This annual report covers the period
1 April 2013 to 31 March 2014

University Hospitals Birmingham NHS
NHS Foundation Trust

Annual Report and Accounts 2013/2014

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

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Strategic Report

1. Overview

1.1 Principal activities of the Trust

University Hospitals Birmingham NHS Foundation Trust (UHB) is a public benefit corporation authorised under the National Health Service Act 2006. It was authorised in 2004 as one of the first wave of Foundation Trusts. It 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 nearly 900,000 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 over 8,500 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 (QEHB) opened in 2010 and 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.

The Trust recently also opened an extra 170 beds in the old Queen Elizabeth Hospital, as well as a second Ambulatory Care facility and two theatres, to ensure capacity for the increase in the number of patients wishing to be treated at the hospitals.

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 second-year anniversary as one of the UK's 22 major trauma centres in March 2014.

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.

1.2 Royal Centre for Defence Medicine

The Royal Centre for Defence Medicine's (RCDM) Clinical Unit, hosted by UHB, 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 rest of the UK.

The combined experience of the military and civilian doctors, nurses and allied health professionals working together combine excellence in clinical care whilst providing the military environment and atmosphere for the military patients.

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 casualties returning from areas of conflict around the world.

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 a trauma ward which has

a high complement of military staff. The over-riding priority is to ensure that the individual receives the most appropriate care and therefore patients will be based on the ward most appropriate for their clinical condition.

The RCDM is a dedicated training centre for defence personnel and a focus for medical research. It 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.

2. Trust's Business Review

2.1 Trust Development and Performance in 2013/14 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 2013/14 which forms part of the Trust's overall 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 2013/14 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:	Workforce
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's values (honesty, responsibility, respect and innovation) provide the framework within which these purposes are delivered.

UHB has made good progress with delivery of its 2013/14 objectives and has achieved the following:

- **Infection Control:** A 25% reduction in the number of MRSA cases compared to 2012/13
- **A&E:** Improvements seen for several timeliness indicators in the department; percentage of patients leaving within four hours, time from arrival to assessment and time from arrival to treatment
- **Dementia Care:** Over 97% 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. Good improvements also seen in response rates to the NHS Friends and Family Test
- **Commissioning for Quality and Innovation Indicators (CQUINS):** Successful delivery of all CQUIN schemes agreed with commissioners
- **Information for Patients and Shared Decision-Making:** Launch of the mystay@qehb website in September 2013, providing patients with information and performance against key clinical indicators by ward, prior to their stay. myhealth@qehb, which was

successfully launched in 2012/13, continues to expand and improve with over 4,272 patients now signed up: more than a three-fold increase since 2012/13

- **Digitisation of Patient Records:** Further 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. Further advances made to the e-prescribing system PICS and upgrades to medical records and patient administration systems underway. A Trust-wide project has also commenced to improve the efficiency and planning of patient appointments across the whole of their pathway
- **New Technologies:** Over 100 patients have now been treated using Cyberknife which went live in July 2013. In addition the trust has purchased a Da Vinci surgical robot and patients are now being treated using this new technology
- **Career Opportunities:** The Learning Hub continues to be active in supporting unemployed young people in Birmingham, particularly through the Birmingham Jobs Fund and delivering The Prince's Trust 'Get Into Hospital Services Programme'. Through programmes such as these more than 170 unemployed people found employment, with over 1,700 in total since the Learning Hub began. In addition nearly 800 training qualifications have been awarded
- **Staff training:** More than 2,100 staff received customer care training; an increase of nearly 300 staff members compared to 2012/13. Improvements also seen in compliance against mandatory training requirements
- **Staff satisfaction:** Increase in positive responses seen in the NHS National Staff Survey alongside a 12% increase in responses
- **Financial Health:** The Trust has reported a surplus for 2013/14 (subject to audit) and remains well placed to meet the challenges facing the sector

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 likely to affect the entity's future development, performance and position

2.2.1 Overview

UHB continues to focus on its vision to deliver the best in care. This is underpinned by the Trust's values of honesty, innovation, respect and responsibility and core purposes of excellent clinical quality, patient experience, workforce, and research and innovation. The environment in which the Trust operates is becoming increasingly challenging due to the ongoing financial pressures, the disruption caused by the system reforms and the enhanced scrutiny on the quality of care across the NHS informed by the Francis, Keogh and Berwick reports. Ensuring improved quality, productivity, and efficiency across patient pathways and collaboration and integration with partners to meet rising demand is a critical issue across health economies. Despite this many providers are now struggling to achieve their financial plans, with 40% of acute Foundation Trusts (FTs) in deficit at Q3 of 2013/14. UHB has reported a surplus of £4.9m for 2013/14 (prior to asset revaluations) and the Trust remains well placed to meet the challenges facing the sector.

The Trust continues to have a strong clinical focus supported by a broad set of objectives within the framework of the four core purposes. With regard to specific quality objectives, these will be supported through the delivery of the Priorities for Improvement contained within the CQUIN schemes agreed with commissioners. In terms of workforce, the Trust has a strong set of strategic objectives to ensure the workforce is fit for purpose to deliver safe and high quality services and support new service developments. The Trust has ensured that workforce plans are in place to address the challenges related to increasing

patient expectations, increasing activity levels, and the impact of the new education tariffs. The Trust faces a range of short-term challenges. These include:

- **Managing capacity including seasonal peaks (Winter Pressures)** – the Trust has experienced significant growth in emergency admissions over recent years resulting in the use of the private sector capacity to maintain elective waiting lists in 2013/14. Additional theatre, recovery and bed capacity has been opened in the old QEH to mitigate this increase in activity
- **Improving quality** – continuing focus on quality, clinical outcomes and patient experience is driving investment in frontline services and the associated systems and support staff
- **Financial Performance** – the Trust is required to deliver annual surpluses in order to maintain investment in its asset base, retain healthy cash balances and avoid regulatory action. The main financial challenges facing the Trust over the next two years include:
  - Flat real terms health funding and growing demand, resulting in annual efficiency requirements of 4% or more leading to year-on-year reductions in national tariffs
  - The impact of commissioning changes such as downward pressure on local prices and the loss of CQUIN payments on excluded drugs and devices
  - Continuing reductions in education funding of £1.3m per annum under the Multi-Professional Education and Training (MPET) Review transition arrangements, building to an eventual recurrent loss of around £9.7m per annum
  - Reducing the reliance on PFI transition funding by circa £2m per annum over each of the next two years
- **Cost Improvement Plan (CIP)** – the continued need to deliver savings whilst maintaining or improving clinical quality is putting significant pressure on FTs. This will require real productivity gains on a scale not previously achieved and radical system changes across local health economies
- **Targets** – maintaining performance across all key targets including A&E waits, referral-to-treatment times and infection control
- **The Institute of Translational Medicine (ITM)** – managing the building works during 2014/15 and the commissioning in early 2015/16 in line with the programme agreed with the Department of Business Innovation and Skills. Work with partner organisations will also be required to agree an operating model that will best meet the objectives for the development

2.2.2 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 2013/14 the Trust continued to build on the strong approach to quality improvement by delivering further enhancements to digital systems; developing and implementing an external website containing performance against key quality indicators (mystay@QEHB); strengthening governance and assurance processes overall for performance and quality; working with commissioners to improve pathways focussing on pre-operative assessment and discharge; and implementing new clinical technologies such as Cyberknife. The Trust's Quality Report is included in Section 3 of this document and provides additional detail on UHB's quality priorities.

In 2014/15, as part of its quality objectives, the Trust is planning to deliver further enhancements to digital systems; work with commissioners to deliver the Better Care Fund and a revised model of care for hyper acute stroke services; further improve capacity management systems and processes; provide support to the other providers in the health economy through buddying arrangements; and further strengthen governance and assurance processes overall for regulation, compliance, and governance.

2.2.3 Patient Experience

Over 2013/14, the Trust worked to further improve processes for maximising opportunities for patient feedback, assessing and addressing issues highlighted, and sharing good practice. Also, there was a focus on further improving discharge processes, the health and well-being of patients, and safeguarding. Work also continued on meeting equality and diversity requirements of patients.

With regard to patient pathways, there was a focus on improving and streamlining these internally and externally with partners. Resource utilisation formed part of this where performance around capacity usage was monitored. The new hospital offered potential to further improve the patient experience. Patient expectations are higher so there was a continuing push to ensure these were met and exceeded.

For 2014/15, there are plans to continue to improve the fundamental standards of care in the areas of pressure ulcer management, hydration, pain management, and end of life. There will also be work with NICE to implement a methodology for publishing staffing levels as part of the national requirement. Further improvements will be made to complaints management, action planning, and learning processes as well as the way the Trust analyses and interprets patient feedback in a more triangulated and integrated manner. Addressing the care and safeguarding of vulnerable patients remains a priority for the organisation and further work will be undertaken for patients with dementia, learning disabilities, and mental health needs.

2.2.4 Workforce

In 2013/14, the Trust further developed automation processes for workforce management and developed 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 was a significant project for the Trust.

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

In 2014/15, the Trust plans to further build leadership strength and resilience, deliver the five-year nurse education and development strategy and a communication skills plan across a range of staff groups. There are also key objectives to deliver a revised Trust mandatory training model, launch a revised non-medical staff appraisal process, and improve workforce governance and further develop system automation. There will continue to be a focus on improving the quality of education provision, ensuring optimal utilisation of education resources, and delivering key performance indicators related to education of the workforce.

2.2.5 Research and Innovation

The research and innovation priorities for UHB in 2013/14 were focused on using the Clinical Academic Group structures to increase research activity across specialty and thematic groupings. The Trust continued to develop opportunities for collaborative working with research partners, and strengthening data collection and reporting systems for research activity.

In addition, the innovation and commercialisation objectives were supported with education and training and a framework of performance outcomes developed by the Academic Health Science Network. Further opportunities for the commercialisation of services and products continued to be explored and developed. The Trust also started work to develop Birmingham as an international

centre for Life Sciences through the Institute of Translational Medicine.

For 2014/15, the development and delivery of the Institute of Translational Medicine is a significant project for UHB. There are also plans to accelerate research translation from bench-to-bed and further strengthen the capacity and capability for research. The innovation agenda remains strong at UHB and work continues to explore alternative pathways of care delivery via home care and innovate the use of routinely collected electronic data to improve quality and safety via the junior doctor monitoring system. UHB will maintain a focus on maximising the opportunities for the commercialisation of Trust services and strengthening the Trust's reputation and profile for delivering high-quality research and innovation.

2.3 The Trust Strategy

2.3.1 Overview

UHB continues to focus on the Trust's vision, values and core purposes of excellent clinical quality, patient experience, workforce, and research and innovation.

In the next 12 months the Trust will undertake a strategy refresh to address the key external drivers over the next five years, including:

- The emerging NHS England five-year strategy which underpins new models of care including the concentration of specialised services into a small number of centres of excellence. This is expected to have a significant impact for the Trust
- The implementation of the Better Care Fund from 2015/16 onwards, and the associated financial risks of shifting resource from health to social care
- A likely further period of flat funding despite rising demand
- The expansion to seven-day working
- Greater vertical and horizontal integration across the sector including mergers and acquisitions and the developments of chains and franchise models
- Other potential policy changes dependent upon the outcome of the next general election

The Trust continues to have a strong clinical focus supported by a broad set of objectives within the framework of the four core purposes. With regard to specific quality objectives, these will be supported through the delivery of the Priorities for Improvement contained within the CQUIN schemes agreed with commissioners. In terms of workforce, the Trust has a strong set of strategic objectives to ensure the workforce is fit for purpose to deliver safe and high quality services and support new service developments. The Trust has ensured that workforce plans are in place to address the challenges related to increasing patient expectations, increasing activity levels, and the impact of the new education tariffs.

2.4 The Trust Business Model

UHB's business model supports the continued delivery of the Trust's vision.

The environment in which the Trust is operating is becoming increasingly challenging due to the ongoing financial pressures, system reforms and the enhanced scrutiny of the quality of care across the NHS following the recent Francis, Keogh and Berwick reports. The key financial elements of the Trust's business plan are summarised below:

- Continued delivery of annual surpluses to enable ongoing investment in the Trust's asset base (medical equipment, buildings, etc)
- Achievement of significant productivity gains to offset the efficiency requirements within the national tariff
- Retention of healthy cash balances to enable prompt payment to suppliers
- Maintaining a Continuity of Services Risk Rating of 2* with Monitor, the system regulator. The avoidance of regulatory action and maintaining performance across all key clinical and governance targets to ensure no financial penalties or fines are incurred due to breaches of national targets or locally agreed quality standards

- Completion of the Institute of Translational Medicine project by managing the building works during 2014/15 and the commissioning in early 2015/16 in line with the programme agreed with the Department of Business Innovation and Skills, University of Birmingham and Birmingham's Children Hospital NHS Foundation Trust
- The Trust will explore other opportunities for collaboration, acquisition or integration as they arise

The Trust offers a diverse range of services to patients in the South Birmingham population and beyond. The Trust provides some services on a regional (Birmingham and the West Midlands) and national basis in areas such as cancer, trauma, renal dialysis, burns and plastics. Circa 60% of its NHS clinical income relates to NHS England specialised service activity with a further 40% coming from a local and regional Clinical Commissioning Groups (CCGs). In addition the Trust also provides healthcare services to Welsh patients, local authority commissioned services and is host to the RCDM which treats British military personnel evacuated from overseas.

The Trust's business model assumes continued growth across specialised service activity with a relatively flat line projection for future CCG-funded activity. Growth in specialised services may come in part from the continued repatriation of existing activity from other neighbouring providers rather than new expenditure for commissioners. This is consistent with NHS England's plans to concentrate specialised services into 15-30 centres of excellence.

To support the delivery of the Trust's business plan, the Trust maintains a two-year and five-year financial plan as well as a long-term (10-year), high-level financial model. These models enable the Trust to forecast the implications and model downside sensitivity analysis for any key decisions. These models take into account a range of changes facing the Trust including changes within national tariff, the impact of approved activity growth and service developments. The financial models also reflect reductions in the amount of education funding available to the Trust and lower reliance on non-recurring PFI transition support year-on-year.

A number of other potential cost pressures and financial risks have been identified. These include the cost of managing unplanned capacity changes (especially during seasonal peaks), future national tariff changes (including Monitor's anticipated widespread changes to the 2015/16 tariff) and the impact of further integration across the sector including mergers and acquisitions. Other external issues likely to impact on the Trust's business plan include the development of hospital chains and franchise models and the implementation of the Better Care Fund (BCF). Business plan changes may also be required to reflect local CCG strategies which are being finalised, any requirements to implement more seven-day-a-week working and any service reconfigurations across local providers which may be approved.

The Trust's business plans will continue to be updated during 2014/15 to reflect the Trust's strategy refresh, further guidance released on any of the issues highlighted above and any other national initiatives or locally approved service developments. The Trust has a good record of exceeding its financial plans and delivering on its operational and business priorities in recent years.

2.5 Principal Risks and Uncertainties Facing the Trust

The principal risks and uncertainties facing the Trust at present are:

- The implementation of the Better Care Fund from 2015/16 onwards and the associated financial risks of shifting resource from health to social care
- A likely further period of flat funding despite rising demand
- Other potential policy changes dependent upon the outcome of the next general election
- Risks and challenges associated with CCG

plans including:

- If forecast activity reductions do not occur following transformation, then resources cannot be released from secondary care to fund alternative models of care; ideally these models need some pump-priming investment and clarity is required on how the healthcare economy shares the financial risk during this period
- Finding investment to fund seven-day working and targeting this in the areas which will make most difference
- Performance of neighbouring providers; further activity drift arising from performance issues at other trusts compromising the ability of UHB to meet expected admission reductions
- Stroke Reconfiguration Programme – Birmingham, Solihull and Black Country. The decision on the future placement of hyper acute and acute stroke units is pending currently and this may affect activity flows into and out of UHB

- Risks and challenges also result from NHS England's plans including:
  - The emerging NHS England five-year strategy which underpins new models of care, including the concentration of specialised services into a small number of centres of excellence. This is expected to have a significant impact for the Trust as it will require the Trust to create significant additional capacity at a time of limited new investment and significant local service change
  - Changes to the calculation methodology for CQUIN payments, no longer on total contract bottom-line value but now net of high-cost drugs and devices, reducing overall income and allowing no direct funding stream for medicines quality and productivity initiatives
  - The risk associated with the full delivery of NHS England (NHSE) service specifications delivery, ie, cost of convergence associated with staffing ratios, etc
  - A negotiated agreement is required regarding a sensible gain-share arrangement with regard to drug procurement, especially recognising historic savings underpinning service-line costs and hence pricing
  - Any changes to non-mandatory (local) tariffs could cause instability; NHSE wish to standardise prices nationally so it will not be possible to have a net zero impact at provider level. This process needs to feed into the annual financial planning process and providers need sufficient notice of impending change

2.6 Performance Against Key Healthcare Targets

The Trust achieved all targets and indicators included in Monitor's Risk Assessment Framework for the full year 2013/14 with the exception of the target for 62-day wait for first treatment from urgent GP referral for suspected cancer and *Clostridium difficile* (post 48-hour cases).

The Trust was above its full-year trajectory of total *Clostridium difficile* infection (CDI) cases in 2013/14 with a total of 80 cases. The total number of cases, however, reduced quarter-on-quarter during the year. During the year the Trust has determined, in partnership with Commissioners, whether or not its cases of CDI are avoidable or unavoidable. This is because it is acknowledged that there are some cases where the development of CDI is unavoidable where treatment has been in line with national protocols of antibiotic use. The Trust's model of judging avoidability has been commended by NHS England and a similar process has been recommended for the 2014/15 CDI objective by NHS England. The Trust continues to update its processes based on learning during 2013/14 to ensure the optimal arrangements for review of cases and development of action plans to address any deficiencies in management. Over the year, 16 cases of CDI could have been avoided giving a total of 16 over the full year 2013/14, significantly below the trajectory.

The Trust also did not achieve the cancer 62-day GP referral target over the year.

During 2013/14 the Trust has experienced an unprecedented increase in referrals for radiotherapy. This has included increases from a number of areas outside the Trust's usual catchment area. A number of actions have been taken to increase capacity, including extending the working hours of our linear accelerators, rescheduling maintenance out-of-hours to further increase capacity and utilising private sector capacity to treat prostate patients. The Trust has also met with NHS England to discuss its concerns over this level of growth and its impact on cancer service performance. NHS England has acknowledged the impact of growth on performance and has supported the Trust's action plan including the provision of radiotherapy in the private sector.

NHS England has also written to referring hospitals to reinforce their traditional referral pathways and is developing a strategic plan for radiotherapy in the region to respond to the growth. In addition the Trust continues to receive a significant proportion of late tertiary referrals, including a number after day 62, which affects 62-day GP performance. This number has increased year-on-year with an 18% increase in 2013/14 on top of a 15% increase the previous year. Despite ongoing discussions with commissioners regarding the future management of late referrals, a system of breach reallocation that is in line with Monitor's Risk Assessment Framework has yet to be developed.

Performance against national targets and indicators included in the Monitor Risk Assessment Framework

National targets and regulatory requirements	Time Period for 2013/14	2012/13 Performance	2012/13 Target	2013/14 Performance	2013/14 Target
Clostridium difficile (post-48 hour cases)	Apr 2013 – Mar 2014	73	76	80 (16 cases judged avoidable)	56
62-day wait for first treatment from urgent GP referral: all cancers	Apr 2013 – Mar 2014	86.2%	85%	79.5%	85%
62-day wait for first treatment from consultant screening service referral: all cancers	Apr 2013 – Mar 2014	95.2%	90%	95.3%	90%
31-day wait from diagnosis to first treatment: all cancers	Apr 2013 – Mar 2014	97.2%	96%	95.9%	96%
31-day wait for second or subsequent treatment: surgery	Apr 2013 – Mar 2014	96.8%	94%	96.2%	94%
31-day wait for second or subsequent treatment: anti cancer drug treatments	Apr 2013 – Mar 2014	99.8%	98%	99.3%	98%
31-day wait for second or subsequent treatment: radiotherapy	Apr 2013 – Mar 2014	99.3%	94%	95.1%	94%
Two week wait from referral to date first seen: all cancers	Apr 2013 – Mar 2014	96.3%	93%	97.1%	93%
Two week wait from referral to date first seen: breast symptoms	Apr 2013 – Mar 2014	98.2%	93%	97.1%	93%
18-week maximum wait from point of referral to treatment (admitted patients)	Apr 2013 – Mar 2014	94.9%	90%	91.4%	90%
18-week maximum wait from point of referral to treatment (non-admitted patients)	Apr 2013 – Mar 2014	99.1%	95%	98.1%	95%

18-week maximum wait from point of referral to treatment (incomplete pathways)	Apr 2013 – Mar 2014	95.7%	92%	94.6%	92%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	Apr 2013 – Mar 2014	94.95%	95%	95.2%	95%
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	Apr 2013 – Mar 2014	Certification made	N/A	Certification made	N/A

During the year the Trust saw a significant increase in outpatient activity linked to an increase in GP referrals. In addition the Trust saw increased inpatient activity: in December 2013 the Trust significantly increased its inpatient general medical capacity to ensure it had sufficient capacity to safeguard quality of care, improve patient flows between the Emergency Department (ED) and Clinical Decision Unit (CDU) and reduce the number of medical outliers in surgical beds. In addition the Trust opened a new dedicated day case facility to ensure there continues to be sufficient bed and theatre capacity to maintain elective admissions.

Activity Type	2012/13	2013/14	Change
Inpatient Finished Consultant Episodes	126,309	132,509	4.91%
Outpatient attendances	585,488	666,943	13.91%
A&E attendances	94,666	97,298	2.78%
Total treatments	806,463	896,750	11.20%

2.7 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 under-achievement 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 in Section 3 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.

2.8 Regulatory Action

The Care Quality Commission inspected the Trust's services in July 2013 against the following outcomes from its Essential Standards of Quality and Safety:

- **Outcome 4**: People should get safe and appropriate care that meets their needs and supports their rights
- **Outcome 7**: Safeguarding people who use services
- **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 it was a minor non-compliance and action has been taken to ensure that the Trust will be compliant.

Full details of Regulatory Ratings are reported from page 60.

2.9 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 its host commissioner Birmingham Cross City Clinical Commissioning Group and NHS England 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 2013/14 with the following exceptions:

- 18 weeks – all treatment functions achieved
- Cancer – 62-day urgent GP referral to treatment – first treatments – all cancers
- Stroke patients spending 90% of length of stay on the stroke unit
- Delayed transfers of care

The 18-week performance has been achieved at Trust level over the financial year but there has been underperformance in some specialty areas. This has been largely due to the rise in emergency activity and the impact this has had on elective activity. Monthly updates were provided to the CCG on progress against treatment function action plans. This has included agreeing a trajectory for each treatment function currently not meeting the target with an intended resolution date.

Cancer performance is related to a 12% increase in radiotherapy referrals and an ongoing issue with late referrals from other providers. The Trust has taken significant action to increase capacity to support performance improvement against the target and this has been recognised by the commissioners and Monitor. The issue of late referrals remains as there is no agreed reallocation process in place. If reallocations are applied to Trust performance, then the target is consistently met. Again this issue is recognised by commissioners and the Trust routinely provides data to the CCG relating to this.

The Trust did not achieve its contractual target that 80% of patients with a diagnosis of stroke should spend more than 90% of their length of stay on a stroke unit (the acute stroke unit at the Queen Elizabeth Hospital Birmingham and/or the rehabilitation stroke unit at Moseley Hall Hospital run by Birmingham Community Healthcare (BCHC) NHS Trust). In response to increased numbers of stroke patients, UHB moved its stroke unit at the end of November 2013 and significantly expanded its capacity from 18 to 26 beds. This has led to the delivery of the stroke target from January 2014 onwards. In addition the CCG has commissioned an Early Supported Discharge service that allows patients to be discharged from hospital earlier, freeing up capacity. However this has yet to be funded on a substantive basis. In addition there continues to be a shortage of beds on the rehabilitation stroke unit and discussions regarding the ongoing funding and provision of these between BCHC and the Birmingham CCGs continues.

The contractual target for 2% or fewer of inpatients to have their discharge delayed due to the NHS or jointly due to the NHS and social care was also exceeded over the year. Limited capacity for the assessment of patients from surrounding areas, including Worcestershire and Sandwell, has led to delays – this is particularly true of vascular surgery patients who would previously have been treated by Sandwell and West Birmingham NHS Trust who now have their surgery at the Queen Elizabeth Hospital Birmingham who have particularly complex needs. In addition the Trust has seen increased numbers of patients exercising their right to choose a nursing or residential home under the Direction on Choice. The Trust continues to work with these patients and their families to see if their needs can be met to allow them to be discharged.

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 (eg. cancer, 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 have not raised any formal contract queries in 2013/14.

2.10 Breakdown of the number of male and female staff at end of 2013/14

	Male	Female	Total
Directors*	10	5	15
Other senior managers**	1	3	4
Employees	2387	6146	8533

*Definition of Directors: Statutory Directors
**Definition of senior manager: a person who: (a) has responsibility for planning, directing or controlling the activities of the Trust, or a strategically significant part of the Trust, and (b) is an employee of the Trust.

2.11 Consultation

The Trust is committed to involving staff in decision-making and keeping them informed of changes and developments across the organisation. 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. The Trust's 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, eg, payslips, training records, absence records. There is also a section called AskHR which contains frequently-asked HR questions, template letters and links to the Trust Policies and Procedures. Nearly 5,700 staff have viewed, and continue to view, the staff portal, which is available 24 hours a day.

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

2.12 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, Autism West Midlands, Guide Dogs, Action for Blindness, and Action for Hearing 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 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' initiative 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 three 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).

2.13 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 QEHB, adjacent to the University of Birmingham, has created one of Europe's largest academic/medical complexes. It is a catalyst for the regeneration of south Birmingham-based on Life Sciences.

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.

2.13.1 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 1,700 people to gain a job – with 170 trainees gaining employment in 2013/14.

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 2013/14 was pre-employment training for apprentices on behalf of Birmingham Community Healthcare NHS 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.

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 The Prince's Trust. Three courses of the Get Into Hospital Services Programme run jointly with The Prince's Trust aimed at unemployed young people and funded by Health Education West Midlands were run during 2013/14. The partnership with Birmingham Community Healthcare NHS Trust continues with the Learning Hub providing pre-apprenticeship training for BCHT, 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 43 patients were provided with information, advice and guidance during 2013/14. 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.

2013/14 has seen a continued focus by the Learning Hub 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 Birmingham City Council which reported in early 2013 with substantive recommendations including the establishment of a Birmingham Jobs Fund (BJF).

BJF provides a subsidy to employers of £4,600 for taking on an unemployed person for six months and £3,000 for an apprenticeship. The Hub leads the programme for the Trust and provided pre-employment for 23 people and pre-apprenticeship training for 19. Not only did this enable 42 people to gain a job but the Trust benefited from £163,000 in grants. Funded by Health Education West Midlands, the Learning Hub continues to work successfully with Health Tec at Baverstock 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 well-being and active citizenship.

Key stakeholders in the Learning Hub are JobCentre Plus, Birmingham City Council, further education colleges, The Prince's Trust, 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.

2.13.2 Increasing Prosperity

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.

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 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 and 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 in the former Queen Elizabeth Hospital; and the designation by the city council of the area centred on the QEHB and the University of Birmingham as a Life Sciences Campus – one of six high-growth Economic Zones across the city. The ITM is due to open mid-2015 and the new Life Sciences Business Park opens in 2017. UHB is also partner in two highly innovative projects funded through the European Regional Development Fund which aim to generate NHS "challenges" and engage with small and medium sized enterprises in the region to provide solutions.

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

The land vacated by the former Selly Oak Hospital offers further significant regeneration potential as a key strategic housing site.

2.14 Environmental Issues

UHB sees carbon reduction in practical terms as energy efficiency; waste minimisation; reducing the harmful effects of transport; and changes to procurement practice.

The Trust recognises that the NHS is a major contributor to CO2 emissions. UHB sees carbon reduction as an integral part of delivering the best in care. It also can save money; provide improved energy security and reduce reputational risk.

UHB has a Sustainability Strategy and a detailed Action Plan covering governance; energy; procurement practice; Travel Plan; waste minimisation, segregation and recycling; together with an overarching communications strategy.

Key areas of development during the past year are detailed below.

Energy

The new hospital meets the Department of Health energy efficiency target of 35-55GJ/100m3, at 54.9 GJ/100m3.

Latest available comparison data is for the third quarter of 2013/14. The Trust saw an 9% saving in energy in that quarter compared to the equivalent quarter in 2007/08 (the baseline for NHS sustainability measurement). Taking the year as a whole the cumulative saving so far is 3.6%.

Data is being regularly analysed to identify progress against target reduction. Considerable progress has been made in creating virtual meters to match divisional and departmental structures. This is key to Trust-wide performance reporting and the development of an effective energy awareness programme.

Work has been completed on evaluating options for inclusion of renewable energy into energy supply contracts and new contracts have been put in place.

A number of potential energy / carbon saving schemes have been identified and are being implemented following a survey of the Trust's estate.

The Trust's Carbon Footprint

Treasury and NHS carbon reduction guidance relates to direct and indirect energy (Scopes 1 and 2) and official business travel (Scope 3). For UHB these together amount to some 50,000 tonnes of CO2 equivalent. Recent analysis indicates the Trust is on target to meet the NHS target of 10% reduction in CO2 emissions between 2007 and 2015 for Scopes 1, 2 and 3 as currently defined.

NHS national data and UHB's own estimates show the largest share of the total healthcare carbon footprint is procurement, especially pharmaceuticals, medical instruments and financial services. Procurement is currently outside of Scope 3 definitions because of measurement difficulties. However, preliminary independent estimates show a total carbon footprint for the Trust of some 230,000 tonnes of which 70% relates to procurement, 25% energy and 5% travel.

Procurement

The Trust's Procurement policy has been recently reviewed. The policy statement recognises that good procurement practice is critical to minimising risk and providing high quality services to patients. This includes carbon reduction. Procurement decisions must be made with due consideration of a number of factors including whole life costs, product standardisation, stock holding and environmental impact. Procedures have been developed to identify opportunities to introduce sustainable practise when contracts are renewed. Evidence of sustainable practise from suppliers is requested in tender documents and features as part of the evaluation and award criteria where applicable.

The "Top 10" most procured items have been analysed to understand their carbon impact. One of the 'Top Suppliers' with highest value/ amount of products purchased is NHSSC (NHS Supply Chain). The Top 10 items purchased from NHSSC have been reviewed i.e. sharps containers, blood collection systems, medicine pots, wipes alcohol/disinfectant/detergent and dry facial tissues. The disposal route for each has been considered to ensure that best practice is adhered to regarding the disposal of the product. As NHSSC are the distributor of the items, their supply chain and sourcing function has been researched to identify its sustainability elements i.e. energy, transport, waste, natural resources, staff travel, ethical procurement, carbon in procurement and sustainability processes.

A 'sustainability toolkit' is in the process of being developed to be used on site visits to supplier organisations to form part of the contracting process.

Buyers within Procurement are completing the Sustainability module within the Chartered Institute of Purchasing and Supply.

0pportunities are being identified where food can be sourced locally with a view to reducing food miles, together with fair-trade and organic farming.

Mixed recycling

As part of the wider Sustainability and Carbon Reduction Action Plan the introduction of mixed recycling will reduce the Trust's carbon footprint and costs. It is also a very tangible way of putting the sustainability agenda on the radar of staff, patients and public. Following a pilot scheme mixed recycling has now been being rolled-out Trust-wide. Items captured are:

- disposable paper and plastic plates, cups and beakers
- magazines, catalogues, "junk mail", wrapping and newspapers
- plastic bottles, coffee containers, milk cartons, tetra packs and cans
- sandwich and other food containers, including plastic meal containers, crisp packets, paper meal bags and carrier bags
- supplies cartons, e.g. glove boxes
- any other "labelled" recycling products

A strong communication strategy including waste "Recycling and Education" packs has been developed to complement the mixed recycling initiative.

Following the introduction of mixed recycling across the Trust the percentage of tonnage recycled rose from 29% in January 2013 to a high of 52% in August 2013. It now seems to have stabilised at 48%, some 48 m tonnes for November. The Trust Mixed Recycling Scheme received the 'Highly Commended' award in the Business recycling section of the Birmingham City Council's annual recycling awards and has been shortlisted for a national award.

Transport

This year the Trust, for first time, carried out a joint Transport survey with the University of Birmingham. Having the survey carried out at both sites and over the same time period allows for greater consistency in the survey results and is representative of the new collaborative approach to travel that both organisations are keen to move towards. The intention of the travel survey is to provide up to date information regarding staff travel patterns so that future transport planning is as efficient and effective as possible.

A key target specified within section 106 of the planning agreement for the New Hospital was a 10% modal shift from single occupancy car journeys to other methods, such as active travel and public transport. The 10% modal shift target is clearly being met. Between 2003 and 2013 there has been a 20% reduction in the number of single occupancy car journeys, which has been complimented by a 7% increase in staff commuting by public transport and a 3% increase in staff cycling to work. At present the majority of staff commute as single occupancy car drivers (53%), 17% travel by bus with 10% commuting by train. The survey indicates 5% of staff cycle and 4% walk.

Work has started on the updating of the Trust's current Green Travel Plan which is aimed at encouraging a further switch away from car travel.

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 has a wholly owned subsidiary company 'Pharmacy@QEHB' Limited, which commenced trading on 4 July 2011, providing 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 2013/14

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 2014 and appropriate to NHS Foundation Trusts. This is the fourth set of full year results prepared in accordance with IFRS accounting policies.

There have been no significant amendments to accounting standards in 2013/14 affecting the Trust.

3.2 Financial Performance

Despite the challenging economic climate the Trust has again reported strong financial results for 2013/14. Total income has increased by 6.7% to £689.4m 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 £4.9m prior to accounting adjustments recognising the reversal of previous asset impairments.

In total the Trust has recognised impairment reversals of £24.0m in 2013/14. This comprises £18.8m due to an increase 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 a change in the actual economic value of the building. A second reversal of impairment of £5.2m has been recognised in year linked to the newly-opened East Block Day Unit, which was a refurbishment of part of the old QEH estate. The reversals of impairment are a technical adjustment to the accounts, rather than actual cash receipt by the Trust, and therefore do not represent an actual flow of money. However, taking these gains into account the Trust has recorded an overall retained surplus of £28.9m for the financial year.

The reported financial performance has resulted in the Trust achieving an overall Continuity of Services Risk Rating of 2* (out of 4) from Monitor.

3.3 Income and expenditure

The table below compares the original planned income and expenditure with the outturn position for 2013/14.

Summary income and expenditure – plan v. outturn

The Trust's consolidated Summarised Income and Expenditure (£M's)		
	Plan 2013/14	Outturn Position 2013/14
Income	646.1	689.4
Expenditure	-602.7	-645.0
EBITDA	**43.4**	**44.4**
Depreciation	-20.0	-20.3
Donated Asset Revenue	2.5	2.5
Interest Receivable	0.8	0.5
Interest Payable	-22.6	-22.1
Corporation Tax	-0.2	-0.1
Surplus before impairments	**3.9**	**4.9**
Reversal of Impairments on Property	0.0	24.0
Retained Deficit	**3.9**	**28.9**

The largest component of the Trust's income is the provision of NHS healthcare, accounting for £559.2m (80.8%) of the total. Non-NHS clinical income contributes a further £9.7m (1.4%) 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 ('commissioner requested services') must exceed 50% of total revenues.

