University Hospitals Birmingham NHS
NHS Foundation Trust

This annual report covers the period
1 April 2014 to 31 March 2015

Annual Report and Accounts 2014-15

University Hospitals Birmingham NHS Foundation Trust
Annual Report and Accounts 2014/2015

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Contents

Section 1: Annual Report

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Section 1 **Annual Report 2014/2015**

Strategic Report

1. Strategic Report

1. Overview

1.1 Principal activities of the Trust

UHB is one of Europe's leading hospitals with a proven international reputation for its quality of care, information technology, clinical education and training and research.

It is located in the heart of an exciting, vibrant, accessible and diverse city providing direct clinical services to nearly 1 million 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 8,800 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 has also opened an extra 170 beds in the original Queen Elizabeth Hospital, now known as the Heritage Building, 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 has been one of the UK's 22 major trauma centres since March 2014.

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.

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 three active subsidiaries:

- Pharmacy@QEHB Ltd, whose principal activity is the provision of outpatient pharmacy services
- Assure Dialysis Services, whose principal activity is the provision of satellite dialysis services
- UHB Facilities Limited, whose principal activity is to manage real estate facilities of the Trust not covered by the private finance initiative

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 2014/15 and Position at Year End

The environment in which the Trust operates is becoming increasingly challenging due to the ongoing financial pressures, the need to achieve performance targets in light of increasing levels of demand, and the enhanced scrutiny on the quality of care across the NHS.

Despite this the Trust has delivered its Annual Plan for 2014/15 which forms part of the overall Trust's five year strategy. The main objective of the strategy and plan continues to be the Trust's vision to deliver the best in care.

Each core purpose within the Trust Strategy and 2014/15 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 2014/15 objectives and has achieved the following:

- **Infection control:** An 18% reduction in *C. difficile* cases compared to 2013/14
- **A&E:** Significant improvement seen in the time to initial assessment

- **Ambulance handover:** improvements seen in the time taken to complete ambulance handover

- **Patient Experience:** Categorised in the 'better' category by the Care Quality Commission in the national survey of inpatients for patients giving overall positive views of care and services. This includes being treated with respect and dignity, feeling well looked after by staff, being asked to give their views on the quality of care, and being made aware of how to complain if required

- **Dementia Care:** Over 97% compliance against requirements for screening, assessment, and onward referral for specialist diagnosis for patients with suspected dementia

- **Care of patients with chronic obstructive pulmonary disease:** The Trust has successfully implemented a discharge bundle on its PICS system for patients with COPD which ensures patients receive a review by a specialist, have a discharge bundle completed along with a safe discharge checklist

- **Harm free care:** A 78% reduction in the incidence of hospital acquired pressure ulcers measured as part of the national Safety Thermometer initiative

- **Clinical observation:** The Trust achieved 98.6% of patients receiving a complete set of clinical observations to ensure that early triggers are generated for patients who need clinical intervention

- **Cancelled operations:** In the context of increasing activity levels, the Trust has delivered a 40% reduction in the proportion of cancelled operations for non-clinical reasons

- **Digitisation of Patients 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

- **Information for Patients and Shared Decision Making:** Myhealth@qehb, which was successfully launched in 2012/13, continues to expand and improve with over 8,200 patients now signed-up, which is double the amount in 2013/14

- **Staff survey:** The Trust participated in the national staff survey generating a 56% response rate which is in the highest 20% of acute trusts nationally. The results showed that 86% of responses were either average, above average, or in the highest 20% of trusts compared to 82% in 2013/14. UHB also successfully implemented the local staff friends and family survey and has delivered improvements in the score, quarter on quarter, ranking within the top 11% of trusts as a recommended place to work or receive care

- **Workforce performance:** The Trust has delivered year-on-year improvements in its rate of staff appraisal completion, mandatory training, and corporate and local induction. An effective system to measure and report safe staffing levels has been implemented to ensure compliance with national guidance

- **Research activity:** UHB has recruited over 11,000 additional patients in clinical trials in 2014/15 with UHB being one of the highest recruiting trusts in the West Midlands Clinical Research Networks. This benefits UHB patients having access to new trial treatments and medicines

- **Institute of Translational Medicine (ITM):** The ITM is a world-class research facility that will be delivered by Birmingham Health Partners to bring together clinical, scientific and academic excellence of UHB, University of Birmingham and the Birmingham Children's Hospital

- **Genomics:** UHB has led a successful West Midlands consortium bid for designation as a NHS Genomic Medicine Centre. The NHS Genomic Medicine Centre-West Midlands is one of 11 centres in England, chosen following a competitive tender managed by NHS England

2.2 Main trends and factors likely to affect the entity's future development, performance, and position

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 outcome/access targets and their financial plans.

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 2014/15. Additional theatre, recovery and bed capacity has been opened in the old QEH to mitigate this

- **Improving quality** – continuing focus on quality, clinical outcomes and patient experience are 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 in light of a tariff offer that will have an adverse impact on the financial performance of the Trust

- **Cost Improvement Plan (CIP) delivery** – the requirement to deliver savings whilst maintaining and 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 to deliver

- **Targets** – maintaining performance across all key targets including A&E waits, referral to treatment times and infection control in the face of year on year rises in demand

- **General Election** – there is a level of uncertainty around the impact this may have on NHS strategy, policy, and funding

In order to help meet these challenges, 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 Quality Report, quality standards agreed with commissioners, and local quality indicators.

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. Details of objectives achieved as part of the Trust Annual Plan in 2014/15 and proposed plans for 2015/16 are described below.

a. Clinical Quality

In 2014/15 the Trust continued to build on the strong approach to quality improvement by delivering further enhancements to digital systems, strengthening governance, regulation, and compliance processes, enhancing the Trust's dashboards and quality improvement systems, working collaboratively with partners on the Better Care Fund project, Your Care Connected initiative, and improving systems to allow effective hospital site management. The Trust's Quality Report is included in Section 3 and provides additional detail on UHB's quality priorities.

In 2015/16, as part of its quality objectives, the Trust is planning to deliver further enhancements to digital systems, further improve medicines management, work with partners to deliver joined up emergency care services and the Better Care Fund, to improve the flow of patients in/through/out of the hospital. It will also deliver higher levels of productivity and efficiency through a variety of workstreams.

b. Patient Experience

Over 2014/15, the Trust worked to further improve the management of pressure ulcers, ensure patients received appropriate nutrition and hydration during their care, improve pain management, and ensured effective end of life care. The Trust also ensured implementation and ongoing compliance with the safe staffing levels guidance. The Trust plan also maintained a focus on the quality of care for vulnerable patients and progress was made in the areas of dementia care, learning disabilities care, mental health care, and safeguarding.

For 2015/16, there are plans to continue to improve the fundamental standards of care in the areas of falls management, pressure ulcer management, hydration, and pain management. There will continue to be a focus on the care of vulnerable patients. Further improvements will be made to the complaints management, action planning, and learning process as well as the way the Trust analyses and interprets patient feedback in a more triangulated and integrated manner.

c. Workforce

In 2014/15, the Trust continued to develop its leadership strength, worked via the Learning Hub to open opportunities for careers at UHB, continued to deliver its communication skills programme, delivered a revised mandatory training model, and continued to enhance the quality of education and training provision.

