safety of patient care with the Trust.

The Quality Account is detailed, clear and comprehensive and provides a balanced view of the Trust's achievements. It reflects the improvements the Trust has made within the year and the Trust's commitment to strive for excellence across all clinical services. We acknowledge the improvements the Trust has made across three of its priorities (improving patient experience and satisfaction, completeness of observation sets and infection prevention and control) and its revised targets for 2013/14. The Commissioning for Quality and Innovation (CQUIN) scheme for 2012/13 reflects the ethos of the Trust to improve patient safety, clinical effectiveness and patient experience as priorities for both the organisation and commissioners. More information could have been provided on the work the Trust has been undertaking around the CQUINs and the impact this has made on patient care and outcomes especially those related to the patient safety thermometer and pressure ulcers.

We have seen significant work being undertaken to reduce patient falls, pressure sores and improvements to meet infection control targets. These continue to challenge all our local health organisations for the coming year and we are pleased that UHB is committed to making significant improvements in all these areas in 2013/14. Further information around the Trust's plans to meet infection control targets, reduce pressure ulcers and reduce patient risk of falls would have been helpful.

The CCG undertook an unannounced visit in February to the Accident and Emergency department and some of the wards and observed good standards of care being delivered to patients. Patients who we spoke to all said that they would recommend the hospital to family and friends. We were also reassured to see that learning from serious incidents relating to patient falls was being acted on by nursing staff.

Commissioners recognise the work the Trust is doing around mortality and its focus on ensuring that unexpected deaths are fully investigated. Although the Trust has issues with some of the measures for mortality, it is encouraging that rates are either within tolerance or on a downward trend.

Safeguarding is not mentioned in the account and reference to how the Trust is complying with the Mental Capacity Act and Deprivation of Liberty Safeguards would have provided assurance around this area.

Workforce information is not evident within the report. This would have been useful particularly as the Trust has experienced a significant increase in activity over the past year in relation to emergency admissions with pressures experienced in the Accident and Emergency department and additional wards opened to deal with the demand.

We particularly commend the approach to improving patient experience and the range of initiatives being progressed and the plans going forward into 2013/14 which includes auditing the experience of carers. We were pleased to see the improvements made in response to patient feedback such as the electric golf buggy. The *myhealth@QEHB* and *mystay@QEHB* websites are also positive developments and shows the Trust's commitment to improving patient access to information. It is also encouraging to see some of the actions the Trust is taking in response to patient complaints.

Overall, this Quality Account is a balanced and accurate view of the Trust's achievements and how it has been working to improve the quality of care it delivers. We will continue to work in partnership with UHB to support the Trust in delivering this year's quality targets.

Catherine Griffiths

Interim Chief Accountable Officer

Birmingham CrossCity Clinical Commissioning Group.

Statement provided by Healthwatch Birmingham

Healthwatch Birmingham welcomes the opportunity to comment on the quality of services within University Hospitals Birmingham Foundation Trust.

Healthwatch Birmingham came into being on the 1st April 2013 following the legislative changes to health and social care as outlined in the Health and Social Care of 2012 that set out how local Healthwatch would be established as the successor to Local Involvement Networks (LINk). However as I'm sure you will appreciate given that Healthwatch Birmingham is not yet in a position to fully respond to your request.

Healthwatch Birmingham is pleased to have started to establish a relationship with University Hospitals Birmingham Foundation Trust and we are looking forward to working with you and providing our comments on the 2013/14 Quality Account.

We thought it may be helpful to identify what we would be looking for in Quality Accounts for 2013/14:

- Evidence of how patients and the public have been involved in the co-production of the Quality Account
- A clear description of how the Quality Account reflects the priorities of the local population
- Evidence that the Quality Account is presented in a clear and straightforward way. We expect that patients and the public can easily use the information it contains to inform choices and understand priorities for improvement
- An open and honest assessment of services or activities where University Hospitals Birmingham Foundation Trust recognises the need for improvement, and the plans for making those improvements
- Evidence of a communications and engagement strategy to ensure that patients and the public are aware or the Quality Account
- Evidence of how the Quality Account links to your own internal risk register and therefore your priorities for the coming year
- An understanding of how up your Quality Account matches national requirements and priorities

Yours sincerely,

Healthwatch Birmingham

Statement provided by Birmingham Health & Social Care Overview and Scrutiny Committee

The Birmingham Health & Social Care Overview & Scrutiny Committee ("the HOSC") recognises that healthcare providers publishing Quality Accounts have a legal duty to send their Quality Accounts to the HOSC in the local authority where the provider has its registered office, giving an opportunity to comment on the provider's Quality Accounts before publication.

Your Quality Accounts were considered at a meeting of the HOSC on 1st May 2013. In the interests of avoiding any potential conflicts of interest and of not fettering its discretion to scrutinise matters which may arise in the course of the year, the Birmingham HOSC will not be supplying an audit statement on the Quality Accounts. The HOSC is sending this statement so as not to hold up publication of the accounts.

Annex 2: Statement of directors' responsibilities in respect of the quality report

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

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.

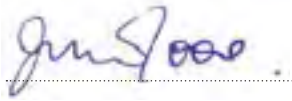
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2012/13;
- 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 2012 to June 2013
  - Papers relating to Quality reported to the Board over the period April 2012 to June 2013
  - Feedback from the commissioners dated 24/05/2013
  - Feedback from governors dated 06/02/2013
  - Feedback from Local Healthwatch organisations dated 23/05/2013
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 02/05/2013;
  - The 2012 national patient surveys: Adult Inpatient Survey April 2013 Accident and Emergency Department Survey December 2012
  - The 2012 national staff survey 28/02/2013
  - The Head of Internal Audit's annual opinion over the trust's control environment dated 02/05/2013
  - CQC quality and risk profiles dated April 2013
- 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

23 May 2013



23 May 2013

KPMG

Independent Auditor's Report to the Council of Governors of University Hospitals Birmingham NHS Foundation Trust on the 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 2013 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2013 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
- Emergency readmissions within 28 days of discharge from hospital.

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 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 consider whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual,* and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2012 to May 2013;
- Papers relating to Quality reported to the Board over the period April 2012 to May 2013;
- Feedback from the Commissioners dated 24 May 2013;
- Feedback from local Healthwatch organisations dated 23 May 2013;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2 May 2013;

- The 2012/13 national patient survey;
- The 2012/13 national staff survey;
- Care Quality Commission quality and risk profiles 2012/13;
- The 2012/13 Head of Internal Audit's annual opinion over the Trust's control environment dated 2 May 2013; and
- Any other information included in our review.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of 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 2013, to enable the Council of Governors to demonstrate they have discharged their 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;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report; and
- Reading the documents.

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

Limitations

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

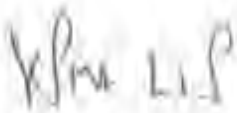
The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, 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 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 2013:

- 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*.



KPMG LLP, Statutory Auditor

Birmingham

29 May 2013

This annual report covers the period
1 April 2012 to 31 March 2013

University Hospitals Birmingham NHS
NHS Foundation Trust

Section 4 **Consolidated Financial Statements 2012-13**

Section 4 | Consolidated Financial Statements

University Hospitals Birmingham NHS Foundation Trust - Consolidated Financial Statements 2012/13

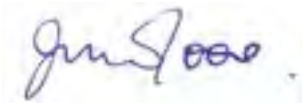
Contents

Foreword to the Financial Statements	I
Statement of the Chief Executive's responsibilities as the accounting officer of University Hospitals Birmingham NHS Foundation Trust	II
Independent Auditor's Report to the Council of Governors of University Hospitals Birmingham NHS Foundation Trust	III
Annual Governance Statement	V
Consolidated Statement of Comprehensive Income	XII
Consolidated Statement of Financial Position	XIII
Consolidated Statement of Changes in Taxpayers' Equity	XIV
Consolidated Statement of Cash Flows	XV
Notes to the Financial Statements	XVI
Directions by Monitor	LXIII

Foreword to the Financial Statements

University Hospitals Birmingham NHS Foundation Trust

These financial statements for the year ended 31 March 2013 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, Chief Executive

23 May 2013

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 Monitor.