Revenue derived from NHS clinical activity in England is £553.5m, the remaining £5.7m of NHS healthcare income is from NHS Wales, Scotland and Northern Ireland. Revenue from the NHS in England is 80.0% 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 £32.1m (4.6%) of the Trust's income in 2013/14 and funding associated with Research and Development (R&D) activities, which totals £30.4m (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 2013/14 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 £335.0m, equivalent to 51.9% of total expenditure. Other significant components include £83.2m on drugs (12.9%) and £86.5m on Clinical Supplies and Services (13.4%).

3.4 Capital Expenditure Plan

In 2013/14 the Trust incurred £14.2m of capital expenditure on equipment, new facilities and improvements to existing buildings. This is summarised below:

Category	Capital Invested £ Million
Brought Forward Programmes from 2012/13	0.4
IT Replacement, Modernisation, Infrastructure and additional capacity	1.2
Trust Buildings	
• Existing Estate	3.7
• New Hospital	0.3
	4.0
Trust Equipment	
• Rolling Replacement	6.1
• New Equipment	2.5
	8.6
TOTAL	**14.2**

The Trust's planned capital expenditure over the next two financial years (2014/15 to 2015/16) totals £39.1m. This plan runs alongside the payments relating to the new hospital.

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 2013/14 included the delivery of cash-releasing efficiency savings of 4% against relevant budgets. In order to achieve this, a formal cost improvement programme (CIP) totalling £16.7m 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 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 £3.8m which is no longer subject to a specific limit, as described above the new commissioner requested services revenue legislation applies.

3.7 QEHB Charity

The charitable funds for the Trust are administered by QEHB Charity, a separate legal entity from the Trust. In 2013/14 the Trust received grants of £0.8m and donated assets worth £2.5m from the QEHB Charity.

3.8 External Auditor

The Trust's external auditor is Deloitte LLP. The audit cost for the year is £123,080 for statutory audit services and £36,665 which relates to non-audit work.

The appointment of external audit services from 2013/14 to 2017/18 was made by the Board of Governors, following a competitive tender exercise. This followed the resignation of KPMG who were the Trust's previous external auditors. In addition Deloitte also provide taxation advice to the Trust which is the non-audit work stated.

3.9 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: 22 May 2014

Directors' Report

4.1 Overview

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

4.2 Audit Information

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

4.3 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.

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

Disclosures regarding likely future developments, employment of disabled persons, and informing and engaging with staff are included within the Strategic Report.

4.5 Names of persons who were Directors of the Trust

The Board is currently comprised as follows:

Chairman: Sir Albert Bore (left the Trust on 30 November 2013)
Chair: Rt Hon Jacqui Smith (from 1 December 2013)

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 (left the Trust on 21 November 2013)
Executive Chief Nurse: Philip Norman (from 28 October 2013)
Executive Chief Operating Officer: Andrew McKirgan
Executive Director of Strategic Operations: Kevin Bolger

Non-Executive Directors:

Professor David Bailey (left the Trust on 30 November 2013)
Gurjeet Bains
David Hamlett
Angela Maxwell
David Ritchie (left the Trust on 21 July 2013)
David Waller
Professor Michael Sheppard
Jane Garvey (from 1 December 2013)
Harry Reilly (from 1 December 2013)

4.6 Patient Care

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

The Trust continues to improve patient care through the work of the Care Quality group chaired by the Executive Chief Nurse. A number of patient-focused initiatives were developed last year in response to feedback from patients and carers. The Trust has monitored feedback via a variety of different methods including the patient advice and liaison contacts, complaints, compliments, mystery patient initiative, friends and family test, local 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. They have demonstrated improvements in the 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 inform customer care training for receptionists. The patients have tested various elements of the services provided and have worked with a number of departments to test services. A number of changes have been made to enhance the patient experience as a result of the feedback received.

The Patient Experience Champion initiative has been further enhanced to engage staff, patient and public representatives in ways of using the feedback from patients and carers to improve their experience of services. There are now over 270 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. Education and training sessions have been provided to develop skills in the use of feedback to enhance patient experience.

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.

4.6.2 Infection prevention and control

The Trust continues to have a robust Infection Prevention and Control programme in place and whilst improvements have been made, challenges have been seen in 2013/14 with the Trust being over the agreed trajectories for MRSA bacteraemia and *Clostridium difficile* infections (CDI). However, in partnership with its local Commissioner, the Trust has developed what has been described nationally as exemplar practice, a process for joint review (with the local Commissioner) of CDI cases to determine avoidable and unavoidable CDI cases. On this basis the Trust has met and exceeded its target for a reduction of avoidable CDI cases. This work and the focus on further improving infection prevention and control will continue in 2014/15.

Performance against, and monitoring of, improvements related to healthcare- associated infections are monitored monthly at the Infection Prevention and Control Group and the wider care quality issues identified are monitored as part of the Care Quality Group chaired by the Executive Chief Nurse.

4.6.3 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 emotional support, privacy, dignity, involvement in decisions and overall care, the Trust has improved when measured in our real-time patient survey.

Following the Trust-wide audit of noise at night last year, the Trust won a National Patient Experience Network award for the improvements made in the experience of patients. Further work has been done to enhance rest and sleep for patients. The awareness-raising with staff who work nights has continued and guidelines for staff and patients to aid rest and sleep have been

implemented across the Trust. Leaflets have been produced for patients with tips to help them to rest and sleep, and relaxation exercises. Continuous monitoring is in place via the bedside electronic survey.

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

4.7 Public and Patient Involvement

4.7.1 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 developments within the Trust and the work programmes for the next year. Membership of the councils has increased, with the total number of patient and public representatives now being 58.

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 responding to feedback from patients and carers. This has included improvements to letters, signage, patient menus and food choices, information and customer care. Councils have continued to be actively involved with ongoing work on nutrition and hydration of inpatients, privacy and dignity, and patient experience data collection.

4.7.2 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 piloting a Buddy Scheme to provide support to young patients, gaining views on the provision of WiFi for inpatients, and reviewing ways in which the hospital environment could be more 'young person friendly' through the use of artwork.

4.7.3 Mystery Patient Council

Council members have undertaken 57 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 and improvements in facilities for patients and visitors.

The council has concentrated on diabetes, oncology and radiotherapy outpatient services and the hospital switchboard this year, but plans to roll out the initiative to other departments and services in 2014/15.

4.7.4 Readership Panel

The group was established seven 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:

- Review of UHB Hospital Information Channel
- Leaflet: Make the Difference, Become a Volunteer Care Maker at the QEHB
- Working with Carers – Common Core Principles/Webpage for Carers
- Booklet: Tena Patient Skincare
- Leaflet: Managing Your Pain
- Leaflet: Bone Anchored Hearing Aid
- Leaflet: Cochlear Implants
- Leaflet: Your Anaesthetic for Brain Surgery
- Leaflet: Anaesthesia for Your Spinal Surgery
- A5 size postcard for patients: mysafety@QEHB
- Leaflet: RAPID Assessment, Interface and Discharge (RAID) Mental Health Team

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

- Guidelines for Urinary Continence Care for adult patients aged 16 or over
- Patient Guidelines for Self Administration of Medicines
- Protocol for the Management of Erectile Dysfunction

4.7.5 Equality Delivery System

Members of the Patient and Carer Councils and public representatives have met throughout the year to discuss the Trust's approach to equality. Members have reviewed the objectives:

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and well-supported staff
- Inclusive leadership at all levels

They have discussed various actions that the Trust is taking to ensure all patients and carers are treated as individuals and consideration given to any special needs they may have. The group have also been involved in the development of the 'Orchard Project' to engage with the local community.

4.7.6 Healthwatch Birmingham

Healthwatch Birmingham is hosted by Birmingham Voluntary Services Council and has taken some time to become established. Links have been maintained with key personnel and members have been invited to take part in events and consultations at the Trust.

4.7.7 Patient and Carer Consultations

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

- Diarising the patient's day
- Trust Annual Plan
- Promoting research to patients and the public
- Volunteer Strategy
- Patient Experience Strategy

4.7.8 Volunteers from the local community

The Trust had around 600 people registered as active volunteers at the end of March 2014. 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:

- 34% male
- 25% black and Asian
- 17% under 30 years old
- 25% over 66 years old
- 24% employed
- 14% unemployed
- 9% students
- 43% retired

UHB volunteers give their time to enhance the experience of its patients, carers, visitors and staff. UHB often received feedback to say how much they are appreciated:

"I was greeted by a lovely elderly lady volunteer who dealt with my query quickly and pleasantly. She was wonderfully helpful."

The volunteers also benefit from being part of the hospital. Here are two quotes from volunteers:

"I cannot explain how much pleasure it has given me to be a volunteer, I feel so lucky."

"I would like to take this opportunity to thank everyone for making me a member of their team and creating such amazing memories and experiences."

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 developing the strategy for volunteering for the next three years.

Voluntary Services commenced a new buggy service in 2012, to transport patients and visitors from the car park to the hospital main entrance. During this year they have had 21,831 passenger journeys, making a total of 33,831 in the first two years of operation. Feedback from patients and visitors has been very positive and the team were nominated and won the Trust's Best in Care Award for the category 'Volunteer of the Year'.

Good working relationships have continued with the Birmingham Voluntary Services Council, and local volunteer organisation networks.

National recognition of the standard of the service has been demonstrated through a request from the Principal Private Secretary to HRH Prince Charles for the Associate Director of Patient Affairs (ADoPA) to be part of a round-table discussion to encourage more young people to volunteer in health and social care. The ADoPA was also invited by the Department of Health to be part of the strategic group to develop active communities and has continued in a key national role as the Chair for the National Association of Voluntary Services Managers, the organisation that leads volunteering in the NHS.

4.8 Complaints

The number of complaints received in 2013/14 was 664, which represents a reduction of more than 11% compared to the previous year.

There has been a reduction in the number and ratio of complaints across in-patients, outpatients and the Emergency Department, despite an increase in activity across all these areas.

Towards the end of the financial year, the Trust moved to divisional 'triaging' of complaints, whereby senior divisional staff have an early opportunity to resolve the issues highlighted, usually via a telephone call from a relevant senior colleague. This can provide a prompt resolution and potentially removes the need for a formal investigation of the issues where it is not warranted or requested. PALS (Patient Advice and Liaison Service) have also continued to work hard in collaboration with Trust staff to resolve concerns locally to prevent them turning into formal complaints.

There has been recruitment to the complaints team, so that the department now has a specific complaints officer to manage the complaints caseload for every clinical division. This has improved the service provided to the divisions and externally to patients and relatives.

Complaints processes continue to be reviewed to improve the service we offer, including how people access our services and how we learn from the feedback we receive. To help with this, the Trust is an active participant in the Shelford Group of trusts' complaints leads

group. Members of this group have shared some best practice and are benchmarking key data around complaints.

The three main issues raised in complaints were the same as in the previous year:

- Perception of clinical care and treatment
- Communication and information issues
- Delay/cancellation of inpatient appointments

A communication skills task and finish group was set up during the year to review and enhance communication training, education and support to all staff groups and levels. This work continues.

The Trust takes a number of steps to review learnings 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. One particular complainant was invited back to talk about her experience with divisional nursing staff. She agreed for the discussion to be recorded, so it could be used in future training sessions. She has also agreed to join one of the Trust's Patient and Carer Councils, to assist further in improving the experience of current and future patients and their families.

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, PALS 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 the reporting noted above, the Head of Patient Relations and Learning and Development colleagues also undertake a number of sessions around complaints and customer care as part of existing induction and development programmes across the Trust. Over 2,100 Trust staff received some form of customer care training during the past year.

Positive feedback is also important in highlighting success and providing opportunities to replicate successful initiatives wherever possible. The Trust consistently receives considerably more compliments than it does complaints. In 2013/14 the Trust received 2,131, compliments, compared to the 664 complaints received.

The Trust's Customer Care Awards scheme also allows grateful patients, relatives and colleagues to nominate members of staff who have gone the 'extra mile' and made a positive difference to their experience.

From April 2013, the Ombudsman advised that they would investigate a higher number of the complaints referred to them, following feedback received from complainants and in the context of the Francis Report into Mid-Staffordshire NHS Trust and associated reports around scrutiny of the NHS. They recently confirmed that, of the total requests for investigation they have received, they have investigated eight times more cases in 2013/14 than the previous year. Despite this, the number of cases referred to the Ombudsman by people who had complained to this Trust has remained stable. Whilst we are awaiting the Ombudsman's

decision on a number of cases, even if they were all investigated, the number of cases accepted for investigation would have increased but not to the extent experienced across the Ombudsman's total caseload.

Three cases were partially upheld by the Ombudsman in 2013/14.

4.9 Research and Development

The Trust's affiliation with its academic partners at the University of Birmingham, coupled with its collaboration with Birmingham Children's Hospital NHS Foundation Trust under the auspices of Birmingham Health Partners, has fostered an environment that attracts nationally and internationally renowned clinicians and investigators at the forefront of their fields.

This partnership serves to make UHB one of few centres internationally that can complete the full circle of translational medicine.

Building work on the £24 million facility, situated in the old Queen Elizabeth Hospital, will commence in May 2014. The ITM vision is to accelerate the delivery of personalised healthcare through pioneering science. It aims to cure disease and save lives by applying transformative science and technology and by educating and training the healthcare workforce.

The Trust has the benefit of being at the heart of an internationally-recognised, clinical academic community, whose competitive advantages are unrivalled in the UK:

- State-of-the-art clinical facilities
- Population scale and diversity
- Established IT infrastructure
- Renowned clinical trials expertise
- Successful commercialisation of healthcare innovation

Access to a wide population base is crucial to advanced and comprehensive translational research and impossible without it. Coupled with this, the West Midlands hosts more small and medium-sized Life Sciences enterprises than any other UK region

4.9.1 Funding

The Trust, in collaboration with the University of Birmingham, has been awarded a £30.6m boost for research into patient care.

The funds comprise a £10 million investment from the National Institute for Health research (NIHR) which will be complemented by £20.6m match-funding from local health and social services to continue evaluating and developing healthcare over the next five years.

The funding will be managed by the Collaboration for Leadership in Applied Health Research and Care for West Midlands (CLAHRC-WM), an innovative partnership hosted by UHB.

In 2013 a new £6 million new burn injury research centre was launched at QEHB. The Healing Foundation Centre for Burn Injury Research will look at understanding how the body responds to burn injury and developing new treatments for repair.

The centre is a partnership between UHB, the University of Birmingham, the Ministry of Defence, Birmingham Children's Hospital NHS Foundation Trust, University College London and the Royal Free Hospital in London.

It is one of two burn injury research centres funded by the Healing Foundation, alongside the Bristol Children's Burns Research Centre. The two centres form the Burns Collective.

The Birmingham centre is supported by Vocational Training Charitable Trust (VTCT) and funded for five years with £1.5m investment from the Healing Foundation and funds from partner organisations of £4.5m.

In early 2014, Microbiologist Professor Robin May was awarded a five-year 1.9m euro grant from the European Research Council (ERC) to study emerging strains of fungi that are causing life-threatening diseases in patients.

Prof May is a key lead in trauma research at the Surgical Construction and Microbiology Research Centre (SRMRC), which is hosted by the QEHB.

In March 2014 researchers at SRMRC won a circa £200,000 grant from the SME Technology Council of Great Britain to pursue the development of an optical pupillometer that could significantly impact the way that traumatic brain injury (TBI) is identified, assessed and treated in civilian and military patients.

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 over £200,000 in research grants and infrastructure.

4.9.2 Public Engagement

The Trust's successful annual Research Showcase in May 2013 coincided with International Clinical Trials Day and allowed members of the public, patients and staff to see how their involvement in research can make a real difference to the healthcare of future generations.

A series of regular Research Awareness Days have now been established with the first, hosted by the Liver Disease Research Team, proving popular with members of the public – both patients and visitors.

Those running the display included researchers, liver PhD students, nurses and support staff, who were able to discuss their involvement in research projects with people interested in finding out more about how they, or their relatives, could take part.

In October 2013 the SRMRC held its first Patient and Families Group Meeting. It was attended by patients who had taken part in an SRMRC study, along with their family members.

The SRMRC's Patient, Carer and Public Involvement (PCPI) Day was held in March 2014. More than 25 patients and relatives attended the trauma research event, which was staged under the theme of Pre-Hospital and Emergency Care. Sister Melanie Brown, Emergency Department Clinical Lead and Sister Aisling Clarkson, Lead Trauma Research Nurse, explained what preparations the trauma team makes in the resuscitation room before the patient arrives, how the patient is managed once in the Emergency Department and how the team balances managing friends and family whilst trying to give immediate care for the patient.

4.9.3 Clinical Trials

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 2013/14, 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.

The number of patients receiving relevant health services provided or sub-contracted by UHB that were recruited during that period to participate in research approved by a research ethics committee was 10,778. The total figure is based on all research studies that were approved between 1 April 2013-31 March 2014.

The table below shows the number of clinical research projects registered with the Trust's Research and Development (R&D) Team during 2011/12, 2012/13 and 2013/14. 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	2013/14
Total number of projects registered with R&D	196	286	306
Out of the total number of projects registered, the number of studies which were abandoned	33	27	39
Trust total patient recruitment	**6,811**	**8,598**	**10,778**

4.10 Stakeholders, Partnerships, Alliances/contractual Arrangements

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

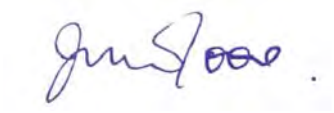
Local Health organisations	
Birmingham and Black Country Area Team (representative of NHS England)	Regular meetings between CEOs and appropriate directors
	Member of Birmingham Better Care Board
	Membership of working groups such as Urgent Care Review, RAID development etc.
Clinical Commissioning Groups	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
	Member of Urgent Care Board
	Well-developed 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
	Two-weekly joint meetings with Community Trust and Commissioners to discuss capacity issues in the local health system
	Meetings between senior clinicians in the Trust and CCG held on a regular basis
Specialised Commissioning Agency (part of NHSE)	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	Joint project on homelessness
	Urgent Care Operational Group including all providers in the city
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 support services to the Women's
	Regular meetings of Chairs and CEOs
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 'Urgent Care working group'
	Trust Director of Partnerships is an Ambulance Trust Governor
Birmingham Community Trust	Agreed pathways for a number of different conditions Agreed shared database to be used for early identification of patients requiring hospital-based rehabilitation services
	Twice-weekly meetings to discuss capacity issues and shared service models
	Local operational managers now part of 'Urgent Care working group'
	Provide pre-employment training for apprentices
	Agreed shared process for allocation of community beds
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
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/Cofely	Relationships continue at all levels to ensure the continued delivery of the new hospital, as well as health and safety issues
BBraun	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 Cit	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 Birmingham Better Care Board
	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 further develop an enablement service with therapy provided by UHB
	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 • Initiated programme of work with an umbrella group of faith organisations called 'Near Neighbours'. This has improved patient pathways and informed approaches to discharge planning • Introduced a monthly Farmers' Market for staff, visitors and local community, which has stalls run by local businesses and charities • Introduced a 'Community Orchard' initiative working in partnership with local and national bodies
Queen Elizabeth Hospital Birmingham Charity	QEHB Charity is the official charity of the Queen Elizabeth 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



Dame Julie Moore
Chief Executive

Date: 22 May 2014

Governance

5.1 NHS Foundation Trust Code of Governance

On 19 December 2013 Monitor, the independent regulator of foundation trusts, published its revised NHS Foundation Trust Code of Governance (the Code). The Code, which was first published in 2006 and then revised in 2010, had to undergo significant changes as a result of changing legislation. The Health and Social Care Act 2012 established a range of new duties for boards and governors of NHS foundation trusts. In addition, Monitor replaced the Terms of Authorisation with the Provider Licence and introduced a Risk Assessment Framework in place of the former Compliance Framework.

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 2013/14. In its Annual Report, the Trust is required to report on how it applies the Code. Whilst foundation trusts must always adhere to the main and supporting principles of the Code, they are allowed to deviate from the Code provisions provided the reasons for any such departure is explained.

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
- The Corporate Governance Policy, incorporating the Schedule Of Reserved Matters and Role Of Officers
- The Chief Executive's Scheme Of Delegation
- The Annual Plan
- Committee Structure

5.1.1 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 constitution, Monitor's Provider Licence, other mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations.

The Trust has a formal Corporate Governance Policy which reserves certain matters to the Council of Governors or the Board of Directors and sets out the division of responsibilities between the Board of Directors and the Council of Governors. The Corporate Governance Policy is reviewed at least annually.

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. As members of a unitary board, non-executive directors are in the same way responsible and accountable as the executive directors.

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 42, 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 Council of Governors has a duty to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors. This includes ensuring the Board of Directors acts within the conditions of its licence. The Council of Governors also receives the annual report and annual accounts, and the outcome of the evaluation of the Chairman and Non-Executive Directors.

The Chairman is responsible for the leadership of both the Board of Directors and Council of Governors and plays a pivotal role in the performance evaluation of the Non-Executive Directors.

Details of the composition of the Council of Governors are set out on page 39 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. Following the expiry of the term of office of the Chairman, Sir Albert Bore, and two Non-Executive Directors, Professor David Bailey and David Ritchie, a new Non Executive Director and Chair, the Rt Hon Jacqui Smith, and two new Non-Executive Directors, Jane Garvey and Harry Reilly, were appointed for terms of three years by the Council of Governors, on the recommendation of the Council of Governors' Remuneration and Nomination Committee for Non-Executive Directors. On the retirement of Kay Fawcett, Chief Nurse, the Executive Appointments and Remuneration Committee of the Board appointed Philip Norman as the new Chief Nurse. Details of the composition of that Committee and its activities are set out on page 53 of the Annual Report. Details of terms of office of the Directors are set out in Board of Directors, page 42, 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.

The Chair ensures all directors and governors receive a full and tailored 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 Executive Appointments and Remuneration Committee as appropriate. The Board of Directors and the Audit Committee have each evaluated their own 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

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.

The Audit Committee is responsible for the relationship with the Trust'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 receives instructions from the Board of Directors as to any areas where additional assurance is required and formally reports to the Board of Directors on how it has discharged its duty.

Deloitte LLP was appointed by the Council of Governors as the Trust's new External Auditor with effect from 1 January 2014.

The Trust's internal audit function is provided through a contract with an independent provider of internal audit services. KPMG LLP was appointed as internal auditors during the reporting year. The role of the internal auditors is to provide independent, objective assurance on the risk management, control, and governance processes within the Trust, through a systematic, disciplined approach to evaluation and improvement of the effectiveness of such processes. The internal audit team agrees a programme of work with the Audit Committee and provides reports during the year to the Committee

Additional information regarding audit is set out in the Audit Committee Report on page 49.

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 29 of the Annual Report and in Membership, page 54.

5.1.2 Compliance with the Code

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

B.2.4 *The chairman or an independent non-executive director should chair the nominations committee(s). In the case of appointments of non-executive directors or the chairperson, a governor should chair the committee.*

During the year, the Council of Governors' Remuneration & Nomination Committee for Non-Executive Directors oversaw the re-appointment of one Non-Executive Director for

a further term of one year and the appointment of three new Non-Executive Directors, including the Chair. Whilst the Committee was chaired by the Governor Vice-Chair for the appointment of the Chair, it was not chaired by a Governor for the Non-Executive Director appointments, because these appointments took place prior to 1 January 2014, when the revised Code became effective.

B.1.2 *At least half the board of directors, excluding the chairman, should comprise non-executive directors determined by the board to be independent.*

The Board of Directors is composed of 14 Directors, excluding the chairman. 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 a result of his connections with the Trust's university medical school, his appointment as Chair of the West Midlands Academic Health Science Network and having served more than six years as a Non-Executive Director.

B.7.4 *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.*

And

B.7.1 *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 past Chairman, Sir Albert Bore, and two of the Non-Executive Directors, David Ritchie and Professor David Bailey, had served for more than six years without being subject to annual re-election. Their terms expired on 30 November 2013. Professor Michael Sheppard was re-appointed for a further three years, subject to annual re-appointment, taking his tenure of service up to seven years. His re-appointment was subject to a rigorous review which took into account the need for re-freshening of the board. However, given that the then Chairman and two other Non-Executive Directors were also retiring at that time, the Council of Governors considered that these exceptional circumstances warranted the further re-appointment of Professor Sheppard to provide a degree of continuity.

C.3.2 *The council of governors should be consulted on the terms of reference [of the Audit Committee], which should be reviewed and refreshed regularly.*

The Council of Governors have not yet been consulted on the terms of reference for the Audit Committee, as these have not been reviewed since the introduction of this provision of the Code, which came into effect on 1 January 2014. The Council of Governors will be consulted as part of a future review.

C.3.3 *The council of governors should take the lead in agreeing with the audit committee the criteria for appointing, reappointing and removing external auditors. The council of governors will need to work hard to ensure they have the skills and knowledge to choose the right external auditor and monitor their performance. However, they should be supported in this task by the Audit Committee, which provides information to the governors on the external auditor's performance as well as overseeing the NHS Foundation Trust's internal financial reporting and internal auditing.*

And

C.3.4 *The audit committee should make a report to the council of governors in relation to the performance of the external auditor, including detail such as the quality and value of the work, and the timeliness of reporting and fees, to enable the council of governors to consider whether or not to reappoint them…*

The Audit Committee has not made a report to the Council of Governors in relation to the performance of the external auditor, because the external auditor resigned during the reporting period and a new external auditor was appointed by the Council of Governors, as more particularly described on page 50. The Audit Committee will be providing a report to the Council of Governors in relation to the performance of the current external auditor following completion of the Annual Audit.

D.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 material change to the remuneration of a Non-Executive Director.*

The Council of Governors have not appointed external professional advisors to market-test the remuneration levels of the Chair and other Non-Executive Directors. A material change to the remuneration of the Non-Executive Directors was last considered in 2009/10, when the proposed increases in remuneration were benchmarked against other similar trusts through a remuneration survey carried out by the Foundation Trust Network. For 2010/11, 2011/12 and 2012/13, the Non-Executive Directors did not receive any increase in remuneration, in line with the majority of NHS staff. In 2013/14, the Non-Executive Directors received a 1% inflationary increase, again in line with the majority of NHS staff.

5.2 Quality Governance Framework

The Board of Directors takes direct responsibility for service quality and has approved a Clinical Quality Strategy setting out the overarching principles underpinning the Trust's approach to Clinical Quality. The Board receives regular reports regarding clinical quality and care quality. The Board of Directors has established a Clinical Quality Committee to support, and provide continuity for, the Board of Directors in relation to the Board's responsibility for ensuring that the care provided by the Trust meets or exceeds the requirements of this strategy.

Operationally, groups including 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. Subsequently, the analysis has been reviewed and the Trust continues to meet the requirements of the framework.

The Trust continually seeks to improve its quality governance framework. All recommendations made as part of the external assurance arrangements for the 2012/13 Quality Report were fully implemented. Current action plans include the development and implementation of a process to replace the NHSLA assessment function, monitoring compliance with key policies and procedures, a review of the Serious Incidents Requiring Investigation process and development of a Risk and Compliance dashboard.

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

6. Council of Governors

6.1 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 Governor 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
- 5 stakeholder Governors appointed by five of its key stakeholders

6.2 Governors

Elections for Staff and Public Governor – Rest of England seats were held in June 2013.

Governors appointed to Staff and Rest of England seats at these elections were appointed for terms commencing on 1 July 2013 and ending on 30 June 2016.

During this year, the Governors have been:

6.2.1 Patient

Shirley Turner
Ian Fairbairn
Aprella Fitch

6.2.2 Public (by Area and Parliamentary Constituency)

Birmingham Area	
Northfield	Edith Davies
	Sandra Haynes, MBE
Selly Oak	Valerie Reynolds
	John Delamere
Hall Green	David Spilsbury
	Tony Mullins MBE
Edgbaston	Christine Beal
	Prof. Ian Trayer
Ladywood, Yardley, Perry Barr, Sutton Coldfield, Erdington & Hodge Hill	Graham Bunch
Rest of England Area	
Rest of England Area	John Cadle (elected 1 July 2013)

6.2.3 Staff

Up to 30 June 2013

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)

From 1 July 2013 for terms of three years

Dr Tom Gallacher (Medical Class) (re-elected)
Susan Price (Clinical Professions Allied to Healthcare) (re-elected)
Helen England (Nursing Class)
Margaret Garbett (Nursing Class)
Patrick Moore (Corporate and Support Services) (re-elected)

6.2.4 Stakeholder

- Rabbi Margaret Jacobi, appointed by the Birmingham Faith Leaders' Group
- Professor Joanne Duberley, appointed by the University of Birmingham
- Air Marshal Paul Evans, appointed by the Ministry of Defence
- Cllr Susan Barnett, appointed by Birmingham City Council
- Mr Richard Crookes, appointed by the South West Area Network of the Secondary Education Sector in Birmingham

6.3 Lead Governor

Dr John Delamere has been appointed by the Council of Governors as Governor Vice-Chair and Lead Governor.

6.4 Meetings

The Council of Governors met regularly throughout the year, holding five meetings in total. The former Chairman (Sir Albert Bore) attended 3 of the 4 meetings held during his term of office, and the newly appointed Chair (the Rt Hon Jacqui Smith) attended the one meeting held since her appointment.

Name of Governor	No. of meetings attended*
Edith Davies	All
Shirley Turner	All
Dr John Delamere	4
David Spilsbury	4
Tony Mullins MBE	3
Prof Ian Trayer	4
Aprella Fitch	4
Graham Bunch	4
Valerie Reynolds	4
Ian Fairbairn	2
Christine Beal	None
Sandra Haynes MBE	4
Dr John Cadle	3
Stakeholder Governors	
Susan Barnett	3
Joanne Duberley	2
Richard Crookes	3
Rabbi Margaret Jacobi	3
Air Marshal Paul Evans	2
Staff Governors	
Helen England	3 out of 4
Dr Tom Gallacher	3
Margaret Garbett	2 out of 4
Patrick Moore	4
Erica Perkins	1*
Susan Price	1**
Barbara Tassa	1*

*While a member of the Council of Governors.
**Susan Price was on long term leave during part of the reporting period.

6.5 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 Council of Governor and Board of 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, Strategic Planning Group, Care Quality Group

6.6 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

7. Board of Directors

7.1 Overview

Throughout the reporting period, the Board of Directors comprised the Chair, seven Executive and seven Non-Executive Directors. Following the expiry of his term of office, the Chairman Sir Albert Bore retired. The Rt Hon Jacqui Smith was appointed as a Non-Executive Director on 9 September 2013 and as Chair from 1 December 2013. Two Non-Executive Directors, Professor David Bailey and Mr David Ritchie, retired at the end of their term of office and were replaced by two new Non-Executive Directors, Jane Garvey and Harry Reilly. On the retirement of Kay Fawcett, Chief Nurse, in November 2013, the Executive Appointments and Remuneration Committee of the Board appointed Philip Norman as the new Chief Nurse

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.

During the reporting period, the Board has been comprised as follows:

Chair: Sir Albert Bore (until 30 November 2013); Rt Hon Jacqui Smith (from 1 December 2013)

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 (until 22 November 2013); Philip Norman (from 28 October 2013)
Executive Chief Operating Officer (interim): Andrew McKirgan
Executive Director of Strategic Operations: Kevin Bolger

Non-Executive Directors:

Professor David Bailey (until 30 November 2013)
Gurjeet Bains
David Hamlett
Angela Maxwell
David Ritchie (until 21 July 2013)
David Waller
Professor Michael Sheppard
Rt Hon Jacqui Smith (from 9 September 2013 to 30 November 2013, when she took up the post of Chair)
Jane Garvey (from 1 December 2013)
Harry Reilly (from 1 December 2013)

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

Name	Date of Appointment/ Latest Renewal	Term	Date of end of term
Sir Albert Bore	1 December 2010	3 years	30 November 2013
Rt Hon Jacqui Smith	As NED 9 September 2013 As Chair 1 December 2013	3 years	8 September 2016
Prof David Bailey	1 December 2010	3 years	30 November 2013
David Ritchie	1 December 2010	3 years	30 November 2013 (resigned 21 July 2013)
Gurjeet Bains	1 December 2011	3 years	30 November 2014

Prof Michael Sheppard	5 December 2013	3 years	4 December 2016
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
Jane Garvey	1 December 2013	3 years	30 November 2016
Harry Reilly	1 December 2013	3 years	30 November 2016

The Board of Directors considers Gurjeet Bains, Angela Maxwell, David Hamlett, David Waller, Jane Garvey and Harry Reilly to be independent. In coming to this determination, the Board of Directors has taken into account the following:

With regard to David Waller, that he, together with the former 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.

7.2 Board meetings

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

Directors	No. of meetings attended
Sir Albert Bore	5 out of 6*
Rt Hon Jacqui Smith	5 out of 5*
Dame Julie Moore	All
Mike Sexton	All
Tim Jones	All
David Ritchie	2 out of 2
Prof Michael Sheppard	7
Dr David Rosser	7
Prof David Bailey	4 out of 6*
Kay Fawcett	6 out of 6*
Philip Norman	2 out of 2*
Gurjeet Bains	6
Angela Maxwell	5
Kevin Bolger	All
David Hamlett	5
David Waller	7
Andrew McKirgan	All
Jane Garvey	2 out of 2*
Harry Reilly	2 out of 2*

*While a member of the Board of Directors.

7.3 The Board of Directors composition

Sir Albert Bore, Chairman (left Trust 30 November 2013)

Sir Albert 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.

Albert holds a number of Non-Executive Director positions, including with, 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.

Rt Hon Jacqui Smith

Jacqui read Philosophy, Politics and Economics (PPE) at Hertford College, Oxford and gained a PGCE from Worcester College of Higher Education. She taught Economics at Arrow Vale High School in Redditch from 1986 to 1988 and at Worcester Sixth Form College, before becoming Head of Economics and GNVQ Co-ordinator at Haybridge High School, Hagley in 1990.

Jacqui was the Member of Parliament for Redditch from 1997 until 2010 and the first ever female Home Secretary in the country. She entered the Government in July 1999 as a Parliamentary Under-Secretary of State at the Department for Education and Employment and became a Minister of State at the Department of Health following the 2001 General Election. Following the 2005 General Election, Jacqui was appointed to serve as the Minister of State for Schools in the Department for Education and Skills. In the 2006 reshuffle she was appointed as the Government's Chief Whip. She was Home Secretary from June 2007 until June 2009.

She formally took up her new role as Chairman of the Trust from December 2013.

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 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 Court of the University of Birmingham, the Faculty Advisory Board of the University of Warwick Medical School. She is a founder member and past Chair of the Shelford Group, ten leading academic hospitals in England.