In 2015/16, the Trust plans to continue the delivery of its leadership strategy, develop and deliver the strategy for the junior medical workforce, strengthen the quality of staff appraisals, and provide a front line managers development programme. In addition, staff health and well-being remains an important area of focus along with the delivery of key performance indicators related to the education and training of the workforce. UHB will also continue its work to broaden access to training and career opportunities via its widening participation strategy.

d. Research and Innovation

The research priorities for UHB in 2014/15 were focussed on preparing for the delivery of the Institute of Translational Medicine (ITM), accelerating research from bench to bedside, further developing the Trust's external profile as a high-performing research organisation and engaging patients and public in research and development activity. The Trust's innovation projects included exploring alternative pathways of care delivery via home care and progressing towards active patient identification via barcode scanning.

Over 2015/16, the delivery of the ITM is a significant project for UHB, along with continuing to grow its research activity, building academic capability and capacity, and identifying alternative routes to drive research activity by working with industry. Key priorities also include the Genomics Medicine Centre and the opening of the Centre for Rare Diseases within the ITM. The Trust will build upon its international profile also by expanding its work with overseas partners.

2.3 The Trust Strategy

UHB continues to focus on the Trust's 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 key strategic aims over the next five years are detailed in the diagram below.

These aims are intended to help mitigate key risks for the organisation as we all as develop opportunities for the enhancement of its services. Delivery of the strategy is supported by the Trust Annual Plan each year.

2.4 The Trust Business Model and Principal Risks and Uncertainties Facing the Trust

UHB's business model supports the continued delivery of the Trust's vision; 'to deliver the best in care'.

The Trust offers a diverse range of clinical services to patients in the South Birmingham population and beyond. The Trust provides specialised services on a regional basis (Birmingham and the West Midlands) and also on a national basis for certain areas of highly specialist care such as transplant surgery. Around 55% of the Trust's NHS clinical income relates to NHS England specialised services with a further 40% coming from Clinical Commissioning Groups (CCGs). In addition, the Trust provides healthcare services to patients from Wales, local authority commissioned services and is host to the Royal Centre for Defence Medicine (RCDM) which treats British military personnel evacuated from overseas.

The Trust's business model assumes continued growth across specialised service activity, partially resulting from plans to concentrate highly specialised activity in fewer centres of excellence as set out in the recent "Five-Year Forward View" published by NHS England. Plans assume more modest increases in CCG funded activity led by population and demographic trends. This reflects the expected impact of the Better Care Fund (BCF).

In recent years, the key financial elements of the Trust's business model have been based on:

- Delivering modest annual surpluses to enable ongoing investment in the Trust's asset base (medical equipment, buildings etc.)
- Making continued productivity and efficiency improvements to meet the increasing efficiency requirements embedded within national tariffs and the wider payment system
- Retaining of healthy cash balances to ensure prompt payment to suppliers
- Maintaining a Continuity of Services Risk Rating of 2* with Monitor, the system regulator

The environment in which the Trust operates is becoming increasingly challenging due to the ongoing financial pressures, the need to achieve performance targets in light of increasing levels of demand, and the enhanced scrutiny on the quality of care across the NHS. The key challenges are listed in more detail on page 4.

This model has enabled the Trust to increase activity in response to growing demand, meet quality standards and access targets, employ more staff and invest in new equipment and technology year-on-year. However, the Trust cannot operate in isolation from changes in the wider healthcare environment including the impact of the Francis, Berwick and Keogh reports and changes required by NHS regulators and commissioners. The environment has become increasingly challenging for providers, both in terms of financial and operational performance over the last 12-18 months. This is evidenced by the widespread financial deficits reported across acute providers and the increased number of Foundation Trusts with red or "under review" governance risk ratings driven by an on-going failure of the sector to achieve key targets, such as the A&E 4 hour waiting time, in the face of rising demand.

For 2015/16 NHS England and Monitor require providers to deliver a further 3.8% efficiency saving against the national prices paid for NHS activity. This is compounded by other changes to the payment system, enhanced contract penalties, cost pressures resulting from quality investments and reductions to education funding. The overall impact is particularly significant for main teaching hospitals and therefore, subject to finalisation of commissioner contracts, the Trust is likely to operate a planned deficit in 2015/16. This will result in a worsening of the Trust's Continuity of Services Risk Rating potentially leading to further investigation and action from the Monitor.

In addition to the delivery of efficiency savings, the main operational and financial pressures include the cost of managing unplanned peaks in demand and the impact of delayed transfers of care due to budget cuts in social care. Other external risks include the impact of further integration across the sector including mergers and acquisitions, the potential development of hospital chains and franchise models and requirements to implement more 7 day working. Clearly the longer term outlook for the Trust and the wider NHS will be shaped following the election and the resultant impact on service priorities and funding levels.

Specifically for 2015/16, the Trust is planning for the opening of the Institute of Translational Medicine (ITM) facility which will be shared with the University of Birmingham and for the provision of sexual health services across Birmingham and Solihull under the Umbrella project, due to start in 2015.

There is also a challenge around the ability to recruit sufficient numbers of sufficiently skilled, trained and competent staff due to an insufficient supply in certain staff groups. These staff groups include the medical workforce, critical care and theatre nursing staff, age profile of the scientist workforce and middle/senior management staff.

The above areas of risk are managed through the Trust's Board Assurance Framework and delivery of the Strategy and Annual Plan.

2.5 Performance Against Key Healthcare Targets

As a consequence of the increased pressure experienced during the year, the Trust faced a more challenging 12 months with regard to achievement of targets and indicators included in Monitor's Risk Assessment Framework.

The Trust was below its full year trajectory of 67 Clostridium Difficile Infection (CDI) cases in 2014/15 with a total of 66 cases, having not achieved this target in 2013/14. When only cases that have been determined, in partnership with Commissioners, to be avoidable are included the Trust is significantly below its trajectory.

The Trust has continued to see increased levels of activity in 2014/15 which has affected delivery of all activity-related targets including Referral to Treatment Time, Cancer and total time in A&E. Overall growth in activity is shown in the table below whilst total cancer pathway activity in 2014/15 to date is 7.3% higher than in 2013/14.

The Trust also participated in the national 'planned failure' of the Referral to Treatment Time target for admitted patients. This saw additional inpatient activity undertaken, including in the private sector to reduce the number of patients in the RTT backlog. This was extremely successful and has seen the Trust's backlog reduced to a quarter of its peak by April 2015. This will now allow sustainable ongoing delivery of this target at the expense of a number of months when the target was not delivered during 2014/15. In addition the Trust continues to receive a significant number of late tertiary referrals, including a number after day 62, which affects 62 day GP performance. 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.