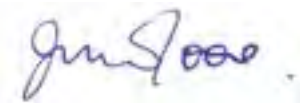
Under the National Health Service Act 2006, Monitor has directed the University Hospitals Birmingham NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must 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, 23 May 2013
Chief Executive

KPMG

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

We have audited the consolidated financial statements of University Hospitals Birmingham NHS Foundation Trust for the year ended 31 March 2013 on pages XII to LXII . These financial statements have been prepared under applicable law and the NHS Foundation Trust Annual Reporting Manual 2012/13.

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 2 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 University Hospitals Birmingham NHS Foundation Trust's affairs as at 31 March 2013 and of its income and expenditure for the year then ended; and
- have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2012/13.

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.

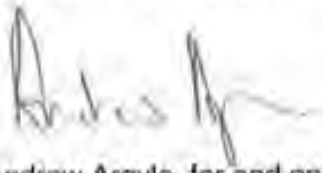
Matters on which we are required to report by exception

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 University Hospitals Birmingham NHS Foundation Trust 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.



Andrew Argyle, for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
Birmingham

29 May 2013

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 2013 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

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

Risk issues are reported through the Clinical 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.

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.

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 that Require 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

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.

The Trust's Risk Management Strategy and Risk Management Policy defines risk management structures, accountability and responsibilities and the level of acceptable risk for the Trust. The Board Assurance Framework identifies key risks to the Trust's corporate aims and objectives and is reviewed on a quarterly basis by Executive Directors and by the Audit Committee, which then provides assurance to the Board of Directors.

NHSLA

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 September 2013.

CQC

The Clinical Governance Support Unit (CGSU) is responsible for liaising with designated 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 and that good practice is shared and celebrated.

The CGSU liaises with designated leads to provide evidence to support their position statements. The CGSU reviews the quality of the evidence and ensures that any changes in compliance be it an improvement or matter for concerns is 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.

Where necessary the CGSU liaises with designated leads to formulate action plans to achieve compliance and ensure the relevant Director is made aware of and approves the plans. The CGSU monitors that action plans are completed when the proposed milestone or completion date is reached.

A summary report of CQC compliance is prepared for the Board on a quarterly basis.

4.1 Risk identification and evaluation

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

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

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.

Other methods of identifying risks are:

- Complaints and Care Quality Commission reports and recommendations;
- Inquest findings and recommendations from HM Coroners;
- Health and Safety visits undertaken by Director of Operations of each Division;
- Medico-legal claims and litigation;

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:

- Incident reports and trend analysis;
- Internally generated reports from the Health Informatics Team;
- Internal and external audit reports;

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 to the Audit Committee through the Assurance Framework process.

Every quarter the Audit Committee undertakes a detailed examination of the Board Assurance Framework (BAF) and the associated risk management processes. This Committee assesses whether there are any gaps in assurance or weaknesses in the effectiveness of controls.

4.2 Risk Control

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

Information Governance

Risks to information are managed and controlled in accordance with the Trust's Information Governance Policy 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. All information governance issues are integrated through the Information Governance Group. The Board of Directors receives a report regarding its systems of control for information governance. These include satisfactory completion of its annual self-assessment against the Information Governance Toolkit, mapping of data flows, monitoring of access to data and reviews of incidents.

The Trust completed the Information Governance Toolkit assessment for 2012/13 and achieved a score of 78%, achieving Level 2 or above for all the requirements, which is satisfactory.

Risk management

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

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.

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.

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.

All SIRIs are reported and managed in accordance with the national framework. The Trust has undertaken an exercise to determine its strategic objectives and, through its Board 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.

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

Financial Risks

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 Audit Committee.

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.

Strategic Risks

The BAF 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.

Changes in the regulatory framework for FTs resulting from the change in government also presents a risk to the Trust. The Trust manages 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.

4.3 Infection Prevention and Control

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.

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.

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 2012/13. The Trust Action Plan makes clear reference to the Code of Practice and there are plans in place to continue the ongoing yearly improvement of performance within the Trust.

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

There are elements of risk management where public stakeholders are closely involved. Members of the public are encouraged to participate through the regular 'Clean your hands' campaign led by the Divisional Patient Council supported by the Trust. There are patient representatives on the Trust Cleaning groups and involved in the PEAT environmental visits. Aspects of risk, including infection control, are discussed at all Divisional Patient Council meetings. The Board of Governors of the Trust represented on the Care Quality Group and receives regular reports on care quality, infection control and the new hospital project.

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

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.

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

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

The Trust's Financial Plan for 2012/13 was approved by the Board of Directors in April 2012. Achievement of the financial plan relied on delivery of cash releasing efficiency savings of around £18.3m during the financial year. This has been accomplished through the establishment of a 4% 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.

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.

During 2012/13 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 sickness absence, bank usage, external agency usage, vacancy rate, delayed transfers of care, appointments where patients did not attend, and letter turnaround times. Data is also used via dashboards at a local level to measure efficiency. The performance reports contain progress against CQUIN delivery, some of which contain efficiency measures such as Cardiac Surgery within 7 days for urgent transfers.

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.

Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual 2012/13.

The content of the Trust's Quality Report for 2012/13 builds on the 2011/12 report and was agreed by the Clinical Quality Monitoring Group, chaired by the Executive Medical Director and the Board of Directors. The Quality Improvement Priorities for 2013/14 were selected with input from the Council of Governors, Care Quality Group, Trust Partnership Team and Birmingham Local Involvement Network (LINk) UHB Action Group.

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.

As in previous years, the Trust has published quarterly update reports showing performance for the quality improvement priorities and other key indicators during 2012/13. These are also routinely shared with the Trust's host commissioner and Birmingham Local Involvement Network (LINk) UHB Action Group.

Data included in the 2012/13 Quality Report has been checked by all teams involved and then signed off by the responsible Director before being approved by the Trust Board of Directors. In line with the Trust's commitment to transparency, the data included is not just limited to good performance.

6. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the Internal Auditors, 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. 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.

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

- the maintenance of a view of the overall position with regard to internal control by the Board of Directors through its routine reporting processes and its work on Corporate risks maintained a view of the overall position;
- 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;
- personal input into the controls and risk management processes from all Executive Directors and Senior Managers and individual clinicians; and
- the provision of comment by Internal Audit, through their annual report, on the Trust's system of Internal Control
- quarterly reports from the clinical governance support unit regarding national and local audit

The Board's review of the Trust's risk and internal control framework is supported by the Annual Head of Internal Audit opinion which states that "significant assurance can be given that there is a sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design and/or inconsistent application of controls put the achievement of particular objectives at risk."

Weaknesses were identified in particular in relation to the Sage Finance system which has led to 'partial limited' assurance (with the remainder been accredited 'substantial' assurance). The weakness was caused by continuing delay in implementing the finance system upgrade with the effect that management was unable to address the weaknesses in disaster recovery arrangements that had been identified in 2011/12. The system upgrade is now set to go live on 23 May 2013 which will allow the Trust to rectify current disaster recovery arrangements.

During 2012/13, 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.