In April 2011 she was asked by the Government to be a member of the NHS Future Forum to lead on the proposals for Education and Training reform and in August was asked to lead the follow up report. In September 2013, in recognition of the high quality of clinical care at UHB, Julie was asked by Secretary of State to lead a UHB team for the turnaround of two Trusts in special measures following the Kehoe review.

She has spoken at numerous national and international conferences including appearing on same programme as President Clinton in 2012 and undertaken many interviews on TV, radio and in the press, internationally, nationally and locally.

Julie was made a Dame Commander of the British Empire in the New Year's Honours 2012. In 2013, she was awarded an Honorary Chair at Warwick University, was included in the BBC Radio 4's Woman's Hour list of the 100 most powerful women in the UK and was included in the HSJ lists of the most influential leaders and in 2014 as one of the top ten CEOs. She has Honorary Doctorates from the University of Birmingham and Birmingham City University.

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 (left Trust on 21 November 2013)

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. She left the Trust in November 2013.

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 a newly created role of Executive Director of Delivery. His key responsibilities are to lead on research, strategy and performance, education, organisational development, and human resources. He is also an executive lead for Birmingham Health Partners and the West Midlands Academic Health Science Centre, and a board member of MidTech and Birmingham Science City.

Andrew McKirgan, Executive Chief Operating Officer

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.

Philip Norman, Executive Chief Nurse (from 28 October 2013)

Philip joined the Trust in October 2013 from Leeds Teaching Hospitals NHS Trust, where he undertook a number of senior nursing and operational roles, including Acting Chief Nurse, Assistant Chief Nurse, Operational Deputy Chief Nurse (Associate Director of Nursing equivalent) and Divisional General Manager (Director of Operations) for Medicine.

Philip has led a number of initiatives, both at divisional and Trust-wide level, to further improve patient care and services. This includes significant improvements in infection prevention and control, redesigned services including admission avoidance schemes, safer medical flow, care closer to home and improved ward environments leading to improved patient, carer and staff experience.

Philip has also worked with university colleagues on the development of new roles and with partners in the community and the local authority to further improve patient care and services across the health and social care setting. He undertook the role of Governor within the Leeds Partnerships NHS Foundation Trust (mental health trust).

Philip qualified as a registered nurse in 1988 and undertook a number of clinical roles within areas such as Older Adults, Emergency Department, High Dependency Care, Colorectal Surgery and Vascular Surgery. Philip also completed a Masters Degree (MA) in Management and Leadership.

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.

David 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 (left the Trust 30 November 2013)

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, 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.

Jane Garvey (from 1 December 2013)

Presenter of "Woman's Hour", Jane was brought up in Liverpool, moving to Birmingham in the early 1980s as a student to study English Literature. Her early experience of the NHS came through her mother, who was a receptionist at the Royal Liverpool Hospital and, after leaving University, Jane's first job was as a Medical Records Clerk at the same hospital.

Jane then returned to the West Midlands and embarked upon her career in broadcasting. In 1994, Jane moved into national radio and after thirteen years at Five Live she moved to Radio 4 to present Woman's Hour.

Jane, who has strong connections to the West Midlands, is keen to broaden her experience outside the "BBC bubble". She brings well-developed, high-level communications skills, developed over her very successful 20 year career in broadcasting. Jane's experience has given her valuable exposure to interacting with both high-profile figures and the public.

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, Angela's latest enterprise is Acuwomen, 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.

Harry Reilly (from 1 December 2013)

Harry, who trained as an accountant with Deloitte in the mid-1970s, joined British Leyland Plc in 1982. He left a role at divisional FD level for a newly acquired business, DAF Holland.

Harry has taken the opportunity to take on broader management positions and when he moved to the Rover Group he spent time in the Far East, Australia and South Africa, as well as some of the more developed markets in Europe and America.

In 1999 Harry was made Managing Director of Land Rover UK, essentially tasked with leading the business' sale to BMW. He subsequently joined Brintons as Finance Director and later Managing Director, tasked with turning around failing performance. Since then Harry has taken on a variety of positions alongside his non-executive work. He supported a start-up technology business and since 2011 has been Chief Executive of a Canadian flooring business. Harry continues to Chair the British American Business Council in the Midlands and is a non-executive director for the West Midlands Manufacturing Consortium.

Harry is passionate about Birmingham and the West Midlands and feels that the Trust is a real beacon of excellence, deserving of its strong regional and national reputation.

David Ritchie CB (left the Trust 21 July 2013)

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.

7.4 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

8.1 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. 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 Committee meets regularly and was chaired by David Ritchie until 23 May 2013 and subsequently by David Waller. The Committee currently comprises of four Non-Executive Directors of the Trust, with the external and internal auditors and other Executive Directors attending by invitation.

8.2 Membership of the Committee

The members of the Committee (i.e. all the Non-Executive Directors of the Trust, apart from the Chairman) during 2013/14 were as follows:

Mr David Ritchie (until 21 June 2013)
Mr David Waller
Professor David Bailey (until 30 November 2013)
Ms Gurjeet Bains
Ms Jane Garvey (since 1 December 2013)
Mr Harry Reilly (since 1 December 2013)

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

Mr David Ritchie – President of Governors of the Queen's Foundation for Ecumenical Theological Education and Trustee of QEHB Charity

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

Ms Jane Garvey – nil declared

Mr Harry Reilly – Director – Juyi TacFast UK Limited; Partner – TacFast Systems UK LLP; Director – West Midlands Manufacturing Consortium Limited; Director – Winning Moves Limited; Director – Galtons and Associates Limited; Chairman – British American Business Council Midlands

The Committee's principal support officer throughout the year was the Director of Corporate Affairs. The Chief Financial Officer, Chief Operating Officer, Chief Nurse 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.

8.3 Operation of the Committee

The Committee is required to meet at least four times a year. A total of six ordinary meetings took place during 2013/14 and were attended as follows:

Directors	No. of meetings attended
Gurjeet Bains	4
Prof David Bailey	4 out of 4*
David Ritchie	2 out of 2*
David Waller	5
Jane Garvey	1 out of 2*
Harry Reilly	2 out of 2*

*While a member of the Audit Committee.

The quorum for meetings of the Committee is two members. All ordinary meetings of the Committee during the period were quorate. An extra-ordinary meeting called on 12 September 2013 was not quorate and the decision to make a recommendation to the Council of Governors for the appointment of the new External Auditors was approved by Written Resolution.

The action plan following the annual self-assessment of 2012/13 was addressed and all recommendations were implemented during the reporting year. The annual self-assessment for 2013/14 is under way and its findings will be reported to the Council of Governors' meeting in July 2014.

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.

The Audit Committee receives specific instructions from the Board of Directors as to the areas where additional assurance is required and has formally reported back to the Board of Directors on how it has discharged its duty. The Audit Committee has thus supported the Board of Directors in making its 'fair, balanced and understandable' statement. During 2013/14, the Audit Committee considered the following significant issues in relation to financial statements, operations and compliance:

- Accounting treatment of the surplus created by the revaluation of the QEHB
- IT Business Continuity and Disaster Recovery Plans – the Committee sought and obtained additional assurance from the Director of IT
- Key Financial Controls – Limited assurance owing to issues to be addressed through implementation of a finance system upgrade. The Committee sought assurance regarding the timing of the upgrade, A subsequent Internal Audit report on key financial controls provided further assurance
- Data Security – Following a report from Internal Audit regarding Data Security, the Committee sought further assurance regarding user administration controls and password protection. It was agreed that Individual Information Asset Owners would be approached to establish the need for enhanced password protection and access controls in each case as the Committee appreciated the need to be mindful of not disrupting clinical care by requiring security settings/controls that were overly burdensome

During the reporting period the Audit Committee submitted formal reports to the Board of Directors' meetings following each Audit Committee meeting.

8.4 Auditors

During 2013/14, following the resignation of KPMG LLP as External Auditor, due to the risk to independence arising out of their potential involvement with the Trust on a commercial project, the Trust carried out a tender for a new External Auditor. Deloitte LLP was appointed by the Council of Governors as the Trust's new External Auditor, following a recommendation from the Audit Committee.

The Trust subsequently undertook a tender for Internal Audit services, following which KPMG

LLP was appointed to provide Internal Audit services.

KPMG LLP resigned as External Auditor on 1 October 2013, without undertaking any work in respect of the audit for the reporting period, and commenced work as newly appointed Internal Auditor on 1 November 2013. Deloitte LLP commenced work as the Trust's new External Auditor with effect from 1 January 2014 and completed a reduced schedule of work as departing Internal Auditor. The Trust took care to avoid any conflicts of interests and work was re-allocated between KPMG and Deloitte as Internal Auditors to ensure independence and objectivity of opinion where required.

The current contract for the appointment of External Auditors is for a term of up to four years from 1 January 2014 subject to annual review by the Audit Committee and reappointment by the Council of Governors. The Audit Committee will carry out a review of the effectiveness of the External Auditor following the completion of the annual audit, seeking the views of officers of the Trust, and shall report the outcome of that review to the Council of Governors, together with a recommendation as to whether the External Auditor should be re-appointed for the following year. The Audit Committee did not made a report to the Council of Governors in relation to the performance of the previous external auditor, because of the resignation of KPMG LLP as external auditor during the reporting period as referred to above.

The value of external audit services provided during the present year is:
Deloitte LLP: £ 123,120

Deloitte LLP provided the following non-audit services during 2013/14:

Statutory and audit-related work: £36,665. (An additional sum of £32,604 was paid to Deloitte LLP for Statutory and audit-related work during the year, but prior to their appointment as External Auditor on 1 January 2014)

Counter Fraud Service: £55,264. (This sum is for the full year, including the period before Deloitte LLP were appointed as External Auditor, ie, prior to 1 January 2014)

Deloitte LLP also received the sum of £63,000 in relation to the Internal Audit services they provided to the Trust prior to their appointment as External Auditors.

8.5 Independence of External Auditor

To ensure that the independence of the External Auditor 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). Statutory and audit-related work assignments do not require further approval from the Audit Committee or the Council of Governors

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

   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. 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.

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.

8.6 Auditor's reporting responsibilities

Deloitte LLP, the Trust's independent auditor, reports to the Council of Governors through the Audit Committee. Deloitte 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

9. Nominations Committees

9.1 Council of Governors' Remuneration & Nominations Committee for Non-Executive Directors

The Council of Governors' Remuneration & Nomination Committee for Non-Executive Directors is a 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 Chair 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 Chair chairs the committee, save when the post/remuneration of the Chair 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' Remuneration and Nominations Committee
Sir Albert Bore (Chairman) (Until 30 November 2013
Rt Hon Jacqui Smith (Chair) (from 1 December 2013)
Dr John Delamere (Governor Vice-Chair)
Ian Trayer
Ian Fairbairn
Dr Tom Gallacher
Richard Crookes

The Remuneration & Nominations Committee met eight times during the year.

Members	No. of meetings attended*
Sir Albert Bore	4 out of 4**
Rt Hon Jacqui Smith	2 out of 2*
Dr Tom Gallacher	5
Dr John Delamere	All
Ian Trayer	All
Ian Fairbairn	All
Richard Crookes	4

*While a member of the Committee.
**While a member of the Committee and excluding meetings concerning the appointment of the Chair

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

9.2 Nominations Sub-Committee

During the reporting year the Executive Appointments and Remuneration Committee appointed a Nominations Sub-Committee on two occasions. The first sub-committee was convened to deal with the appointment of a new Chief Nurse and consisted of: Sir Albert Bore, Dame Julie Moore and Prof Michael Sheppard.

The second sub-committee was appointed to deal with the appointment to a vacant Divisional Director post and consisted of the Rt Hon Jacqui Smith, Prof Michael Sheppard and the Chief Executive.

Membership

10.1 Overview

The Trust has three membership constituencies as follows:

- Public constituency (including the Rest of England constituency)
- Patient constituency
- 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:

- Who live in the area of the Trust
- Who are not eligible to become members of the staff constituency

In order to ensure that the membership is representative of the constituencies it serves, an additional constituency was created from 1 April 2013 – the Rest of England constituency – which allows individuals who live outside the Public constituency, but are not Patient or Staff members, to become members of the Public constituency. There are currently 551 members of the Rest of England constituency (up from 416 in 2013/14).

Patient Constituency

Patient members are individuals who are:

- Patients or Carers who are aged 16 or over
- Not eligible to become members of the staff constituency and are not members of any other constituency

N.B. A patient who lives in a public constituency area of the Trust will normally be registered as a member of the Public Constituency but this does not affect his/her ability to be a patient member by making an application for that membership.

Staff Constituency

The Staff Constituency is divided into four classes:

- Medical Staff
- Nursing Staff
- Clinical Professions Allied to Healthcare Staff
- Corporate and Support Services Staff

10.2 Membership Overview by Constituency

Constituency	Total at 31/03/14	%
Public	11,302	46
Patient	4,694	19
Staff	8,536	35
Total Membership	**24,532**	**100**

*Numbers correct up to 31 March 2014

10.3 Membership Strategy

10.3.1 Membership Development 2013/14

During 2013/14 the overall membership grew 2.5% from 23,941 to 24,532. The biggest growth was in the Patient constituency where numbers increased by 10%. This was due to two main reasons – an increase in clinical activity and membership recruitment campaigns run in the hospital. The Staff constituency also saw an increase in members – some 400 – due

to recruitment of permanent staff to manage the increase in capacity.

The membership is representative of the constituencies it serves.

10.3.2 Membership Objectives 2013/14

In April 2013 the Board of Directors approved the proposed Membership Engagement and Recruitment Strategy to replace the annual churn and maintain existing membership numbers to no less than 23,000. Emphasis was placed on the retention of existing members and further engagement, and achieved through:

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

In January 2013, UHB also launched an ambitious campaign – to attract 2,013 new members by the end of the calendar year.

Throughout the year, patients and visitors pledged support by signing up. As a result, 4,636 new members (including staff members) joined the Trust over the calendar year (1 Jan 2013-31 December 2013).

10.3.4 Forward Plan/Objectives 2014-15

The successful strategy employed in 2013/14 – ie, 'maintain numbers and replace churn' will be employed again in 2014/15.

There are no plans to launch a major recruitment campaign during the year. Such a campaign would cost between £12,000 and £15,000 to yield around 3,000 new members. Some 4,500 members were recruited in 2013/14 by UHB staff manning a membership stand for a week each month.

The objectives for 2014/15 are:

- To replace the annual churn and maintain existing membership numbers to no less than 23,500. With a membership of 23,500, UHB would be in the top 10 of foundation trusts with the highest number of members, based on 2012/13 figures which are the most recently available
- To ensure the membership is representative

10.3.5 Governors Development 2013/14

The Governors' Development Group meets two or three times a year to consider the development and training needs of the Governors and also ensure the standard and content of the Governors induction programme.

Topics for Governors Seminars are agreed – those held during 2013/14 have included:

- The role of the Council of Governors – including changes brought about by the Health & Social Care Act 2012
- The Francis Report – what impact this will have on the Trust
- Significant Transactions
- Discharge Process
- Patient Experience
- Monitor's New Role
- Hospital Mortality
- Research and Translational Medicine in the Trust
- Initial Discussion on 2014/15 Annual Plan (this is a regular topic for a joint seminar with the Board of Directors each year)

Educational visits on site have widened the understanding of how our Trust operates. Areas covered in the last year have included:

- Outpatient Pharmacy
- New laboratories
- A visit to the Institute of Biomedical Research

The Trust has also started to hold talks in addition to the Seminars – the first one is scheduled for October 2014 and will cover the Education of Junior Doctors – to be presented by staff Governor Dr Tom Gallacher.

The Governors are invited to attend FTN events on a rotational basis and these also include the GovernWell Courses held in Birmingham – topics to be covered this year will include:

- Accountability
- Effective Questioning and Challenge
- Core Skills
- The Governor Role in Non-Executive Appointments
- NHS Finance and Business Skills

UHB has also designed and held events hosted by the law firm Mills & Reeve when the following topics have been presented:

- The Government's Response to the Francis Report and the legal implications thereof
- The Regulatory Framework including Monitor's Enforcement Powers
- Data Protection for Governors (due in April 2014)

These have been followed by an informal networking opportunity for our Governors to meet fellow Governors from other local Trusts.

A further networking event was organised by the Birmingham & Solihull Mental Health Foundation Trust in January 2014 – this was well attended by a number of local Trusts and a similar event is being planned for later in the year.

10.3.6 Member communication with governors and/or directors

There are several ways for members to communicate with governors and/or directors.

The principal ones are as follows:

- Face-to-face interaction at monthly Members' Seminars. Governors attend these meetings and use them as a 'surgery' for members
- Governors' Drop-in Sessions. 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
- Governors attend community presentations held their constituency in relation to the hospital/patients issues
- Health Talks. Governors attend health talks which are held on a monthly basis for members and 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 5 days aimed at promoting membership
- Monthly recruitment stand in the hospital atrium

NHS Staff Survey

11.1 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 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

11.2 Summary of Performance

Each year the Trust's results are compared against other similar acute 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 2013 compared with 2012

2012		2013		Difference
UHB	National Average	UHB	National Average	
48%	48%	60%	46.9%	12% higher response rate locally and 13% higher than the national average, in the highest 20% of acute trusts in England.

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 2012 survey

	2012	2013	Difference
KF22: % of staff able to contribute to improvements at work	71%	73%	3% increase. Nat av 68%
KF1: % of staff feeling satisfied with the quality of work and patient care they are able to deliver	86%	85%	Reported as no change. Nat av 79%
KF23: Staff job satisfaction	3.64	3.74	0.10 scale point improvement. Nat av 3.60
KF26: % of staff having equality and diversity training in the last 12 months	57%	62%	5% increase. Nat av60%
KF24: Staff recommendation of the Trust as a place to work or receive treatment	3.93	4.04	0.11 scale point improvement. Nat av 3.86

Areas of deterioration from 2012 survey

There are no areas of deterioration since 2012

2013 Top 5 Ranking Scores

	2012		2013		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	86%	78%	85%	79%	No change
KF11. Percentage of staff suffering work-related stress in last 12 months (lower score better)	29%	37%	30%	37%	No change
KF2. Percentage of staff agreeing that their role makes a difference to patients	94%	89%	94%	91%	No change
KF23. Job satisfaction	3.64		3.74	3.60	0.10 scale point increase
KF6. Percentage of staff receiving job-relevant training, learning or development in last 12 months	85%		87%	81%	2% increase

2013 Bottom 5 Ranking Scores

	2012		2013		Difference
	UHB	National Average	UHB	National Average	
KF5. Percentage of staff working extra hours (lower score better)	73%	70%	71%	70%	2% actual decrease
KF14.Percentage of staff reporting errors, near misses or incidents witnessed in the last month.	92%		86%	90%	6% actual decrease
KF 16. Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months.	15%		16%	15%	1% increase
KF10. Percentage of staff receiving health and safety training in last 12 months	72%	74%	73%	76%	1% increase
KF17. Percentage of staff experiencing physical violence from staff in the last 12 months.	2%		4%	2%	2% increase

11.3 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
- Communication around what constitutes health and safety training
- An increase in incident reporting

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.

11.4 Future priorities and targets

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

- A reduction in the number of staff experiencing physical violence from patients, relatives or the public
- Reduction in percentage of staff experiencing physical violence from staff

Regulatory ratings

12.1 Monitor Risk Ratings in 2012/13

	APR 2012/13	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13
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 did not have a further case of MRSA from 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 opened additional bed capacity and introduced acute medical and surgical clinics together with an Older Person's Assessment and Liaison Service to avoid admissions.

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

12.2 Explanation of the change in regulatory regime in 2013/14 and any impact this has had on the Trust's ratings

Under the Compliance Framework foundation trusts' risk ratings were updated each quarter following the submission of a declaration by each trust that provides confirmation that they are well governed, financially sound and offering high quality services. Quarter 2 ratings were the last produced under the Compliance

Framework as this was replaced from 1 October 2013 by the Risk Assessment Framework (RAF).

The RAF for 2013/14 set out Monitor's new approach to regulating foundation trusts. It assesses trusts' compliance with their conditions under the licence in relation to continuity of services and governance. The Framework is designed to identify where there is a substantial risk to the financial sustainability or there is poor governance of a foundation trust.

The RAF contains three stages of review of foundation trusts' governance – monitoring, assessing risks to compliance and investigating potential breaches. As part of its monitoring, Monitor will continue to use annual submissions such as the Trust's three-year strategic plan, annual report, etc.; in-year submissions (primarily the quarterly governance declaration including performance against targets, CQC judgments and 'organisational quality indicators'); exception reports where a trust identifies concerns relevant to governance and external reviews of governance, commissioned by the trust on a three-yearly basis.

Monitor has changed the system of assigning governance ratings to trusts from the system of 'Green', 'Amber-Green', 'Amber-Red' and 'Red'. In 2013/14 trusts were assigned a 'Green' rating where there is no evident governance concern. Where there is an emerging concern and Monitor has requested further information, it is conducting an investigation or action is pending Monitor will give a trust a 'descriptive rating' describing the concerns, actions Monitor has taken or is considering taking and the next steps. If Monitor takes formal regulatory action it will assign a 'Red' rating. Risk ratings will be updated in real-time as Monitor receives information, makes decisions as to whether trusts should be investigated and completes investigations.

Where Monitor believes a trust may not be meeting its licence conditions in relation to governance, Monitor will conduct an investigation as to whether or not a breach occurred or is likely to occur. This will determine the scope and scale of any breach and identify the appropriate action to be taken up to and including enforcement action. Monitor will carry out an initial assessment using information already and readily available from the trust to decide whether there are grounds to investigate. After this it will prioritise the decision dependent on the likely benefit to the public, the impact on patients and provision of healthcare, the scale and scope of the breach and the resources required to investigate and address the breach.

If it is decided that investigation is required Monitor will ask for additional information to understand the nature of the issue, the plans in place to address it and whether or not these can be successfully implemented. Monitor may then ask the trust to develop and commit to delivering a plan to address the breach, commission an external report or commission external advice in line with their Enforcement Guidance. Where a trust is found to be potentially in breach of its governance condition Monitor may take a number of actions including asking the trust to investigate further, develop a recovery plan, agree measures of progress or consider management and organisational capability. It may then take formal regulatory action which would be associated with a 'Red' governance rating.

12.3 Monitor Risk Ratings in 2013/14

	Annual Plan 2013/14	Q1 2013/14	Q2 2013/14	Q3 2013/14	Q4 2013/14
Under the Compliance Framework					
Financial Risk Rating	3	3	3		
Governance Risk Rating	Amber-Red	Amber-Red	Amber-Green		
Under the Risk Assessment Framework					
Continuity of Service Rating				2*	2* (based on self assessment)
Governance Rating			Green	Green	TBC at time of publication

In its Annual Plan for 2013/14 the Trust declared a risk to the achievement of the *C. difficile* and Total Time in A&E targets. The Board declared *C. difficile* due to the challenging trajectory of 56 cases for the Trust in 2013/14 which was fewer than the 2012/13 outturn of 73 cases. As previously detailed the Trust did exceed its trajectory with the total number of cases but had significantly fewer avoidable cases with only 16 cases judged avoidable over the year. The Board also declared a risk to achievement of the Total Time in A&E target due to the unprecedented numbers of A&E attendance and levels of emergency medical and surgical activity seen and a sustained increase in the number of delayed transfer of care patients and the number of patients awaiting transfer to Birmingham Community Healthcare NHS Trust. Due to the action taken by the Trust over the year the target was achieved for 2013/14 as a whole.

In Quarter 1 2013/14 the Trust achieved all targets with the exception of *C. difficile* and Total Time in A&E. Based on the Compliance Framework the Trust should have received a 'Red' rating as this was the third consecutive quarter the Trust had not achieved the Total Time in A&E target. However Monitor took into account the steps the Trust has taken to manage its emergency pathway pressures, the factors within the local health economy outside of the Trust's control which affected performance and the improvement in performance achieved since April 2013 against the target and did not open an investigation to assess whether the Trust could be in breach of its licence. Consequently the 'Red' override was not applied and the Trust received an 'Amber-Red' rating for governance for Quarter 1.

In Quarter 2 2013/14 the Trust achieved all targets with the exception of *C. difficile*. This gave it an 'Amber-Green' rating under the Compliance Framework in the last quarter that the Framework applied. Following the introduction of the Risk Assessment Framework in October 2013, Monitor decided not to undertake an investigation into the Trust's governance nor take regulatory action against the Trust in response to that failure as it was assured about the reasons for this and the action taken by the Trust in response and therefore the Trust maintained a 'Green' governance rating under the Risk Assessment Framework.

In Quarter 3 2013/14 the Trust achieved all targets with the exception of *C. difficile*, Cancer 62 day GP referral, Cancer 31 day first treatment and Cancer 31 day subsequent radiotherapy. Monitor again decided not to undertake an investigation into the Trust's governance nor take regulatory action and therefore a 'Green' governance rating was maintained. Communication with Monitor has

indicated that the low number of avoidable cases of *C. difficile* infection has provided them with significant assurance that, despite its trajectory being exceeded, the Trust continues to exercise good governance. Likewise the increase in referrals for radiotherapy and the significant action that the Trust has taken to increase capacity in response meant that there were no governance concerns resulting from the non-achievement of the cancer targets.

In Quarter 4 2013/14, the *C. difficile* target was declared again as The Trust had already exceeded its full year *C. difficile* trajectory by the end of Quarter 3. However there continue to be low numbers of avoidable cases and the Trust's model of judging the avoidability of cases has been adopted as an exemplar and used by NHS England to develop a similar system nationally in 2014/15. The outcome of this declaration has yet to be published by Monitor.

12.4 Details and actions from any formal interventions

There have been no formal interventions.

Public Interest Disclosures

13.1 Sickness absence

In 2013/14, the Trust recorded an annual average sickness absence, across all clinical and corporate divisions, of 3.79%; a slight reduction from 3.9% in 2012/13. Trust management is working in partnership with Staffside to reduce this to 3.5% by 2015 and therefore the reduction from the previous year demonstrates our commitment and progress on reaching that target.

May 2013 saw the introduction of the new Health and Well-being staff 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. Work is ongoing to implement Mindfulness across the Trust and a project working in conjunction with the Sports & Exercise Consultant to increase fitness activity of staff is to commence in early summer. The Trust's Staff Survey did however show that our staff recognise that we take an interest in their health & wellbeing and we hope to increase this further.

13.2 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.

13.3 Health and Safety

Incidents reported last year (April 2013 – March 2014) include:
632 Violence and aggression incidents; 318 Inoculation injuries; 129 Slips, trips and falls; 81 Musculoskeletal
The violence and aggression incidents include 72 intentional assaults as validated to NHS Protect standards, 283 verbal assaults, and 277 other types. The Trust has worked hard to increase the compliance rate for staff attending conflict resolution training and attendance of frontline staff has increased from 35% three years ago to 92% currently.

Following the introduction of safer cannulae last year (phase 1 of Safer Sharps programme), safer devices for collecting blood samples were introduced during 2013 (phase 2) and the Trust is now partway through the final phase of the Safer Sharps programme, the review and introduction of new safety blood collection systems. The Trust has introduced other measures for preventing inoculation injury, for example, mandating the use of face protection for some clinical tasks identified as higher risk of inoculation injury from splashes with body fluids. This and other preventive measures have been supported by increased monitoring of practice, with Directors of Operations, Senior Nursing staff and Health and Safety team carrying out both planned and unannounced inspections in wards and departments around the Trust.

The Trust's manual handling service has continued to provide a range of services including training (currently 88.2% compliance); specialised review and advice for management of some patients, especially bariatric patients. The Trust is planning on review and upgrade of older hoists with a rolling programme over the next three years.

Flu vaccination continues to be made available to all frontline staff as close to their place of work as possible to reduce any disruption to services and this, combined with support from Trust nursing staff, has led to an increased uptake of the flu vaccine.

The Trust Health and Safety Committee approved an improved quarterly Health and Safety report format enabling executive directors from all areas of the organisation to report compliance to the committee. The recently introduced reports capture a wider range of data than previously, with the aim of providing increased oversight, transparency and control.

13.4 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 2013/14.

The table below sets out a summary of other personal data related incidents in 2013/14.

Summary of other personal data related incidents in 2013/14		
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	1
IV	Unauthorised disclosure	0
V	Other	2

13.5 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, also included within this programme is a virtual intruder operation when a person not known to staff wearing casual clothes will try to obtain access to secure areas, this is encouraging staff to be more challenging to visitors, also 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.

13.6 Better Payment Practice Code

	Number	£000
Total bills paid in the year	109,237	332,302
Total bills paid within target	106,330	327,776
Percentage of bills paid within target	97.34%	98.64%

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.

13.7 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.

13.8 Management costs

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

13.9 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 or £220 a day for 6 or more months.

No. of existing engagements as of 31 March 2014	5
Of which:	
No. that have existed for less than one year at time of reporting.	2
No. that have existed for between one and two years at time of reporting.	1
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	2

Assurance has been sort from all individuals who are defined as 'off payroll engagements' that they have satisfied their taxation commitments to HMRC.

No. of new engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014	2
No. of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations	0
No. for whom assurance has been requested	2
Of which:	
No. for whom assurance has been received.	2
No. for whom assurance has not been received.	0
No. that have been terminated as a result of assurance not being received.	0

This annual report covers the period
1 April 2013 to 31 March 2014

University Hospitals Birmingham NHS
NHS Foundation Trust

Section 2 **Remuneration Report 2013/2014**

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 six times in the year. Attendance was as follows:

Directors	No. of meetings attended
Sir Albert Bore	3 out of 3*
Rt Hon Jacqui Smith	3 out of 3*
Dame Julie Moore	All
Gurjeet Bains	1
Prof David Bailey	0 out of 3*
David Ritchie	1 out of 1*
Prof Michael Sheppard	All
Angela Maxwell	5
David Hamlett	5
David Waller	All
Jane Garvey	3 out of 3*
Harry Reilly	3 out of 3*

*While a member of the Committee

The Committee was assisted by a report from Hay Group PLC when it reviewed the remuneration policy in March 2010. The Committee has not received advice or services from any person that materially assisted the Committee in their consideration of any matter relating to remuneration during the reporting period.

2. Executive Remuneration Policy

The remuneration policy was reviewed by the Committee in March 2010. The Committee recognises that, in order to ensure optimum performance, it is necessary to have a competitive pay and benefits structure. The objective of the Trust's policy for remuneration of Executive Directors and Senior Managers is to attract and retain suitably skilled and qualified individuals of high calibre, providing sufficient resources, strength and maintaining stability throughout the senior management team. Remuneration for such officers will be set and maintained at levels that remain competitive.

Remuneration levels will also reflect that the posts undertaken by some of the Executive Directors and Senior Managers at the Trust differ from those elsewhere in NHS organisations in combining several roles or in undertaking work not undertaken in other Trusts.

Benchmarking evidence, locally and nationally, is used to ensure that the salaries paid remained competitive, but are not excessive. The last independent review was undertaken in March 2010 by the Hay Group Plc. When determining Executive Directors' and Senior Managers' pay and conditions, the Committee has had regard to the pay and conditions of other staff on Agenda for Change and professional pay scales.

Executive Directors are on substantive contracts with a notice period of six months. There are no Executive Directors on fixed term contracts. 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. The Trust does not use performance-related pay mechanisms.

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 2013/14.

3. Pensions

All the Executive Directors are members of the NHS Pensions Scheme, with the exception of Dame Julie Moore. Under this scheme, members are entitled to a pension based on their service and final pensionable salary subject to HM Revenue and Customs' limits. The scheme also provides life assurance cover of twice the annual salary. The normal pension age for directors is 60. None of the Non-Executive Directors are members of the schemes. Details of the benefits for Executive Directors are given in the tables provided on pages 70 and 71.

4. Salary and Pension Entitlements of Senior Managers

The following is subject to audit: senior manager remuneration table, senior manager pension benefit table and the ratio of the highest paid director compared to the staff pay median. The remainder of the remuneration report is not subject to audit.

A. Remuneration

Salary entitlements of senior managers 2013/2014

Name and Title	Year Ended 31 March 2014					
	Salary	Expense payments (taxable)	Perfor-mance pay and bonuses	Long term Perfor-mance pay and bonuses	All pension-related benefits	Total
	(bands of £5000)	Total to nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2500)	(bands of £5000)
	£000	£00	£000	£000	£000	£000
SENIOR MANAGERS						
Dame Julie Moore Chief Executive	235-240					235-240
Kay Fawcett Executive Chief Nurse (left office 22/11/2013)	80-85					80-85
Philip Norman Executive Chief Nurse (commenced office 22/11/2013)	50-55				122.5-125	175-180
Dr David Rosser Executive Medical Director	100-105				50-52.5	150-155
Tim Jones Executive Director of Delivery	135-140				15-17.5	155-160
Mike Sexton Chief Financial Officer	135-140				7.5-10	145-150
Kevin Bolger Executive Director Strategic Operations	135-140				5-7.5	145-150
Andrew McKirgan, Chief Operating Officer - acting	125-130				117.5-120	245-250
Fiona Alexander Director of Communications	100-105				12.5-15	115-120
Morag Jackson New Hospitals Project Director	120-125				7.5-10	125-130
David Burbridge Director of Corporate Affairs	100-105				0-2.5	100-105
Viv Tsesmelis Director of Partnerships	75-80					75-80
NON EXECUTIVE DIRECTORS						
Sir Albert Bore Chairman (left office 30/11/2013)	35-40					35-40
Rt Hon Jacqui Smith Chair (commenced office 01/12/2013)	15-20					15-20

Rt Hon Jacqui Smith, Non Exec (Commenced office 09/09/2013-30/11/2013)	0-5					0-5
Angela Maxwell	10-15					10-15
David Ritchie (left office 21/07/2013)	0-5					0-5
David Waller	10-15					10-15
Gurjeet Bains	10-15					10-15
Professor Michael Sheppard	10-15					10-15
Professor David Bailey (left office 30/11/2013)	5-10					5-10
Harry Reilly (commenced 01/12/2013)	0-5					0-5
Jane Garvey (commenced 01/12/2013)	0-5					0-5
David Hamlett	10-15					10-15

Salary entitlements of senior managers – 2012/13

Name and Title	Year Ended 31 March 2013					
	Salary	Expense payments (taxable)	Perfor-mance pay and bonuses	Long term Perfor-mance pay and bonuses	All pension-related benefits	Total
	(bands of £5000)	Total to nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2500)	(bands of £5000)
	£000	£00	£000	£000	£000	£000
SENIOR MANAGERS						
Dame Julie Moore Chief Executive	230-235					230-235
Kay Fawcett Executive Chief Nurse	120-125				0-2.5	120-125
Dr David Rosser Executive Medical Director	90-95				12.5-15	100-105
Tim Jones Executive Director of Delivery	135-140				55-57.5	190-195
Mike Sexton Chief Financial Officer	135-140				35-37.5	170-175
Kevin Bolger Executive Director Strategic Operations	135-140				62.5-65	200-205
Andrew McKirgan, Chief Operating Officer - acting (commenced office 01/09/2012)	70-75				145-147.5	220-225
Fiona Alexander Director of Communications	100-105				22.5-25	125-130
Morag Jackson New Hospitals Project Director	115-120				2.5-5	120-125
David Burbridge Director of Corporate Affairs	100-105				37.5-40	135-140
Viv Tsesmelis Director of Partnerships	90-95					90-95

NON EXECUTIVE DIRECTORS						
Sir Albert Bore Chairman	50-55					50-55
Angela Maxwell	10-15					10-15
David Ritchie	15-20					15-20
David Waller	10-15					10-15
Gurjeet Bains	10-15					10-15
Professor Michael Sheppard	10-15					10-15
Professor David Bailey	10-15					10-15
David Hamlett	10-15					10-15

The remuneration of the highest paid director – the Chief Executive, Dame Julie Moore includes an amount of £22,330 (2012/13: £22,163) in lieu of her exit from the NHS Pension Scheme, disclosed as a pension related benefit. 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.