During the year the Trust saw a further increase in both outpatient and inpatient activity linked to an increase in GP referrals with new outpatient appointments referred by GPs seeing a 4.4% increase. The Trust continues to see increased numbers of attendances at its Emergency Department which have increased by 14.0% since 2011/12. Although the Trust did not achieve the target of 95% of patients having a maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge over the full year it continued to significantly outperform all other local trusts, the majority of its peers nationally and national average performance. This is despite the Trust only having a Type 1 (major) A&E department where many other trusts see their performance bolstered by Type 3 (minor injury unit or walk in centre) performance.

Activity Type	2013/14	2014/15	Change
Inpatient Finished Consultant Episodes	132,509	139,094†	5.0%
Outpatient attendances	729,695*	752,971	3.2%
A&E Attendances	97,299	102,052	4.9%
Total treatments	**959,503**	**994,117**	**3.6%**

* 2013/14 outpatient attendances have been rebased due to a change in the recording of renal dialysis attenders.
† 2014/15 inpatient FCEs currently based on months 1-11 extrapolated to full year.

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

National targets and regulatory requirements	2014/15 Performance	2014/15 Target	2013/14 Performance	2013/14 Target
Clostridium difficile (post-48 hour cases)	66 (17 cases judged avoidable)	67	80 (16 cases judged avoidable)	56
62-day wait for first treatment from urgent GP referral: all cancers	73.8%	85%	79.5%	85%
62-day wait for first treatment from consultant screening service referral: all cancers	89.3%	90%	95.3%	90%
31-day wait from diagnosis to first treatment: all cancers	91.9%	96%	95.9%	96%
31-day wait for second or subsequent treatment: surgery	82.9%	94%	96.2%	94%
31-day wait for second or subsequent treatment: anti-cancer drug treatments	98.5%	98%	99.3%	98%
31-day wait for second or subsequent treatment: radiotherapy	98.0%	94%	95.1%	94%
Two week wait from referral to date first seen: all cancers	95.1%	93%	97.1%	93%
Two week wait from referral to date first seen: breast symptoms	99.9%	93%	97.1%	93%
18-week maximum wait from point of referral to treatment (admitted patients)	88.9%	90% *	91.4%	90%
18-week maximum wait from point of referral to treatment (non-admitted patients)	96.1%	95%	98.1%	95%
18-week maximum wait from point of referral to treatment (incomplete pathways)	93.6%	92%	95.7%	92%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	94.8%	95%	94.95%	95%
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	Certification made	N/A	Certification made	N/A

* The target for an 18-week maximum wait from point of referral to treatment for admitted patients was subject to a national 'managed fail' sanctioned by Monitor NHS England for 8 months of 2014/15.

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

The Trust continues to have a robust and effective framework in place to provide assurance around the quality of care it offers and to monitor organisational performance.

The Board of Directors and Executive Director-level groups receive monthly performance reports which present performance against national and local targets and priorities. These reports adopt a risk-based approach to reporting to ensure that the consequences of underachievement are highlighted to the Executive Team and Board of Directors as well as the actions that are in place to improve performance. Findings from Care Quality Commission assessments are also reported. The framework provides a good level of assurance and supports effective decision-making. UHB also has a Clinical Quality Monitoring Group and a Care Quality Group in place led by the Executive Medical Director and the Executive Chief Nurse respectively. These groups report to the Board of Directors and provide additional assurance and effective accountability around clinical quality and the patient experience. See the Trust's Quality Account 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.

2.7 Regulatory Action

The Care Quality Commission inspected the Trust's services twice during 2014/15. In November 2014 a follow-up inspection was carried out following the Trust's inspection in July 2013 of specific services in the Trust against two outcomes from the CQC's Essential Standards of Quality and Safety:

- Outcome 4: Care and welfare of people who use services
- Outcome 16: Assessing and monitoring the quality of service provision

The services inspected were found to be compliant with both outcomes and therefore the Trust is currently judged by the CQC to be compliant with all outcomes.

In January 2015 the CQC carried out a full inspection of the Trust's full range of services against the five key questions the CQC now uses:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs
- Are they well-led?

The report of this inspection is expected to be published in May 2015 which will result in a rating for each service against these questions together with an overall rating as to whether the Trust's services are 'Outstanding', 'Good', 'Requires Improvement' or is 'Inadequate'. No immediate significant concerns were raised with the Trust at the time of the inspection.

2.8 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.

Apart from those targets included in Monitor's Risk Assessment Framework that were not achieved, as detailed above, the Trust achieved all targets for the full year 2014/15 with the following exceptions:

- 18-week maximum wait from point of (admitted, non-admitted and incomplete) – performance in all treatment functions
- 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 increase seen in activity. Recovery trajectories for these areas have been submitted to commissioners and all treatment functions apart from General Surgery are expected to be achieved from April 2015.

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. Since October 2014 a new system for monitoring and escalating delayed transfers has been in place which has seen a significant reduction in delays with performance having been below target since December 2014. Full year performance remained above target due to higher performance earlier in the year.

2.9 Breakdown of the number of male and female staff at end of 2014/15

	Female	Male	Total
All staff	6264	2394	8658
Directors*	6	10	16
Senior Managers**	1	2	3
All Other staff	6271	2406	8677

*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.

2.10 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. Staff are able to directly access information which affects them individually, eg. payslips, training records, absence records, via the Trust's staff portal me@QEHB. There is also a section called AskHR which contains frequently-asked HR questions, template letters and links to the Trust's Policies and Procedures. The portal is available 24 hours a day so staff and managers can access it whenever they need to and get advice outside normal office hours.

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.

2.11 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 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).

2.12 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.

2.12.1 Reducing Disadvantage

A key priority for the Trust has been to broaden access to the jobs and training healthcare 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 nearly 1,900 people to gain a job – with 210 trainees gaining employment in 2014/15. A further 35 have been offered jobs and are awaiting Occupational Health and other clearances. Just under a third of those helped into work were young (18 to 24) reflecting the success of the 'Get into Hospitals' programme delivered for The Prince's Trust.

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 2014/15 has been the provision of pre-apprenticeship training for Birmingham Community Healthcare and Sandwell and West Birmingham NHS trusts. The latter is a particularly innovative programme providing intensive training for young homeless people. Three intakes have been funded by Health Education West Midlands with trainees nominated by St. Basil's Charity and apprenticeships provided by Sandwell and West Birmingham NHS Trust (which also offers accommodation). Some 31 homeless clients have been engaged of whom 20 completed training; seven have started an apprenticeship; eight have been offered an apprenticeship and are awaiting clearances to start; and one has taken up a permanent NHS job. Given the level of disadvantage this is a very positive outcome.

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.

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. Most recently, the Hub has started delivery with Pertemps and The Prince's Trust of its first formal Traineeship programme alongside the existing Get Into Hospitals. Trainees will receive two placements from UHB, Birmingham Children's Hospital and the Royal Orthopaedic Hospital – reflecting the variety of job opportunities in healthcare.

The Learning Hub's Inspired programme continues to provide long-term patients with educational and vocational skills and mentoring support whilst being treated. Some 33 patients were provided with information, advice and guidance during 2014/15. 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.

2014/15 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.

The City Council is now preparing a major bid to the European Social Fund to provide training for young unemployed people. UHB is coordinating the healthcare element with the Learning Hub being the healthcare delivery partner.