7. Conclusion

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, Chief Executive

23 May 2013

Consolidated statement of comprehensive income

	Notes	Year Ended 31 March 2013 Total £000	Before non-recurring costs £000	Material non-recurring costs £000	Year Ended 31 March 2012 Total £000
Revenue	3 - 4	**640,031**	586,640	-	586,640
Operating expenses	5	**(624,941)**	(567,969)	(33,510)	(601,479)
Operating surplus / (deficit)		**15,090**	18,671	(33,510)	(14,839)
Finance costs					
Finance income	10	**658**	738	-	738
Finance expense	10	**(21,948)**	(19,531)	-	(19,531)
Net finance expense		**(21,290)**	(18,793)	-	(18,793)
Surplus / (deficit) before taxation		**(6,200)**	(122)	(33,510)	(33,632)
Taxation	12	**(118)**	(10)	-	(10)
Surplus / (deficit) after taxation		**(6,318)**	(132)	(33,510)	(33,642)
PDC Dividends payable	11	**-**	-	-	-
Retained surplus / (deficit) for the year		**(6,318)**	(132)	(33,510)	(33,642)
Other comprehensive income					
Revaluation gains / (losses) on property, plant and equipment		**(1,416)**			3,637
Total comprehensive income / (expense) for the year		**(7,734)**			**(30,005)**

All income and expenditure is derived from continuing operations.

A significant element of the -£6,318,000 retained deficit for the year arises from the -£9,996,000 impairment in respect of the Trust's PFI 'Queen Elizabeth Hospital Birmingham' building valuation carried out in year. See notes 5 and 14.2 to the financial statements on pages XXXIV and XLV respectively. Without this non cash accounting adjustment the Trust would have shown a retained surplus for the year of £3,678,000.

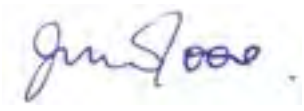
In the prior reporting period material non-recurring costs were associated with the relocation of healthcare services to the new 'Queen Elizabeth Hospital Birmingham' PFI hospital and the consequent decommissioning of the Selly Oak hospital site. This reorganisation of healthcare provision was completed in the prior reporting period, all current expenditure is considered recurring in nature because the new PFI hospital has been fully operational during the reporting period.

The notes on pages XVI to LXII are an integral part of these financial statements.

Consolidated statement of financial position

		Group		Trust	
		31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	Notes	**£000**	£000	**£000**	£000
Assets					
Non-current assets					
Intangible assets	13	**495**	806	**495**	806
Property, plant and equipment	14	**491,760**	513,279	**491,670**	513,187
Trade and other receivables	20	**2,842**	2,922	**2,842**	2,922
Other assets	21	**-**	213	**-**	213
		495,097	517,220	**495,007**	517,128
Current assets					
Inventories	19	**13,438**	13,056	**12,447**	12,247
Trade and other receivables	20	**38,410**	35,964	**41,243**	38,040
Other current assets	21	**-**	41	**-**	41
Cash and cash equivalents	22	**76,200**	67,696	**75,352**	66,728
		128,048	116,757	**129,042**	117,056
Total assets		**623,145**	633,977	**624,049**	634,184
Liabilities					
Current liabilities					
Borrowings	26	**(11,828)**	(12,254)	**(11,828)**	(12,254)
Trade and other payables	23	**(98,402)**	(78,130)	**(99,800)**	(78,356)
Current tax liabilities		**(111)**	-	**-**	-
Provisions	30	**(1,800)**	(2,420)	**(1,800)**	(2,420)
Other liabilities	24	**(21,015)**	(23,858)	**(21,015)**	(23,858)
		(133,156)	(116,662)	**(134,443)**	(116,888)
Total assets less current liabilities		**489,989**	517,315	**489,606**	517,296
Non-current liabilities					
Borrowings	26	**(534,449)**	(545,877)	**(534,449)**	(545,877)
Provisions	30	**(1,698)**	(1,645)	**(1,698)**	(1,645)
Deferred tax liabilities	25	**(17)**	(10)	**-**	-
Other liabilities	24	**(21,613)**	(29,837)	**(21,613)**	(29,837)
		(557,777)	(577,369)	**(557,760)**	(577,359)
Total liabilities		**(690,933)**	(694,031)	**(692,203)**	(694,247)
Net assets / (liabilities)		**(67,788)**	(60,054)	**(68,154)**	(60,063)
Taxpayers' equity					
Public dividend capital		**171,012**	171,012	**171,012**	171,012
Revaluation reserve		**106,764**	108,389	**106,764**	108,389
Income and expenditure reserve		**(345,564)**	(339,455)	**(345,930)**	(339,464)
Total taxpayers' equity		**(67,788)**	(60,054)	**(68,154)**	(60,063)

The financial statements on pages XII to LXII were approved by the Board of Directors on 23 May 2013 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	Income and Expenditure Reserve	**Total**
	£000	£000	£000	**£000**
Balance at 1 April 2011	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 as restated	171,012	108,389	(339,455)	**(60,054)**
Deficit for the year			(6,318)	**(6,318)**
Transfers in respect of assets disposed of		(209)	209	**-**
Transfers between reserves		-	-	**-**
Revaluation gains / (losses)		(1,416)	-	**(1,416)**
Total comprehensive income for the year	-	(1,625)	(6,109)	**(7,734)**
Balance at 31 March 2013	**171,012**	**106,764**	**(345,564)**	**(67,788)**

Trust	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	**Total**
	£000	£000	£000	**£000**
Balance at 1 April 2011	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 as restated	171,012	108,389	(339,464)	**(60,063)**
Deficit for the year			(6,675)	**(6,675)**
Transfers in respect of assets disposed of		(209)	209	**-**
Transfers between reserves		-	-	**-**
Revaluation gains / (losses)		(1,416)	-	**(1,416)**
Total comprehensive income for the year	-	(1,625)	(6,466)	**(8,091)**
Balance at 31 March 2013	**171,012**	**106,764**	**(345,930)**	**(68,154)**

Consolidated statement of cash flows for the year ended 31 March 2013

	Notes	Year Ended 31 March 2013 £000	Year Ended 31 March 2012 £000
Cash flows from operating activities			
Operating surplus for the year before non-recurring items		**15,090**	18,671
Non-recurring items		**-**	(33,510)
Operating surplus for the year		**15,090**	(14,839)
Depreciation and amortisation		**21,026**	20,105
Impairments		**9,996**	31,695
Loss on disposal of property, plant and equipment		**73**	-
(Increase) / decrease in inventories		**(382)**	(266)
(Increase) / decrease in trade and other receivables		**(2,353)**	17,940
(Increase) / decrease in other assets		**213**	41
Increase / (decrease) in trade and other payables		**20,106**	6,814
Increase / (decrease) in other liabilities		**(11,067)**	(11,597)
Increase / (decrease) in provisions		**(617)**	(29)
Net cash generated from operating activities		**52,085**	49,864
Cash flows from investing activities			
Interest received		**686**	685
Payments to acquire property, plant and equipment		**(10,067)**	(14,124)
Receipts from sale of property, plant and equipment		**8**	-
Payments to acquire intangible assets		**(20)**	(181)
Net cash used in investing activities		**(9,393)**	(13,620)
Cash flows from financing activities			
Capital element of finance lease obligations		**(36)**	(7)
Interest element of finance lease obligations		**(32)**	-
Capital element of PFI obligations		**(12,254)**	(10,928)
Interest element of PFI obligations		**(21,866)**	(19,491)
PDC dividends received / (paid)		-	(131)
Net cash used in financing activities		**(34,188)**	(30,557)
Net increase / (decrease) in cash and cash equivalents		**8,504**	5,687
Cash and cash equivalents at 1 April		**67,696**	62,009
Cash and cash equivalents at 31 March	22	**76,200**	67,696

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 2012/13 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 2013, 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.

1.1 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 2013, together with the Group's share of the results of joint ventures and associates up to the 31 March 2013. 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 ventures 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.