The other pension related benefits disclosed arise from membership of the NHS Pensions defined benefit scheme. They are not remuneration paid, but the increase in pension benefit net of inflation for the current year and applying the HMRC methodology multiplier of 20. Further details of the Board's pension benefits are disclosed in the Pension Benefits table below.

The Executive Medical Officer – Dr David Rosser also receives remuneration in his other capacity of medical consultant, this is an additional banding disclosure (in £000) of 100-105 (2012/13: 95-100).

Kay Fawcett held the post of Executive Chief Nurse until her retirement on 22 November 2013. Philip Norman commenced in this role on the same date.

Sir Albert Bore held the post of Chair until he left office on 30 November 2013 due to having reached the maximum term allowed in the post. The Rt Hon. Jacqui Smith commenced in this role on the same date.

Two non-executives also left in the reporting year having reached their maximum allowable terms of office: David Ritchie and David Bailey. Two new non-executives were appointed: Harry Reilly and Jane Garvey.

There are no benefits in kind, performance related pay, nor severance payments (2012/13 - £nil) paid to any executive or non-executive. There are no payments to any past senior managers that relate to the function of the Board of Directors (2012/13 - £nil).

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 2014	Year Ended 31 March 2013
Band of Highest Paid Director's Total Remuneration (£ '000)	235-240	230-235
Median Total Remuneration	27,617	26,742
Ratio	8.5	8.7

Total remuneration includes salary, performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions, the cash

equivalent transfer value of pensions nor any other accrued pension benefits not yet taken.

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

Expenses

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

	Year Ended 31 March 2014		
	Number in Office	Number receiving expenses	Total £000
Directors	19	2	3.7
Governors	23	5	2.7

	Year Ended 31 March 2013		
	Number in Office	Number receiving expenses	Total £000
Directors	19	4	5.3
Governors	23	3	1.7

B. Pension Benefits

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 2014	Total accrued pension related lump sum at age 60 at 31 March 2014	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2014	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, Executive Director of Finance	0-2.5	0-2.5	55-60	175-180	1,138	1,222	60	N/A
Tim Jones, Executive Director of Delivery	0-2.5	2.5-5	40-45	120-125	627	685	44	N/A
Philip Norman, Executive Chief Nurse	0-2.5	5-7.5	35-40	110-115	510	628	45	N/A
Kevin Bolger, Executive Director Strategic Operations	0-2.5	2.5-5	55-60	165-170	1,084	1,164	56	N/A
Dr David Rosser, Executive Medical Director	2.5-5	7.5-10	55-60	175-180	927	1,032	85	N/A
David Burbridge, Director of Corporate Affairs	0-2.5	0-2.5	15-20	55-60	333	361	21	N/A
Fiona Alexander, Director of Communications	0-2.5	2.5-5	10-15	30-35	141	167	23	N/A
Morag Jackson, New Hospitals Project Director	0-2.5	2.5-5	45-50	135-140	811	1,090	261	N/A
Andrew McKirgan, Acting Chief Operating Officer	5-7.5	17.5-20	35-40	105-110	453	569	107	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 53.

The Chair does not attend when the committee considers matters relating to her own remuneration.

Dame Julie Moore, Chief Executive

Date: 22 May 2014

This annual report covers the period
1 April 2013 to 31 March 2014

University Hospitals Birmingham NHS
NHS Foundation Trust

Section 3 **Quality Report 2013/2014**

Contents

Part 1: Chief Executive's Statement

During 2013/14, University Hospitals Birmingham NHS Foundation Trust (UHB) has continued to focus on delivering high quality care and treatment to patients in the Queen Elizabeth Hospital Birmingham. The Trust is treating ever more patients whilst trying to deliver the efficiency savings required by the national Quality, Innovation, Productivity and Prevention (QIPP) programme which aims to deliver £20billion of savings by 2014/15. UHB has therefore reorganised care across existing wards and opened new wards over the past year to create extra capacity to treat patients and ensure a better flow through the Emergency Department. This has also helped deliver a better experience for our patients, relatives and staff.

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 excellent progress in relation to four of the six priorities for improvement in 2013/14 set out in last year's Quality Report: improving venous thrombo-embolism (VTE) prevention, improving patient experience and satisfaction, completeness of observation sets and improving patient safety through barcoded wristbands. The Trust has made some progress towards reducing medication errors (missed doses) in 2013/14 but there is still work to be done to further reduce missed non-antibiotics in 2014/15. Infection prevention and control has proved challenging in 2013/14 with the Trust being over the agreed trajectories for MRSA bacteraemia and *C. difficile* infections (CDI). The majority of CDI cases were however deemed to be unavoidable following review by Commissioners and the Trust. UHB will continue to focus on reducing avoidable MRSA bacteraemia and *C. difficile* infections in 2014/15.

The Trust has chosen to continue with five of the six priorities for improvement in 2014/15 and has set improvement targets where possible; improving patient safety through barcoded wristbands will be discontinued as this was successfully implemented in 2013/14.

UHB'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. A wide range of omissions in care have been reviewed in detail during 2013/14 at the regular Executive Care Omissions Root Cause Analysis (RCA) meetings chaired by the Chief Executive. Cases are selected for review from a range of sources including an increasing number put forward by senior medical and nursing staff: wards selected for review, missed or delayed drugs, Serious Incidents Requiring Investigation (SIRIs), serious complaints, infection incidents, incomplete observations and cross-divisional issues.

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 again implemented some additional data quality checks for this year's Quality Report

in line with the recommendations of the *Report of the Mid Staffordshire NHS Foundation Trust* Public Inquiry by Robert Francis QC published in February 2013.

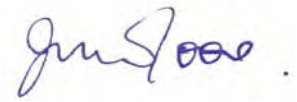
A key part of UHB's commitment to quality is being open and honest with our staff, patients and the public, with published information not simply limited to good performance. The Quality web pages provide up to date information on the Trust's performance in relation to quality: http://www.uhb.nhs.uk/quality.htm. The Trust launched a new website called mystay@QEHB in September 2013 in response to feedback from Trust Members about the type of information they would like to receive before they come into hospital. Quality information is published monthly showing how each inpatient specialty is performing for a range of indicators: infection rates, medication given, observations, clinical assessments and patient feedback. UHB plans to review and expand the information provided to patients and the public on the Quality web pages during 2014/15 in keeping with the national drive for greater transparency.

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 Healthwatch Birmingham. 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 over key parts of the Quality Report. For example, our internal auditor reviewed the Trust's processes for handling clinical audit, Serious Incidents Requiring Investigation (SIRIs) and compliance with the Care Quality Commission standards over the past year. The Trust's external auditor has reviewed both the content of the 2013/14 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 auditor 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, 2014/15 will be challenging for UHB as we enter the second year of the new NHS structure led by clinicians introduced in April 2013 and the final year of the current national efficiency savings programme. The Trust will continue working with commissioners and other healthcare providers to deliver further improvements to quality in the context of growing demand and changes within the wider health economy.



Dame Julie Moore, Chief Executive
May 22, 2014

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

2.1 Priorities for Improvement

The Trust's 2012/13 Quality Report set out six priorities for improvement during 2013/14:

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 Trust has made excellent progress in relation to four of these quality improvement priorities: improving venous thrombo-embolism (VTE) prevention, improving patient experience and satisfaction, completeness of observation sets and improving patient safety through barcoded wristbands.

The Trust has made some progress towards reducing medication errors (missed doses) in 2013/14 but there is still work to be done to reduce missed non-antibiotics further in 2014/15. Infection prevention and control has proved challenging in 2013/14 with the Trust being over the agreed trajectories for MRSA bacteraemia and *C. difficile* infections (CDI). It was disappointing to have had four avoidable (preventable) MRSA bacteraemia but pleasing to see that the majority of UHB's CDI cases were unavoidable. The Trust will continue to focus on reducing avoidable MRSA bacteraemia and *C. difficile* infections in 2014/15.

The Board of Directors has chosen to continue with five of the six priorities for improvement in 2014/15 as follows:

No.	2013/14 Priorities for Improvement	2014/15 Priorities for Improvement
1	Improving VTE Prevention	Improving VTE Prevention
2	Improve patient experience and satisfaction	Improve patient experience and satisfaction
3	Electronic observation chart – completeness of observation sets (to produce an early warning score)	Electronic observation chart – completeness of observation sets (to produce an early warning score)
4	Reducing medication errors (missed doses)	Reducing medication errors (missed doses)
5	Infection prevention and control	Infection prevention and control
6	Active patient identification via bar-coded patient wristbands for drug administration	Discontinued due to being implemented in 2013/14

The improvement priorities for 2014/15 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 discussed with various Trust groups including staff, patient and public representatives during quarter 4 2013/14 as shown in the table below. The priorities for improvement in 2014/15 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.

The focus of the patient experience priority was decided by the Care Quality Group and the priorities for improvement in 2014/15 were then finally approved by the Board of Directors in March 2014.

Date	Group	Key Members
January 2014	Chief Executive's Team Brief (cascaded to all Trust staff)	Chief Executive, Executive Directors, Directors, Clinical Service Leads, Heads of Department, Associate Directors of Nursing, Matrons, Managers
February 2014	Council of Governors	Chairman, Chief Executive, Executive Directors, Directors and Staff, Patient and Public Governors
March 2014	Care Quality Group	Executive Chief Nurse, Associate Directors of Nursing, Matrons, Senior Managers with responsibility for complaints, PALS (Patient Advice and Liaison Service), patient experience and governance.
March 2014	Patient and Carer Council (Wards)	Patient and Carer Council Representatives Associate Directors of Nursing, Matrons, Senior Managers with responsibility for complaints, PALS (Patient Advice and Liaison Service), patient experience and Human Resources
March 2014	Trust Partnership Team	Executive Directors, Directors, Human Resources Managers, Divisional Directors of Operations, Staff Side Representatives
March 2014	UHB Contract Review Meeting	Various managers and clinical staff from Birmingham and Cross-City Clinical Commissioning Group and UHB

The performance for 2013/14 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 2012/13.

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 from 2012/13. This means improving VTE prevention through appropriate administration of preventative (prophylactic) treatment. Preventative treatments include anti-embolism stockings (AES) and/or enoxaparin medication used to reduce the risk of blood clots forming.

Performance

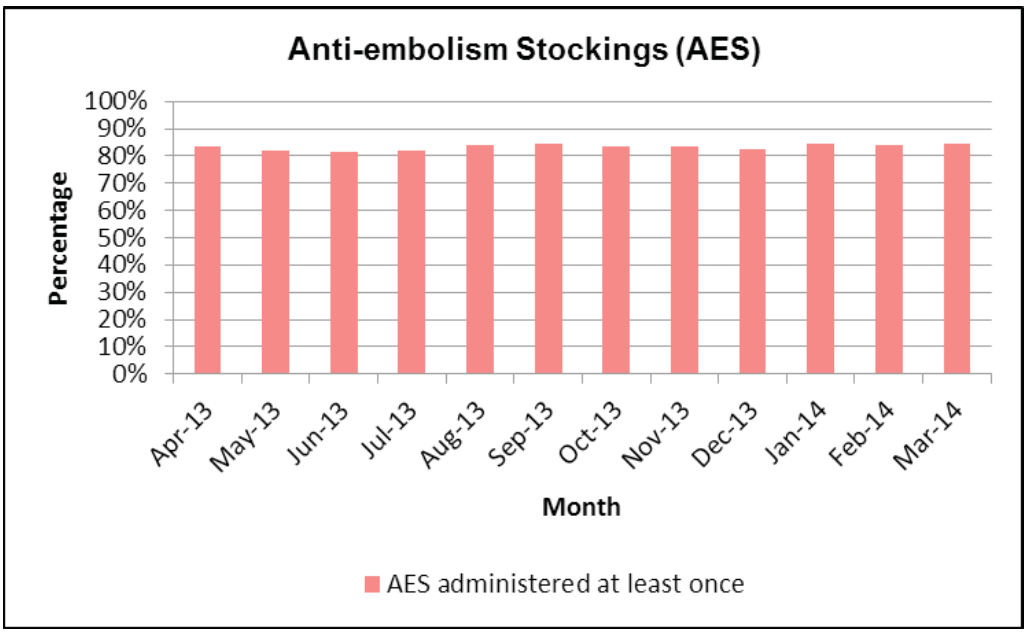
VTE Risk Assessment Completion

The Trust has achieved a VTE risk assessment completion rate of at least 98% since September 2010 and 99% or over since June 2012. This is above the national average of 96% for NHS acute providers as published on the NHS England website (October-December 2013).

VTE Prevention – Anti-embolism Stockings

The graph below shows the percentage of anti-embolism stockings administered at least once by episode for those patients who require them as recorded in the electronic Prescribing Information and Communication System. In the 2012/13 Quality Report, the Trust committed to maintaining performance for anti-embolism stockings during 2013/14. Overall, 83.4% of anti-embolism stockings were administered at least once per episode during 2013/14 compared to 87.9% in 2012/13.

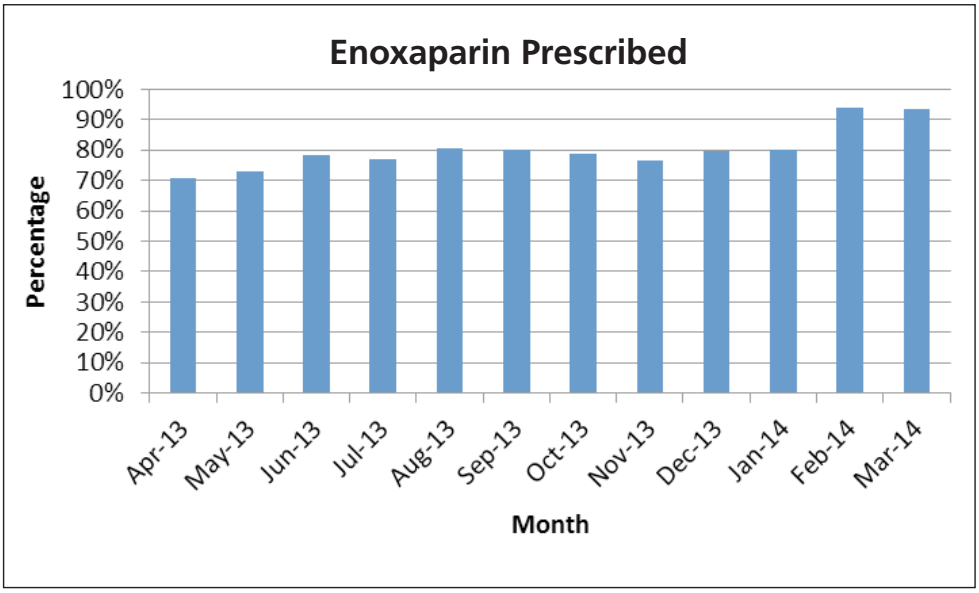
One patient admission or spell in hospital can comprise a number of different episodes of care. If the outcome of a VTE risk assessment shows that a patient requires anti-embolism stockings, they are automatically prescribed by PICS. It is not always appropriate to administer anti-embolism stockings 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. In the 2012/13 Quality Report, the Trust committed to 80% of patients who require enoxaparin following VTE risk assessment to have it prescribed by the end of 2013/14. This was against a baseline of 68.1% in 2012/13. Overall, 80.3% of patients who required enoxaparin following VTE risk assessment were prescribed it in 2013/14*. Performance increased during the year with 93.6% of patients being prescribed with enoxaparin who required it in the period February-March 2014. Of the patients who were prescribed enoxaparin, 96.0% 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.

* The Trust changed the methodology for measuring enoxaparin prescription from April 2013 to include a time limit so that only those prescriptions which are done within the first 12 hours after the VTE risk assessment are counted.



Initiatives implemented during 2013/14:

- Regular junior doctor monitoring clinics continued during 2013/14 with a particular focus on improving timeliness of enoxaparin prescription for those patients who require it following VTE risk assessment.
- 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 have been regularly reviewed.
- Enoxaparin prescription performance has been reviewed at specialty level so that best practice can be shared and implemented.
- A change was made to the VTE risk assessment module of the Trust's Prescribing Information and Communication System (PICS) at the end of January 2014 to drive better practice by medical staff. When a Doctor completes a VTE risk assessment and enoxaparin is required, the system automatically takes the Doctor to a blank prescription proposal for them to complete. This has driven the significant improvement in performance during February and March 2014.

Changes to Improvement Priority for 2014/15:

The Trust will focus on maintaining performance for administration of anti-embolism stockings at 83% or above and enoxaparin prescription at 90% or above. The Trust will continue to monitor administration of enoxaparin medication to ensure it remains high.

Initiatives to be implemented in 2014/15:

- Regular junior doctor monitoring clinics to continue and focus on compliance with VTE risk assessment outcomes and timely enoxaparin prescription completion for those patients who require it.
- Themes identified through root cause analysis of cases where patients developed VTE during their hospital or within 3 months after discharge will be presented to the Clinical Quality Monitoring Group. Trust-wide improvement actions will be implemented as required.
- Compliance with completion of enoxaparin prescription proposals by doctors will be monitored at specialty level to ensure the change made in PICS continues to deliver improved performance.

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 2013/14, 33,168 patient responses were received for the electronic inpatient survey and 1581 responded to the discharge survey. The table below shows the patient experience data collected by UHB for the past four financial years. The results show that the Trust has made improvements across all areas of patient experience during the 2013-14 as a result of the action plans for improvement which are developed in conjunction with Governors and Patient and Carer Council representatives. 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	2013/14
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%	**84.45%**
	Yes to some extent	20.9%	17.90%	15.18%	**12.93%**
	No	5.8%	5.00%	3.52%	**2.62%**
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%	**79.68%**
	Yes, to some extent	27.5%	22.70%	18.18%	**15.01%**
	No	11.8%	10.30%	7.50%	**5.31%**
3. Were you given enough privacy when discussing your condition or treatment?	Yes, always	87.4%	89.50%	91.35%	**93.44%**
	Yes, sometimes	10.6%	8.50%	6.93%	**5.29%**
	No	2.0%	2.00%	1.72%	**1.26%**
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%	**83.49%**
	Yes, to some extent			17.38%	**14.18%**
	No			2.58%	**2.33%**
5. Do you think the hospital staff do all they can to help control your pain?	Yes, definitely	80.8%	83.30%	85.37%	**87.98%**
	Yes, to some extent	16.0%	14.20%	12.61%	**10.44%**
	No	3.1%	2.50%	2.02%	**1.58%**
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%	**73.50%**
	Yes, occasionally		28.00%	23.87%	**21.81%**
	Yes, often		5.90%	4.81%	**4.69%**
7. Overall how would you rate the hospital food you have received?	Excellent	Data collection for these questions began in April 2011	20.30%	21.85%	**29.34%**
	Very Good		27.90%	28.51%	**26.90%**
	Good		27.20%	26.11%	**24.42%**
	Fair		16.50%	15.91%	**13.48%**
	Poor		8.10%	7.62%	**5.87%**
8. Sometimes in hospital a member of staff says one thing and another says something quite different. Has this happened to you?	No, never	Data collection for these questions began in April 2011	70.00%	74.30%	**77.30%**
	Yes, sometimes		24.30%	20.77%	**18.15%**
	Yes, often		5.70%	4.93%	**4.45%**

Question	Answer	2010/11	2011/12	2012/13	2013/14
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%	**49.44%**
	Yes, to some extent	*12.2%	9.30%	22.39%	**19.73%**
	No	*27.5%	44.40%	36.35%	**30.83%**
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%	**81.95%**
	No	*11.1%	27.60%	21.05%	**18.05%**

*The methodology used for questions 9 and 10 changed from a telephone survey to a postal survey from 2011/12 onwards; more responses have been received for the postal survey so the data is more reliable. Data for 2013/14 goes up to February 2014.

Friends and Family Question

The Trust has monitored performance for the Friends and Family Test question during 2013/14:

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

Patients staying overnight on an inpatient ward 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

From 1 April 2013, the Trust transferred to the new Department of Health guidance for the Friends and Family Test requirements. This involved the expansion of the survey to the Emergency Department. Response rates are reported together with the scores for each ward and the Emergency Department (ED) on the Trust website. Response rates from ED had been very poor during the first half of 2013/14 despite promotion and publicity of the request to complete the survey before leaving the department. A three-month pilot survey via text messaging was implemented at the end of September 2013 for Emergency Department patients. Initial response rates were encouraging and so the pilot was extended to the end of March 2014. Response rates significantly improved in the final three months of the year. The Trust's overall response rate has increased three-fold over the year, largely due to the increase in responses from ED patients.

In line with the national methodology, only those patients who pick 'extremely likely' are classed as promoters, 'likely' responses are classed as passive and all the rest are classed as detractors. The Friends and Family Score is calculated by subtracting the detractors from the promoters, dividing the answer by the number of responses (excluding the "don't know" responses), then multiplying by 100 to give the final score. The highest possible score is 100; the lowest possible score is -100.

The table below shows the Trust's responses and scores by month during 2013/14:

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Extremely Likely	690	1061	1062	1218	975	793	1371	1264	1261	1533	1574	2369
Likely	142	260	221	230	215	179	319	309	297	283	364	561
Neither Likely or Unlikely	19	20	12	26	38	27	40	52	44	35	55	96
Unlikely	6	13	12	17	15	22	24	31	25	22	39	58
Extremely Unlikely	11	13	18	20	33	30	47	34	30	39	47	83
Don't Know	8	13	12	11	14	9	14	17	12	12	17	26
Total Responses	876	1380	1337	1522	1290	1060	1815	1707	1669	1924	2096	3193
Total Discharges	8529	9461	9022	9773	9306	8886	9659	8952	8789	9226	8643	9973
Response Rate	10.27%	14.59%	14.82%	15.57%	13.86%	11.93%	18.79%	19.07%	18.99%	20.85%	24.25%	32.02%
Score	75	74	77	76	69	68	70	68	70	75	69	67

Initiatives implemented in 2013/14:

The following initiatives were implemented during the year to help to improve the experience of patients, carers and visitors.

- The Department of Health Friends and Family Test question was implemented on the inpatient bedside survey and for patients attending the Emergency Department
- A survey of patients around involvement in decisions about their care and being given conflicting information was completed; it also included a survey of staff perception of these two areas. The results have been used to inform education programmes for staff. The Patient Experience Team has raised awareness of the issues amongst staff through presentations to staff development programmes and via regular drop-in sessions
- Volunteer Dining Companions were introduced as part of a pilot scheme on three wards. The volunteers support patients during mealtimes by assisting and encouraging them to eat and drink – this helps with patients' nutrition and hydration. Due to the success of the scheme it is now being rolled out to more wards
- Following feedback from patients a new supplier of Halal meals has been chosen. Members of the local faith community were engaged in food tasting as part of the decision
- A survey of the experience of carers has continued throughout the year. As a result of feedback, a leaflet to inform carers of the support available and a carers page on the Trust's website are in development
- A method for gaining feedback from patients attending for outpatient chemotherapy has been agreed
- The Patient Experience Team won the National Patient Experience Network Award for the improvements made in helping patients to rest and sleep in hospital
- The Young Persons' Council undertook a survey of patients' views on Wi-Fi availability within the hospital. The results fed into a three month pilot to provide access to Wi-Fi for patients which commenced in March 2014
- A Buddy Scheme for 16-25 year olds was piloted by the Young Person's Council. The scheme involved young volunteers visiting two wards to chat and play games with young patients. It also gave the volunteers the opportunity to get feedback from the patients. The pilot scheme proved to be a success and so will be implemented in 2014-15
- In the Endoscopy Unit, following feedback from patients and relatives, drinks and sandwiches are available for patients and focussed work has been undertaken to further improve communication between staff and relatives

Changes to improvement priority for 2014/15:

A new set of local survey questions for 2014/15 was chosen by the Care Quality Group which has Governor representation and then approved by the Board of Directors. The new set of questions includes the lowest performing ones from the Trust's regular inpatient, outpatient, Emergency Department and discharge surveys.

Patient survey questions for 2014/15:

Type of Survey	Survey Question	Number of applicable responses (local survey) 2013/14	% positive responses / score (local survey) 2013/14	UHB ranking in national survey compared to other Trusts	Date of national survey
Inpatient	1. Did you find someone on the hospital staff to talk about your worries or fears?	14434	79.7%	About the same	2013
	2. Do you think that the ward staff do all they can to help you rest and sleep at night?	18859	83.5%	NA (local question only)	
	3. Have you been bothered by noise at night from hospital staff?	18931	73.5%	About the same	2013
	4. Sometimes in hospital a member of staff says one thing and another says something quite different. Has this happened to you?	27695	77.3%	About the same	2013
	5. Did the staff treating and examining you introduce themselves?	*To be introduced during 2014/15*			
Outpatient (Up to Feb-14)	6. Was your appointment changed to a later date by the hospital?	2153	80.7%	About the same	2011
	7. Did the staff treating and examining you introduce themselves?	2139	77.0%	About the same	2011
	8. Did a member of staff tell you about medication side effects to watch out for?	459	48.4%	Top 20% of Trusts	2011
Emergency Depart-ment	9. Were you involved as much as you wanted to be in decisions about your care and treatment?	1680	68.8%	Better	2012
	10. Do you think the hospital staff did everything they could to help control your pain?	1608	70.3%	About the same	2012
Discharge	11. Did a member of staff tell you about medication side effects to watch for when you went home?	1409	49.4%	NA – no national survey	
	12. Did you feel you were involved in decisions about going home from hospital?	1396	55.2%		

Improvement target for 2014/15:

In line with the Trust's Annual Plan for 2014/15, the improvement targets for the proportion of positive responses are as follows:

- Questions scoring 87% or more in 2013/14 are to maintain or improve this performance
- Questions scoring less than 87% in 2013/14 are to increase performance by at least 5%, and/or achieve 87%

All of the selected questions above scored below 87% in 2013/14, so the target for all is to improve by 5%, and/or meet 87%.

Methodology: The proportion of positive responses is calculated by dividing the number of the most positive responses e.g., 'Yes, definitely' by the total number of applicable responses.

Initiatives to be implemented in 2014/15:

- Family and Friends Test to be implemented in Outpatients and day case settings from October 2014
- A publicity campaign to ensure staff always introduce themselves to patients and carers.
- Launch of a dedicated Carers page on the Trust website
- Buddy Scheme for 16-25 year olds to be implemented in key wards across the Trust
- Review and revision of patient menus to reflect patient choice and ethnicity

How progress will be monitored, measured and reported:

- Feedback rates and responses will continue to be measured and reported 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 Governors and 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 the quarterly Quality Report update published on the Trust Quality web pages

Complaints

The number of complaints received in 2013/14 was 664, which represents a reduction of more than 11% compared to the previous year. The top three main subjects of complaints received in 2013/14 related to: clinical treatment (293), communication and information (92) and inpatient appointment delay/cancellation (75).

There has been a reduction in the number of complaints across inpatients, outpatients and the Emergency Department, despite an increase in activity across all these areas.

	2010/11	2011/12	2012/13	2013/14
Total number of complaints	840	797	752	664

Ratio of complaints to activity		2010/11	2011/12	2012/13	2013/14
Inpatients	FCEs*	123,139	118,504	126,309	132,280
	Complaints	444	434	428	379
	Rate per 100 FCEs	**0.36**	**0.37**	**0.34**	**0.29**
Outpatients	Appointments**	517,516	544,876	585,488	729,695
	Complaints	312	289	214	200
	Rate per 100 appointments	**0.06**	**0.05**	**0.04**	**0.03**
Emergency Department	Attendances	82,925	87,744	94,662	97,298
	Complaints	84	72	110	85
	Rate per 100 attendances	**0.10**	**0.08**	**0.12**	**0.09**

* 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 & Language Therapy and Occupational Therapy)

Learning from complaints

The table below provides some examples of how the Trust has responded to complaints where serious issues have been raised, a number of complaints have been received about the same or similar issues or for the same location, or where an individual complaint has resulted in specific learning and/or actions.

Theme/Issue	Area of Concern	Action taken	Outcome
Delays with administration of chemotherapy	Patients having to wait several hours before chemotherapy was administered.	New unit manager appointed. Triage nurse appointed to review patients prior to treatment and liaise with doctors and pharmacy staff to ensure any problems are promptly resolved. Some treatments now provided on Saturdays. Sterile Laboratory has extended opening hours to accommodate more requests for chemotherapy.	Feedback from patients has been positive – waiting times have been reduced. No formal complaints received about delays with chemotherapy since the end of 2013 when the triage nurse was appointed.
Delays with GP referred patients having scans performed.	Excessive waiting times to have scans carried out.	Specific afternoon period allocated for GP referred patients to have scans performed.	Feedback from staff and patients has been positive and no further complaints have been received.
Communication of delays in out-patient areas	Anxiety experienced by patients waiting for their appointments.	Clinic waits are now shown on the screens in the main waiting areas and will be introduced to the sub-wait areas in the Summer. Clinic staff have been reminded of the importance of informing patients of any delays in clinic.	This issue will continue to be monitored, especially during the monthly Governor visits to outpatients.
Cancellation of non-emergency surgery	Cancellation of Neurosurgery procedures.	Beds were ring-fenced on a ward in March 2014 for non-emergency Neurosurgical patients to reduce the risk of cancellation of their surgery.	A decrease in the number of complaints about the cancellation of non-emergency neurosurgery procedures has started to emerge.

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 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, Patient Advice and Liaison Service (PALS) concerns and compliments, as well as highlighting trends around specific issues and/or wards, departments or specialties. Trends around staff attitude and communication for particular locations feed into 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 incorporates information on incidents and legal claims. Complaints and PALS data is reported monthly to the Care Quality Group as part of the Patient Experience report. A monthly complaints report is presented at the Chief Executive's Advisory Group.

Serious Complaints

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

Parliamentary and Health Service Ombudsman (PHSO) - Independent review of complaints

PHSO Involvement	2011/12	2012/13	2013/14
Cases referred to PHSO by complainant for investigation	16	16	16
Cases which then required no further investigation	8	9	3
Cases which were then referred back to the Trust for further local resolution	1	2	1
Cases where the outcome of the initial review was awaited at the time of compiling the report	6	5	9
Cases suspended pending outcome of associated HM Coroner's inquest	1	0	0
Cases which were not upheld following review by the PHSO	0	1	2
Cases which were partially upheld following review by the PHSO	1	1	3
Cases which were fully upheld following review by the PHSO	0	1	0

The total number of outcomes of cases received and awaited does not match the total referred to the Ombudsman as some cases were referred in one year but the final outcome reports received the following year.

From April 2013, the Parliamentary and Health Service Ombudsman advised that it would investigate a higher number of the complaints referred to it. This was in response to feedback from complainants and in the context of the Francis report into Mid-Staffordshire NHS Trust and associated reports around scrutiny of the NHS. The PHSO recently confirmed that it has investigated eight times more cases in 2013/14 compared to the previous year. The number of UHB complaints referred to the Parliamentary and Health Service Ombudsman has however remained stable.

Three cases were partially upheld by the PHSO in 2013/14 relating to delays in reporting test results in Cardiology, a delayed diagnosis and the circumstances of the discharge of an elderly patient. The Trust has taken action to address all these concerns.

Compliments

Compliments are recorded by the Patient Advice and Liaison Service (PALS), and also by the Patient Experience Team. 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 2013/14, and more than in 2012/13. The Patient Experience team have continued to provide support and guidance to divisional staff around the collation and recording of compliments received directly to wards and departments. In addition, they have been scoping additional methods of capturing positive feedback received.

Compliment Subcategories	2010/11	2011/12	2012/13	2013/14
Nursing care	310	605	356	424
Friendliness of staff	306	492	207	191
Treatment received	251	300	766	1202
Medical care	122	391	92	79
Other	54	20	38	9
Efficiency of service	47	124	151	187
Information provided	17	16	10	27
Facilities	9	18	24	12
Totals:	**1,116**	**1,966**	**1,644**	**2,131**

Examples of compliments received during 2013/14:

Date received	Compliment
31/07/2013	We want to thank all the staff on W622 for the great service x received during her time with you. She really valued the caring atmosphere. We as a family were also extremely impressed and thankful for all the care given by such dedicated staff. The ward has such a lovely atmosphere and helped us through a very difficult time.
22/08/2013	The Sister conducted the interview in such a professional but compassionate manner and we left the hospital feeling more confident. This has been a major decision for my daughter to make, but with professional people, her Consultant, her Surgeon, Sister and all the staff we have encountered on all our visits to UHB, we, her family are looking to the future with confidence.
05/09/2013	All staff both medical and non-medical made efforts to put me at my ease and ensure that I was comfortable before and after my operation. In particular I would like to thank the staff at the Wellcome Short Stay Unit, theatre staff and the nurses on Ward 624 who performed all tests and checks efficiently and smiled. It may seem a small thing but it made a big difference to me as a patient.
19/12/2013	My treatment was undertaken with kindness and sympathy. Explanation of my treatment was made clear and concise. I felt that all the treatment which I received in the department was so professional and considerate, I wish to offer my sincere thanks to everyone.
26/01/2014	The surgeons mended my heart, ward 306 nursed me back to health but the Rehabilitation Team have given me back my normal life. What a wonderful team, all of you! My deepest thanks
28/02/2014	Was seen immediately upon arrival. Staff were excellent. As a wheelchair user patient was assisted well and describe staff as cheerful and helpful.
03/02/2014	Nursing care by some of the staff was excellent. I do not remember all their names but 3 in particular were lovely. They spoke to mom with respect and took the time to listen to her. They were very caring and shining examples of how to treat patients with dignity. I would especially like to thank the Charge Nurse. On every occasion he needed to treat or care for mom, he addressed her, explained what he was going to do, apologised for any pain that the treatment would cause, and above all was respectful, always.
07/03/2014	Cleaners, cooks, doctors, nurses, everybody. Thanks for taking care of my dad.