Funded by Health Education West Midlands, the Learning Hub continues to work successfully with HealthTec at Baverstock Academy to broaden access for young people to the jobs and training healthcare can offer, as well as promoting young people's awareness of their own health and well-being and active citizenship. The Trust's Learning and Development department also work closely with over 30 schools and local colleges to promote the various careers available and Hub/L&D staff regularly attend job fairs, most recently the major Apprenticeship Show at Millennium Point in March 2015.

The Learning Hub continues to provide a focal point for the Trust's relationships with disadvantaged communities and third sector organisations. Links with voluntary organisations supporting the homeless are being developed through the RISE project and the Learning Hub has been instrumental in involving Bromford Housing Group in projects across the Trust eg. with Renal and A&E services. UHB is represented on the steering group of the Birmingham and Solihull Talent Match programme. This major Lottery-funded initiative led by Birmingham Voluntary Services Council aims to provide training and employment support for young people furthest from the labour market.

UHB in partnership with The Trussell Trust and the Hospital's Faith and Community Centre, has just started to operate a food collection point to which members of staff, patients or visitors can donate food items to help those in real need. As a result of this partnership, staff will be able to use this resource by giving vouchers to patients who are in need of support. This may come in the form of a Trussell Trust referral voucher, which can be redeemed at a food bank for a three-day supply of food, or out-of-hours, staff will be able to supply an emergency food box for those in need. The Trussell Trust food banks are about more than food. People who are referred to them are also offered practical and emotional support by sign posting other agencies, whether that is financial advice or counselling services or in some cases help with clothing.

2.12.2 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 £12m, matched by local partners, for the establishment of an Institute of Translational Medicine (ITM) in the former Queen Elizabeth Hospital; and the designation by the City Council of the area centred on the Queen Elizabeth Hospital Birmingham and the University of Birmingham as a Life Sciences Campus – one of six high-growth Economic

Zones across the city. The ITM is due to open in the summer of 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 ITM is operating in a "virtual" capacity and already creating real benefit in care, financial and jobs terms.

The land vacated by the former Selly Oak Hospital has now been sold and offers significant regeneration potential as a key strategic housing site.

2.13 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.

2.13.1 Energy

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

Latest available comparison data is for the 3rd quarter of 2014/15. The Trust saw a 23% 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 18%.

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.

2.13.2 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.

2.13.3 Physical Environment

The designs for the new hospital have been dictated by the large area of natural wildlife habitat surrounding the site. Careful management of this area has protected it during the construction phase of the new hospital and provided sustainability for wildlife. Additionally, the site is the home of a Roman fort and the Trust has put considerable effort into its interpretation.

The configuration of the new building has been developed to maximise light penetration. Extensive use of courtyards together with the clinical plan arrangement, particularly within a deep plan podium, provides a natural light source. It is recognised that both natural ventilation and natural light are important to staff and patient wellbeing.

Most recently, the Trust has identified in excess of 16,000m2 of land that will either be re-designated for food production or habitat enhancement. From wildflowers to growing fruit and bee keeping to woodland walks, the Community Orchard and Gardens project covers a huge variety of areas on the hospital campus that will have a variety of aims but the main focus is on improving the areas for use by the local community, hospital patients, visitors and staff. A formal orchard of fruit trees and more mature trees has been planted. Activities across the project will reach each corner of the hospital site and in total will include improvement and activity on almost four acres of land.

Two other notable projects which continue to have a social and environmental benefit are:

Fruit and Vegetable stall - As part of its sustainability and health and wellbeing strategies the Trust wanted to make available to staff, patients, visitors and the wider community, fresh competitively priced fruit and vegetables to give everyone healthier options both at work and at home. The Trust makes no financial gain from the fruit and veg stall so that prices can remain competitive and the full benefits are passed on to all of its customers.

Farmers' Market – The Farmers' Market was started in November 2012. This is held on the last Wednesday of each month. It has grown from eight stalls to the current 18. Key to the establishment of the market was the desire to provide staff, visitors, patients and local people with access to local produce as well as supporting local businesses. Many of the businesses are regulars at the region's Farmers Markets but others are new to selling their produce. Three stalls are run by social enterprises, two (Frost and Snow and Change Kitchen) assisting homeless people and one (Park Lane Nurseries) people with mental health needs. The social enterprise aspect is important to UHB to continue our support for the local communities which we serve in alternative ways, not just healthcare provision.

2.14 Procurement

The Trust's Procurement strategy has been reviewed this financial year and as a consequence, the emphasis on Sustainability has focused on SME's and other Encouraged Enterprises. One of the key elements of the Strategy is 'Working with our Suppliers' and Sustainability sits comfortably under this heading. We are working with suppliers to delivery excellence for the Trust through continued sustainable practise within the Procurement team.

We have developed a Sustainability Team within the department incorporating staff from Strategic Sourcing, Efficiency and Implementation and the Pharmacy Purchasing Team. 'Raising Awareness' training is being developed to educate its members. Two staff members within the Team have now passed modules within the CIPS Professional qualification on Sustainability.

The Procurement Department, represented the Trust at the Innovation Engine Project SME workshop, delivered to West Midland based SME's in October 2014 focusing on the relationships they can build with contracting authorities including UHB procurement for Trust bespoke contracts and other Procurement partners including NHS Supply Chain and

Crown Commercial Services all of which champion the encouragement of SME's in their Sustainability policies.

Sustainability policies from contractors continue to be requested in all tendering exercises and are being collated within the ProContract tendering database. The Sustainability team recognise the abundance of data collected and are hoping to develop ways of usefully incorporating this information to support Trust contracting decisions.

The NHS Standards of Procurement remain pivotal in our planning and working with SME's is an indicator within the Partnership element. Procurement will continue to work through the levels with a vision to be a Procurement Centre for Excellence

2.15 Mixed recycling

As part of the wider Sustainability and Carbon Reduction Action Plan the introduction of mixed recycling has significantly reduced 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 the introduction of mixed recycling across the Trust the percentage of tonnage recycled rose from 29% in January 2013 to 52% in August 2013 and is now standing at 56%.

2.16 Transport

The Trust employs some 8,600 staff and last year treated nearly 1million patients with an estimated 2m visitors. Consequently, the QEHB site is a major generator of traffic from across the city and beyond. Encouraging sustainable transport modes, especially through a comprehensive Green Travel Plan, is a key part of the Trust's Sustainability Strategy and Action Plan.

All the targets set out in the Travel Plan produced in 2005 were achieved by 2010. In particular, a key target was a 10% modal shift from single occupancy car journeys to other methods, such as active travel and public transport. This 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.

Over the past year the Trust has completely updated its Green Travel Plan aimed at encouraging a further switch away from car travel by re-invigorating staff to travel sustainability and inform new staff of the travel package offers available to them. The Strategy commits the Trust to developing incentives for staff to minimise car use and increase the use of sustainable transport modes and to continue to work with stakeholders to promote sustainable travel. The Trust is discussing with the City Council, as part of its medium term transportation strategy 'Birmingham Connected', the potential for a Green District Plan (GDC) for Life Sciences centred on the QE campus, reflecting the high concentration of existing and future employment and high number of journeys.