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, GP 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 actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of 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 and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2013, is based on the valuation data as at 31 March 2012, updated to 31 March 2013 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.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published 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 due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

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:

c) Scheme provisions

"The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service."

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

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 2011/12 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

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.

Disclosed in note 5 to the financial statements on pages XXXIV and XXXV are non-recurring expenditure items related to the prior reporting period. The Trust's management considered that these items should be separately identified 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

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.

The estimated useful economic lives of property, plant and equipment and intangible assets are as follows:

- Buildings are depreciated over 10 to 50 years according to the estimated useful life of the asset;
- Dwellings are depreciated over 15 to 30 years;
- Land and properties under construction are not depreciated;
- Plant and machinery is depreciated over 5 to 15 years;
- Information technology is depreciated over 2 to 5 years;
- Furniture and fittings are depreciated over 5 to 10 years; and
- Intangible software and licences are depreciated over 2 to 5 years

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

Following the accounting policy change outlined in the HM Treasury Financial Reporting Manual for 2011/12, a donated asset reserve is no longer maintained. Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to revenue. 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.

1.9 Government grants

Following the accounting policy change outlined in the HM Treasury Financial Reporting Manual for 2011/12, a government grant reserve is no longer maintained. The 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.

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 29.1 to the financial statements on page LV. 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 29.1 to the financial statements on page LV.

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 XLVIII.

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 26 and 27 to the financial statements on page LIII. 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 30 to the financial statements on page LVII, 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 31 to the financial statements on page LVIII, 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 31 to the financial statements on page LVIII 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 income tax in respect of activities where income is received from a non public sector source.

The tax expense on the surplus or deficit for the year comprises current and deferred tax due to the Trust's trading commercial subsidiaries, see note 12 to the financial statements on page XL. Current tax is the expected tax payable for the year, using tax rates enacted or substantively enacted at the balance sheet date, and any adjustment to tax payable in respect of previous years.

Deferred tax is provided using the balance

sheet liability method, providing for temporary differences between the carrying amounts of the assets and liabilities for financial reporting purposes and the amounts used for taxation purposes. Deferred tax is not recognised on taxable temporary differences arising on the initial recognition of goodwill or for temporary differences arising from the initial recognition of assets and liabilities in a transaction that is not a business combination and that affects neither accounting nor taxable profit.

Deferred taxation is calculated using rates that are expected to apply when the related deferred asset is realised or the deferred taxation liability is settled. Deferred tax assets are recognised only to the extent that it is probable that future taxable profits will be available against which the assets can be utilised.

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 2013. 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'). The result of this valuation, based on estimates provided by a suitably qualified professional in accordance with HM Treasury guidance, is disclosed in note 14.2 to the financial statements on page XLV. 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 30 to the financial statements on page LVII.

1.29 Accounting standards, interpretations and amendments adopted in the year

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.

Transforming community services ('TCS') transactions

The HM Treasury Financial Reporting Manual requires the use of merger or absorption accounting for these transactions as they are considered to be 'machinery of government change'. The transaction is a transfer of services between the Trust and another body in the Department of Health resource accounting boundary. Such transfers fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Income, and is disclosed separately from operating costs.

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 2012 (effective 1 April 2013)
- 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 'Separate Financial Statements' - (effective 1 April 2013)
- IAS 28 'Investments in Associates and Joint Ventures' - (effective 1 April 2013)
- IPSAS 32 'Service Concession Arrangements' - (effective 1 January 2014)

IPSAS 32 is an International Public Sector Accounting Standard, issued by the International Public Sector Accounting Standards Board. It is adapted from IFRIC 12 see accounting policy note 1.11 and formalises the accounting approach for Private Finance Initiative (PFI) schemes as determined by HM Treasury.

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 XXXI. Other operating revenue is analysed in note 4 to the financial statements on 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 33 to the financial statements on page LVIII, where individual customers within the public sector are considered material. The proportion of total revenue receivable from whole HM Government is 95.6% (2011/12 - 95.3%).

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 2013	Healthcare services £000	Commercial dispensary £000	Inter-Group Eliminations £000	Total £000
Total segment revenue	640,337	15,403	(15,709)	640,031
Total segment expenditure	(625,744)	(14,906)	15,709	(624,941)
Operating surplus	**14,593**	**497**	-	**15,090**
Net financing	(21,268)	(22)	-	(21,290)
PDC dividends payable	-	-	-	-
Taxation	-	(118)	-	(118)
Retained surplus - before non-recurring items	**(6,675)**	**357**	-	**(6,318)**
Non-recurring items	-	-	-	-
Retained surplus / (deficit)	**(6,675)**	**357**	-	**(6,318)**
Reportable Segment assets	624,049	4,906		628,955
Eliminations			(5,810)	(5,810)
Total assets	**624,049**	**4,906**	**(5,810)**	**623,145**
Reportable Segment liabilities	(692,203)	(4,540)		(696,743)
Eliminations			5,810	5,810
Total liabilities	**(692,203)**	**(4,540)**	**5,810**	**(690,933)**
Net assets / (liabilities)	**(68,154)**	**366**	**-**	**(67,788)**

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 / (liabilities)	**(60,063)**	**9**	**-**	**(60,054)**

All activities are based in the UK.

3. Revenue from Activities

By Commissioner	Year Ended 31 March 2013 £000	Year Ended 31 March 2012 £000
Foundation Trusts	**125**	95
NHS Trusts	**423**	428
National Commissioning Group (Strategic Health Authority)	**24,381**	19,654
Primary Care Trusts	**479,692**	430,066
NHS Scotland, Wales and Northern Ireland	**6,829**	4,577
Private Patients	**3,580**	2,701
NHS Injury Cost Recovery scheme	**3,215**	2,580
Ministry of Defence	**5,177**	8,980
	523,422	469,081

Healthcare activity income from the Ministry of Defence of £5,177,000 relates to the Trust contract with the Royal Centre for Defence Medicine (2011/12 - £8,980,000).

NHS Injury Cost Recovery scheme income, received from commercial insurance providers, is subject to a provision for impairment of receivables of 19.8% (2011/12 - 12.6%) to reflect expected rates of collection.

By Activity	Year Ended 31 March 2013 £000	Year Ended 31 March 2012 £000
Elective	**102,459**	96,756
Non elective	**97,887**	91,598
Outpatients	**80,034**	75,323
A & E	**9,824**	8,241
Other NHS clinical	**221,246**	182,902
Private patients	**3,580**	2,701
Other non-protected clinical	**8,392**	11,560
	523,422	469,081

With the exception of private patient and other non-protected clinical income (NHS injury cost recovery scheme and Ministry of Defence), all of the revenue from clinical activities arises from mandatory NHS services as set out in the Trust's Terms of Authorisation from Monitor.

3.1 Principal and non-principal revenue

	Year Ended 31 March 2013	Year Ended 31 March 2012
	£000	£000
Principal purpose revenue		
Revenue derived from NHS clinical activity in England	**504,621**	450,243
Non-principal purpose revenue		
Non-English NHS derived clinical activity	**18,801**	18,838
Other operating revenue (see note 4 to the financial statements)	**116,609**	117,559
	135,410	136,397
Total revenue	**640,031**	586,640
Principal revenue as a percentage	**78.84%**	76.75%

Following changes to the Health and Social Care Act 2012 (the 'Act'), Monitor removed the requirement for foundation trusts to limit private patients revenue as a percentage of total revenue from activities. In its place, the Act requires that a foundation trust's principal activity is to deliver goods and services for the purposes of the National Health Service in England. Therefore, this clinical revenue must exceed the total of revenues derived from all other activities ('non-principal purpose revenue').