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 sent to the relevant service/ department manager for information and action. A response is posted to each comment received which acknowledges the comment and provides general 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

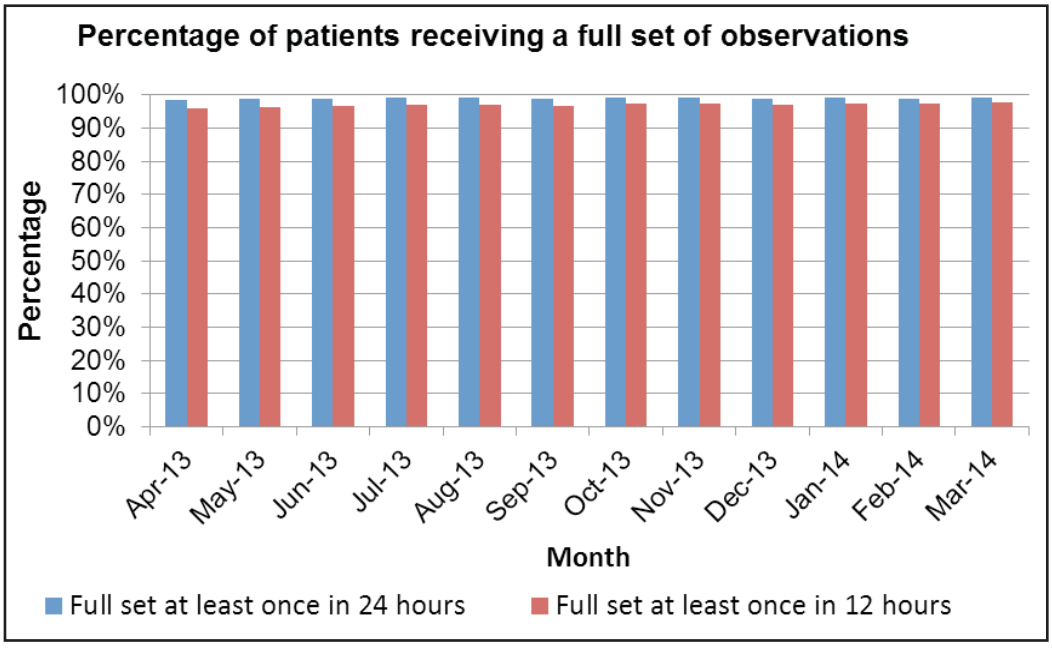
The Trust started to implement an electronic observation chart during 2010/11 within the Prescribing Information and Communication System (PICS) to record patient observations: temperature, blood pressure, oxygen saturation score, respiratory rate, pulse rate and level of consciousness.

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. A specific and detailed electronic observation chart has now been developed for Critical Care and is due to be implemented during 2014/15.

Performance

In the 2012/13 Quality Report, the Trust committed to all wards achieving at least 98% for completion of observations by the end of 2013/14. The Trust has improved performance during 2013/14 with an overall completion rate of 98.9% compared to 97.7% for 2012/13. All of the wards in the Trust are now achieving at least 98.0% for completion of observations except for Harborne ward. This ward cares for patients who are waiting to be transferred elsewhere, for example to a nursing home, their own home with a care package or a hospice. These patients have been deemed medically fit for discharge from hospital so it is not always clinically appropriate to do a full set of observations on these patients.



Initiatives implemented in 2013/14:

- Wards performing below the 98.0% target for observation completion were reviewed at the Executive Care Omissions Root Cause Analysis meetings to identify where improvements could be made
- Performance for observation completion has been published monthly by specialty as part of the new mystay@QEHB website which was launched in September 2013. Further information about the mystay@QEHB website is provided in part 3 of this report
- Second observation completion indicator was developed – full set of observations completed at least once in 12 hours – and started to be monitored on the Clinical Dashboard

Changes to Improvement Priority for 2014/15:

As the Trust is now performing at 98.9% for completeness of observation sets within 24 hours, the Board of Directors has chosen to focus on improving performance for completeness of observation sets within 12 hours. The Trust achieved an overall completion rate of 97.0% for completeness of observation sets within 12 hours during 2013/14 and is aiming for all wards to achieve 98.0% or above by the end of 2014/15. Harborne ward will be excluded from the 12 hour indicator for the reasons outlined above.

Initiatives to be implemented in 2014/15:

- Wards performing below the 98.0% target for 12 hour observation completion will be reviewed at the Executive Care Omissions Root Cause Analysis meetings to identify where improvements can be made
- Work will be undertaken with clinical staff to determine the set of observations required at least once in every 24 period for the specific cohort of patients on Harborne ward
- Observation compliance will be monitored as part of the unannounced Executive Governance Visits to wards which take place each month

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 continue to be reported publicly each month on the mystay@QEHB website

Priority 4: Reducing medication errors (missed doses)

Background

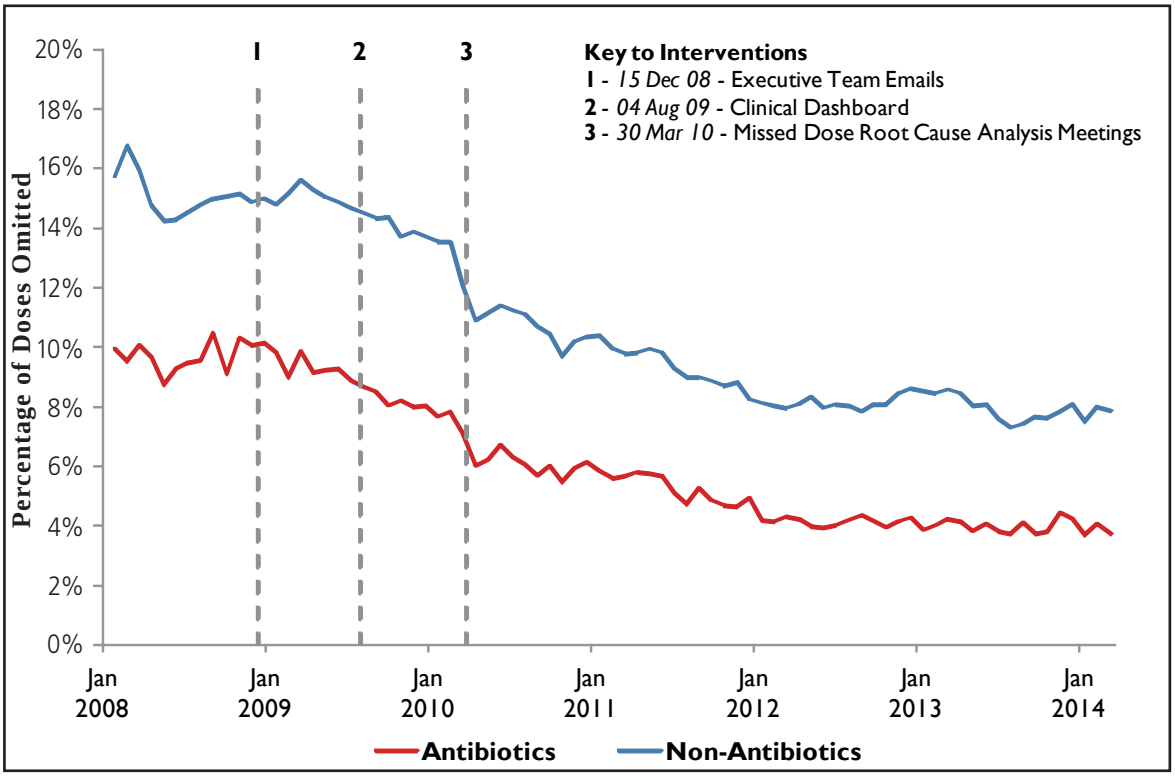
Since April 2009, the Trust has focused on reducing the percentage of drug doses prescribed but not recorded as administered (omitted) to patients on the Prescribing Information and Communication System.

The most significant improvements occurred when the Trust began reporting missed doses data on the Clinical Dashboard in August 2009 and the Executive Care Omissions Root Cause Analysis (RCA) meetings started at the end of March 2010.

Performance

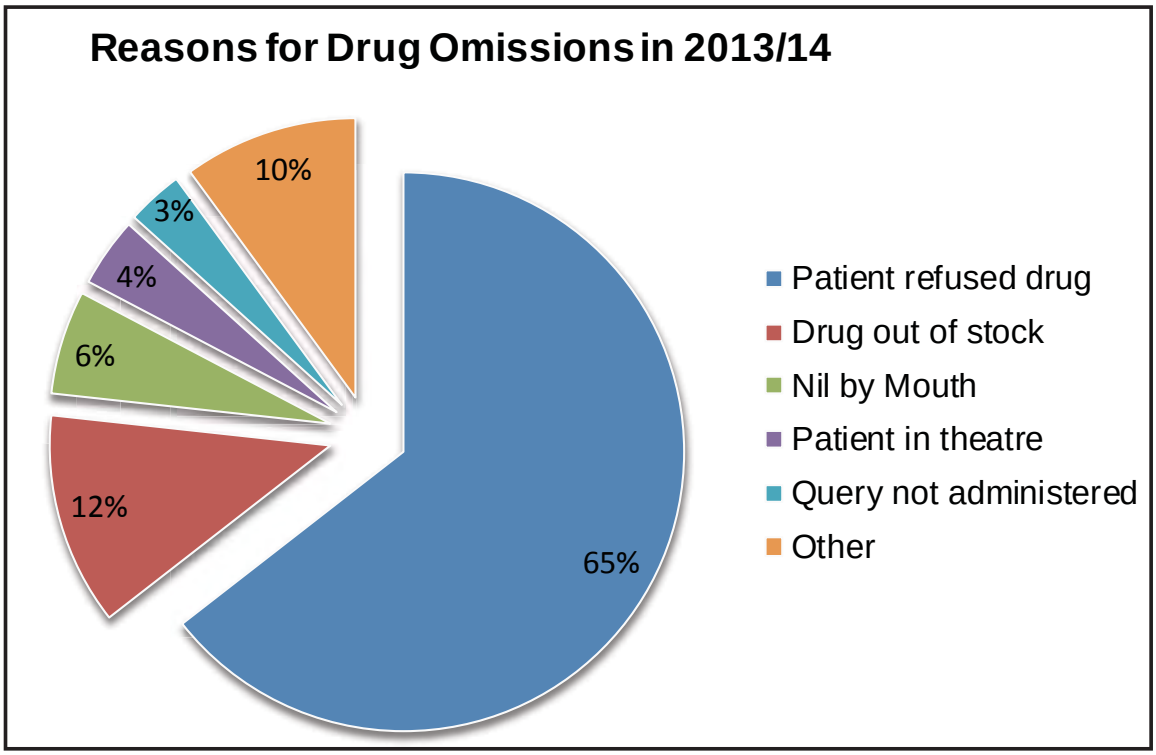
In the 2012/13 Quality Report, the Trust committed to maintaining performance for missed antibiotics at around 4.0% and reducing missed non-antibiotics by 20%. UHB has successfully maintained performance for antibiotics at 3.9% for 2013/14 and reduced missed antibiotics to 9.3% during 2013/14 which is a 7% reduction compared to last year (10.0% missed non-antibiotics in 2012/13).

The graph below shows that missed antibiotic and non-antibiotic doses have stabilised during the past two financial years 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 more work to be done to reduce non-antibiotic missed doses further.



The pie chart below shows the main categories of reasons recorded for non-antibiotic doses missed in 2013/14. 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% still being recorded as being out of stock. 'Query not administered' means that nursing staff have not recorded whether the drug dose was 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.

In 2014/15, the Trust will focus on trying to reduce patient refusals, reducing missed doses due to medication being out of stock and ensuring all doses are appropriately recorded as given or not.



Initiatives implemented during 2013/14:

- Patient refusal rates for missed doses were reviewed at ward level to ensure all our clinical staff do their best to encourage patients to take the medication they need
- Work was undertaken to review the medications most commonly recorded as being out of stock in the Clinical Decisions Unit. These include specific types of inhaler, emollient creams and eye drops which can only be used on an individual patient basis
- Performance for missed doses by specialty has been published for patients and the public each month from September 2013 as part of the new mystay@QEHB website. Further information about mystay@QEHB is provided in part 3 of this report

Changes to Improvement Priority for 2014/15:

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 10% reduction in missed non-antibiotic doses by the end of 2014/15.

Initiatives to be implemented in 2014/15:

- New reports will be developed to monitor consecutive missed doses of non-antibiotics e.g., four doses missed in a row
- Wards with the highest percentage of consecutive missed doses will be selected for review at the Executive Care Omissions Root Cause Analysis meetings to identify where changes need to be made
- Automated incident reporting from the Prescribing Information and Communication System to Pharmacy will be implemented for drugs which are recorded as out of stock

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. Performance for missed doses by specialty will continue to be provided to patients and the public each month on the mystay@QEHB website

Priority 5: Infection prevention and control

Performance

MRSA Bacteraemia

The national objective for all Trusts in England in 2013/14 was to have zero avoidable MRSA bacteraemia. During the financial year 2013/14, there were five Trust apportioned cases (cases linked to UHB) of MRSA bacteraemia. Four of the five cases were deemed to be avoidable.

These were subject to additional review at the Trust's Executive Care Omissions Root Cause Analysis meetings chaired by the Chief Executive and action plans developed to ensure any learning was disseminated across the organisation.

The table below shows the Trust apportioned cases reported to Public Health England (Health Protection Agency prior to April 2013) for the past four financial years including avoidable cases for 2013/14:

Time Period	2010/11	2011/12	2012/13	2013/14
Actual performance	11	4	5	5
Agreed trajectory	11	7	5	0

C. difficile infection (CDI)

The Trust's annual agreed trajectory was a total of 56 cases for 2013/14. The Trust used a new review tool with the local Clinical Commissioning Group to establish whether cases were avoidable, so that the Trust could focus on reducing avoidable (preventable) cases.

The majority of the Trust's CDI cases were unavoidable; there were 16 CDI cases which were deemed to be avoidable out of a total of 80 reportable cases (64 unavoidable).

The table below shows the total Trust apportioned cases reported to Public Health England for the past four financial years:

Time Period	2010/11	2011/12	2012/13	2013/14
Actual performance	145	85	73	80
Agreed trajectory	164	114	76	56

Initiatives implemented in 2013/14:

- Maintained improvements in patient safety through a robust Infection Prevention and Control surveillance programme. This included all alert organisms, surgical site infection, urinary catheter associated infection, incidence of blood culture contamination and the identification and management of multi-drug resistant microorganisms
- Continued monthly prevalence audit of urinary tract infections as part of the nationally agreed CQUIN (Commissioning for Quality and Innovation Indicator)
- Continued to minimise the risk from healthcare associated infections to patients through better management of invasive devices

Changes to Improvement Priority for 2014/15:

For 2014/15, the zero tolerance approach to avoidable MRSA bloodstream infections with timely post infection reviews will continue as previously. For *C. difficile* infections, the national approach will closely mirror what was done at UHB during 2013/14 with a system of joint reviews with commissioners to assess

avoidable (preventable) factors and those cases will count towards penalties based on breaching trajectory. For 2014/15 the UHB trajectory will be 67, based on a reduction from actual performance in 2013/14.

Initiatives to be implemented in 2014/15:

- Deliver improvements to antimicrobial prescribing through a system of audits, feedback to teams and educational initiatives
- Build on the work undertaken last year to refine the review process for CDI cases
- Continue to support reductions in surgical site infections through improving the process of surveillance and feedback to surgical teams
- Further address improvements to urinary catheter care by developing a group to focus on data collection, awareness raising, audit and feedback
- Continue to improve systems for surveillance of alert organisms including timely feedback to clinical teams

How progress will be monitored, measured and reported:

- The number of cases of MRSA bacteraemia and *C. difficile* infections will be submitted monthly to Public Health England and measured against the 2014/15 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 Group meetings
- All MRSA bacteraemia and CDI deaths will be reported as serious incidents requiring investigation (SIRIs) to Birmingham Cross City Clinical Commissioning Group (CCG)
- 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 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 planned to improve patient safety during 2013/14 by implementing barcoded patient wristbands in addition to the processes currently used to check patient identity for medication administration.

Progress

The Trust has successfully implemented barcoded wristbands for all inpatient wards and Ambulatory Care for the administration of medication by April 2014. Handheld barcode scanners have been purchased and fully integrated with the Trust's computers on wheels on each ward to allow electronic identification of patients at the bedside.

The purpose of barcode scanning is to add an extra safety check to ensure the right medication is given to the correct patient. This means that patients are asked to verbally confirm their details first before their wristband is scanned. Scanning the wristband automatically opens the correct patient's drug chart in the Trust's Prescribing Information and Communication System (PICS). Patients are then given their medication according to the drug chart.

Barcode scanning will also be introduced within Critical Care as part of the wider observation chart roll out in the future. There are also plans to use barcoded wristbands to improve patient safety in other areas such as for ordering scans or blood tests for patients.

Initiatives implemented in 2013/14:

- An implementation sub-group was set up to oversee the implementation of barcoded wristbands across the Trust. The sub-group reports to the Trust's Electronic Patient Record (EPR) Executive Group and to the Clinical Quality Monitoring Group chaired by the Executive Medical Director
- Staff training requirements were identified and a staggered ward implementation plan was developed
- IT hardware requirements were scoped for each ward. Handheld scanners were then purchased and integrated with the ward computers on wheels
- A mechanism for monitoring the use of handheld scanners and barcoded wristbands for medication administration at ward level has been developed

Changes to Improvement Priority for 2014/15:

As barcoded wristbands have been implemented across the Trust as planned, the Board of Directors has chosen not to continue with this priority for improvement in 2014/15. The Trust will continue to monitor the use of handheld scanners and barcoded wristbands for medication administration at ward level during 2014/15.

2.2 Statements of assurance from the Board of Directors

2.2.1 Information on the review of services

During 2013/14 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 2013/14 represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2013/14.

* 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 2013/14 31 national clinical audits and 4 national confidential enquiries covered relevant health services that UHB provides. During that period 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 2013/14 are as follows: (see tables below). The national clinical audits and national confidential enquiries that UHB participated in during 2013/14 are as follows: (see tables below).

The national clinical audits and national confidential enquiries that UHB participated in, and for which data collection was completed during 2013/14, 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 2013-14	Percentage of required number of cases submitted
Part of the National Clinical Audit and Patient Outcomes Programme	Inflammatory bowel disease (IBD)	Yes	100%
	Oesophago-gastric Cancer	Yes	Data is being reviewed and will be submitted by the 1st October 2014 deadline.
	Bowel cancer (NBOCAP)	Yes	Data is being reviewed and will be submitted by the 1st October 2014 deadline.
	Adult cardiac surgery	Yes	100%
	Heart failure	Yes	71%. Heart Failure cases as identified by UHB and not HES data. On target to meet 20 cases per month (100%) to be submitted by June 2014
	Adult cardiac interventions (e.g., angioplasty)	Yes	100%
	Myocardial Infarction (MINAP)	Yes	N/A no required case target.
	Cardiac rhythm management (Pacing / Implantable Defibrillators)	Yes	100%
	Congenital heart disease (children and adults) / Paediatric cardiac surgery	Yes	100%
	National Vascular Registry (CIA, National Vascular Database, AAA, peripheral vascular surgery/VSGBI Vascular Surgery Database)	Yes	AAA: 66 (>90% data submitted) CIA: 53 (>80% of data submitted) Bypass: 91 (>60% data submitted) Amputation: 45 (>60% data submitted).
	Lung Cancer	Yes	Expected cases 245 Submitted cases 265 (108%)
	Chronic Obstructive Pulmonary Disease (COPD)	Yes	N/A deadline is 31 May 2014
	Rheumatoid and early inflammatory arthritis	Yes	N/A commenced in February 2014
	National Diabetes Audit	Yes	N/A no required case target
	National Diabetes Inpatient Audit (NaDIA)	Yes	N/A No required case Target. Bedside audits: 197 Patient questionnaires: 112
	Head and Neck Cancer (DAHNO)	Yes	100%

Audit type	Audit UHB eligible to participate in	UHB participation 2013-14	Percentage of required number of cases submitted
Part of the National Clinical Audit and Patient Outcomes Programme	Falls and Fragility Fractures Audit Programme (FFFAP) – includes National Hip Fracture Database (NHFD)	Yes	100%
	SSNAP	Yes	Target 100% Data collected for 85-90% of patients in 2013.
	National Emergency Laparotomy Audit (NELA)	Yes	Data collection started January 2014 0% submission as yet

Audit type	Audit UHB eligible to participate in	UHB participation 2013/14	Percentage of required number of cases submitted
Not part of the National Clinical Audit and Patient Outcomes Programme	Renal Registry – Renal Replacement Therapy	Yes	97%
	National Cardiac Arrest Audit	No	N/A
	ICNARC - Adult Critical Care Case Mix Programme	Yes	75% (of required cases for April-December 2013 will be submitted by the end of May 2014)
	PROMs	Yes	69.3% Pre-operative questionnaire completion for groin hernias and varicose veins as published on the HSCIC website (above national average). Data covers April-September 2013. Participation in PROMS by patients is voluntary.
	BTS Emergency Oxygen	Yes	N/A - no required case target
	CEM Paracetamol Overdose	Yes	50 consecutive cases Deadline 31/03/14
	CEM Severe sepsis & septic shock	Yes	50 consecutive cases Deadline 31/03/14
	CEM Moderate or severe asthma in children (care provided in emergency departments)	No	Very few cases seen, data would not be useful.
	Severe Trauma - TARN (Trauma Audit and Research Network)	Yes	98.2%
	National Joint Registry	Yes	100%
	National Comparative Audit of Blood Transfusion	Yes	100%
	National Audit of Seizures in Hospitals (NASH)	No	N/A

National Confidential Enquiries (NCEPOD)

National Confidential Enquiries (NCEPOD)	UHB participation 2013-14	Percentage of required number of cases submitted
Lower Limb Amputation	Yes	100%
Tracheostomy Care	Yes	97%*
Subarachnoid Haemorrhage	Yes	100%
Alcohol Related Liver Disease	Yes	100%

Percentages given are the latest available figures.

*The Tracheostomy Care Study was a prospective study, a total of 71 cases were included. The study involved completion of 3 questionnaires however a very small number of questionnaires were not returned. All case notes requested were completed and returned.

The reports of 25 national clinical audits were reviewed by the provider in 2013/14 and UHB intends to take the following actions to improve the quality of healthcare provided: (see separate clinical audit appendix published 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 795 clinical audits were registered with UHB's clinical audit team as having commenced or been completed at UHB during 2013/14.

The reports of 215 local clinical audits were reviewed by the provider in 2013/14 and UHB intends to take the following actions to improve the quality of healthcare provided:

This figure indicates that the results of 215 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.

2.2.3 Information on participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by UHB in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 10,778. The total figure is based on all research studies that were approved in the period 1 April 2013–March 2014.

The table below shows the number of clinical research projects registered with the Trust's Research and Development (R&D) Team during the past three financial years. 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	2013/14
Total number of projects registered with R&D	196	286	306
Out of the total number of projects registered, the number of studies which were abandoned	33	27	39
Trust total patient recruitment	6,811	8,598	10,778

The table below shows the number of projects registered in 2013/14 split by specialty:

Projects registered during this period by Specialty	Registered
A&E	1
Anaesthetics	6
Breast Services	2
Burns & Plastics	4
Cardiac Surgery	1
Cardiology	15
Clinical Haematology	6
Clinical Immunology	1
Critical Care	2
Dermatology	11
Diabetes	9
Elderly Care	1
Endocrinology	14
ENT	9
General Surgery	1
Genito-Urinary Medicine	6
GI Medicine	5
GI Surgery	3
Haematology	22
HIV	2
Imaging	1
ITU	1
Liver Medicine	23
Liver Services	1
Liver Surgery	1
Microbiology	1
Neurology	15
Neuropsychology	2
Neuroradiology	2
Neurosurgery	6
Non-specific	39
Nuclear Medicine	1
Nursing	1
Oncology	41
Ophthalmology	6
Palliative Care	1
Physiotherapy	1
Renal Medicine	16
Renal Services	1

Projects registered during this period by Specialty	Registered
Respiratory Medicine	10
Rheumatology	11
Stroke Services	4
Total	**306**

Patient Benefits of Research

The Trust's extensive and innovative Research and 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 2013/14, 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 2013/14 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 2013/14 and for the following 12 month period are available electronically at http://www.uhb.nhs.uk/quality.htm.

The amount of UHB income in 2013/14 which was conditional upon achieving quality improvement and innovation goals was £12.1m*. The Trust received £11,404,686 in payment in 2012/13. Final payment for 2013/14 will not be known until June 2014.

* This figure has been arrived at as a percentage of the healthcare income which will be included within the Trust's 2013/14 accounts and does not represent actual outturn (as an estimate has to be included for March 2014 income). The actual figure will not be known until the final position has been reconciled with Healthcare Commissioning Services (HCS).

2.2.5 Information relating to registration with the Care Quality Commission (CQC) and special reviews/investigations

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 regulated activities UHB has registered for may only be undertaken at Queen Elizabeth Medical Centre.

The Care Quality Commission has not taken enforcement action against UHB during 2013/14.

UHB has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2013/14 (see table below). UHB intends to take the following action to address the conclusions or requirements reported by the CQC (see table below). UHB has made the following progress by 31 March 2014 in taking such action (see 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 2013/14, there were 11 external visits to the Trust.

Responding to Key National Recommendations

Three key NHS reports were published in 2013 known as the Francis, Keogh and Berwick

reports. Robert Francis QC published the *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* in February 2013. The Inquiry looked at failures in care at Mid-Staffordshire NHS Foundation Trust and the report made 290 recommendations with major implications for all levels of the health service across England. Sir Bruce Keogh led a *Review into the quality of care and treatment provided by 14 hospital trusts in England* in July 2013. The report set out aims for improvement to tackle some of the underlying causes of poor patient care. Professor Don Berwick published *A promise to learn – a commitment to act: Improving the Safety of Patients in England* in August 2013. This brought together the Francis Inquiry findings and recommendations for the Government and specified the changes required to improve patient safety.

Following the publication of the Francis, Keogh and Berwick reports, UHB held a Board of Directors' Seminar and a dedicated Council of Governors' Sub Group meeting in 2013/14 to review the recommendations in more detail. The Trust also aligned key applicable recommendations to the Trust's Governance Framework which sets out the groups and committees which oversee hospital activity. Assurance against applicable recommendations and other key national regulations, including the Care Quality Commission's Essential Standards of Quality and Safety, is built into the effective operation of these groups and committees. A review of the Terms of Reference of key groups and committees was also undertaken in 2013/14 to establish how their effectiveness can be assessed to ensure they provide high quality assurance.

UHB is committed to providing the best in care and there are a wide range of measures in place to improve the quality of services provided to patients as detailed within this Quality Report.

Inspections/visits undertaken by the Care Quality Commission and Birmingham Cross City Clinical Commissioning Group

Date	Regulatory body	Type of inspection	Outcome	Actions taken
July 2013	Care Quality Commission	Unannounced inspection of Core Essential Standards	Met 4 of the 5 standards inspected. Inspectors requested the Trust to take action in respect of Outcome 16: an issue was identified in relation to the documentation of patients' food intake. **Impact:** Minor	UHB submitted a report of actions to the CQC setting out plans to improve the implementation and compliance with the standard. The Nutrition and Hydration Steering Group has implemented regular auditing of the red equipment system which identifies patients that require support and assistance with nutrition and feeding. The audit has been carried out on a monthly basis. Results are monitored by the divisional nutrition leads and the Nutrition and Hydration Steering Group. Documentation of food intake will also be monitored through audit and the Back to the Floor visits where senior nursing staff assess the care and systems within clinical areas. A monthly food survey that includes a section of whether the patients were made comfortable and that help was available is reviewed by Divisional teams. Actions are monitored by the Care Quality Group chaired by the Executive Chief Nurse.
December 2013	Birmingham Cross City Clinical Commissioning Group (CCG)	Announced visit - Review of Radiology systems following a cluster of IRMER reports	Meeting with representatives from CCG, UHB and North Staffordshire Radiology department. Substantial assurance that systems and process are robust and that additional actions are being taken to strengthen those systems.	Follow up meetings with North Staffordshire to share good practice. Implement results tracking system within the Trust Clinical Portal. Follow up visit with CCG to be arranged to review implementation of new systems.

2.2.6 Information on the quality of data

UHB submitted records during 2013/14* 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:
98.7% for admitted patient care;
99.1% for out patient care; and
95.7% for accident and emergency care.

- which included the patient's valid General Medical Practice Code was:
99.9% for admitted patient care;
99.9% for out patient care; and
100% for accident and emergency care.

* Percentages shown are for the period April 2013 to February 2014. Data for the whole year will be available by mid May 2014.

UHB Information Governance Assessment Report overall score for 2013/14 was 80% and was graded green (satisfactory).

UHB was not subject to the Payment by Results clinical coding audit during 2013/14 by the Audit Commission.

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

- Continue to drive forward the strategy of the West Midlands Clinical Coding Academy to further improve training and clinical coding across the West Midlands
- Continue to provide a robust programme of internal audit and training, which is undertaken by the Trust's own Accredited Auditor and Trainer
- Implementation of a new integrated Trust-wide patient administration system which will simplify data entry, increase validation and reduce duplication of data entry
- Ensuring continued compliance with the Information Governance Toolkit Level 2 for data quality standards
- Continue to reinforce the embedded data quality culture by monitoring data at monthly executive forums and investigating any potential issues
- Ensure all new staff are informed of the importance of data accuracy and the Trust Data Quality Policy at Trust Induction

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 2013/14 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 2013/14

The tables below show the Trust's latest performance for 2013/14 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 2012/13 Quality Report to enable patients and the public to understand performance over time.

The stroke indicator - Percentage of stroke patients (infarction) on aspirin, clopidogrel or warfarin – has been replaced as the Trust consistently performs at over 99% for this indicator. The new indicator – Stroke in-hospital mortality – measures the percentage of patients who die in hospital following admission with a stroke. The goal is for stroke mortality to be less than 20%. Data collection for the Sentinel Stroke National Audit Programme (SSNAP) audit started from April 2013 so no data is shown for 2011/12 or 2012/13.

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 2013/14 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	2011/12	2012/13	2013/14	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*	**1.50**	**1.41**	**1.24**	**0.96**
Time period	2011/12	2012/13	April 2013-January 2014	April 2013-January 2014
Data source(s)	Trust MRSA data reported to PHE, HES data (bed days)	Trust MRSA data reported to PHE, HES data (bed days)	Trust MRSA data reported to PHE, HES data (bed days)	Trust MRSA data reported to PHE, HES data (bed days)
Peer group				Acute trusts in West Midlands
1(b). MRSA: Patients with MRSA infection/100,000 bed days (aged >15, excluding Obstetrics Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	**1.51**	**1.42**	**1.25**	**1.13**
Time period	2011/12	2012/13	April 2013-January 2014	April 2013-January 2014
Data source(s)	Trust MRSA data reported to PHE, HES data (bed days)	Trust MRSA data reported to PHE, HES data (bed days)	Trust MRSA data reported to PHE, HES data (bed days)	Trust MRSA data reported to PHE, HES data (bed days)
Peer group				Acute trusts in West Midlands

Indicator	2011/12	2012/13	2013/14	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*	**25.44**	**20.31**	**21.34**	**14.96**
Time period	2011/12	2012/13	April 2013-January 2014	April 2013-January 2014
Data source(s)	Trust CDI data reported to PHE, HES data (bed days)	Trust CDI data reported to PHE, HES data (bed days)	Trust CDI data reported to PHE, HES data (bed days)	Trust CDI data reported to PHE, 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*	**25.60**	**20.44**	**21.48**	**18.20**
Time period	2011/12	2012/13	April 2013-January 2014	April 2013-January 2014
Data source(s)	Trust CDI data reported to PHE, HES data (bed days)	Trust CDI data reported to PHE, HES data (bed days)	Trust CDI data reported to PHE, HES data (bed days)	Trust CDI data reported to PHE, HES data (bed days)
Peer group				Acute trusts in West Midlands

Indicator	2011/12	2012/13	2013/14	Peer Group Average (where available)
3(a) Patient safety incidents (reporting rate per 100 admissions) *Higher rate indicates better reporting*	**9.3**	**10.4**	**10.7**	**7.6**
Time period	2011/12	2012/13	2013/14	Oct 2012-March 2013
Data source(s)	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	Calculated from data on NRLS website (Organisational Patient Safety Incidents Workbook)
Peer group				Acute teaching hospitals
3(b) Never Events *Lower number indicates better performance*	**1** (see explanatory note below table)	**0**	**2**	*Not available*
Time period	2011/12	2012/13	2013/14	
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*	**70.4%**	**64.4%**	**71.1%**	**74.9%**
Time period	2011/12	2012/13	2013/14	Oct 2012-March 2013
Data source(s)	Datix (incident data)	Datix (incident data)	Datix (incident data)	NRLS website (Organisational Patient Safety Incidents Workbook)
Peer group				Acute teaching hospitals

Indicator	2011/12	2012/13	2013/14	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*	**1.06%**	**0.27%**	**0.24%**	**0.43%**
Time period	2011/12	2012/13	2013/14	Oct 2012-March 2013
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)	Calculated from data on NRLS website (Organisational Patient Safety Incidents Workbook)
Peer group				Acute teaching hospitals
4(c) Number of patient safety incidents reported to the National Reporting and Learning System (NRLS)	**8,514**	**9,536**	**9,828**	**5,389**
Time period	2011/12	2012/13	2013/14	Oct 2012-March 2013
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)	Average number of patient safety incidents reported calculated from data on NRLS website (Organisational Patient Safety Incidents Workbook)
Peer group				Acute teaching hospitals

Notes on patient safety indicators

1(a), **1(b)**, **2(a)**, **2(b)**: The data for C.difficile infection has been calculated using 100,000 bed days rather than 1,000 used previously, in line with DH guidance.

3(a): The admissions data has been changed to include dialysis patients from 2012/13 as these are also classed as admissions. The data for 2011/12 has been recalculated to aid comparison. In January 2014 the Trust implemented an automatic incident reporting process whereby incidents are directly reported from the Trust's Prescribing Information and Communication System (PICS). These include missed observations and patients who need to be discharged off PICS. The plan is to include other automated incidents such as consecutive missed drug doses during 2014/15. The Trust's incident reporting rate has therefore slightly increased and this trend is likely to continue. The purpose of automated incident reporting is to ensure even small errors or omissions are identified and addressed as soon as possible.

3(b): The Trust reported two never events in 2013/14 relating to wrong site surgery. There was no significant harm caused to either patient.