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 three wholly owned subsidiary companies:

- Pharmacy@QEHB Limited, which commenced trading on 4 July 2011, providing an Outpatients Dispensary service in the Queen Elizabeth Hospital Birmingham

- UHB Facilities Ltd, which commenced trading on 16 September 2014, providing estate management services

- Assure Dialysis Services Ltd, which commenced trading on 23 October 2014, providing renal dialysis services to the Trust

The results of the subsidiary companies are consolidated with those of the Trust to produce the group financial statements enclosed.

3.1 Changes in accounting policies by the Trust in 2014/15

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 2015 and appropriate to NHS Foundation Trusts. This is the fifth set of full year results prepared in accordance with IFRS accounting policies.

There have been no significant amendments to accounting standards in 2014/15 affecting the Trust.

3.2 Financial Performance

Despite the challenging economic climate the Trust has again reported strong financial results for 2014/15. Total income has increased by 6.0% to £732.6m 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 £7.7m, prior to accounting adjustments recognising the reversal of previous asset impairments and a profit on the disposal of the Selly Oak land.

The Trust has recognised an impairment reversal of £4.1m in 2014/15, reflecting an increase in the value of the new hospital, based on the latest external valuation report. The Trust has also recognised an impairment loss of -£1.8m against other estate, based on the same report. These both reflect the accounting valuation, which estimates the fair value in operational use, rather than a change in the actual economic value of any building. They are both technical adjustments to the accounts, rather than actual cash transactions by the Trust, and therefore do not represent an actual flow of money.

The Trust has sold the surplus Selly Oak land site to Persimmon Homes Ltd for a gain on disposal of £5.7m, as disclosed in the financial statements. This is made up of the actual sales price of £31.8m (discounted cash flows receivable by the Trust) less an accounting cost of £26.1m (technical accounting only).

However, taking these gains into account the Trust has recorded an overall retained surplus of £15.6m 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 2014/15.

Summary income and expenditure - plan v. outturn

The Trust's consolidated Summarised Income and Expenditure (£M's)		
	Plan 2014/15	Outturn Position 2014/15
Income	688.7	732.6
Expenditure	-643.7	-681.5
EBITDA	**45.0**	**51.1**
Depreciation	-20.2	-21.7
Donated Asset Revenue	0.2	0.7
Interest Receivable	0.5	0.3
Interest Payable	-22.4	-22.5
Corporation Tax	-0.1	-0.2
Surplus before impairments	**3.0**	**7.7**
Gain on sale of Selly Oak land	0.0	5.7
Impairments on Property	0.0	-1.8
Reversal of Impairments on Property	0.0	4.1
Retained Surplus	**3.0**	**15.6**

The largest component of the Trust's income is the provision of NHS healthcare (including Local Authority commissioned services), accounting for £605.6m (82.7%) of the total. Non-NHS clinical income contributes a further £8.9m (1.2%) 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 patient 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 £597.3m, the remaining £8.3m of NHS healthcare income is from NHS Wales, Scotland and Northern Ireland. Revenue from the NHS in England is 81.5% 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 £30.7m (4.2%) of the Trust's income in 2014/15 and funding associated with Research and Development (R&D) activities, which totals £24.3m (3.3%). Education funding comprises the Service Increment for Teaching (SIFT), recognising the cost of training medical undergraduates from the University of Birmingham, the Medical and Dental Education Levy (MADEL), which supports the salary costs of post graduate doctors in training, and the Non-Medical Education and Training (NMET) levy.

R&D income includes grants from the National Institute of Healthcare Research including revenue support for the Wellcome Trust Clinical Research Facility. 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 2014/15 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.

The largest item of expenditure is salaries and wages, accounting for £374.0m, equivalent to 54.9% of total expenditure. Other significant components include £103.3m on drugs (15.1%) and £89.1m on Clinical Supplies and Services (13.0%).

3.4 Capital Expenditure Plan

In 2014/15 the Trust incurred £33.6m of capital expenditure on equipment, new facilities and improvements to existing buildings. This is summarised below:

Category	Capital Invested £ Million
Brought Forward Programmes from 2013/14	0.2
IT Replacement, Modernisation, Infrastructure and additional capacity	1.6
Trust Buildings	
• ITM	12.4
• New Offices	7.9
• New Hospital	0.9
• Other	0.7
UHB Facilities Ltd	
• Rabone Lane site	1.2
Trust Equipment	
• Rolling Replacement	6.4
• New Equipment	2.1
	8.5
TOTAL	**33.6**

The Trust's planned capital expenditure over the next two financial years (2015/16 to 2016/17) totals £30.1m. This plan runs alongside the payments relating to the new hospital.

The 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 2014/15 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 £18.9m 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 £3.9m 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 2014/15 the Trust received grants of £0.8m and donated assets worth £0.7m from the QEHB Charity.

3.8 External Auditor

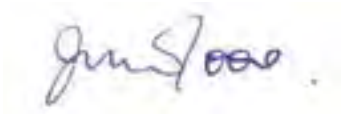
The Trust's external auditor is Deloitte LLP. The audit cost for the year is £126,720 for statutory audit services to the parent Trust, an additional £21,040 for audit services to the three subsidiaries and £48,961 which relates to non-audit work.

The appointment of external audit services from 2013/14 to 2017/18 was made by the Council of Governors, following a competitive tender exercise. In addition Deloitte also provide local counter fraud services to the Trust which is the non-audit work stated.

3.9 Going Concern

Despite the currently expected deficit for 2015/16, the Trust's cash balances are expected to remain sufficient to meet its working capital requirements for at least the next 16 months with headroom remaining under both the base case plan scenario and after applying downside sensitivity modelling.

Therefore 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: 21 May 2015

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.

The Trust has had regard to Monitor's quality governance framework in arriving at its overall evaluation of the organisation's performance, internal control and board assurance framework and any action plans to improve the governance of quality, should it be necessary.

More detail around quality governance can be found on page 39. The Quality Report can be found in Section 3.

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.

Sickness absence data is reported in the Public Interest Disclosures on page 62.

4.5 Names of persons who were Directors of the Trust

During the reporting period, the Board was comprised as follows:

Chair: Rt Hon Jacqui Smith

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: Philip Norman
Executive Chief Operating Officer:
Andrew McKirgan (up to 31 August 2014)
Executive Director of Strategic Operations:
Kevin Bolger
Executive Chief Operating Officer:
Cherry West (from September 1 2014)

Non-Executive Directors:

Gurjeet Bains (left the Trust on November 30 2014)
David Hamlett
Angela Maxwell
David Waller
Professor Michael Sheppard

Jane Garvey
Harry Reilly
Catriona McMahon (from June 1 2014)
Jason Wouhra (from December 1 2014)

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. A ward-level dashboard is also in place allowing staff to see their own patient experience results for local surveys and the friends and family test and then act on any issues.