Revenue derived from NHS clinical activity in England is contained within note 3 to the financial statements on page XXXI. By commissioner type, it is revenue from Foundation Trusts, NHS Trusts, PCTs and the National Commissioning Group. The Trust is therefore, compliant with the required legislation.

4. Other Operating Revenue

	Year Ended 31 March 2013	Restated Year Ended 31 March 2012
	£000	£000
Research and development	**28,048**	25,933
Education and training	**33,051**	32,681
Charitable and other contributions to expenditure	**1,033**	3,334
Non-patient care services to other bodies	**10,118**	11,501
Other revenue	**44,359**	44,110
	116,609	117,559

Other revenue includes PFI related income of £9,000,000 (2011/12 - £11,000,000); rental income of £2,033,000 (2011/12 - £1,993,000) due to the leasing of new hospital facilities by the University of Birmingham and Ministry of Defence; £4,023,000 from Clinical Excellence Awards (2011/12 - £4,150,000); recharges of £2,803,000 to the Ministry of Defence to fund the training expenditure of Nurses along with catering and car parking costs associated with the military contract (2011/12 - £4,184,000); £1,542,000 from the National Quality Assurance Service (2011/12 - £1,579,000); and funding of £2,311,000 (2011/12 - £3,345,000) for the organ retrieval service.

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

5. Operating Expenses

	Year Ended 31 March 2013			Year Ended 31 March 2012
	Total	Before non-recurring costs	Material non-recurring costs	Total
	£000	£000	£000	£000
Services from Foundation Trusts	**3,121**	3,102		3,102
Services from other NHS Trusts	**4,606**	6,041		6,041
Services from PCTs	**82**	362		362
Services from other NHS bodies	**2,692**	403		403
Purchase of healthcare from non NHS bodies	**13,340**	10,801		10,801
Directors' costs	**1,784**	1,693		1,693
Non executive directors' costs	**162**	166		166
Staff costs	**325,416**	304,416	1,621	306,037
Supplies and services - clinical	**155,105**	135,726	188	135,914
Supplies and services - general	**8,336**	7,197	153	7,350
Consultancy services	**2,152**	2,711	112	2,823
Establishment	**5,133**	4,628	58	4,686
Transport	**1,130**	1,016	320	1,336
Premises	**19,932**	18,570	802	19,372
Provision for Impairment of Receivables	**1,295**	(204)		(204)
Depreciation on property, plant and equipment	**20,695**	19,737		19,737
Amortisation on intangible assets	**331**	368		368
Impairments of property, plant and equipment	**9,996**	2,504	29,191	31,695
Loss on Disposal of property, plant and equipment	**73**	-		-
Audit services - statutory audit	**97**	90		90
Other auditors remuneration - taxation services	**62**	27		27
Other auditors remuneration - audit of subsidiary	**5**	6		6
Other auditors remuneration - other services	**17**	13		13
Clinical negligence	**5,595**	3,492		3,492
Other	**43,784**	45,104	1,065	46,169
	624,941	567,969	33,510	601,479

Other expenditure includes £23,355,000 (2011/12 - £22,470,000) in relation to payments to the Trust's PFI partner for services provided; Research Grants distributed to other West Midlands NHS organisations of £11,798,000 (2011/12 - £11,828,000) due to the Trust acting as host body for the Comprehensive Local Research Network; Training, Courses and Conference fees of £3,607,000 (2011/12 - £4,753,000) and fees payable to Deloitte LLP with regard to internal audit and counter fraud services of £146,000 (2011/12 - £136,000).

Non-recurring items in the prior reporting period are detailed in note 5.1 to the financial statements on 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.

5.1 Material non-recurring costs

	Year Ended 31 March 2013	Year Ended 31 March 2012
	Total	Total
	£000	£000
Non-recurring operating expenses:		
Transition costs relating to relocation to the new PFI hospital (a)	**-**	4,319
Impairment of property - new PFI hospital (b)	**-**	29,191
	-	33,510

(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 relocation to the new hospital which was completed in 2011/12 is disclosed in note 29.1 to the financial statements on page LV. Details of the transition costs incurred in 2011/12 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 XLV. The impairment of property, plant and equipment in the reporting period of £9,996,000 is due entirely to the new PFI hospital. Changes in valuation are now considered to be recurring in nature because the building has been fully operational during the reporting period.

6. Operating leases

6.1 As lessee

Payments recognised as an expense	Year Ended 31 March 2013	Year Ended 31 March 2012
	£000	£000
Minimum lease payments	**1,033**	1,098

Total future minimum lease payments	Year Ended 31 March 2013	Year Ended 31 March 2012
	£000	£000
Payable:		
Not later than one year	**1,066**	1,039
Between one and five years	**985**	1,277
After 5 years	**2,053**	1,857
Total	**4,104**	4,173

6.2 As lessor

Rental revenue	Year Ended 31 March 2013	Year Ended 31 March 2012
	£000	£000
Rents recognised as income in the period	**2,151**	2,182

Total future minimum lease payments	Year Ended 31 March 2013	Year Ended 31 March 2012
	£000	£000
Receivable:		
Not later than one year	**2,159**	1,875
Between one and five years	**3,224**	4,356
After 5 years	**4,452**	5,331
Total	**9,835**	11,562

7. Employee costs and numbers

7.1 Employee costs *

	Year Ended 31 March 2013			Year Ended 31 March 2012		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Short term employee benefits - salaries and wages	**265,833**	**249,136**	**16,697**	252,727	235,571	17,156
Short term employee benefits - social security costs	**21,279**	**21,279**	**-**	20,174	20,174	-
Post employment benefits - employer contributions to NHS pension scheme	**27,777**	**27,777**	**-**	26,915	26,915	-
Pension cost - other contributions	**2**	**2**	**-**	-	-	-
Termination benefits	**218**	**218**	**-**	129	129	-
Agency/contract staff	**13,543**	**-**	**13,543**	13,948	-	13,948
Revenue in respect of Salaries and wages where netted off expenditure	**(1,234)**	**(1,234)**	**-**	(6,034)	(6,034)	-
	327,418	**297,178**	**30,240**	307,859	276,755	31,104

7.2 Average number of persons employed *

	Year Ended 31 March 2013			Year Ended 31 March 2012		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
Medical and dental	**1,041**	**956**	**85**	982	925	57
Administration and estates	**1,439**	**1,439**	**-**	1,463	1,463	-
Healthcare assistants and other support staff	**603**	**603**	**-**	540	540	-
Nursing, midwifery and health visiting staff	**2,934**	**2,934**	**-**	2,666	2,666	-
Scientific, therapeutic and technical staff	**1,054**	**1,054**	**-**	1,050	1,050	-
Bank and agency staff	**229**	**-**	**229**	201	-	201
	7,300	**6,986**	**314**	6,902	6,644	258

* The disclosure of employee costs does not include non-executive directors. Termination benefits are disclosed within other operating expenses in note 5 to the financial statements on page XXXIV.

7.3 Key management compensation

	Year Ended 31 March 2013	Year Ended 31 March 2012
	£000	£000
Salaries and short term benefits	**1,451**	1,355
Social Security Costs	**179**	165
Employer contributions to NHSPA	**154**	173
	1,784	1,693

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	1	3	-	-	1	3
£10,000 - £25,000	1	14	-	-	1	14
£25,000 - £50,000	1	29	-	-	1	29
£50,000 - £100,000	1	75			1	75
	4	121	-	-	4	121
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

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 (2011/12 - £nil).