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	2011/12	2012/13	2013/14	Peer Group Average (where available)
5(a). Emergency readmissions within 28 days (Medical and surgical specialties - elective and emergency admissions aged >15) % *Lower % indicates better performance*	**12.56%** **England: 13.18%**	**12.66%** **England: 13.39%**	**12.78%**	**12.86%** **England: 13.33%**
Time period	2011/12	2012/13	April-December 2013	April-December 2013
Data source(s)	HES data	HES data	HES data	HES data
Peer group				University Hospitals
5(b). Emergency readmissions within 28 days (all specialties) % *Lower % indicates better performance*	**12.54%** **England: 12.40%**	**12.63%** **England: 12.52%**	**12.79%**	**12.63%** **England: 12.71%**
Time period	2011/12	2012/13	April-December 2013	April-December 2013
Data source(s)	HES data	HES data	HES data	HES data
Peer group				University hospitals

Indicator	2011/12	2012/13	2013/14	Peer Group Average (where available)
5(c). Emergency readmissions within 28 days of discharge % *Lower % indicates better performance*	**9.29%**	**9.87%**	**10.18%**	*Not available*
Time period	2011/12	2012/13	2013/14	
Data source(s)	Lorenzo	Lorenzo	Lorenzo	
Peer group				
6. Falls (incidents reported as % of patient episodes) *Lower % indicates better performance*	**2.2%**	**2.2%**	**2.1%**	*Not available*
Time period	2011/12	2012/13	2013/14	
Data source(s)	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	
Peer group				
7. Stroke in-hospital mortality *Lower % indicates better performance*	*Data collected as part of national audit from April 2013*	*Data collected as part of national audit from April 2013*	**8.7%**	*Not available*
Time period			2013/14	
Data source(s)			SSNAP data	
Peer group				
8. Percentage of beta blockers given on the morning of the procedure for patients undergoing first time coronary artery bypass graft (CABG) *Higher % indicates better performance*	**93.6%**	**96.4%**	**88.2%**	*Not available*
Time period	2011/12	2012/13	2013/14	
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 methodology has been updated to reflect the latest guidance from the Health and Social Care Information Centre. The key change is that day cases and regular day case patients, all cancer patients or patients coded with cancer in the previous 365 days are now excluded from the denominator. This indicator includes patients readmitted as emergencies to the Trust or any other provider within 28 days of discharge. Further details can be found on the Health and Social Care Information Centre website: https://mqi.ic.nhs.uk/IndicatorDefaultView.aspx?ref=1.01.17

5(c): This indicator only includes patients readmitted as emergencies to the Trust within 28 days of discharge and excludes UHB cancer patients. The data source is the Trust's patient administration system (Lorenzo). The data for previous years has been updated to include readmissions from 0 to 27 days and exclude readmissions on day 28 in line with the national methodology.

6: The admissions data includes daycase patients as well as all elective and emergency admissions. The admissions data now also includes dialysis patients from 2012/13 as these are also classed as admissions. The data for 2011/12 has been recalculated to aid comparison and therefore differs from that shown in the Trust's 2011/12 Quality Account.

7: The previous stroke indicator - *Percentage of stroke patients (infarction) on aspirin, clopidogrel or warfarin* – has been replaced as the Trust consistently performs at over 99% for this indicator. The new indicator – *Stroke in-hospital mortality* – measures the percentage of patients who die in hospital following admission with a stroke. The goal is for stroke mortality to be less than 20%. Data collection for the SSNAP audit started from April 2013 so no data is shown for 2011/12 or 2012/13.

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 2013 National Inpatient Survey reported that the Trust was about the same as other Trusts in all questions. However, there was an increased positive score for questions relating to information provided prior to surgery, discharge from hospital and overall views and experiences.

Patient survey question	2011/12	2012/13	Comparison with other NHS trusts in England (2012/13)	2013/14	Comparison with other NHS trusts in England (2013/14)
9. Overall were you treated with respect and dignity	**9.1**	**8.9**	**About the same**	**9.1**	**About the same**
Time period & data source	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	2013, Trust's Survey of Adult Inpatients 2013 Report, Care Quality Commission	2013, Trust's Survey of Adult Inpatients 2013 Report, Care Quality Commission
10. Involvement in decisions about care and treatment	**7.4**	**7.5**	**About the same**	**7.5**	**About the same**
Time period & data source	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	2013, Trust's Survey of Adult Inpatients 2013 Report, Care Quality Commission	2013, Trust's Survey of Adult Inpatients 2013 Report, Care Quality Commission
11. Did staff do all they could to control pain	**8.0**	**8.0**	**About the same**	**7.9**	**About the same**
Time period & data source	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	2013, Trust's Survey of Adult Inpatients 2013 Report, Care Quality Commission	2013, Trust's Survey of Adult Inpatients 2013 Report, Care Quality Commission

Patient survey question	2011/12	2012/13	Comparison with other NHS trusts in England (2012/13)	2013/14	Comparison with other NHS trusts in England (2013/14)
12. Cleanliness of room or ward	**9.2**	**9.3**	**About the same**	**9.3**	**About the same**
Time period & data source	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	2013, Trust's Survey of Adult Inpatients 2013 Report, Care Quality Commission	2013, Trust's Survey of Adult Inpatients 2013 Report, Care Quality Commission
13. Overall rating of care	**8.1**	**8.2***	**About the same**	**8.3**	**About the same**
Time period & data source	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	2013, Trust's Survey of Adult Inpatients 2013 Report, Care Quality Commission	2013, Trust's Survey of Adult Inpatients 2013 Report, Care Quality Commission

*The rating for this question changed in 2013/14 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 benchmark report presents the data as a score out of 10; the higher the score for each question, the better the Trust is performing.

3.2 Performance against indicators included in the Monitor Risk Assessment Framework

Indicator	2011/12 Target	2011/12 Performance	2012/13 Target	2012/13 Performance	2013/14 Target	2013/14 Performance
C. difficile infection (Trust apportioned)	114	85	76	73	56	80 (16 avoidable cases)
62-day wait for first treatment from urgent GP referral: all cancers	85%	85.3%	85%	86.2%	85%	79.5%
62-day wait for first treatment from consultant screening service referral: all cancers	90%	94.7%	90%	95.2%	90%	95.3%
31-day wait from diagnosis to first treatment: all cancers	96%	97.2%	96%	97.2%	96%	95.9%
31-day wait for second or subsequent treatment: surgery	94%	98.1%	94%	96.8%	94%	96.2%
31-day wait for second or subsequent treatment: anti cancer drug treatments	98%	99.7%	98%	99.8%	98%	99.3%
31-day wait for second or subsequent treatment: radiotherapy	94%	99.9%	94%	99.3%	94%	95.1%
Two week wait from referral to date first seen: all cancers	93%	98.0%	93%	96.3%	93%	97.1%
Two week wait from referral to date first seen: breast symptoms	93%	98.6%	93%	98.2%	93%	97.1%
18-week maximum wait from point of referral to treatment (admitted patients)	90%	95.6%	90%	94.9%	90%	91.4%
18-week maximum wait from point of referral to treatment (non-admitted patients)	95%	98.3%	95%	99.1%	95%	98.1%
18-week maximum wait from point of referral to treatment (incomplete pathways)	92%	94.1%	92%	95.7%	92%	94.6%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	95%	96.1%	95%	94.95%	95%	95.2%
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A	Certification made	N/A	Certification made	N/A	Certification made

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.

The Trust received one mortality outlier notification letter from the Care Quality Commission during 2013/14 relating to higher than expected mortality for the Intracranial Injury diagnosis group in December 2012. This diagnosis group was fully investigated with no concerns identified with the care provided to this group of patients. UHB also proactively contacted the CQC in June 2013 relating to a number of diagnosis groups for which there appeared to be a higher than expected mortality rate: Other Psychoses, Burns and Cancer of Testis. These diagnosis groups were fully investigated by the Trust and no concerns were 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 Health and Social Care Information Centre published data for the Summary Hospital-level Mortality Indicator. This is the 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 Health and Social Care 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 99.78 for the period April-December 2013 which is within tolerance. The latest SHMI value for the Trust which is available on the Health and Social Care Information Centre website is 103 for the period April-June 2013. This is within tolerance.

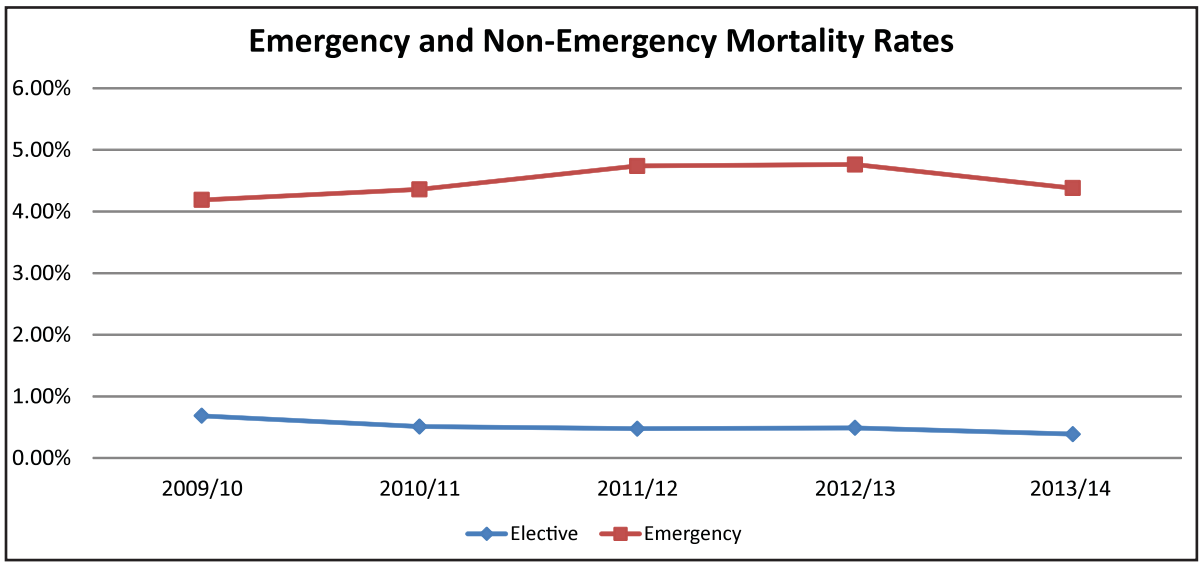
The Trust has concerns about the validity of the Hospital Standardised Mortality Ratio which has been superseded by the SHMI but it is included here for completeness. UHB's HSMR value is 97.83 for the period April 2013-January 2014 as calculated by the Trust's Health Informatics team. The validity and 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.

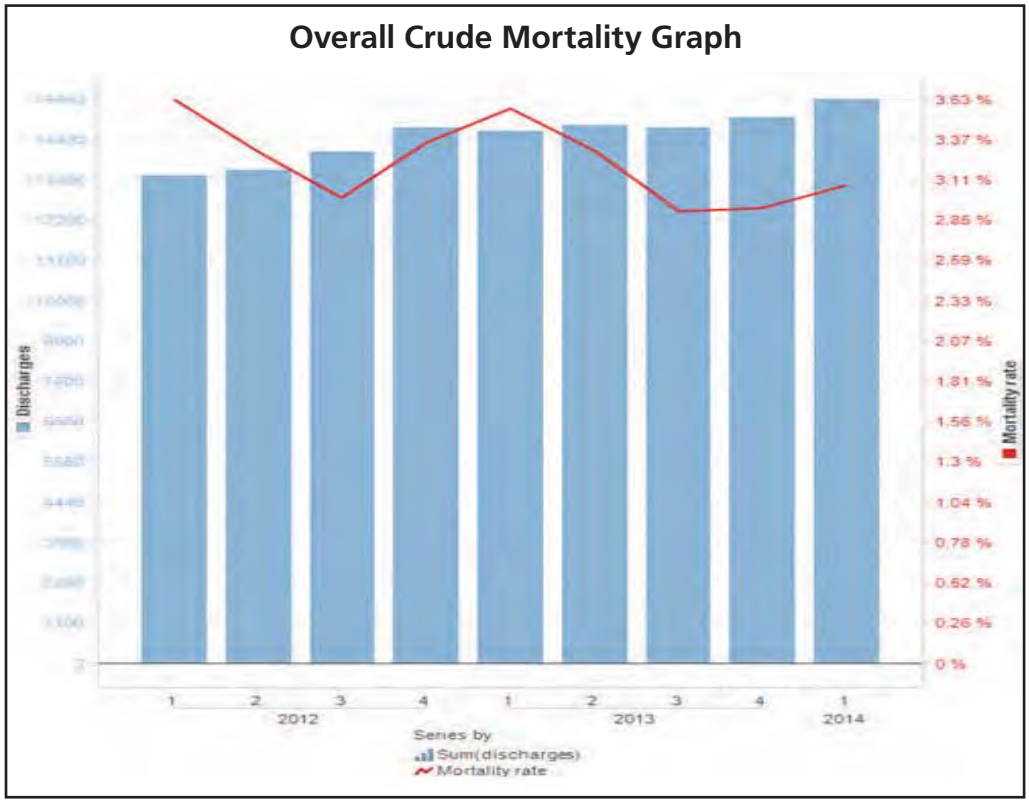
[1] Freemantle N, Richardson M, Wood J, Ray D, Khosla S, Sun P, Pagano, D. Can we update the Summary Hospital Mortality Index (SHMI) to make a useful measure of the quality of hospital care? An observational study. BMJ Open. 31 January 2013.
[2] Hogan H, Healey F, Neale G, Thomson R, Vincent C, Black, 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.

Crude Mortality

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

The Trust's overall crude mortality rate is slightly lower for 2013/14 (3.15%) compared to 2012/13 (3.42%). This is due to an increase in the number of patient admissions and a reduction in the number of deaths.





3.4 Safeguarding

The Trust's framework for safeguarding adults at risk is based on national guidance arising from the Health Service Circular 2000/007 'No Secrets' on developing inter-agency policy and procedures for safeguarding vulnerable adults.

University Hospitals Birmingham NHS Foundation Trust (UHB) has continued to ensure that safeguarding of adults at risk remains a high priority within the Trust. The aim of safeguarding within the Trust is to ensure that there is a robust policy with supporting procedural documents which allow a consistent approach to the delivery of safeguarding principles across the Trust.

The policy provides a framework that can be consistently followed, reinforced by training and support, to enable all clinical staff to recognise and report incidence of adults who are at risk, ensuring that patients receive a positive experience, including support in relation to safeguarding, where necessary. Further information can be found in the Trust's Annual Report for 2013/14: http://www.uhb.nhs.uk/reports.htm.

3.5 Staff Survey

The Trust's Staff Survey results for 2013 show that performance was average or better for 23 of the 28 survey questions and below average for 5 questions, when compared to other trusts. The results are based on responses from 480 staff which represents an increase in response rate from 48% last year to 60% this year. This response rate is also above the national median average of 49%.

The results for the Staff Survey questions which most closely relate to quality of care are shown in the table below. When compared to other trusts nationally, three questions (1-3) stayed consistently high compared to 2012 (in the top 20% of trusts), one question improved from below average to above average (5), and one deteriorated from above average to the lowest 20% of trusts (4). UHB will continue to encourage staff to report all incidents including minor incidents and near misses. The number of incidents reported by UHB is one of the highest compared to other Acute Teaching Trusts and the percentage of all reported incidents that are deemed serious is low at UHB compared to the national average. This shows that the Trust has a very good reporting culture in place.

Staff survey question	2010/11	2011/12	2012/13	2013/14	Comparison with other NHS trusts 2013/14
1. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver	**79%**	**76%**	**86%**	**85%**	**Highest (best) 20%**
Time period & data source	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	Trust's 2013 Staff Survey Report, NHS England	
2. Percentage of staff agreeing their role makes a difference to patients	**93%**	**91%**	**94%**	**94%**	**Highest (best) 20%**
Time period & data source	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	Trust's 2013 Staff Survey Report, NHS England	
3. Staff recommendation of the trust as a place to work or receive treatment	**3.81**	**3.78**	**3.93**	**4.04**	**Highest (best) 20%**
Time period & data source	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	Trust's 2013 Staff Survey Report, NHS England	

Staff survey question	2010/11	2011/12	2012/13	2013/14	Comparison with other NHS trusts 2013/14
4. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	**96%**	**95%**	**92%**	**86%**	**Lowest (worst) 20%**
Time period & data source	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	Trust's 2013 Staff Survey Report, NHS England	
5. Percentage of staff saying hand washing materials are always available	**63%**	**60%**	**59%**	**65%**	**Above (better than) average**
Time period & data source	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	Trust's 2013 Staff Survey Report, NHS England	

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 2013/14 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 21% of the indicators during 2013/14 with support from the Quality and Informatics teams. Performance for 67% has stayed about the same (including 40% which were already performing very well and continue to do so). Performance for 12% has deteriorated during 2013/14. The vast majority of the 80 indicators have a goal; 49% of those with a goal met them in 2013/14. Table 1 shows the performance for those specialty quality indicators where the most notable improvements have been made during 2013/14. 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 2013/14. Performance for the remaining indicators can be viewed on the Quality web pages: http://www.uhb.nhs.uk/quality.htm.

Table 1

Specialty	Indicator	Goal	Percentage Apr 11 - Mar 12	Percentage Apr 12 - Mar 13	Numerator Apr 13 - Mar 14	Denominator Apr 13 - Mar 14	Percentage Apr 13 - Mar 14	Data Sources
Ambulatory Care	Patients who were intended to be treated as a daycase but were admitted to hospital as an inpatient	<5%	4.2%	4.3%	692	18582	3.7%	Lorenzo Galaxy
Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - Post-operative stroke	<2%	0.7%	0.8%	1	299	0.3%	PATS
Dementia	Administration of anti-psychotic medication for patients with a diagnosis of dementia under the care of Geriatricians	<8%	-	7.8%	141	2182	6.5%	Lorenzo PICS
Emergency Department	CT head scans performed within more than 3 hours of arrival to the Emergency Department	<10%	13.4%	10.7%	347	3832	9.1%	Oceano CRIS
Gastroenterology	Patients with inflammatory bowel disease admitted under the care of Gastroenterology Consultants who receive low molecular weight (LMW) heparin medication	>90%	90.3%	89.0%	97	99	98.0%	Lorenzo PICS
Liver Medicine	Patients who have endoscopic retrograde cholangio-pancreatography (ERCP) who develop pancreatitis.	<5%	2.6%	1.9%	3	369	0.8%	Unisoft Lorenzo PICS
Pharmacy	Pharmacy error rate per 100,000 items/lines dispensed	<15	-	17	31	434002	7	Pharmacy database Datix
Routine Surgery / Care	Unplanned return to theatre for all non-emergency surgical patients	<2.5%	1.6%	1.4%	261	25693	1.0%	Galaxy
Rheumatology	Rheumatology outpatients that saw the same clinician at least 3 times out of their 6 most recent visits - NURSES ONLY	>85%	-	77.4%	375	438	85.6%	OPTIMS

Table 2

Specialty	Indicator	Goal	Percentage Apr 11 - Mar 12	Percentage Apr 12 - Mar 13	Numerator Apr 13 - Mar 14	Denominator Apr 13 - Mar 14	Percentage Apr 13 - Mar 14	Data Sources
Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - Patients on betablockers who were given them on the day of surgery	100%	93.6%	96.4%	105	119	88.2%	PATS PICS
Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - Reopening (all causes)	<=5%	7.0%	4.9%	17	304	5.6%	PATS
Imaging	Proportion of Outpatients who have report turnaround time of less than or equal to 5 days for CT	>85%	78.1%	70.9%	13018	20422	63.7%	CRIS
Imaging	Proportion of Outpatients who have report turnaround time of less than or equal to 5 days for MRI	>75%	44.7%	55.4%	9674	22827	42.4%	CRIS
Surgery – Emergency	Perianal abscess operations should take place on the day of admission or the next day	>90%	93.9%	90.7%	97	113	85.8%	Lorenzo

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. 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.

Over 5000 patients are now signed up to use myhealth@QEHB. Work is underway to incorporate care planning tools within myhealth@QEHB: a Renal care planning tool is due to be launched in June 2014. A competency framework is also being developed to give patients greater control over their care. For example, a framework is being developed for Renal patients which will provide them with an opportunity to learn how best to undertake treatment at home such as dialysis. The competencies will provide a means to measure and assess how far patients have come in applying this knowledge. Further work is underway to integrate medical devices with myhealth@QEHB. Work will be done over the course of 2014/15 to identify medical device vendors and develop a suitable strategy for piloting this. The concept of virtual clinics/video consultations is also being developed which will give patients greater flexibility and choice over how to access healthcare services.

3.8 mystay@QEHB

The Trust launched a new website for patients and the public called mystay@QEHB in September 2013. The website was developed 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. The Trust is also aiming to encourage patients to get more involved in their care.

Quality information is published monthly showing how each inpatient specialty is performing for the following aspects of care:

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

The website can accessed via the following link: https://www.mystay.uhb.nhs.uk/. A link to the new website is provided in letters to patients who are due to come into the Trust for a planned operation or procedure. The site has been positively reviewed by Trust Members and was launched following approval by the Board of Directors. The Trust will continue to raise awareness of and develop mystay@QEHB in response to feedback from patients, staff and the public during 2014/15.

3.9 Glossary of Terms

Term	Definition
AAA	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
Administration	When relating to medication, this is when the patient is given the tablet, infusion or injection. It can also mean when anti-embolism stockings are put on a patient.
Alert organism	Any organism which the Trust is required to report to Public Health England
Angioplasty	A coronary angioplasty operation is carried out to treat angina or heart attack by relieving blockages or narrowing of the arteries
Audit Committee	A Committee of the Board of Directors which is chaired by a Non-Executive Director. The role of the Audit Committee is to provide an independent and objective review of the Trust's systems of internal control. This includes financial systems, financial information, governance arrangements, approach to risk management and compliance with legislation and other regulatory requirements.
Back to the Floor	Visits by senior nursing staff to clinical areas, where they assess the care and systems in place
Bacteraemia	Presence of bacteria in the blood
Bed days	Unit used to calculate the availability and use of beds over time
Betablockers	A class of drug used to treat patients who have had a heart attack, also used to reduce the chance of heart attack during a cardiac procedure
Birmingham Health & Social Care Overview Scrutiny Committee	A committee of Birmingham City Council which oversees health issues and looks at the work of the NHS in Birmingham and across the West Midlands
BTS	British Thoracic Society
CABG	Coronary artery bypass graft procedure
CIA	Carotid Interventions Audit – this looks at Carotid Endarterectomy (a surgical procedure used to prevent stroke by correcting narrowing in the common carotid artery)
CEAG	Chief Executive's Advisory Group
CCG	Clinical Commissioning Group
CDI	*C. difficile* infection
CEM	College of Emergency Medicine
Clinical Audit	A process for assessing the quality of care against agreed standards
Clinical Dashboard	An internal website used by staff to measure various aspects of clinical quality
Commissioners	See CCG
Congenital	Condition present at birth
Contra-indication	A condition which makes a particular treatment or procedure potentially inadvisable
CQC	Care Quality Commission
CQG	Care Quality Group - a group at UHB, chaired by the Chief Nurse, which assess the quality of care, mainly nursing

Term	Definition
CQMG	Clinical Quality Monitoring Group - a group at UHB, chaired by the Executive Medical Director, which reviews the quality of care, mainly medical
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 a planned procedure where the patient does not stay overnight
DCQG	Divisional Clinical Quality Group - the divisional subgroups of the CQMG
Division	Specialties at UHB are grouped into Divisions
ED	Emergency Department (previously called Accident and Emergency Department)
ECG	Electrocardiography
Elective	A planned admission, usually for a procedure or drug treatment
Enoxaparin	An anticoagulant drug used to treat or prevent venous thrombo-embolism (blood clots)
ENT	Ear, Nose and Throat
Episode	The time period during which a patient is under a particular consultant and specialty. There can be several episodes in a spell.
EPR	Electronic Patient Record
ERCP	Endoscopic Retrograde Cholangiopancreatography
Essential Standards	Sixteen standards used by the CQC to assess the quality and safety of patient care
FCE	Finished/Full 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.
Francis Report	The report by Robert Francis QC into the failings at Mid Staffordshire NHS Foundation Trust, published in February 2013
Galaxy	Database used in Theatres
GI	Gastro-intestinal
GP	General Practitioner
Halal (food)	A method of food preparation to ensure the food is lawful under Islamic dietary law
HCS	Healthcare Commissioning Services
HCV	Hepatitis C infection
Healthwatch Birmingham	An independent group who represent the interests of patients and the public.
HES	Hospital Episode Statistics
HPA	Health Protection Agency
HSCIC	Health and Social Care Information Centre
HSMR	Hospital Standardised Mortality Ratio
IBD	Inflammatory Bowel Disease

Term	Definition
ICNARC	Intensive Care National Audit & Research Centre
IT	Information Technology
ITU	Intensive Care Unit
Lorenzo	Patient administration system
MINAP	Myocardial Ischaemia National Audit Project
Monitor	Independent regulator of NHS Foundation Trusts
Mortality	A measure of the number of deaths compared to the number of admissions
MRSA	Meticillin-resistant *Staphylococcus aureus*
Myocardial Infarction	Heart attack
myhealth@ QEHB	An online system that allows patients to view their own clinical information, as well as submitting information directly to their consultant and interacting with other patients
mystay@QEHB	An online system that allows patients to view information / indicators on particular specialties
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
NHS	National Health Service
NHS Choices	A website providing information on healthcare to patients. Patients can also leave feedback and comments on the care they have received
NRLS	National Reporting and Learning System
NVR	National Vascular Registry
Observations	Measurements used to monitor a patient's condition e.g. pulse rate, blood pressure
OPAL	Older Person Assessment and Liaison
PALS	Patient Advice and Liaison Service
Patient Opinion	A website where patients can leave feedback on the services they have received. Care providers can respond and provide updates on action taken.
PATS	Patient Analysis and Tracking System (Cardiac Surgery database)
Peri-operative	Period of time prior to, during, and immediately after surgery
PHE	Public Health England
PHSO	Parliamentary and Health Service Ombudsman
PICS	Prescribing Information and Communication System
PRN	Pro ne rata. A type of prescription that allows a drug (e.g. painkiller) to be given as required rather than at scheduled time.
PROMS	Patient Reported Outcome Measures
Prophylactic / prophylaxis	A treatment to prevent a given condition from occurring
Pulmonary embolism	A blood clot in the blood vessels of the lungs
QEHB	Queen Elizabeth Hospital Birmingham
QIPP	Quality, Innovation, Productivity and Prevention programme
QuORU	Trust's Quality and Outcomes Research Unit

Term	Definition
R&D	Research and Development
Rapid Access Chest Pain Clinic	A clinic that patients are referred to for further investigation after experiencing chest pain
RCA	Root cause analysis
Readmissions	Patients who are readmitted to hospital after being discharged from hospital within a short period of time e.g., 28 days
Ring-fenced	Protection (e.g. of beds, a budget) to ensure it is only used for a specific purpose
RRMS	Relapsing Remitting Multiple Sclerosis
Safeguarding	The process of protecting vulnerable adults or children from abuse, harm or neglect, preventing impairment of their health and development.
SEWS	Standardised Early Warning System
SHMI	Summary Hospital Mortality Indicator
SIRI	Serious incident requiring investigation
Spell	The time period from a patient's admission to hospital to their discharge. A spell can consist of more than one episode if the patient moves to a different consultant and/or specialty.
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
Thrombosis	A blood clot
Trajectory	In infection control, the maximum number of cases expected in a given time period
Triage	The process of determining the priority of patients' treatments based on the severity of their condition
Trust apportioned	A case (e.g. MRSA or CDI) that is deemed as 'belonging' to the Trust in question
Trust Partnership Team	Attendees include Staff Side (Trade Union representatives), Directors, Directors of Operations and Human Resources staff. The purpose of this group is to provide a forum for Staff Side to hear about and raise issues about the Trust's strategic and operational plans, policies and procedures.
UHB	University Hospitals Birmingham NHS Foundation Trust
VTE	Venous thromboembolism – a blood clot
Young Person's Council	The Young Persons' Council (YPC) is one of the Trust's four Patient and Carer Councils and members are aged 16-25 years. The YPC looks at ways to improve the experience for teenagers and young adults in our hospitals.

Appendix A: Performance against core 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 2013/14 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 2012 - March 2013	July 2012 - June 2013	July 2012 - June 2013	July 2012 - June 2013	July 2012 - June 2013	
(a) Summary Hospital-level Mortality Indicator (SHMI) value	1.0600	1.0619	-	0.6259	1.1563	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 this indicator, and so the quality of its 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	14.4	21.7	-	0	44.1	

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 2011-March 2012	April 2012 - March 2013	April 2012 - March 2013	April 2012 - March 2013	April 2012 - March 2013	
Groin hernia surgery (Average health gain)	0.098	0.081	0.085	0.157	0.015	The Trust considers that this data is as described for the following reasons as it is the latest available on the HSCIC website. The Trust's performance for average health gain is around the same as the national average for groin hernias. The Trust intends to take the following actions to improve this data (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)	0.081	-	0.093	0.023	0.175	
Hip replacement surgery	Not applicable to UHB					
Knee replacement surgery	Not applicable to UHB					

3. Readmissions to hospital within 28 days

	UHB Previous	UHB Current Period	National (England)	National Best (Acute teaching providers)	National Worst (Acute teaching providers)	Comment
	April 2010 - March 2011	April 2011 - March 2012	April 2011 - March 2012	April 2011 - March 2012	April 2011 - March 2012	
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)	-	-	10.01	5.86	12.50	The Trust considers that this data (standardised percentages) is as described for the following reasons as this 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 data has been calculated. The Trust intends to take the following actions to improve this data (standardised percentages), 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)	11.60	11.54	11.45	10.64	13.55	

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 2011 - March 2012	April 2012 - March 2013	April 2012 - March 2013	April 2012 - March 2013	April 2012 - March 2013	
Responsiveness to personal needs – average weighted score of 5 questions from the National Inpatient Survey (Score out of 100)	71.1	72.42	68.14	84.36	57.43	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 priority for improvement in 2014/15 (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 Current Period	National Best Performance	National Worst Performance	Comment
	2012	2013	2013	2013	2013	
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.	75.39	81.76	-	93.92	39.57	The Trust considers that this data (scores) is as described for the following reasons as it is the latest available on the HSCIC website and UHB has improved performance compared to 2012. The Trust intends to take the following actions to improve this data, 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 2013-14	Q3 2013-14	Q3 2013-14	Q3 2013-14	Q3 2013-14	
Percentage of admitted patients risk-assessed for VTE	99.23%	99.37%	95.84%	100.0%	77.70%	The Trust considers that this data (percentages) is as described for the following reasons as UHB has consistently performed above the national average for the past three years. The Trust intends to take the following actions to improve this data, and so the quality of its services, by continuing to ensure our patients are risk assessed for venous thromboembolism (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 Current Period	National Best Performance	National Worst Performance	Comment
	2011/12	2012/13	2012/13	2012/13	2012/13	
C. difficile infection rate per 100,000 bed-days (patients aged 2 or over)	24.6	20.9	17.3	0	30.80	The Trust considers that this data 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 12 - Sep 12	Oct 12 - Mar 13	Oct 12 - Mar 13	Oct 12 - Mar 13	Oct 12 - Mar 13	
Incident reporting rate per 100 admissions	10.85	11.00	-	13.7	3.2	The Trust considers that this data 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 data and so the quality of its services, by continuing to have a high incident reporting rate. 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	77	11	-	74	2	
Rate of patient safety incidents that resulted in severe harm or death (per 100 admissions)	0.18	0.03	-	0.08	0.00	

Annex 1: Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

The Trust has shared its 2013/14 Quality Report with NHS England (Birmingham, Solihull and the Black Country Area Team), Birmingham Cross City Clinical Commissioning Group, Healthwatch Birmingham and Birmingham Health & Social Care Overview and Scrutiny Committee.

NHS England (Birmingham, Solihull and the Black Country Area Team), 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 2013/14 and provided the statements below.

Joint statement provided by NHS England (Birmingham, Solihull and the Black Country Area Team) and Birmingham Cross City Clinical Commissioning Group

University Hospitals Birmingham NHS Foundation Trust

Quality Account 2013/14

Statement of assurance from Birmingham CrossCity CCG May 2014

As lead commissioner Birmingham CrossCity CCG welcomes the opportunity to provide this statement for the University Hospitals Birmingham NHS Foundation Trust's Quality Account for 2013/14. 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 Birmingham, Solihull and Black Country Area Team and has also been commented on by the Birmingham CrossCity CCG Patient Council.

Birmingham CrossCity CCG is committed to ensuring that the services it commissions provides the very highest of standards in respect to clinical quality, patient safety and patient experience, and therefore we have worked closely during the year with the Trust's clinicians and managers, monitoring service delivery and reviewing performance through monthly Clinical Quality Review Group meetings and addressing any issues around the quality and safety of patient care with the Trust. In addition to this we have maintained high vigilance in respect to the delivery of care and treatment on the frontline by conducting a number of visits to clinical areas within the Trust in order to obtain appropriate assurance that standards of care are being met.

Overall the Quality Account generally appears to be balanced and a comprehensive reflection of the activity within the Trust during 2013/14, whilst also clearly setting out the Trust's quality intentions for the coming year. We welcomed how the Trust offered clear explanations of the statistics and terminology utilised within the document, but wondered if more could be done to ensure that this information could be presented in a more easily accessible format for patients and the general public. Our thoughts on the Quality Account are;
We were pleased to note how the Quality Account describes the current Governance arrangements for monitoring quality and safety, escalating concerns, and learning from failure. In reading the document there was also no doubt about the commitment and hands-on role of the Board, the Chief Executive and Senior Clinical Staff to ensure that this happens. It was also pleasing to see how action plans had been developed with patients, carers and governors. However we noted that there appeared to be no mention of the two Never Events that occurred earlier in the year and the learning and actions that were obtained from the investigation of these.

Whilst reviewing the Quality Account we were pleased to note some of the specific areas of work the Trust has undertaken during 2013/14

to improve its services and the quality of the care it provides, in particular those projects or workstreams which promoted the overall safety of patients and/or their experiences of care. Examples of this included the pilot of the Buddy Scheme for 16-25 year olds, which we were happy to note will be continuing into 2014/15, the work undertaken in helping patients to rest and sleep in hospital which has been recognised nationally, and the development of e-based resources such as the mystay@QEHB and myhealth@QEHB websites. We also welcome the positive work that has been undertaken to tackle healthcare associated infections, in particular in respect to learning from, and reducing rates of, Clostridium difficile, which has received national recognition.

We also noted the extensive work undertaken by the Trust to be open and transparent about the quality of their services, and consider that the commitment the Trust made in developing a system for patients to add their data to their hospital record is impressive.

We welcomed the progress that the Trust made during 2013/14 against four of the six priorities for improvement and how much of this work will be continuing onwards over the next year. However we were disappointed that the Trust did not take the opportunity within this Quality Account to set itself any additional priorities for 2014/15, particularly in respect to patient safety, as we felt that this would have provided the organisation with an opportunity to showcase some of the Trust's current plans to reduce avoidable harms relating to pressure ulcers and falls.

Currently the Quality Account does not appear to make any direct reference with respect to how the Trust is responding to its Public Sector Equality Duty, or indeed information to show how the Trust is responding to the needs of groups with protected characteristics in the way it provides its services.

There is also minimal reference made to the current systems and processes that the Trust has in place to ensure that vulnerable patients, particularly children, are protected from harm.

The Quality Account also fails to identify any key strategic issues and challenges for the organisation, either as a result of specific local or national safeguarding priorities. For example there is no reference currently made within the document in respect to ensuring the Mental Capacity Act and the Deprivation of Liberty Safeguards are implemented effectively within practice across the Trust. This is an important topic in light of the recent parliamentary scrutiny report and the findings of local Serious Case Reviews, and hence we assume that the Trust will ensure that this information will be available within the final published document.

We note that during 2013/14 Birmingham CrossCity CCG conducted a number assurance visits into the Trust. As a direct result of these visits there has been positive work undertaken in respect to improving radiology and stroke services.

With respect to CQUIN performance it would have been useful if the Quality Account had included more details, such as a summary of outcomes in the terms of promoting the quality of the services provided to patients.