Staff who have completed the Trust's Patient Experience Champions programme training have developed innovative ways of collecting, displaying and acting on patient experience feedback in their areas. This has resulted in a number of improvements which have been shared and duplicated across other areas.

The patient experience team have supported staff in clinical areas and departments to ensure they are taking every opportunity to collect feedback from patients and carers, using it to inform changes to practice or service improvements. Focus has also been provided by the team to staff to share and publicise actions taken as a result of feedback to staff, patients and the public.

The Trust held its first Patient Experience Conference entitled 'Listen, Involve, Learn, Improve' in October 2014, with delegates coming from all parts of the country to see examples of good practice from this Trust and other organisations. The conference received excellent evaluation and is planned to be repeated in 2016.

4.6.2 Infection prevention and control

The Trust continues to have a robust Infection Prevention and Control programme in place and whilst significant improvements have been made, challenges have been seen in 2014/15 with the Trust being over the agreed trajectory for MRSA bacteraemia. In relation to clostridium difficile infections (CDI), improvements continue to be seen and the Trust is below the agreed trajectory.

Performance against, and monitoring of, improvements related to healthcare associated infections are monitored monthly at the Infection Prevention and Control Group chaired by the Executive Chief Nurse 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

The Trust has identified a number of areas from local and national surveys where further improvement is required and these have been selected as our patient experience quality priorities. More information about these can be found in the Quality Account section of this report.

Feedback around mealtimes has been consistently evaluated via a variety of different methods and a number of 'touch points' along the patient journey. This has enabled the catering team to be very responsive around making further improvements; in particular they have been able to take an individualised approach, working directly with clinical areas to

look at bespoke solutions for particular groups of patients.

The Trust has embraced the "hello my name is" initiative, a significant amount of work has been carried out in relation to ensuring staff introduce themselves properly to patients, a question relating to this was added to all relevant patient experience surveys so this can be monitored and areas where further improvement is needed are identified.

In addition to the above, in order to further improve communication a 'communicating@ QEHB' toolkit was developed enabling staff to access information and training around this important issue. The impact of the toolkit will be evaluated via the patient experience feedback mechanisms in place.

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. Following a review in 2014/15 this will be reduced to three Councils from 1 April 2015 with the Mystery Patient Council being amalgamated into the other councils.

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. There are currently 54 patient and public representatives on the councils.

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 participated in the 'Back to the Floor' quality and safety visits undertaken by the senior nursing team.

For these purposes all Patient and Carer Council members undergo the volunteer recruitment process and induction enabling them to safely undertake visits.

Members of the Councils presented at the first UHB Patient Experience Conference in October 2014, with members delivering presentations on topics such as 'How engagement of patients and carers by involvement in the Adopt-a-Ward and Back to the Floor visits to wards have made an impact on ward routines', 'Helping young people to feel welcome: the Young Person's Council', and 'Not just on the high street: Mystery Shoppers in hospital'.

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 looks at ways to improve the experience for young people aged 16-25 years in our hospitals, and are involved in visits to wards and departments to ask patients and staff for their views.

Projects that the Young Person's Council have been involved in during 2014/15 include:

- Menu tasting
- Designing a logo for the Young Person's Council
- Piloting a 'buddying scheme' to provide companionship for young people who are inpatients
- Filming a young persons' introduction to access and facilities within the hospital to put on the hospital's website. This film was presented at the Patient Experience Conference in October 2014
- Facilitating at feedback events for young patients
- Surveying patients' wi-fi requirements to

inform the hospital's business case for wi-fi provision

- Planning an art activity for young patients
- Contributed to a workshop at the Trust's Dignity in Care conference 2014
- Young Person's Council members continue to have an opportunity to contribute to research through patient and public involvement

The Young Person's Council were finalists in the Youth Achievement Awards 2014 organised by the Community Foundation.

4.7.3 Mystery Patient Council

Council members have undertaken 14 Mystery Patient visits to test services and facilities in the hospital during 2014/15. The initiative has been very useful in highlighting key areas for improvement. This year the Council concentrated their visits in Reception areas and the Plaza restaurant.

Visits to the Plaza restaurant highlighted a number of improvements which could be made to further enhance the experience of patients and the public. A number of changes were made and a follow up visit demonstrated that all the issues raised had been resolved. The mystery patient scheme has also been extended to include staff who are also patients, enabling them to feedback anonymously on their experiences.

4.7.4 Readership Panel

The group provides a forum for involving patients and the public in reviewing and influencing the way in which information is provided.

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, doesn't contain NHS jargon and is provided in the most appropriate format. This year the group has specifically been involved with:

- Review of Patient Experience information on UHB website
- Development of carers information for UHB website
- Review of patient letter regarding Bicuspid Aortic Valve
- Review of patient letter inviting patients to take part in research in Cardiology
- Leaflet: Patient Experience
- Leaflet: Chemotherapy
- Leaflet: Plaster of Paris/Synthetic Cast

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 at a meeting chaired by the Deputy Director of Partnerships. 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 has also been involved in the development of the 'Orchard Project' to engage with the local community.

4.7.6 Healthwatch Birmingham

The Trust maintains links with Healthwatch Birmingham and members have been invited to take part in events such as patient-led assessments of the care environment (PLACE) during the year.

4.7.7 Patient and Carer Consultations

During the year Patient and Carer Council members were consulted on:

- Diarising the patient's day
- Trust Annual Plan
- Trust Quality Priorities
- Promoting research to patients and the public
- Volunteer Strategy
- Patient Experience Strategy
- Nurse recruitment interview questions

There have been no formal consultations undertaken by the Trust in 2014/15.

4.7.8 Volunteers from the local community

The Trust highly values its 600-plus active volunteers who provide an enhanced experience for our patients and terrific support to our staff. During the year a continued effort has been made to recruit from groups that would not traditionally be linked with hospital volunteering.

The profile of our volunteers as at 31 March 2015 is:

Volunteer demographic profile	2014/ 2015	2013/ 2014
GENDER		
Male	35%	34%
Female	65%	66%
AGE		
18-30 years old	20%	17%
31-50 years old	17%	*
51-65 years old	37%	*
66-74 years old	21%	25%
75+ years old	6%	
ETHNICITY		
White British	69%	*
Black/mixed	8%	25%
Asian/mixed	18%	
Other/undisclosed	4%	*
EMPLOYMENT		
Employed	21%	24%
Unemployed	10%	14%
Students	16%	9%
Retired	46%	43%
Other/undisclosed	7%	10%

* Not reported in 2013/14

A Volunteer Committee, established in 2011 and chaired by a Governor, continues to formally involve volunteers in the development of voluntary services within the Trust and participate in developing the Trust's volunteering strategy. The Committee continues to meet regularly to discuss volunteer recruitment, new volunteer roles, Volunteers' Week and to support volunteers in the hospital.

It's been another busy year for developing volunteering at the Trust and there are a number of projects in progress. A task and finish group has been set up to look at the feasibility of introducing an internal buggy service to complement the service currently offered by the external car park buggy. This follows feedback from patients regarding the distance patients and visitors have to walk once they are inside the QEHB. Recruitment for the Smethwick Renal Dialysis Centre is underway and meetings have also taken place with the Sexual Health Team regarding the transfer of volunteers when UHB formally deliver Sexual Health Services in August 2015. Following pilots of the Young Person's Buddy Scheme and Dining Companions, both of these projects will be re-launched in 2015/16.