8. Retirements due to ill-health

During the year to 31 March 2013 there were 6 early retirements from the Trust agreed on the grounds of ill-health (2011/12 - 11). The estimated additional pension liabilities of these ill-health retirements will be £378,913 (2011/12 - £837,548). 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 2013		Year Ended 31 March 2012	
	Number	**£000**	Number	£000
Trade				
Total trade bills paid in the year	**100,761**	**288,794**	100,761	288,794
Total trade bills paid within target	**99,632**	**287,323**	99,632	287,323
Percentage of trade bills paid within target	**98.88%**	**99.49%**	98.88%	99.49%
NHS				
Total NHS bills paid in the year	**9,091**	**176,369**	9,091	176,369
Total NHS bills paid within target	**8,829**	**174,867**	8,829	174,867
Percentage of NHS bills paid within target	**97.12%**	**99.15%**	97.12%	99.15%

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 2013	Year Ended 31 March 2012
	£000	£000
Financing income		
Interest receivable	**658**	738
	658	738
Financing costs		
Interest on obligations under PFI contracts	**(21,866)**	(19,491)
Interest on obligations under finance leases	**(32)**	-
Other financing charges	**(50)**	(40)
	(21,948)	(19,531)
Net finance expense	**(21,290)**	(18,793)

11. Public dividend capital dividends

Public dividend capital ('PDC') dividends paid and due to the Department of Health amounted to £nil (2011/12 - £nil). 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. Tax recognised in SOCI

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.

Recognised in the income statement	**Year Ended 31 March 2013**	Year Ended 31 March 2012
	£000	£000
Current tax expense		
Current year	**115**	-
Adjustments in respect of prior years	**(4)**	-
	111	-
Deferred tax expense		
Origination and reversal of temporary differences	**4**	10
Adjustments in respect of prior years	**3**	-
Reduction in tax rate	**-**	-
	7	10
Total tax expense recognised in income statement	**118**	10

Tax recognised in other comprehensive income is £nil.

Tax recognised directly in equity is £nil.

Reconciliation of effective tax rate	**Year Ended 31 March 2013**	Year Ended 31 March 2012
Operating surplus before taxation - subsidiary only *	**475**	19
Tax at the standard rate of corporation tax in the UK 24%	**114**	5
Current year impact of rate change	**-**	(1)
Adjustments in respect of prior years	**(4)**	-
Tax effect of expenditure not deductible	**1**	6
Total tax expense	**111**	10

* Liability for corporation tax only arises from the activity of the commercial subsidiary whose operating surplus before taxation is disclosed in the segmental analysis note 2 to the financial statements on page XXX. The activities of the Trust do not incur corporation tax, see accounting policy note 1.24 for detailed explanation.

The impact of rate change arises from the reduction in the rate at which the temporary differences are expected to reverse from 24% to 23%. The standard rate of corporation tax in the UK changed from 24% to 23% with effect from 1 April 2013.

13. Intangible assets

Group	Computer software - purchased	Licences and trademarks	Total
	£000	£000	£000
Cost			
At 1 April 2011	1,670	264	1,934
Additions	61	120	181
At 31 March 2012	**1,731**	**384**	**2,115**
Additions	20	-	20
Reclassifications	97	(97)	-
At 31 March 2013	**1,848**	**287**	**2,135**
Amortisation			
At 1 April 2011	830	111	941
Charged for the year	303	65	368
At 31 March 2012	**1,133**	**176**	**1,309**
Charged for the year	275	56	331
Reclassifications	92	(92)	-
At 31 March 2013	**1,500**	**140**	**1,640**
Net book value			
At 31 March 2013	**348**	**147**	**495**
At 31 March 2012	598	208	806
At 1 April 2011	840	153	993

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 - 2012/13

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 2012	68,875	407,821	1,427	139	91,410	11	15,555	4,789	590,027
Additions purchased	-	4,555	-	(19)	4,681	-	1,153	104	10,474
Additions donated	-	-	-	-	195	-	-	-	195
Reclassifications	-	(478)	-	827	(60)	-	(289)	-	-
Impairments charged to operating expenses	-	(9,996)	-	-	-	-	-	-	(9,996)
Impairments charged to revaluation reserve	-	(1,309)	(107)	-	-	-	-	-	(1,416)
Disposals other than by sale	-	-	-	-	(9,461)	-	(1,595)	(829)	(11,885)
At 31 March 2013	**68,875**	**400,593**	**1,320**	**947**	**86,765**	**11**	**14,824**	**4,064**	**577,399**
Depreciation									
At 31 March 2012	-	13,430	80	-	49,140	-	9,854	4,244	76,748
Provided during the year	-	9,605	92	-	8,998	2	1,904	94	20,695
Disposals other than by sale	-	-	-	-	(9,380)	-	(1,595)	(829)	(11,804)
At 31 March 2013	**-**	**23,035**	**172**	**-**	**48,758**	**2**	**10,163**	**3,509**	**85,639**
Net book value									
Owned	26,125	45,999	1,126	841	34,144	9	4,661	526	113,431
Donated	-	6,180	22	106	3,475	-	-	29	9,812
Private Finance Initiative	-	325,379	-	-	-	-	-	-	325,379
Finance Lease	42,750	-	-	-	388	-	-	-	43,138
At 31 March 2013	**68,875**	**377,558**	**1,148**	**947**	**38,007**	**9**	**4,661**	**555**	**491,760**
Analysis of property, plant and equipment									
Net book value									
Protected assets	42,750	374,974	-	-	-	-	-	-	417,724
Unprotected assets	26,125	2,584	1,148	947	38,007	9	4,661	555	74,036
At 31 March 2013	**68,875**	**377,558**	**1,148**	**947**	**38,007**	**9**	**4,661**	**555**	**491,760**

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 £90,000 (31 March 2012 - £92,000) 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 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)
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
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.

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 2013**
	£000
Impairments charged to consolidated statement of comprehensive income	
Queen Elizabeth Hospital - new PFI facility	**9,996**
Trust owned property	**-**
	9,996

The valuation of the 'Queen Elizabeth Hospital Birmingham' PFI hospital gave rise to an impairment resulting from the difference between the fair value in operational use (depreciated replacement cost), as measured at 31 March 2013 compared to 31 March 2012. The impairment is disclosed in operating expenses, 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 XIV of the financial statements.

Revaluation gains / (losses) on property, plant and equipment	31 March 2013	31 March 2012
Group	**£000**	£000
Surpluses / (deficits) due to revaluation of property recognised in other comprehensive income		
Land	-	-
Buildings	(1,244)	3,508
Dwellings	(172)	129
	(1,416)	3,637

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 2011	266,562	42,988	309,550
Additions	111,812	-	111,812
Impairments to operating expenses	(29,191)	-	(29,191)
At 31 March 2012	**349,183**	**42,988**	**392,171**
Additions	2,777	436	3,213
Impairments to operating expenses	(9,996)	-	(9,996)
At 31 March 2013	**341,964**	**43,424**	**385,388**
Depreciation			
At 1 April 2011	3,301	232	3,533
Charged for the year	5,993	6	5,999
At 31 March 2012	**9,294**	**238**	**9,532**
Charged for the year	7,291	48	7,339
At 31 March 2013	**16,585**	**286**	**16,871**
Net book value			
At 31 March 2013	**325,379**	**43,138**	**368,517**
At 31 March 2012	339,889	42,750	382,639
At 1 April 2011	263,261	42,756	306,017

The Private Finance Initiative asset is the new Queen Elizabeth Hospital Birmingham as detailed in note 29.1 to the financial statements on page LV. The impairment is detailed in note 14.2 to the financial statements on page XLV.

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 £2,635,000 (31 March 2012 - £1,318,000). 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 2013.

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 XXIX.

Birmingham Systems 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 absorption accounting for these transactions as they are considered to be 'machinery of government change', see accounting note 1.29 for details. 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.

The assets are to be transferred on 1 April 2013, events after the reporting date are detailed in note 32 to the financial statements on page LVIII.

18. Non-current assets held for sale

The Trust has no non-current assets held for sale (31 March 2012 - £nil).