In relation to patient experience we noted that the Trust reported how the overall level of complaints had reduced by over 11%. However during the same time period activity had significantly increased and we felt that potentially this issue should be explored in greater detail so as to ensure that patients still felt that they had appropriate opportunities to raise concerns or complaints throughout their care and treatment.

In summary, we welcomed the opportunity to comment on the University Hospitals Birmingham NHS Foundation Trust's Quality Account for 2013/14 and generally consider that this report was well written and provided a balanced view of the activities of the Trust. As the co-ordinating commissioner Birmingham CrossCity CCG will continue to work in partnership with the Trust to deliver the quality agenda in 2014/15.

Barbara King
Accountable Officer
Birmingham CrossCity Clinical Commissioning Group

Statement provided by Healthwatch Birmingham

Response to University Hospitals Birmingham NHS Foundation Trust Quality Report 2013/14

Healthwatch Birmingham recognise that Quality Reports are a useful contribution to ensuring NHS providers are accountable to patients and the wider public about the quality of the services they provide. We welcome the opportunity to comment on the Quality Report for University Hospitals Birmingham NHS Foundation Trust.

We are pleased to see the improvements in four of the Trust's six priorities for improvement, particularly regarding patient experience. This data demonstrates that, across most of the measures, patients feel well engaged by staff. The reports of patients not being informed of medication side effects to watch for when discharged is relatively high at 30%. Given the high performance on other measures, the Trust may wish to explore what could be done to improve this measure.

We welcome the range of initiatives to improve the experience of patients, carers and visitors that were implemented during the year, and recognise the work done with the Young Person's Council to respond to issues raised by younger people.

The Trust's commitment to learning from complaints is well-documented. Whilst there is strong evidence of reporting on actions taken as a result of complaints within corporate structures, it would be helpful to see how feedback is given to complainants and other patients and carers on what changes as a result of their complaints.

The implementation of barcoded wristbands as an additional safety measure for all patients is welcomed.

Healthwatch Birmingham is aware of the continued challenges across Birmingham in responding to emergency admissions. We understand that the Trust's accident and emergency services deal with a proportion of patients who may have more appropriately been taken elsewhere. Whilst the Trust is to be commended in the high levels of quality in its emergency care, there is a challenge for the wider health community to ensure it is making the best use of accident and emergency services across the city.

Healthwatch Birmingham looks forward to seeing the results of the Trust's continued focus on improving patient experience in the year ahead.

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 the HOSC an opportunity to comment on the Quality Accounts before publication.

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 2013/14 draft Quality 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.

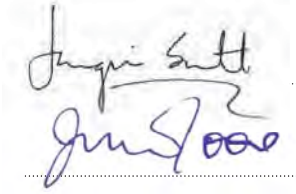
In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2013/14*;
- 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 2013 to June 2014
  - papers relating to Quality reported to the Board over the period April 2013 to June 2014
  - feedback from the commissioners dated 21/05/2014
  - feedback from governors dated 11/02/2014
  - feedback from local Healthwatch organisations dated 16/05/2014
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 29/04/2014
  - 2013 national patient survey 08/04/2014
  - 2013 national staff survey 24/02/2014
  - the head of internal audit's annual opinion over the trust's control environment dated 01/05/2014
  - CQC quality and risk profiles dated 31/03/2013-14/03/2014
- 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) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the Board

22 May 2014 ..... Chair



22 May 2014 ..... Chief Executive

Annex 3: Independent Auditor's Report on the Quality Report

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 2014 (the "Quality Report") and certain performance indicators contained therein.

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 2014, 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, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter
The indicators for the year ended 31 March 2014 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Emergency readmissions within 28 days; and
- C. Difficile infection.

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:
  - Board minutes for the period April 2013 to March 2014;
  - papers relating to Quality reported to the Board over the period April 2013 to March 2014;
  - feedback from the Commissioners dated 21/05/2014;
  - feedback from local Healthwatch organisations dated 16 May 2014;
  - the Trust's complaints Report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 29 April 2014;
  - the latest national patient survey for 2013;
  - the latest national staff survey for 2013;

- Care Quality Commission Quality and risk profiles dated 31 May 2013, 30 June 2013, 31 July 2013, 21 October 2013 and 14 March 2014; and
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 1 May 2014.

- 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 the documents listed above and specified within the detailed guidance for external assurance on Quality Reports.

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.

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.
- Reading the documents.

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

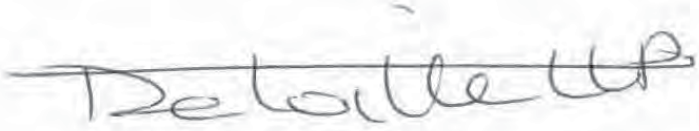
Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

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

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 2014:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual;*
- the Quality Report is not consistent in all material respects with the sources specified in Monitor's Detailed Guidance for External Assurance on Quality Reports 2013/14; 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.*



Deloitte LLP
Chartered Accountants
Birmingham
27 May 2014

This annual report covers the period
1 April 2013 to 31 March 2014

University Hospitals Birmingham NHS
NHS Foundation Trust

Section 4 **Consolidated Financial Statements 2013/2014**

Section 4 | Consolidated Financial Statements

University Hospitals Birmingham NHS Foundation Trust - Consolidated Financial Statements 2013/14

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Foreword to the Financial Statements

University Hospitals Birmingham NHS Foundation Trust

These financial statements for the year ended 31 March 2014 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

22 May 2014

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.

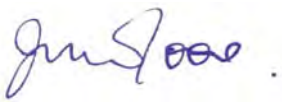
Under the National Health Service Act 2006, Monitor has directed the University Hospitals Birmingham NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must 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
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- 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, Chief Executive

22 May 2014

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

We have audited the financial statements of University Hospitals Birmingham NHS Foundation Trust for the year ended 31 March 2014 which comprise the Consolidated Statement of Comprehensive Income, the Consolidated Statement of Financial Position, the Consolidated Statement of Changes in Taxpayer's Equity and the Consolidated Statement of Cash Flows and the related notes 1 to 32. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

This report is made solely to the Council of Governors and Board of Directors ("the Boards") of University Hospitals Birmingham NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards 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 Trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the accounting officer and auditor

As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices 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 Group's and 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 and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the Group's and the Trust's affairs as at 31 March 2014 and of the Group's and the Trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Strategic Report and 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 in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls; or
- proper practices have not been observed in the compilation of the financial statements; or
- the NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Certificate

We certify that we have completed the audit of the accounts 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.

Gus Miah (Senior Statutory Auditor)
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
Birmingham, United Kingdom
27 May 2014

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 2014 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.

The Annual Plan sets out the Trust's principal aims for the year ahead. Each Executive Director has responsibility for identifying any risks that could compromise the Trust from achieving these aims. These strategic risks form the Board Assurance Framework (BAF). It maps out the key controls to manage the aims and provide the Board of Directors with sufficient assurance about the effectiveness of the controls and any gaps. Further detail is provided in the Procedure of the Assessment of Risks and Risk Registers.

The Audit Committee monitors and oversees both internal control issues and the process for risk management. Both the Internal Auditors and External Auditors attend the Audit Committee meetings.

In August/September 2013 the Trust conducted tenders for the Internal and External Audit services. Following due procurement process the Audit Committee made a recommendation to the Council of Governors to appoint Deloitte as new External Auditors with effect from 1 January 2014. Deloitte continued to work as Internal Auditors until 31 December 2013 and submitted all outstanding reports to the Audit Committee meetings in February and March 2014.

KPMG LLP was appointed as new Internal Auditors by the Chief Executive on 8 October 2013. KPMG resigned as External Auditors with effect from 1 October 2013 and commenced work as new Internal Auditor on 1 November 2013. Consequently, the Trust received two Heads of Internal Audit Opinion which are referenced in section 6.

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 risk management. Nominated Managers as defined in the Health & Safety Policy 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, as appropriate, in Trust and Divisional Development programmes. It is incorporated into the Corporate, Consultant and Junior Doctor Induction programmes. Risk Management training is provided for nursing band 5 and 6 development programmes, Root Cause Analysis (RCA) training is provided to Senior Managers as identified in the Trust Training Needs Analysis. Ad-hoc training is also provided for divisional education development.

Learning from incidents, RCA and good practice is discussed at the Clinical Quality Monitoring Group and the Chief Executive's RCA Meeting that reports to the Board of Directors. Learning is fed back to the Divisions via the Divisional Clinical Quality Group.

4. The risk and control framework

"The Board of Directors is responsible for the strategic direction of the Trust in relation to Risk Management. It is supported by the Audit Committee which provides assurance to the Board of Directors on risk management as identified in the Internal Audit Programme. In addition, the Trust Executive and Non-Executive Directors carry out visits. These are reported to the Board of Directors by the Executive Medical Director. The Trust's Risk Management Strategy and Policy defines risk management structures, accountability and responsibilities and the level of acceptable risk for the Trust. The Board Assurance Framework (BAF) identifies key risks to the Trust's corporate aims and objectives and is reviewed on a quarterly basis by Executive Directors."

NHSLA

The Trust was successfully assessed at level 2 against the NHSLA Risk Management Standards for Trusts in September 2013.

CQC

Compliance with the Care Quality Commission (CQC) Essential Standards of Quality and Safety, and other national requirements, is a natural by-product of the effective operations of the Trust's groups and committees which report to the Board of Directors through Executive Directors. The process and groups and committees that provide direct reports to the Board are detailed in the Trust's Procedure for Monitoring Compliance Against the Care Quality Commission Essential Standards of Quality and Safety.

Based on the discussions at the Clinical Quality Monitoring Group the Executive Medical Director provides a quarterly Clinical Quality Monitoring Report to the Board of Directors. In April the Medical Director submits a Draft Quality Report/Account to the Board and a Final Quality Report/Account is provided in May.

The Executive Chief Nurse provides a quarterly Care Quality Report, Infection Prevention and Control Report and a 6-monthly Emergency Preparedness Update Report to the Board. He is also responsible for the annual report regarding the National Inpatient Survey and the annual Safeguarding Adults and Children report.

The Director of Corporate Affairs provides a quarterly report to Board on Audit Committee Activity, Clinical Compliance Activity and the Board Assurance Framework.

A summary report of RCU 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. Incident trends 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 local/departmental 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 in the Compliance and Assurance Report. Any non compliance is addressed with the appropriate Divisional Management Team and where required, Executive Directors escalate high level risks identified by the Divisional and Corporate Management Team to the Board of Directors through the Board Assurance Framework (BAF) process.

The Board of Directors undertakes a review of the BAF and the associated risk management processes every quarter, to assess whether there are any gaps in assurance or weaknesses in the effectiveness of controls. Additionally, the Audit Committee reviews the BAF annually, to support its review of the assurance provided to the Board of Directors on risk management.

4.2 Risk Control

Clinical risks are reported directly to the Board of Directors through the BAF. 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 and the Incident Reporting Policy and reviewed during the Information Governance Group meetings, 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, including information security 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 2013/14 and achieved a score of 80%, achieving Level 2 or above for all the requirements, which is satisfactory.

Risk management

Risk Management is well embedded throughout the organisation. Risks are usually reported locally through the Divisional Clinical Quality Groups. The Procedure for the

Assessment of Risks and Management of Risk Registers details how risks are escalated from a local/departmental level to Specialty/Divisional/ Executive and finally Board level. The Board of Directors establishes which risk tolerance is deemed to be acceptable to the Trust.

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 'severe' (as defined by the National Patient Safety Agency (NPSA) definition) are escalated by the Clinical Risk and Compliance Unit 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.

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

Compliance Risks

The Governance Assurance Framework provides oversight of the responsibilities of the Trust's various Committees/Groups and the effectiveness of the Trust's overall governance structure. The Groups/Committees are linked to the CQC standards and evidence of assurance is analysed quarterly for completeness and quality purposes. Where the Trust is exposed to new compliance standards or recommendations (e.g. Francis recommendations), these are cross-referenced to standards already logged on the framework and any gaps in assurance highlighted. This ensures the collection of timely, accurate and relevant assurance data on any compliance risks. Any anomalies, gaps in assurance or concerns about the quality of available assurance are reported on an exception basis to the relevant Executive Director and the DCA Governance Group meetings. The meetings are chaired by the Director of Corporate Affairs who decides whether further escalation to the Audit Committee or Board of Directors is required.

Financial Risks

Failure to maintain financial balance in future years has been identified as a key risk. This will be managed and mitigated through detailed financial planning, an ongoing efficiency programme, performance management and reporting, robust and effective negotiation, engagement with commissioners and oversight by The Board of Directors and relevant committees.

Strategic Risks

The BAF contains strategic level risks that may impact on the achievement of the Trust's overarching Strategic Priorities for 2013/2014. These are linked to the Annual Plan and the Care Quality Commission's Essential Standards. 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 out 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 2013/14. 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 Infection Prevention and Control report is a standing item on the agendas for meetings of the Council of Governors, the Board of Directors and the Chief Executive's Advisory Group.

All Serious Incidents Requiring an Investigation (SIRI) are reported to commissioners, 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 involved in the PLACE (Patient Led Assessment of the Care Environment) environmental visits. Aspects of risk, including infection control, are discussed at all Divisional Patient Council meetings. The Council of Governors is 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.

4.4 Corporate Governance Statement

The Board has reviewed an assessment of the assurance available to it regarding the validity of its Corporate Governance Statement. Key sources of assurance are as follows:

- The Trust's Corporate Governance Policy, Standing Orders, SFIs, Scheme of Delegation, clinical quality dashboards/ monitoring and financial systems. The Board receives regular reports regarding the quality of care. The systems underpinning the data on which such reports are based are continually improved and expanded.
- Compliance with good corporate governance standards/practices, as generally monitored via the Governance Assurance Framework. In March 2014 the Audit Committee received a report on compliance with the new Corporate Governance Code. The Trust has regard to the Code of Governance and has reviewed its governance framework against Monitor's Quality Governance Framework.
- The effectiveness of structures and reporting lines is monitored by the Governance Framework. Any gaps in assurance are reported to the Board of Directors on an exception basis.
- The Board and Board Sub-Committees have annual cycles which ensure that relevant, accurate and timely information is received so as to enable scrutiny of the Trust's operations. The Audit Committee obtains regular assurances on processes and systems of internal control from within the Trust as well as Internal/External Audit. The DCA Governance Group assists the Audit Committee in obtaining assurances on all compliance matters and reports gaps in assurances to the Audit Committee with a view to take further action.
- All Business Plans are to be submitted to either the Business Case Development Group or the Chief Executive Advisory Group who will assess the viability of the plan. Delivery against the approved plan is later monitored by the Board.
- Board member capability is monitored by the Executive Appointment and Remuneration Committee (EARC). The EARC gives full consideration to succession planning, taking into account the challenges and opportunities facing the Trust and the skills and expertise required within the Board of Directors to meet them.
- Patients' perception of 'quality of care' is monitored by the Complaints and PALS team. Staff and patient surveys assist in completing the picture.
- The Trust has rigorous processes in place for the recruitment of staff at all levels to ensure prompt and effective recruitment and monitors indicators associated with staffing levels, such as incidents and agency usage.

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

The Trust's Financial Plan for 2013/14 was approved by the Board of Directors in May 2013. Achievement of the financial plan relied on delivery of cash releasing efficiency savings of around £16.7m 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 quarterly Finance and Activity Performance Report. In overall terms the Trust has exceeded its planned surplus for the year during 2013/14.

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 2013/14 the Board of Directors has continued to receive a quarterly report on Key Performance Indicators. This includes trend data on a number of measures of efficiency and use of resources such as sickness absence, bank usage, external agency usage, vacancy rate, delayed transfers of care and letter turnaround times. Reporting is by exception and focusses on the key areas of risk to achievement of targets, particularly in relation to Monitor's Risk Assessment Framework. In 2013/14 the

Trust achieved all the targets included in the Framework with the exception of C. difficile, cancer 62 day GP referral and cancer 31 day first treatment. 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.

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.

The effectiveness of the Board Sub-Committees, notably the Audit Committee and Executive Appointment and Remuneration Committee, are discussed in more detail in the Governance section of the Annual Report.

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 2013/14.

The content of the Trust's Quality Report for 2013/14 builds on the 2012/13 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 Patient and Carer Council, Council of Governors, Care Quality Group and Trust Partnership Team.

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 Board level by the Clinical Quality Monitoring Group, Care Quality Group and Board of Directors, for example.

As in previous years, the Trust has produced quarterly update reports, showing performance for the quality improvement priorities and other key indicators during 2013/14. These are also routinely shared with the Trust's main Clinical Commissioning Group and made available to patients and the public on the Trust's external website.

Data included in the 2013/14 Quality Report has been checked by all teams involved and then signed off by the responsible Executive Director before being approved by the 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 and a plan to address weaknesses and ensure continuous improvement of the system is 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

- 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
- 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. Due to the transfer of role of Internal Auditor from Deloitte to KPMG (section 3 above), the Trust received two Heads of Internal Audit Opinion. Both opinions are based upon and limited to their work performed on the overall adequacy and effectiveness of the Trust's risk management, control and governance processes.

The Head of Internal Audit Opinion by Deloitte (Internal Auditor until 31 December 2013) is derived from 4 core internal audit reports, including budgetary control, patient property, CQC compliance, procurement (estates). Its Opinion for 2013/14 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."

KPMG's Head of Internal Audit Opinion (Internal Auditor since 1 January 2014) is derived from the reviews of the key financial controls (treasury management; income and debtors; expenditure and creditors, fixed assets and general ledger), IT control and the BAF. Its Opinion for 2013/14 states that "significant assurance can be given that there is a sound system of internal control on key financial and management processes. These are designed to meet the organisation's objectives, and controls are generally being applied consistently".

In 2012/13, both the Trust's external auditors and internal auditors reviewed the effectiveness of some of the processes through which data is extracted and reported in the Quality Report. The External Auditors made two recommendations in relation to the recording of severe harm in Serious Incident Requiring Investigation (SIRI) reports and electronic incident forms held in the Datix system. Both recommendations have been fully implemented during 2013/14.

7. Conclusion

There are no significant internal control issues. 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

22 May 2014

Consolidated statement of comprehensive income

	Notes	Year Ended 31 March 2014 Total £000	Year Ended 31 March 2013 Total £000
Revenue	3 - 4	**691,896**	640,031
Operating expenses	5	**(665,284)**	(624,941)
Impairments reversed to operating revenue	14.2	**23,993**	-
Operating surplus		**50,605**	15,090
Finance costs			
Finance income	10	**483**	658
Finance expense	10	**(22,045)**	(21,948)
Net finance expense		**(21,562)**	(21,290)
Surplus / (deficit) before taxation		**29,043**	(6,200)
Taxation	12	**(110)**	(118)
Surplus / (deficit) after taxation		**28,933**	(6,318)
PDC Dividends payable	11	**-**	-
Retained surplus / (deficit) for the year		**28,933**	(6,318)
Other comprehensive income			
Gain from transfer by absorption from demising bodies	17	**1,578**	-
Revaluation gains / (losses) on property, plant and equipment		**6,755**	(1,416)
Total comprehensive income / (expense) for the year		**37,266**	(7,734)

All income and expenditure is derived from continuing operations.

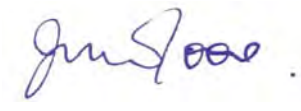
All income and expenditure is attributable to the Group, there are no minority interests.

A significant element of the £28,933,000 retained surplus for the year arises from the £23,993,000 reversal of impairment in respect of both the Trust's PFI 'Queen Elizabeth Hospital Birmingham' building valuation carried out in year and the opening of the refurbished East Block Day Unit. See note 14.2 to the financial statements on page XLIV.
The notes on pages XVII to LX are an integral part of these financial statements.

Consolidated statement of financial position

	Notes	Group 31 March 2014 £000	Group 31 March 2013 £000	Trust 31 March 2014 £000	Trust 31 March 2013 £000
Assets					
Non-current assets					
Intangible assets	13	**494**	495	**494**	495
Property, plant and equipment	14	**518,196**	491,760	**518,075**	491,670
Trade and other receivables	20	**3,065**	2,842	**3,065**	2,842
Other assets	21	**-**	-	**-**	-
		521,755	495,097	**521,634**	495,007
Current assets					
Inventories	19	**15,231**	13,438	**13,892**	12,447
Trade and other receivables	20	**55,876**	38,410	**60,637**	41,243
Other current assets	21	**-**	-	**-**	-
Cash and cash equivalents	22	**63,088**	76,200	**60,377**	75,352
		134,195	128,048	**134,906**	129,042
Total assets		**655,950**	623,145	**656,540**	624,049
Liabilities					
Current liabilities					
Borrowings	26	**(12,097)**	(11,828)	**(12,097)**	(11,828)
Trade and other payables	23	**(114,152)**	(98,402)	**(115,591)**	(99,800)
Current tax liabilities		**(109)**	(111)	**-**	-
Provisions	29	**(1,260)**	(1,800)	**(1,260)**	(1,800)
Other liabilities	24	**(16,965)**	(21,015)	**(16,965)**	(21,015)
		(144,583)	(133,156)	**(145,913)**	(134,443)
Total assets less current liabilities		**511,367**	489,989	**510,627**	489,606
Non-current liabilities					
Borrowings	26	**(522,204)**	(534,449)	**(522,204)**	(534,449)
Provisions	29	**(1,838)**	(1,698)	**(1,838)**	(1,698)
Deferred tax liabilities	25	**(17)**	(17)	**-**	-
Other liabilities	24	**(17,813)**	(21,613)	**(17,813)**	(21,613)
		(541,872)	(557,777)	**(541,855)**	(557,760)
Total liabilities		**(686,455)**	(690,933)	**(687,768)**	(692,203)
Net assets / (liabilities)		**(30,505)**	(67,788)	**(31,228)**	(68,154)
Taxpayers' equity					
Public dividend capital		**171,029**	171,012	**171,029**	171,012
Revaluation reserve		**113,496**	106,764	**113,496**	106,764
Income and expenditure reserve		**(315,030)**	(345,564)	**(315,753)**	(345,930)
Total taxpayers' equity		**(30,505)**	(67,788)	**(31,228)**	(68,154)

The financial statements on pages XIII to LX were approved by the Board of Directors on 22 May 2014 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 2012	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)**
Surplus for the year	-	-	28,933	**28,933**
Transfers by modified absorption: gains on 1 April transfers from demising bodies	17	-	1,578	**1,595**
Transfers in respect of assets disposed of	-	(23)	23	**-**
Transfers between reserves	-	-	-	**-**
Revaluation gains / (losses)	-	6,755	-	**6,755**
Total comprehensive income for the year	17	6,732	30,534	**37,283**
Balance at 31 March 2014	**171,029**	**113,496**	**(315,030)**	**(30,505)**

Trust	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	**Total**
	£000	£000	£000	**£000**
Balance at 1 April 2012	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)**
Surplus for the year	-		28,576	**28,576**
Transfers by modified absorption: gains on 1 April transfers from demising bodies	17	-	1,578	**1,595**
Transfers in respect of assets disposed of	-	(23)	23	**-**
Transfers between reserves	-	-	-	**-**
Revaluation gains / (losses)	-	6,755	-	**6,755**
Total comprehensive income for the year	17	6,732	30,177	**36,926**
Balance at 31 March 2014	**171,029**	**113,496**	**(315,753)**	**(31,228)**

Consolidated statement of cash flows for the year ended 31 March 2014

	Notes	Year Ended 31 March 2014 £000	Year Ended 31 March 2013 £000
Cash flows from operating activities			
Operating surplus for the year		**50,605**	15,090
Depreciation and amortisation		20,275	21,026
(Reversals of) / impairments		**(23,993)**	9,996
Non-cash donations/grants credited to income		**(2,474)**	-
Loss on disposal of property, plant and equipment		**29**	73
(Increase) / decrease in inventories		**(1,793)**	(382)
(Increase) / decrease in trade and other receivables		**(17,746)**	(2,353)
(Increase) / decrease in other assets		**-**	213
Increase / (decrease) in trade and other payables		**15,662**	20,106
Increase / (decrease) in other liabilities		**(7,850)**	(11,067)
Increase / (decrease) in provisions		**(433)**	(617)
Tax (paid) / received		**(112)**	-
Net cash generated from operating activities		**32,170**	52,085
Cash flows from investing activities			
Interest received		**540**	686
Payments to acquire property, plant and equipment		**(11,631)**	(10,067)
Receipts from sale of property, plant and equipment		**-**	8
Payments to acquire intangible assets		**(178)**	(20)
Net cash used in investing activities		**(11,269)**	(9,393)
Cash flows from financing activities			
Capital element of finance lease obligations		**(35)**	(36)
Interest element of finance lease obligations		**(31)**	(32)
Capital element of PFI obligations		**(11,966)**	(12,254)
Interest element of PFI obligations		**(21,981)**	(21,866)
PDC dividends received / (paid)		**-**	-
Net cash used in financing activities		**(34,013)**	(34,188)
Net increase / (decrease) in cash and cash equivalents		**(13,112)**	8,504
Cash and cash equivalents at 1 April		**76,200**	67,696
Cash and cash equivalents at 31 March	22	**63,088**	76,200

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 2013/14 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 2014, 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 2014, together with the Group's share of the results of joint ventures and associates up to the 31 March 2014. 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.

The 2013/14 NHS Foundation Trust Annual Reporting Manual requires the consolidation

of any NHS charity that meets the criteria of control under IAS 27. The Queen Elizabeth Hospital Birmingham Charity is not considered to be a subsidiary of the Trust under IAS 27 and consequently is not consolidated within these financial statements. The charity is a separate legal entity with an independent Board of Trustees and the benefits from its activities are shared between the Trust, University of Birmingham and Royal Centre of Defence Medicine.

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.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2014, is based on valuation data as 31 March 2013, updated to 31 March 2014 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 were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service 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 at 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:

"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) has been used and replaced 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 statement of comprehensive income at the time the Trust commits itself to the retirement, regardless of the method of payment.

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.

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
- 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
- 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.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- The asset is available for immediate sale
- Management are committed to a plan to sell
- The sale is highly probable
- An active programme has begun to find a buyer and complete the sale
- The asset is being actively marketed at a reasonable price
- The actions required to complete the planned sale indicate that it is unlikely that the plan will be significantly changed or withdrawn

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

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
- 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
- The grantor controls the residual interest in the infrastructure at the end of the arrangement as service concession arrangements

The Trust therefore recognises the PFI asset as an item of property, plant and equipment on the Statement of Financial Position together with a liability to pay for it. The PFI asset recognised is the 'Queen Elizabeth Hospital Birmingham' as detailed in note 28.1 to the financial statements on page LII. The services received under the contract are recorded as operating expenses.

Valuation

The PFI assets are recognised as property, plant and equipment, when they come into use, in accordance with the HM Treasury interpretation of IFRIC 12. The assets are measured initially at fair value in accordance with the principles of IAS 17, HM Treasury guidance for PFI assets is the construction cost and capitalised fees incurred as at financial close, disclosed in the PFI contract. Subsequently, the assets are measured at fair value, which is kept up to date in

accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16, as detailed in accounting policy note 1.5 'Property, plant and equipment - valuation'. For specialised buildings this is depreciated replacement cost.

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

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

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 XXXV.

Lifecycle replacement

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

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

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

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

Other assets contributed by the Trust to the operator

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

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

1.12 Inventories

Inventories are valued at the lower of cost and net realisable value. Pharmacy and warehouse stocks are valued at weighted average cost, other inventories are valued on a first-in first-out basis. This is considered to be a reasonable

approximation to fair value due to the high turnover of stocks. Work-in-progress comprises goods and services in intermediate stages of production.

1.13 Cash and cash equivalents

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

1.14 Finance income and costs

Interest earned on bank accounts and interest charged on overdrafts is recorded as, respectively, 'interest receivable' and 'interest payable' in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

1.15 Financial assets and financial liabilities

Recognition and de-recognition

Financial assets and financial liabilities are recognised when the Trust becomes party to the contractual provision of the financial instrument, or in the case of trade receivables and payables, when the goods or services have been delivered or received, respectively.

Financial assets and financial liabilities are initially recognised at fair value. Public Dividend Capital is not considered to be a financial instrument, see accounting policy note 1.21 and is measured at historical cost.

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

Classification

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

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

Loans and receivables

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

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

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

Other financial liabilities

Other financial liabilities 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 prudential borrowing code requirements in section 41 of the NHS Act 2006 have been repealed with effect from 1 April 2013 by the Health and Social Care Act 2012. The financial statements disclosures that were provided previously are no longer required. The Trust has not utilised any loan or working capital facility, borrowings as at the reporting date consist 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 1.8% in real terms.

Clinical Negligence Costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA,

which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed in note 29 to the financial statements on page LIV, but is not recognised in the Trust's financial statements.

Non-Clinical Risk Pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises. The Trust has also taken out additional insurance to cover claims in excess of £1million.

1.20 Contingencies

Contingent liabilities are not recognised but are disclosed in note 30 to the financial statements on page LV, 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

- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 30 to the financial statements on page LV 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) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, (iii) for 2013/14 only, net assets and liabilities transferred from bodies which ceased to exist on 1 April 2013, and (iv) 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 2014. 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 XLIV. Future revaluations of the Trust's property may result in further material changes to the carrying values of non-current assets.

Provisions

Provisions have been made for probable legal and constructive obligations of uncertain timing or amount as at the reporting date. These are based on estimates using relevant and reliable information as is available at the time the financial statements are prepared. These provisions are estimates of the actual costs of future cash flows and are dependent on future events. Any difference between expectations and the actual future liability will be accounted for in the period when such determination is made.

The carrying amounts of the Trust's provisions are detailed in note 29 to the financial statements on page LIV.

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 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. The assets and liabilities are recognised in the financial statements at the date of the transfer and are not adjusted to fair value prior to recognition. 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.

For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, HM Treasury has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in reserves rather than the Statement of Comprehensive Income.

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 Treasury FReM does not require the following Standards and Interpretations to be applied in 2013-14:

- IFRS 9 'Financial Instruments' - recognition and measurement
- IFRS 10 'Consolidated Financial Statements'
- IFRS 11 'Joint Arrangements'
- IFRS 12 'Disclosure of Interests in Other Entities'
- IFRS 13 'Fair Value Measurement'
- IAS 27 'Separate Financial Statements'
- IAS 28 'Investments in Associates and Joint Ventures'
- IAS 32 'Financial Instruments' - presentation (offsetting financial assets and liabilities)
- IPSAS 32 'Service Concession Arrangements'

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 XXXIII. Other operating revenue is analysed in note 4 to the financial statements on page XXXIV and materially consists of revenues from

healthcare research and development, medical education and related support services to other organisations. Revenue is predominately from HM Government and related party transactions are analysed in note 32 to the financial statements on page LV, where individual customers within the public sector are considered material. The proportion of total revenue receivable from whole HM Government is 95.0% (2012/13 - 95.6%).

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

Commercial pharmaceutical dispensary

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

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

Year ended 31 March 2014	Healthcare services £000	Commercial dispensary £000	Inter-Group Eliminations £000	Total £000
Total segment revenue	692,316	18,341	(18,761)	691,896
Total segment expenditure	(666,171)	(17,874)	18,761	(665,284)
Total segment reversal of impairment	23,993	-	-	23,993
Operating surplus	**50,138**	**467**	-	**50,605**
Net financing	(21,562)	-	-	(21,562)
PDC dividends payable	-	-	-	-
Taxation	-	(110)	-	(110)
Retained surplus - before non-recurring items	**28,576**	**357**	-	**28,933**
Non-recurring items	-	-	-	-
Retained surplus / (deficit)	**28,576**	**357**	-	**28,933**
Reportable Segment assets	656,540	6,629	-	663,169
Eliminations	-	-	(7,219)	(7,219)
Total assets	**656,540**	**6,629**	**(7,219)**	**655,950**
Reportable Segment liabilities	(687,768)	(5,906)		(693,674)
Eliminations	-	-	7,219	7,219
Total liabilities	**(687,768)**	**(5,906)**	**7,219**	**(686,455)**
Net assets	**(31,228)**	**723**	**-**	**(30,505)**

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)	586,640
Total segment expenditure	(625,744)	(14,906)	15,709	(567,969)
Operating surplus	**14,593**	**497**	-	**18,671**
Net financing	(21,268)	(22)	-	(18,793)
PDC dividends payable	-	-	-	-
Taxation	-	(118)	-	(10)
Retained surplus - before non-recurring items	**(6,675)**	**357**	-	**(132)**
Non-recurring items	-	-	-	(33,510)
Retained surplus / (deficit)	**(6,675)**	**357**	-	**(33,642)**
Reportable Segment assets	624,049	4,906	-	637,093
Eliminations	-	-	(5,810)	(3,116)
Total assets	**624,049**	**4,906**	**(5,810)**	**633,977**
Reportable Segment liabilities	(692,203)	(4,540)		(697,147)
Eliminations	-	-	5,810	3,116
Total liabilities	**(692,203)**	**(4,540)**	**5,810**	**(694,031)**
Net assets	**(68,154)**	**366**	**-**	**(60,054)**

All activities are based in the UK.

3. Revenue from patient care activities

	Year Ended 31 March 2014	Year Ended 31 March 2013
By commissioner		
Foundation Trusts	**168**	125
NHS Trusts	**501**	423
NHS England	**319,436**	-
Strategic Health Authorities	**-**	24,381
Clinical Commissioning Groups	**224,989**	-
Primary Care Trusts	**-**	479,692
Local Authorities	**8,392**	-
NHS Scotland, Wales and Northern Ireland	**5,719**	6,829
Private Patients	**3,830**	3,580
NHS Injury Cost Recovery scheme	**3,695**	3,215
Ministry of Defence	**2,221**	5,177
	568,951	523,422

From 1 April 2013 the Primary Care Trusts and Strategic Health Authorities were abolished and replaced by Clinical Commissioning Groups (CCGs) under the Health and Social Care Act of 2012. The responsibility for commissioning nationally funded NHS healthcare 'specialist healthcare activity' transferred to NHS England which is the parent body of the CCGs. NHS England is the single largest commissioner of healthcare from the Trust under the new Social Care Act of 2012.

From 1 April 2013 the commissioning of community service healthcare was transferred from Primary Care Trusts to Local Authorities.

In prior years this revenue had been disclosed as being received from Primary Care Trusts (2012/13 - £8,376,000).

Healthcare activity income from the Ministry of Defence of £2,221,000 relates to the Trust contract with the Royal Centre for Defence Medicine (2012/13 - £5,177,000).

NHS Injury Cost Recovery scheme income, received from commercial insurance providers, is subject to a provision for impairment of receivables of 19.8% (2012/13 - 19.8%) to reflect expected rates of collection.

	Year Ended 31 March 2014	Year Ended 31 March 2013
By activity		
Elective	**108,649**	102,459
Non elective	**106,827**	97,887
Outpatients	**83,776**	80,034
A & E	**10,399**	9,824
Other NHS clinical	**249,554**	221,246
Private patients	**3,830**	3,580
Other non-NHS clinical	**5,916**	8,392
	568,951	523,422

With the exception of private patient and other non-NHS clinical income (NHS injury cost recovery scheme and Ministry of Defence), all of the revenue from clinical activities arises from NHS services within the United Kingdom.