Voluntary Services at UHB continue to participate at a national level including requests to provide speakers at various events, being cited as a case study for the National Council for Voluntary Organisations young person volunteer's toolkit for our young person's buddy scheme, and recommendations from the Department of Health as a trust to contact for good practice.

In 2014, the Buggy Service, run by volunteers to transport less mobile patients and visitors from the car park to the main entrance, received two national awards - a highly commended from the National Association of Voluntary Services

Managers (NAVSM) and winners in the Patient Experience Network Awards for the patient environment.

As a thank you to our volunteers we run regular afternoon tea events, where volunteers can come together socially and listen to an interesting speaker. An annual long service awards dinner also helps us to show our volunteers how much we value them.

4.8 Complaints and Compliments

We welcome patients and families to contact us where they have any concerns about our services to help us to learn and continuously improve our services.

The number of complaints received in 2014/15 was 792, which represents an increase of 128 complaints compared to the previous year.

The complaints team liaise closely with key divisional colleagues to ensure that complaints are investigated and responded to in a timely manner to the satisfaction of the complainant.

Senior divisional management 'triaging' of complaints is now embedded into an updated complaints process and is used effectively to secure an early resolution of complaints wherever appropriate, for example issues around appointments can often by resolved quickly via a telephone call.

Where a complaint requires a full investigation, the complaints team make early contact with the complainant, wherever possible, to agree the issues to be investigated, the preferred method of response and a realistic timescale for responding. Regular contact is maintained to ensure the complainant is kept updated with progress, especially when we are unable to meet the initially agreed deadline.

Cases are now subject to a more formal escalation process, when delays are experienced, which has been incorporated into a newly created complaints timeline, which maps out the responsibilities and timescales within the various stages of the complaint lifecycle.

To support staff in this, bespoke complaints investigation and response training has been provided to complaints and divisional staff by an external training company. Following this, a review is being undertaken of the style, tone and content of our responses and associated correspondence.

To further improve our complaints service a survey of complainants was carried out in quarter three to gain an insight into the experience of patients and families going through our complaints process to actively seek their views on what we could do better. The survey results were being analysed at the time of compiling this report but their views will be integral in shaping changes to our processes and a current revision of our Complaints Policy and Procedures.

The Trust takes a number of steps to ensure we learn from complaints. Agreed actions 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. A new process was introduced in 2014/15 to then track completion of actions via Datix (our complaints database).

Details of all actions/learning from individual complaints and Patient Advice and Liaison Service (PALS) concerns are shared via divisional and high level reporting – often alongside learning taken from patient experience, compliments, incidents and claims to highlight trends around specific issues and/or wards/ departments/specialties.

Learning from complaints is being further developed to include sharing across the organisation in conjunction with the Risk and Compliance Unit.

Whilst the Trust makes every effort to resolve complaints to the satisfaction of the complainant, this may not always be possible for a variety of reasons. Complainants are made aware of the option of approaching the Parliamentary and Health Service Ombudsman to assess their complaint independently. Since the publication of the Francis report, the

Ombudsman has significantly increased the number of complaints they investigate. However, the number of this Trust's complaints they investigate and then uphold remains relatively low. In 2014/15 they partly upheld 9 complaints.

During 2014/15 work has been undertaken to raise the profile of the Patient Advice and Liaison Service (PALS) to ensure that patients, relatives and carers are aware of how to raise concerns with us, as well as colleagues being aware how to signpost to the service. Initiatives have included regular 'ward rounds' (visits to wards and departments to talk to staff and patients); a survey of staff around PALS awareness; delivery of training sessions around PALS and providing PALS information on the screens in Outpatients.

In addition to the customer care sessions held specifically in response to trends highlighted from patient complaints/concerns, a number of Trust staff received some form of customer care training during the past year. Including an innovative session created this year where actors, posing as course delegates, took the parts of a staff member and a patient to play out an anonymised but real complaint scenario.

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 2014/15 the Trust formally recorded receipt of 2,328 compliments, compared to the 792 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.

4.9 Research and Development

In July 2015 a new Institute of Translational Medicine (ITM) will open on the Trust campus, connecting patients with clinicians and trials teams embedded in personalised medicine.

The ITM is being delivered by Birmingham Health Partners, a collaboration between the Trust, the University of Birmingham and Birmingham Children's Hospital NHS Foundation Trust.

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

The ITM vision is to accelerate the delivery of personalised healthcare through pioneering science. It will also house the Centre for Rare Diseases where coordinated clinics will cut down the burden of travel for patients and allow clinicians and researchers to work side by side to diagnose, treat and cure rare diseases.

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.

In December 2014 the West Midlands was announced as one of 11 centres that will deliver the 100,000 Genomes Project.

The three-year project, announced by NHS England, will involve the Trust leading 17 other healthcare organisations across the region to transform diagnosis and treatment for patients with cancer and rare diseases.

The initiative involves collecting and decoding 100,000 human genomes – complete sets of

people's genes – that will enable scientists and doctors to understand more about specific conditions.

The West Midlands Genomics Medicine Centre (WM GMC) will deliver up to 18,000 of the total number of genomes, drawing on its unique population demographic.

In October 2014 HRH The Countess of Wessex GCVO officially opened The Healing Foundation Centre for Burns Research based at the Queen Elizabeth Hospital Birmingham.

As well as improving our understanding of how the body responds to burn injury in adults and children, the £6 million Research Centre also carries out translational clinical research to develop new treatments.

The 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 June 2014 the Trust took part in two-day nationwide study to assess the impact of increasing levels of specialist care for emergency weekend admissions.

UHB was one of 126 NHS trusts in England taking part in the High-intensity Specialist Led Acute Care (HiSLAC) project, which involved consultants and specialists completing a short, anonymised survey to contribute to a nationwide "snapshot" of care provided for emergency hospital admissions.

In May 2014 patients arriving at the Queen Elizabeth Hospital Birmingham for elective surgery were invited to take part in an International Surgical Outcomes Study **(ISOS)**.

The aim of the study is to learn more about surgical treatment and outcomes worldwide including the frequency, severity and nature of any complications. The findings could, in turn, act as a catalyst for new research trials to examine anomalies more closely.

4.9.1 Funding

The Trust, in collaboration with the University of Birmingham, has been awarded a £30.6m boost for a five-year research project 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 until December 2018.

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

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 £273,000 in research grants and infrastructure.

Colleagues from the NIHR SRMRC have been awarded just under £10,000 from the West Midlands Neuroscience Teaching and Research Fund to complement other novel research being conducted in the trauma research centre. Dr Jon Hazeldine, Professor Janet Lord, and Professor Tony Belli will use the money to buy new materials that will extend the range of analyses that can be performed using blood and other samples collected for the 'Golden Hour' research study.

4.9.2 Public Engagement

The Trust's successful annual Research Showcase in May 2014 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.