19. Inventories

	Group		Trust	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Raw materials	**13,430**	13,050	**12,439**	12,241
Finished goods	**8**	6	**8**	6
	13,438	13,056	**12,447**	12,247

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 £147,485,000 of inventories during the year (2011/12 - £130,869,000). The Trust charged £13,000 to operating expenses in the year due to write-downs of obsolete inventories (2011/12 - £20,000).

20. Trade and other receivables

Current	Group		Trust	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
NHS receivables	**20,028**	20,173	**20,028**	20,173
Receivables with other related parties	**3,966**	3,358	**3,966**	3,358
Commercial trade receivables	**3,458**	2,852	**7,672**	5,211
Provision for impaired receivables	**(1,777)**	(1,247)	**(1,777)**	(1,247)
PFI prepayments - lifecycle replacements	**2,969**	1,496	**2,969**	1,496
Prepayments	**2,394**	2,911	**2,390**	2,911
Accrued income	**255**	597	**255**	597
Other receivables	**7,117**	5,824	**5,740**	5,541
	38,410	35,964	**41,243**	38,040

Non current	Group		Trust	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Provision for impaired receivables	**(702)**	(343)	**(702)**	(343)
Other receivables	**3,544**	3,265	**3,544**	3,265
	2,842	2,922	**2,842**	2,922

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 33 to the financial statements on page LVIII.

Included within trade and other receivables of both Group and Trust are balances with a carrying amount of £12,290,000 (31 March 2012: £10,679,000) 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 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Not past due date	**28,962**	28,207	**31,795**	30,283
By up to three months	**4,514**	3,255	**4,514**	3,255
By three to six months	**1,444**	705	**1,444**	705
By more than six months	**6,332**	6,719	**6,332**	6,719
	41,252	38,886	**44,085**	40,962

Provision for impaired receivables	**Group**		**Trust**	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Balance at 1 April	**1,590**	2,567	**1,590**	2,567
Increase in provision	**2,945**	945	**2,945**	945
Amounts utilised	**(406)**	(773)	**(406)**	(773)
Unused amounts reversed	**(1,650)**	(1,149)	**(1,650)**	(1,149)
	2,479	1,590	**2,479**	1,590

Aged analysis of impaired receivables	**Group**		**Trust**	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
By up to three months	**246**	387	**246**	387
By three to six months	**16**	-	**16**	-
By more than six months	**2,217**	1,203	**2,217**	1,203
	2,479	1,590	**2,479**	1,590

21. Other non financial assets

Current	Group		Trust	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
PFI deferred assets - bullet payment	**-**	41	**-**	41

Non current	Group		Trust	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
PFI deferred assets - bullet payment	**-**	213	**-**	213

'Deferred assets - bullet payment' arose from the Trust making payments direct to the PFI partner for the provision of IT services. This payment made to the PFI partner has now been fully amortised.

22. Cash and cash equivalents

	Group		Trust	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Cash and cash equivalents	**76,200**	67,696	**75,352**	66,728
Made up of				
Cash with Government Banking Service	**8,948**	689	**8,948**	689
Commercial banks and cash in hand	**67,252**	67,007	**66,404**	66,039
Current investments	**-**	-	**-**	-
Cash and cash equivalents as in statement of financial position	**76,200**	67,696	**75,352**	66,728
Bank overdraft - Government Banking Service	**-**	-	**-**	-
Bank overdraft - Commercial banks	**-**	-	**-**	-
Cash and cash equivalents as in statement of cash flows	**76,200**	67,696	**75,352**	66,728

23. Trade and other payables

Current	Group		Trust	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
NHS payables	**8,900**	7,016	**8,900**	7,016
Amounts due to other related parties	**4,103**	3,638	**4,103**	3,638
Commercial trade payables	**26,048**	18,413	**27,086**	18,413
Trade payables - capital	**1,220**	1,054	**1,218**	1,052
Taxes payable	**7,014**	6,880	**7,007**	6,874
Other payables	**1,522**	1,521	**1,859**	1,521
Accruals	**49,205**	39,583	**49,237**	39,817
Receipts in advance	**390**	25	**390**	25
	98,402	78,130	**99,800**	78,356

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 33 to the financial statements on page LVIII. Included within amounts due to other related parties are NHS pension contributions of £3,765,000 (31 March 2012: £3,406,000).

Non current trade and other payables are nil (31 March 2012 - £nil).

24. Other liabilities

Current	Group		Trust	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Deferred income	**21,015**	23,858	**23,858**	26,598

Non current	Group		Trust	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Deferred income	**21,613**	29,837	**29,837**	38,694

25. Deferred Tax

An analysis of the movements in the deferred tax liabilities and assets recognised by the group is set out below:

Group only*	Capital allowances	Tax losses	Total
	£000	£000	£000
At 1 April 2011	-	-	-
Credit / (charge) to the income statement	17	(7)	10
At 31 March 2012	**17**	**(7)**	**10**
Credit / (charge) to the income statement	-	7	7
At 31 March 2013	**17**	**-**	**17**

* Liability for corporation tax only arises from the activity of the commercial subsidiary, the activities of the Trust do not incur corporation tax, see accounting policy note 1.24 for detailed explanation.

Deferred tax assets and liabilities have been offset and are to be recovered / settled after more twelve months. The offset amounts are as follows:

Group only*	31 March 2013	31 March 2012
	£000	£000
Deferred tax assets	-	(7)
Deferred tax liabilities	**17**	17
Net non current deferred tax liability	**17**	10

26. Borrowings

Group and Trust	Current		Non current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Obligations under finance leases	**33**	-	**367**	-
Obligations under Private Finance Initiative contracts	**11,795**	12,254	**534,082**	545,877
	11,828	12,254	**534,449**	545,877

The Private Finance Initiative obligation relates to the new Queen Elizabeth Hospital Birmingham as detailed in note 29.1 to the financial statements on page LV.

27. Prudential borrowing limit

	31 March 2013	31 March 2012
	£000	£000
Total long term borrowing limit set by Monitor	**558,100**	564,500
Working capital facility agreed by Monitor	**46,600**	30,000
	604,700	594,500
Long term borrowing at 1st April	**558,131**	458,869
Net actual borrowing / (repayment) in year - long term	**(11,854)**	99,262
Long term borrowing at 31st March	**546,277**	558,131
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 2013**	31 March 2012
Minimum dividend cover	> 1.0	**n/a**	76.9
Minimum interest cover	> 2.0	**2.3**	2.3
Minimum debt service cover	> 1.5	**1.4**	1.4
Maximum debt service to revenue	< 10%	**4.82%**	4.85%

The 'minimum debt service cover' ratio is marginally outside the Tier 2 limit however, this is in line with the 2012/13 financial reporting year plan submitted to Monitor.