3.1 Commissioner requested services

	Year Ended 31 March 2014 £000	Year Ended 31 March 2013 £000
Commissioner requested services		
Revenue derived from NHS clinical activity in England	**553,486**	504,621
Non-commissioner requested services		
NHS Scotland, Wales and Northern Ireland	**5,719**	6,829
Non-NHS derived clinical activity	**9,746**	11,972
Other operating revenue (see note 4 to the financial statements)	**122,945**	116,609
	138,410	135,410
Total revenue	**691,896**	640,031
Commissioner requested services as a percentage of revenue	**80.00%**	78.84%

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. These 'commissioner requested services' (as defined in the Trust's provider licence) are disclosed separately as a percentage of all revenue.

4. Other Operating Revenue

	Year Ended 31 March 2014 £000	Year Ended 31 March 2013 £000
Research and development	**30,375**	28,048
Education and training	**32,130**	33,051
Charitable and other contributions to expenditure	**3,324**	1,033
Non-patient care services to other bodies	**11,891**	10,118
Other revenue	**45,225**	44,359
	122,945	116,609

Other revenue includes PFI related income of £7,000,000 (2012/13 - £9,000,000); rental income of £2,175,000 (2012/13 - £2,033,000) due to the leasing of new hospital facilities by the University of Birmingham and Ministry of Defence; £4,214,000 from Clinical Excellence Awards (2012/13 - £4,023,000); recharges of £2,449,000 to the Ministry of Defence to fund the training expenditure of Nurses along with catering and car parking costs associated with the military contract (2012/13 - £2,803,000); £1,434,000 from the National Quality Assurance Service (2012/13 - £1,542,000); and funding of £3,166,000 (2012/13 - £2,311,000) 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 2014	Year Ended 31 March 2013
	Total	Total
	£000	£000
Services from Foundation Trusts	**5,253**	3,121
Services from other NHS Trusts	**502**	4,606
Services from CCGs and NHS England	**10**	-
Services from PCTs	**-**	82
Services from other NHS bodies	**9**	2,692
Purchase of healthcare from non NHS bodies	**15,509**	13,340
Directors' costs	**1,769**	1,784
Non executive directors' costs	**160**	162
Staff costs	**353,095**	325,416
Supplies and services - clinical	**169,683**	155,105
Supplies and services - general	**9,654**	8,336
Consultancy services	**1,471**	2,152
Establishment	**5,496**	5,133
Transport	**1,559**	1,130
Premises	**19,504**	19,932
Provision for Impairment of Receivables	**211**	1,295
Depreciation on property, plant and equipment	**20,066**	20,695
Amortisation on intangible assets	**209**	331
Impairments of property, plant and equipment	**-**	9,996
Loss on Disposal of property, plant and equipment	**29**	73
Audit services - statutory audit	**123**	97
Other auditors remuneration - taxation services	**37**	62
Other auditors remuneration - audit of subsidiary	**7**	5
Other auditors remuneration - other services	**-**	17
Clinical negligence	**5,418**	5,595
Other	**55,510**	43,784
	665,284	624,941

Other expenditure includes £27,210,000 (2012/13 - £23,355,000) in relation to payments to the Trust's PFI partner for services provided; Research Grants distributed to other West Midlands NHS organisations of £14,928,000 (2012/13 - £11,798,000) due to the Trust acting as host body for the Comprehensive Local Research Network; Training, Courses and Conference fees of £4,222,000 (2012/13 - £3,607,000) and fees payable with regard to internal audit and counter fraud services of £161,000 (2012/13 - £146,000).

The Trust's contract with its external auditors, Deloitte LLP, provides for a limitation of the auditors liability of one million pounds sterling.

6. Operating leases

6.1 As lessee

Payments recognised as an expense	Year Ended 31 March 2014	Year Ended 31 March 2013
	£000	£000
Minimum lease payments	**949**	1,033

Total future minimum lease payments	Year Ended 31 March 2014	Year Ended 31 March 2013
	£000	£000
Payable:		
Not later than one year	**800**	1,066
Between one and five years	**558**	985
After 5 years	**1,125**	2,053
Total	**2,483**	4,104

6.2 As lessor

Rental revenue	Year Ended 31 March 2014	Year Ended 31 March 2013
	£000	£000
Rents recognised as income in the period	**2,249**	2,151

Total future minimum lease payments	Year Ended 31 March 2014	Year Ended 31 March 2013
	£000	£000
Receivable:		
Not later than one year	**2,248**	2,159
Between one and five years	**8,102**	3,224
After 5 years	**4,190**	4,452
Total	**14,540**	9,835

7. Employee costs and numbers

7.1 Employee costs *

	Year Ended 31 March 2014			Year Ended 31 March 2013		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Short term employee benefits - salaries and wages	**283,103**	**266,767**	**16,336**	265,833	249,136	16,697
Short term employee benefits - social security costs	**22,731**	**22,731**	**-**	21,279	21,279	-
Post employment benefits - employer contributions to NHS pension scheme	**30,311**	**30,311**	**-**	27,777	27,777	-
Pension cost - other contributions	**2**	**2**	**-**	2	2	-
Termination benefits	**256**	**256**	**-**	218	218	-
Agency/contract staff	**18,873**	**-**	**18,873**	13,543	-	13,543
Revenue in respect of Salaries and wages where netted off expenditure	**(156)**	**(156)**	**-**	(1,234)	(1,234)	**-**
	355,120	**319,911**	**35,209**	327,418	297,178	30,240

7.2 Average number of persons employed *

	Year Ended 31 March 2014			Year Ended 31 March 2013		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
Medical and dental	**1,089**	**1,024**	**65**	1,041	956	85
Administration and estates	**1,521**	**1,521**	**-**	1,439	1,439	**-**
Healthcare assistants and other support staff	**639**	**639**	**-**	603	603	**-**
Nursing, midwifery and health visiting staff	**3,236**	**3,236**	**-**	2,934	2,934	**-**
Scientific, therapeutic and technical staff	**1,069**	**1,069**	**-**	1,054	1,054	**-**
Bank and agency staff	**223**	**-**	**223**	229	**-**	229
	7,777	**7,489**	**288**	7,300	6,986	314

* 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 XXXV.

7.3 Key management compensation

	Year Ended 31 March 2014	Year Ended 31 March 2013
	£000	£000
Salaries and short term benefits	**1,417**	1,451
Social Security Costs	**187**	179
Employer contributions to NHSPA	**165**	154
	1,769	1,784

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 2014						
< £10,000	2	8	-	-	2	8
£10,000 - £25,000	2	41	-	-	2	41
£25,000 - £50,000	2	70	-	-	2	70
£50,000 - £100,000	2	137			2	137
	8	256	-	-	8	256
Termination benefit by band - Year Ended 31 March 2013						
< £10,000	1	3	-	-	1	3
£10,000 - £25,000	1	14	-	-	1	14
£25,000 - £50,000	1	29	-	-	1	29
	1	75	-	-	1	75
	4	121	-	-	4	121

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 (2012/13 - £nil).

8. Retirements due to ill-health

During the year to 31 March 2014 there were 7 early retirements from the Trust agreed on the grounds of ill-health (2012/13 - 6). The estimated additional pension liabilities of these ill-health retirements will be £601,813 (2012/13 - £378,913). 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 2014		Year Ended 31 March 2013	
	Number	**£000**	Number	£000
Trade				
Total trade bills paid in the year	**109,237**	**332,302**	100,761	288,794
Total trade bills paid within target	**106,330**	**327,776**	99,632	287,323
Percentage of trade bills paid within target	**97.34%**	**98.64%**	98.88%	99.49%
NHS				
Total NHS bills paid in the year	**6,589**	**182,839**	9,091	176,369
Total NHS bills paid within target	**6,105**	**180,190**	8,829	174,867
Percentage of NHS bills paid within target	**92.65%**	**98.55%**	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 2014	Year Ended 31 March 2013
	£000	£000
Financing income		
Interest receivable	**483**	658
	483	658
Financing costs		
Interest on obligations under PFI contracts	**(21,981)**	(21,866)
Interest on obligations under finance leases	**(31)**	(32)
Other financing charges	**(33)**	(50)
	(22,045)	(21,948)
Net finance expense	**(21,562)**	(21,290)

11. Public dividend capital dividends

Public dividend capital ('PDC') dividends paid and due to the Department of Health amounted to £nil (2012/13 - £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

Recognised in the income statement	Year Ended 31 March 2014	Year Ended 31 March 2013
	£000	£000
Current tax expense		
Current year	**109**	115
Adjustments in respect of prior years	**1**	(4)
	110	111
Deferred tax expense		
Origination and reversal of temporary differences	**2**	4
Adjustments in respect of prior years	**-**	3
Reduction in tax rate	**(2)**	-
	-	7
Total tax expense recognised in income statement	**110**	118

Tax recognised in other comprehensive income is £nil.

Tax recognised directly in equity is £nil.

Reconciliation of effective tax rate	Year Ended 31 March 2014	Year Ended 31 March 2013
Operating surplus before taxation - subsidiary only *	**467**	475
Tax at the standard rate of corporation tax in the UK 23%	**107**	114
Current year impact of rate change	**(2)**	**-**
Adjustments in respect of prior years	**1**	(1)
Tax effect of expenditure not deductible	**4**	5
Total tax expense	**110**	118

* 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 23% to 21%. The standard rate of corporation tax in the UK changed from 23% to 21% with effect from 1 April 2014.

13. Intangible assets

Group	Computer software - purchased	Licences and trademarks	Total
	£000	£000	£000
Cost			
At 1 April 2012	1,731	384	2,115
Additions	20	-	20
Reclassifications	97	(97)	-
At 31 March 2013	**1,848**	**287**	**2,135**
Transfers by absorption - modified	52	-	52
Additions	163	15	178
Reclassifications	(52)	30	(22)
At 31 March 2014	**2,011**	**332**	**2,343**
Amortisation			
At 1 April 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**
Charged for the year	154	55	209
Reclassifications	-	-	-
At 31 March 2014	**1,654**	**195**	**1,849**
Net book value			
At 31 March 2014	**357**	**137**	**494**
At 31 March 2013	348	147	495
At 1 April 2012	598	208	806

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 - 2013/14

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 2013	68,875	400,593	1,320	947	86,765	11	14,824	4,064	577,399
Transfers by absorption - modified	475	1,015	-	-	26	-	27	-	1,543
Additions purchased / leased	-	3,271	-	920	6,391	-	1,126	36	11,744
Additions donated	-	-	-	-	2,474	-	-	-	2,474
Reclassifications	-	478	-	(927)	116	-	337	18	22
Reversal of impairments credited to operating income	-	23,993	-	-	-	-	-	-	23,993
Impairments charged to revaluation reserve	-	6,651	104	-	-	-	-	-	6,755
Disposals other than by sale	-	-	-	-	(923)	-	-	(357)	(1,280)
At 31 March 2014	**69,350**	**436,001**	**1,424**	**940**	**94,849**	**11**	**16,314**	**3,761**	**622,650**
Depreciation									
At 31 March 2013	-	23,035	172	-	48,758	2	10,163	3,509	85,639
Provided during the year	-	9,208	76	-	9,201	1	1,485	95	20,066
Disposals other than by sale	-	-	-	-	(905)	-	-	(346)	(1,251)
At 31 March 2014	**-**	**32,243**	**248**	**-**	**57,054**	**3**	**11,648**	**3,258**	**104,454**
Net book value									
Owned	26,600	59,714	1,153	934	32,377	8	4,666	462	125,914
Donated	-	6,349	23	6	5,051	-	-	41	11,470
Private Finance Initiative	-	337,695	-	-	-	-	-	-	337,695
Finance Lease	42,750	-	-	-	367	-	-	-	43,117
At 31 March 2014	**69,350**	**403,758**	**1,176**	**940**	**37,795**	**8**	**4,666**	**503**	**518,196**

A separate schedule for the Trust's tangible assets has not been produced as the subsidiaries' tangible assets represent just £121,000 (31 March 2013 - £90,000) of the net book value held by the Group.

The property. plant and equipment transferred in under modified absorption accounting are the assets associated with the transfer of community services of the now disbanded Primary Care Trusts. The land and buildings consist of the offices of the community sexual health service in Whittal Street, Birmingham.

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**

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.

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 the reversal of two previous impairments being credited to operating revenue, within the consolidated statement of comprehensive income.

Impairments of property, plant and equipment		**Year Ended 31 March 2014 £000**
Reversals of impairments credited to consolidated statement of comprehensive income		
Queen Elizabeth Hospital - new PFI facility	1	**18,803**
Trust owned property	2	**5,190**
		23,993

1 The valuation of the 'Queen Elizabeth Hospital Birmingham' PFI hospital gave rise to a reversal of impairment resulting from the difference between the fair value in operational use (depreciated replacement cost), as measured at 31 March 2014 compared to 31 March 2013. The reversal of impairment is disclosed on the face of the consolidated statement of comprehensive income to the financial statements on page XIII.

2 The valuation of the newly opened refurbished 'East Block Day Unit' gave rise to a reversal of impairment equivalent to the estimated fair value of the original building, at the reporting date, had it not actually been written off in 2006. This reversal of impairment is also disclosed on the face of the consolidated statement of comprehensive income to the financial statements on page XIII. The remainder of the actual fair value in operational use, as measured at 31 March 2014 is disclosed as an increase to the revaluation reserve.

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

Revaluation gains / (losses) on property, plant and equipment	31 March 2014	31 March 2013
Group	**£000**	£000
Surpluses / (deficits) due to revaluation of property recognised in other comprehensive income		
Land	**-**	-
Buildings	**6,651**	(1,244)
Dwellings	**104**	(172)
	6,755	(1,416)

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

Included within the revaluation surplus arising on buildings is a gain of £3,496,000 relating to the newly opened refurbished 'East Block Day Unit'. As noted above this surplus is the balance of the fair value in operational use less construction costs, as measured at 31 March 2014, less the reversal of impairment equivalent to the estimated fair value of the original building had it not actually been written off in 2006. The refurbishment and re-opening of the East Block Day Unit are noted in the annual report.

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 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**
Additions	445	25	470
Reversal of impairments credited to operating income	18,803	-	18,803
At 31 March 2014	**361,212**	**43,449**	**404,661**
Depreciation			
At 1 April 2012	9,294	238	9,532
Charged for the year	7,291	48	7,339
At 31 March 2013	**16,585**	**286**	**16,871**
Charged for the year	6,932	46	6,978
At 31 March 2014	**23,517**	**332**	**23,849**
Net book value			
At 31 March 2014	**337,695**	**43,117**	**380,812**
At 31 March 2013	325,379	43,138	368,517
At 1 April 2012	339,889	42,750	382,639

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

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

15. Capital commitments

Commitments under capital expenditure contracts at the end of the period, not otherwise included in these financial statements, were £1,503,000 (31 March 2013 - £2,635,000). 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 2014.

Pharmacy@QEHB Limited

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

Birmingham Systems 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.

UHB Satellite Dialysis Limited

The company is registered in the UK, company no. 8642238, 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.

UHB Facilities Limited

The company is registered in the UK, company no. 8642236, 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 modified 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 its associated property, plant and equipment.

The property, plant and equipment was transferred on 1 April 2013, and is detailed in note 14 to the financial statements on page XLII.

18. Non-current assets held for sale

The Trust has no non-current assets held for sale (31 March 2013 - £nil).

19. Inventories

	Group		Trust	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000	£000	**£000**	£000
Consumables	**8,838**	7,850	**8,838**	7,849
Drugs	**6,384**	5,580	**5,045**	4,590
Finished goods	**9**	8	**9**	8
	15,231	13,438	**13,892**	12,447

Inventories carried at fair value less costs to sell where such value is lower than cost are nil (31 March 2013 - £nil).

The Trust expensed £162,314,000 of inventories during the year (2012/13 - £147,485,000). The Trust charged £248,000 to operating expenses in the year due to write-downs of obsolete inventories (2012/13 - £13,000).

20. Trade and other receivables

Current	Group		Trust	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000	£000	**£000**	£000
NHS receivables	**31,581**	20,028	**31,581**	20,028
Receivables with other related parties	**5,870**	3,966	**5,870**	3,966
Commercial trade receivables	**3,944**	3,458	**9,303**	7,672
Provision for impaired receivables	**(1,711)**	(1,777)	**(1,711)**	(1,777)
PFI prepayments - lifecycle replacements	**5,314**	2,969	**5,314**	2,969
Prepayments	**3,437**	2,394	**3,431**	2,390
Accrued income	**669**	255	**698**	255
Other receivables	**6,772**	7,117	**6,151**	5,740
	55,876	38,410	**60,637**	41,243

Non current	Group		Trust	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000	£000	**£000**	£000
Provision for impaired receivables	**(757)**	(702)	**(757)**	(702)
Other receivables	**3,822**	3,544	**3,822**	3,544
	3,065	2,842	**3,065**	2,842

NHS receivables consist of balances owed by NHS bodies in England, receivables with other related parties consist of balances owed by other HM Government organisations. Related party transactions are detailed in note 32 to the financial statements on page LV.

Included within trade and other receivables of both Group and Trust are balances with a carrying amount of £11,592,000 (31 March 2013: £12,290,000) 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 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000	£000	**£000**	£000
Not past due date	**47,349**	28,962	**52,110**	31,795
By up to three months	**3,553**	4,514	**3,553**	4,514
By three to six months	**1,011**	1,444	**1,011**	1,444
By more than six months	**7,028**	6,332	**7,028**	6,332
	58,941	41,252	**63,702**	44,085

Provision for impaired receivables	**Group**		**Trust**	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000	£000	**£000**	£000
Balance at 1 April	**2,479**	1,590	**2,479**	1,590
Increase in provision	**1,823**	2,945	**1,823**	2,945
Amounts utilised	**(222)**	(406)	**(222)**	(406)
Unused amounts reversed	**(1,612)**	(1,650)	**(1,612)**	(1,650)
	2,468	2,479	**2,468**	2,479

Aged analysis of impaired receivables	**Group**		**Trust**	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000	£000	**£000**	£000
By up to three months	**58**	246	**58**	246
By three to six months	**11**	16	**11**	16
By more than six months	**2,399**	2,217	**2,399**	2,217
	2,468	2,479	**2,468**	2,479

21. Other non financial assets

The Trust has no non-financial assets as at the reporting date (31 March 2013 - £nil).

22. Cash and cash equivalents

	Group		Trust	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000	£000	**£000**	£000
Cash and cash equivalents	**63,088**	76,200	**60,377**	75,352
Made up of				
Cash with Government Banking Service	**519**	8,948	**519**	8,948
Commercial banks and cash in hand	**62,569**	67,252	**59,858**	66,404
Current investments	**-**	-	**-**	-
Cash and cash equivalents as in statement of financial position	**63,088**	76,200	**60,377**	75,352
Bank overdraft - Government Banking Service	**-**	-	**-**	-
Bank overdraft - Commercial banks	**-**	-	**-**	-
Cash and cash equivalents as in statement of cash flows	**63,088**	76,200	**60,377**	75,352

23. Trade and other payables

Current	Group		Trust	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000	£000	**£000**	£000
NHS payables	**9,206**	8,900	**9,206**	8,900
Amounts due to other related parties	**4,489**	4,103	**4,489**	4,103
Commercial trade payables	**41,432**	26,048	**41,295**	27,086
Trade payables - capital	**1,308**	1,220	**1,307**	1,218
Taxes payable	**7,385**	7,014	**7,376**	7,007
Other payables	**1,479**	1,522	**2,993**	1,859
Accruals	**45,252**	49,205	**45,324**	49,237
Receipts in advance	**3,601**	390	**3,601**	390
	114,152	98,402	**115,591**	99,800

NHS payables consist of balances owed to NHS bodies in England, amounts due to other related parties consist of balances owed to other HM Government organisations. Related party transactions are detailed in note 32 to the financial statements on page LV. Included within amounts due to other related parties are NHS pension contributions of £4,342,000 (31 March 2013: £3,765,000).

Non current trade and other payables are nil (31 March 2013 - £nil).

24. Other liabilities

Current	Group		Trust	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000	£000	**£000**	£000
Deferred income	**16,965**	21,015	**16,965**	21,015
Deferred government grant	**-**	-	**-**	-
	16,965	21,015	**16,965**	21,015

Non current	Group		Trust	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000	£000	**£000**	£000
Deferred income	**16,413**	21,613	**16,413**	21,613
Deferred government grant	**1,400**	-	**1,400**	-
	17,813	21,613	**17,813**	21,613

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 2012	17	(7)	10
Credit / (charge) to the income statement	-	7	7
At 31 March 2013	**17**	-	**17**
Credit / (charge) to the income statement	-	-	-
At 31 March 2014	**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:

	31 March 2014	31 March 2013
	£000	£000
Deferred tax assets	-	-
Deferred tax liabilities	**17**	17
Net non current deferred tax liability	**17**	17

26. Borrowings

Group and Trust	Current		Non current	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000	£000	**£000**	£000
Obligations under finance leases	**38**	33	**352**	367
Obligations under Private Finance Initiative contracts	**12,059**	11,795	**521,852**	534,082
	12,097	11,828	**522,204**	534,449

The Private Finance Initiative obligation relates to the new Queen Elizabeth Hospital Birmingham as detailed in note 28.1 to the financial statements on page LII.

The prudential borrowing code requirements in section 41 of the NHS Act 2006 have been repealed with effect from 1 April 2013 by the Health and Social Care Act 2012. The financial statements disclosures that were provided previously are no longer required.

The Trust has not utilised any loan or working capital facility in year and there is no such facility in place at the reporting date. In prior years the Trust had a working capital facility (31 March 2013 - £46,600,000) which whilst never used its availability was a requirement of Monitors then Liquidity rating performance measure. In 2013/14 Monitor introduced a new financial reporting framework (the 'Continuity of Services Risk Rating') whose Liquidity ratio excluded all working capital facilities, the Trust then cancelled the facility that was in place at 31 March 2013.

27. Finance lease obligations (other than PFI)

	Minimum lease payments		Present value of minimum lease payments	
Group and Trust	**31 March 2014**	31 March 2013	**31 March 2014**	31 March 2013
	£000	£000	**£000**	£000
Gross lease liabilities	**533**	557	**438**	447
Of which liabilities are due:				
Not later than one year	**67**	62	**67**	62
Later than one year, not later than five years	**266**	250	**231**	217
Later than five years	**200**	245	**140**	168
Net finance charges allocated to future periods	**(143)**	(157)	**(124)**	(134)
Net lease liabilities	**390**	400	**314**	313
Not later than one year	**38**	33	**38**	33
Later than one year, not later than five years	**180**	161	**155**	139
Later than five years	**172**	206	**121**	141

28. Private finance initiative contracts

28.1 PFI schemes on-statement of financial position

A contract for the development of the new hospital was signed by the Trust and its PFI partner on 14 June 2006. The purpose of the scheme was to deliver a modern, state of the art acute hospital facility on the QE site which is now fully operational as at the reporting date. This is part of a wider PFI deal between the Trust, Birmingham & Solihull Mental Health Trust and a consortium led by Consort Healthcare (Birmingham) Limited. The ownership of the consortium entity is as follows:

Balfour Beatty Infrastructure Investments Ltd (40%), HSBC Infrastructure Fund (30%) and Royal Bank of Scotland Investments Ltd (30%).

The contracted value of the new PFI hospital is £584,600,000 (of which £484,889,000 is capital and £99,711,000 are fees and finance costs incurred prior to 15 June 2010). The 'Queen Elizabeth Hospital Birmingham' was handed over in three phases:

- phase 1 on 15 June 2010 and phase 2 on 17 November 2010 were delivered on schedule and were complete as at 31 March 2011
- phase 3 on 11 October 2011 was delivered on schedule and was complete as at 31 March 2012

Total obligations for on-statement of financial position PFI contracts due:

Group and Trust	**31 March 2014**	31 March 2013
	£000	£000
Gross PFI liabilities	**864,574**	907,160
Of which liabilities are due:		
Not later than one year	**29,071**	29,807
Later than one year, not later than five years	**113,749**	117,106
Later than five years	**721,754**	760,247
Net finance charges allocated to future periods	**(330,663)**	(361,283)
Net PFI liabilities	**533,911**	545,877
Not later than one year	**12,059**	11,795
Later than one year, not later than five years	**49,682**	49,068
Later than five years	**472,170**	485,014

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 is £50,809,000 (2012/13 - £48,799,000). 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 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000	£000	**£000**	£000
Of which commitments are due:				
Not later than one year	**52,163**	50,365	**52,163**	50,365
Between one and five years	**208,652**	201,460	**189,028**	184,995
After 5 years	**1,427,614**	1,428,771	**732,937**	781,370
Total PFI commitments	**1,688,429**	1,680,596	**974,128**	1,016,730

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

Group and Trust	Unitary payments		Present value of unitary payments	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000	£000	**£000**	£000
Of which commitments are due:				
Not later than one year	**14,535**	13,292	**14,535**	13,292
Between one and five years	**61,866**	56,577	**56,048**	51,898
After 5 years	**635,262**	614,471	**326,143**	316,779
Total service expense commitments	**711,663**	684,340	**396,726**	381,969

The Trust has the rights to use the Queen Elizabeth Hospital Birmingham for the length of the Project Agreement and has the rights to expect provision of the range of allied and clinical support services, including facilities management and lifecycle maintenance. In addition, the Trust has the rights to possible deductions from the unitary payment due to the non availability of the infrastructure or under performance regarding the services provided. At the end of the Project Agreement the assets will transfer back to the Trust's ownership.

28.2 PFI schemes off-statement of financial position

The Trust does not have any PFI schemes which are deemed to be off-statement of financial position at the period end.

29. Provisions

Group and Trust	Current		Non current	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000	£000	**£000**	£000
Pensions relating to other staff	**30**	35	**65**	83
Legal claims	**662**	1,308	**1,773**	1,615
Other	**568**	457	**-**	-
	1,260	1,800	**1,838**	1,698

	Pensions relating to former directors	**Pensions relating to other staff**	**Legal claims**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
At 1 April 2013	-	118	2,923	457	**3,498**
Arising during the year	-	6	623	233	**862**
Used during the year	-	(31)	(478)	-	**(509)**
Reversed unused	-	-	(664)	(122)	**(786)**
Unwinding of discount	-	2	31	-	**33**
At 31 March 2014	**-**	**95**	**2,435**	**568**	**3,098**
Expected timing of cash flows:					
Within one year	-	30	662	568	**1,260**
Between one and five years	-	60	417	-	**477**
After five years	-	5	1,356	-	**1,361**

The provisions included under 'legal claims' are for personal injury pensions £1,884,000 (31 March 2013: £1,720,000), employers and public liability £399,000 (31 March 2013: £402,000) and other claims notified by the Trust's solicitors £152,000 (31 March 2013: £801,000). 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 £95,000 (31 March 2013: £118,000), 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 £335,000 (31 March 2013: £433,000).

Provisions within the annual accounts of the NHS Litigation Authority at 31 March 2014 include £24,773,000 in respect of clinical negligence liabilities of the Trust (31 March 2013: £20,875,000).

30. Contingencies

There are £132,000 of contingent liabilities at the reporting date which relate to amounts notified by the NHSLA for potential employer and public liability claims over and above the amounts provided for in note 29 to the financial statements on page LIV (31 March 2013: £190,000). There are no contingent assets at the reporting date (31 March 2013: £nil).

31. Events after the reporting period

There are no after date reporting events.

32. Related party transactions

University Hospitals Birmingham NHS Foundation Trust is a corporate body established by order of the Secretary of State for Health.
The Trust has taken advantage of the partial exemption provided by IAS 24 'Related Party Disclosures', where the Government of the United Kingdom is considered to have ultimate control over the Trust and all other related party entities in the public sector.

The Trust considers other NHS Foundation Trusts to be related parties, as they and the Trust are under the common performance management of Monitor - part of the NHS in England. During the year the Trust contracted with certain other Foundation Trusts for the provision of clinical and non clinical support services.

The Department of Health is also regarded as a related party. During the year University Hospitals Birmingham NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities of the NHS in England to which the Department is regarded as the parent organisation.

The Trust has had a number of material transactions with other Government Departments and local Government bodies.

These 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	Payables	Revenue	Expenditure
	£000	£000	£000	£000
NHS in England				
NHS Birmingham Crosscity CCG	4,660	-	92,717	-
NHS Birmingham South And Central CCG	3,903	-	63,829	-
NHS Dudley CCG	716	-	6,786	-
NHS Redditch And Bromsgrove CCG	391	-	8,521	-
NHS Sandwell And West Birmingham CCG	75	279	19,967	-
NHS Solihull CCG	19	105	6,638	-
NHS South Worcestershire CCG	17	108	3,607	-
NHS Walsall CCG	2	587	3,763	-
NHS England (specialised commissioning)	13,671	281	326,660	319
Health Education England	135	-	31,691	-
Birmingham Women's FT	1,978	628	6,145	1,006
The Royal Orthopaedic Hospital FT	63	227	2,483	901
Birmingham Children's Hospital FT	194	711	2,554	2,678
Birmingham Community Healthcare NHS Trust	1,208	140	3,968	201
Department of Health	3	-	21,880	-
West Midlands Ambulance Service FT	3	376	25	4,477
NHS Litigation Authority	-	2	-	5,429
Other related parties - Whole of Government Accounts				
Ministry of Defence	1,720	-	6,871	1,332
NHS Pension Scheme	-	4,342	-	30,311
Birmingham City Council	746	96	7,872	7,702
NHS Wales	2,824	37	6,989	103
HMRC	1,119	7,511	-	22,731

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 2013/14, was also a non-executive director of the Trust up to 27 July 2013.

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 £5,388,000 (31 March 2013 - £4,208,000) owed by the subsidiary and the Trust's payables includes £1,831,000 (31 March 2013 - £1,602,000) owed to the subsidiary.

33. Financial instruments and related disclosures

The fair value of a financial instrument is the price at which an asset could be exchanged, or a liability settled, between knowledgeable, willing parties in an arms-length transaction. All the financial instruments of the Trust are initially measured at fair value on recognition and subsequently at amortised cost. The following table is a categorisation of the carrying amounts and the fair values of the Trust's financial assets and financial liabilities:

Carrying values by category of financial instruments		Group		Trust	
		31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	Notes	**£000**	£000	**£000**	£000
Current financial assets					
Cash and cash equivalents	1	**63,088**	76,200	**60,377**	75,352
Loans and receivables:					
Trade and receivables	1	**47,125**	33,047	**51,892**	35,884
		110,213	109,247	**112,269**	111,236
Non-current financial assets					
Loans and receivables:					
Trade and receivables	1	**3,065**	2,842	**3,065**	2,842
		3,065	2,842	**3,065**	2,842
Total financial assets		**113,278**	112,089	**115,334**	114,078
Current financial liabilities					
Other financial liabilities:					
Finance leases	2	**38**	33	**38**	33
Private Finance Initiative contracts	2	**12,059**	11,795	**12,059**	11,795
Trade and other payables	1	**103,166**	90,998	**104,614**	92,403
Provisions under contract	1	**1,119**	1,660	**1,119**	1,660
		116,382	104,486	**117,830**	105,891
Non-current financial liabilities					
Other financial liabilities:					
Finance leases	2	**352**	367	**352**	367
Private Finance Initiative contracts	2	**521,852**	534,082	**521,852**	534,082
Provisions under contract	1	**-**	-	**-**	-
		522,204	534,449	**522,204**	534,449
Total financial liabilities		**638,586**	638,935	**640,034**	640,340
Net financial assets / (liabilities)		**(525,308)**	(526,846)	**(524,700)**	(526,262)

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

(1) Fair values of cash, trade receivables, trade payables and provisions under contract are assumed to approximate to cost due to the short-term maturity of the instruments.

(2) Fair values of borrowings - finances leases and private finance initiative contracts, are carried at amortised cost. Fair values are estimated by discounting expected future contractual cash flows using interest rates implicit in the contracts. The maturity profile of both finance lease and private finance initiative contract liabilities are disclosed in notes 27 and 28.1 to the financial statements on pages LI and LII respectively.

The financial assets and financial liabilities of cash and cash equivalents, finance leases and private finance initiative contracts all equate to the amounts disclosed on the statement of financial position and supporting notes to the financial statements. Trade receivables, trade payables and provisions include non-financial assets and liabilities not disclosed in the table above. The reconciling amounts are as follows:

- Trade receivables includes prepayments which are not a financial instrument, see note 20 to the financial statements on page XLVII.
- Trade payables includes receipts in advance and PDC payable which are not financial instruments, see note 23 to the financial statements on page XLIX.
- Provisions includes liabilities incurred under legislation, rather than by contract - early retirements due to ill health or injury. These are not considered by HM Treasury to fit the definition of a financial instrument, see note 29 to the financial statements on page LIV.

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
- 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 XXX, there is limited exposure to credit risk from individuals and commercial entities. The maximum exposures to trade and other receivables as at the reporting date, are disclosed in note 20 to the financial statements on page XLVII. The Trust mitigates its exposure to credit risk through regular review of receivables due and by calculating a bad debt provision.

In accordance with the Trust's treasury policy, the Trust's cash is held in current accounts at UK banks only. There are no cash or cash equivalent investments held, the result being to minimise the counter party credit risk associated with holding cash at financial institutions.

(ii) Inflation risk

The Trust's has exposure to annual price increases of medical supplies and services (pharmaceuticals, medical equipment and agency staff) arising from its core healthcare activities. The Trust mitigates this risk through, for example, transferring the risk to suppliers by contract tendering and negotiating fixed purchase costs (including prices set by nationally agreed frameworks across the NHS) or reducing external agency staff costs via operation of the Trust's own employee 'staff bank'.

The unitary payment of the new 'Queen Elizabeth Hospital Birmingham' private finance initiative contract is subject to change based on movements in the Retail Prices Index (RPI), as disclosed in note 28.1 to the financial statements on page LII. For the reporting year the relevant RPI index was 247.6 (annualised rate of 3.2%) fixed at February 2013. 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 2014**		**Year Ended 31 March 2013**	
	£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 Clinical Commissioning Groups and NHS England, 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 regulated by the Trust's compliance with the 'Continuity of Services Risk Rating' system created by Monitor, the Independent Regulator of NHS Foundation Trusts, detailed in note 26 to the financial statements on page LI. 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.

34. Third Party Assets

The Trust held £2,963 of cash at the reporting date (31 March 2013: £2,963) which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

35. Losses and Special Payments

	Year Ended 31 March 2014		Year Ended 31 March 2013	
	Number	£000	Number	£000
Losses				
Cash losses	**19**	**6**	30	28
Bad debts and claims abandoned	**140**	**53**	127	22
Damage to property and stores losses	**4**	**54**	6	13
	163	**113**	163	63
Special payments				
Compensation payments	**2**	**20**	2	18
Ex gratia payments	**229**	**172**	215	192
	231	**192**	217	210
Total losses and special payments	**394**	**305**	380	273

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.

These amounts are stated on an accruals basis but exclude any provisions for future losses.

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:

Name: David Bennett (Chairman) Dated: 31 March 2014

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 2014