28. Finance lease obligations (other than PFI)

	Minimum lease payments		**Present value of minimum lease payments**	
Group and Trust	**31 March 2013**	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Gross lease liabilities	**557**	-	**447**	-
Of which liabilities are due:				
Not later than one year	**62**	-	**62**	-
Later than one year, not later than five years	**250**	-	**217**	-
Later than five years	**245**	-	**168**	-
Net finance charges allocated to future periods	**(157)**	-	**(134)**	-
Net lease liabilities	**400**	-	**313**	-
Not later than one year	**33**	-	**33**	-
Later than one year, not later than five years	**161**	-	**139**	-
Later than five years	**206**	-	**141**	-

29. Private finance initiative contracts

29.1 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 31 March 2011.
- phase 3 on 11 October 2011 was delivered on schedule and was complete as at 31 March 2012

As at the reporting date there were 190 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 2013**	31 March 2012
	£000	£000
Gross PFI liabilities	**907,160**	937,828
Of which liabilities are due:		
Not later than one year	**29,807**	30,668
Later than one year, not later than five years	**117,106**	118,430
Later than five years	**760,247**	788,730
Net finance charges allocated to future periods	**(361,283)**	(379,697)
Net PFI liabilities	**545,877**	558,131
Not later than one year	**11,795**	12,254
Later than one year, not later than five years	**49,068**	48,771
Later than five years	**485,014**	497,106

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 £48,799,000 (2011/12 - £43,893,000) reflects the phased opening of the new PFI hospital in prior years. The Trust will be committed to the full unitary payment 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 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Of which commitments are due:				
Not later than one year	**50,365**	48,799	**50,365**	48,799
Between one and five years	**201,460**	194,660	**184,995**	178,751
After 5 years	**1,428,771**	1,432,408	**781,370**	772,348
Total PFI commitments	**1,680,596**	1,675,867	**1,016,730**	999,898

Annual service expense for on-statement of financial position PFI contracts due:

Group and Trust	**Unitary payments**		**Present value of unitary payments**	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Of which commitments are due:				
Not later than one year	**13,292**	12,968	**13,292**	12,968
Between one and five years	**56,577**	55,197	**51,898**	50,632
After 5 years	**614,471**	629,143	**316,779**	318,421
Total PFI commitments	**684,340**	697,308	**381,969**	382,021

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.

29.2 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.

30. Provisions

Group and Trust	Current		Non current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Pensions relating to other staff	**35**	34	**83**	111
Legal claims	**1,308**	1,512	**1,615**	1,534
Other	**457**	874	**-**	-
	1,800	2,420	**1,698**	1,645

	Pensions relating to former directors	**Pensions relating to other staff**	**Legal claims**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
At 1 April 2012	-	145	3,046	874	**4,065**
Arising during the year	-	5	452	54	**511**
Used during the year	-	(36)	(369)	(295)	**(700)**
Reversed unused	-	-	(252)	(176)	**(428)**
Unwinding of discount	-	4	46	-	**50**
At 31 March 2013	**-**	**118**	**2,923**	**457**	**3,498**
Expected timing of cash flows:					
Within one year	-	35	1,308	457	**1,800**
Between one and five years	-	73	382	-	**455**
After five years	-	10	1,233	-	**1,243**

The provisions included under 'legal claims' are for personal injury pensions £1,720,000 (31 March 2012: £1,631,000), employers and public liability £402,000 (31 March 2012: £365,000) and other claims notified by the Trust's solicitors £801,000 (31 March 2012: £1,050,000). 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 £118,000 (31 March 2012: £145,000), 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 £433,000 (31 March 2012: £735,000).

Provisions within the annual accounts of the NHS Litigation Authority at 31 March 2013 include £20,875,000 in respect of clinical negligence liabilities of the Trust (31 March 2012: £20,678,000).

31. Contingencies

There are £190,000 of contingent liabilities at 31 March 2013 which relate to amounts notified by the NHSLA for potential employer and public liability claims over and above the amounts provided for in note 30 to the financial statements on page LVII (31 March 2012: £146,000). There are no contingent assets at the reporting date (31 March 2012: £nil).

32. Events after the reporting period

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 Trust has delivered the service since this date, but the assets (property, plant and equipment) associated with the delivery of this service have remained under the ownership of the PCT. The assets will transfer to the Trust on 1 April 2013, a date set for all the asset transfers brought about by the Health and Social Care Act 2012 which reorganised the National Health Service in England.

On 1 April 2013, the Trust will recognise in the financial statements the following non current assets, both disclosed within property, plant and equipment: premises (Whittal Street, Birmingham) and IT equipment currently valued at £1,505,000 and £400,000 respectively. The income and expenditure reserve will be credited with an equal value under the absorption accounting requirement of the HM Treasury Financial Reporting Manual.

33. 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 related parties are summarised below by Government Department, with 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
Monitor (Foundation Trusts)	3,445	(4,516)	15,238	(11,750)
Department of Health (NHS)	16,481	(4,384)	578,694	(23,499)
Local Government	43	(176)	923	(3,306)
Central Government	6,624	(11,069)	17,164	(50,381)
	26,593	**(20,145)**	**612,019**	**(88,936)**

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 2013 has resulted in a net income to the Trust of £2,289,000.

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 2012/13, 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 £4,208,000 (31 March 2012 - £2,876,000) owed by the subsidiary and the Trust's payables includes £1,602,000 (31 March 2012 - £240,000) owed to the subsidiary.

34. 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 2013	31 March 2012	**31 March 2013**	31 March 2012
	Notes	**£000**	£000	**£000**	£000
Current financial assets					
Cash and cash equivalents	1	**76,200**	67,696	**75,352**	66,728
Loans and receivables:					
Trade and receivables	1	**33,047**	31,557	**35,884**	33,633
		109,247	99,253	**111,236**	100,361
Non-current financial assets					
Loans and receivables:					
Trade and receivables	1	**2,842**	2,922	**2,842**	2,922
		2,842	2,922	**2,842**	2,922
Total financial assets		**112,089**	102,175	**114,078**	103,283
Current financial liabilities					
Financial liabilities:					
Finance leases	2	**33**	-	**33**	-
Private Finance Initiative contracts	2	**11,795**	12,254	**11,795**	12,254
Trade and other payables	1	**90,998**	71,225	**92,403**	71,457
Provisions under contract	1	**1,660**	3,545	**1,660**	3,545
		104,486	87,024	**105,891**	87,256
Non-current financial liabilities					
Financial liabilities:					
Finance leases	2	**367**	-	**367**	-
Private Finance Initiative contracts	2	**534,082**	545,877	**534,082**	545,877
Provisions under contract	1	**-**	3	**-**	3
		534,449	545,880	**534,449**	545,880
Total financial liabilities		**638,935**	632,904	**640,340**	633,136
Net financial assets / (liabilities)		**(526,846)**	(530,729)	**(526,262)**	(529,853)

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 28 and 29.1 to the financial statements on pages LIV and LV 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 XLVIII.
- Trade payables includes receipts in advance and PDC payable which are not financial instruments, see note 23 to the financial statements on page LI.

- 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 30 to the financial statements on page LVII.

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 NHS Commissioners and the way those organisations 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 NHS Commissioners must manage increasing healthcare demand and affordability within fixed budgets, the Trust regularly reviews the level of actual and contracted activity with the NHS Commissioners 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 XXIX, 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 XLVIII. 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 29.1 to the financial statements on page LV. For the reporting year the relevant RPI index was 239.9 (annualised rate of 3.7%) fixed at February 2012. 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 2013		Year Ended 31 March 2012	
	£000	£000	£000	£000
	+1.0%	-1.0%	+1.0%	-1.0%
Retained surplus / (deficit)	(470)	470	(417)	419
Taxpayers' equity	(470)	470	(417)	419

(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 LIII. 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 XXXIX. Therefore, the Trust does not manage its own capital. Liquidity risk and the funding of the Trust's activities are described above.

35. Third Party Assets

The Trust held £2,963 of cash at 31 March 2013 (31 March 2012: £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.

36. Losses and Special Payments

There were 2,377 cases of losses and special payments (2011/12 - 2,311 cases) totalling £273,219 (2011/12 - £377,120) 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, IN RESPECT OF FOUNDATION TRUSTS' ANNUAL REPORTS AND THE PREPARATION OF ANNUAL REPORTS

Monitor, 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 2013

DIRECTIONS BY MONITOR IN RESPECT OF NATIONAL HEALTH SERVICE FOUNDATION TRUSTS' ANNUAL ACCOUNTS

Monitor, with the approval of the Secretary of State, 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 the Secretary of State.

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

Signed:

Name: David Bennett (Chairman) Dated: 31 March 2013