There were more than 40 presentation stands on the day, plus a series of talks with topics ranging from the 'Bionic Ear' and 'Pupillometer' to

'Microbiology' and 'Sexual Health'. Patients and healthy members of the public were able to find out how they can get involved in research which offers cutting-edge treatments or expands our understanding of how the human body works.

On 21 June 2014 the Trust hosted a Rare Disease Patient Information Day for patients living with rare conditions and their family members and carers.

The day featured a mixture of talks and workshops from both expert health care professionals and patient representatives.

Topics included current projects to improve care, psychological support, transition, genetics and inheritance, and there was an opportunity to meet a variety of patient support groups.

In March 2015, the National Institute for Health Research Surgical Reconstruction and Microbiology Research Centre (NIHR SRMRC) held its second event in the Science of Trauma: Outcomes and Prevention (STOP) series. The first event was the 'It's Vital to be Visible' cycle safety campaign held in the QEHB atrium in December 2014, which highlighted the work being done by researchers to treat patients with traumatic brain injuries.

The Trust, in collaboration with its GMC WM partners, has established a Patient and Public Involvement (PPI) Group to bring together regional good practice in PPI for the benefit of those taking part in the 100,000 Genomes project and to create a legacy for the wider NHS.

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 2014/15, 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.

The total number of patients recruited into all studies open during 2014/15 was 11,400 (based on returns from annual reports).

The number of new studies registered with the R&D Governance Office during 2014/15 was 307. Of these, processing was abandoned for 56 studies.

The table below shows the number of clinical research projects registered with the Trust's Research and Development (R&D) Team during 2012/13, 2013/14 and 2014/15. 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	2012/13	2013/14	2014/15
Total number of projects registered with R&D	286	306	307
Out of the total number of projects registered, the number of studies which were abandoned	27	39	56
Trust total patient recruitment	**8,598**	**10,778**	**11,400**

4.10 Stakeholders, Partnerships, Alliances/contractual Arrangements

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

When, and if, funding should be required for any of the initiatives below, it is provided directly from the Trust for the benefit of patients and their carers.

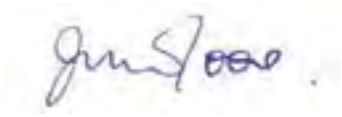
Local health organisations	
Birmingham and Black Country Local Area Team	Regular meetings between CEOs and appropriate directors
	Membership of working groups such as the Urgent Care Review, RAID development etc
Clinical Commissioning Groups	Within South Birmingham, participating and leading work across a range of specialties on redesigned pathways working in partnership with primary care and community trust as appropriate
	Introduction in September 14 of the Local CCGs/UHB System Resilience Group (SRG). Trust leads are the Director of Partnerships, the Head of Contracting and the Associate Medical Director with responsibility for community and primary care
	Introduction in October 14 of the SRG Clinical Sub Group with a membership including 2 of the Trust's Associate Medical Directors and GP leads from the CCGs
	Member of the Birmingham wide System Resilience Group incorporating local CCGs (including Solihull CCG) Heart of England Foundation Trust (HoEFT), Birmingham Community Healthcare Trust (BCHC), Birmingham & Solihull Mental Health Foundation Trust (B&SMHT) Birmingham City Council (BCC) and West Midlands Ambulance Service (WMAS)
	Member of the Unit of Planning Forum, chaired by Birmingham Cross City CCG. Includes membership from CCGs from Birmingham, Sandwell and Solihull and the respective Trusts. Trust lead is the Director of Partnerships
	Member of the Better Care Fund Board. Trust lead is the Director of Partnerships
	Established forums for the contracting / contract monitoring process incorporating representatives from local CCGs and specialised commissioning representatives
	The Trust's Associate Medical Director with lead responsibility for the community and primary care holds regular meetings with CCG lead doctors
	Established Medicines Management Group across primary and secondary care
	Meetings between Trust Executive Team and CCG teams/Boards
	Regular meetings between the CEO and the Accountable Officers of Birmingham Cross City and Birmingham South Central CCGs
	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
NHS England Prescribed Services Specialised Commissioning	Director of Partnerships and Head of Contracting hold regular meetings with the head of the SCA
	Member of major trauma network

Local health organisations	
Heart of England NHS Foundation Trust	Ongoing discussions with regard to operational issues
	Member of Birmingham wide SRG, Unit of Planning Forum and the Better Care Board
Sandwell and West Birmingham NHS Trust	Ongoing discussions with regard to operational issues
	Member of Birmingham wide SRG, Unit of Planning Forum and the Better Care Board
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
	Ongoing discussions with regard to operational issues
	Member of Unit of Planning Forum
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 Birmingham wide SRG
	Trust Deputy Director of Partnerships is an Ambulance Trust Governor
Birmingham & Solihull Mental Health Foundation NHS Trust	Ongoing discussions with regard to operational issues
	Member of Birmingham wide SRG, Unit of Planning Forum and the Better Care Board
Birmingham Community Healthcare NHS 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
	Fortnightly meetings to discuss capacity issues and shared service models
	Member of Birmingham wide SRG, Unit of Planning Forum and the Better Care Board
	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 COO and the Director of Delivery
Care Quality Commission	Routine contact with relationship manager
	Regular contact with Regional Director to discuss any particular issues of risk/concern
	Extensive dialogue/meetings in relation to the Trust CQC Inspection in January 2015
Department of Health	Ongoing discussions between key personnel at both organisations
Non NHS contractual partners	
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
	Partner in the development and provision of the Institute of Translational Medicine (ITM)
	Partner in the development and provision of Genomics
	Partner in a variety of Research Programmes
University of Warwick	The recruitment of 3 joint clinical appointments
	The development of a Joint MSC in NHS Operational Management. To open in October
Business Innovation & Skills (BIS)	Partner in the development of the ITM
European Union (EU)	Members of EIT Healthy Ageing consortium awarded EU funding
	Secured FP7 bid funding for rare diseases
	Working various bids in development with partners
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)
	Partners in the Surgical Reconstruction and Microbiology Centre

Non NHS contractual Partners	
Greater Birmingham and Solihull Local Enterprise Partnership (LEP)n	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
	UHB has a seat on Life sciences Commission
Birmingham Science City	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 (BCC)	Member of Birmingham Better Care Board
	Member of the Birmingham wide SRG
	Member of the CCG led Unit of Planning Group
	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 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
	Collaborating with BCC on the Battery Park development
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.
FMC Renal Services Limited	Fresenius provides UHB's community dialysis service across nine sites
Diaverum Dialysis Services	Diaverum provides UHB's community dialysis service across four sites

Non NHS contractual Partners	
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 - 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: 21 May 2015

Governance

5.1 NHS Foundation Trust Code of Governance

The NHS Foundation Trust Code of Governance (the Code) was first published by Monitor, the sector regulator for health services in England, in 2006 and was most recently updated in July 2014.

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 2014/15. 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 Chair, 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 44 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 Chair 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 Chair and Non-Executive Directors.

The Chair 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 40 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. During the year, an additional Non-Executive Director, Catriona McMahon was appointed to the Board. Following the expiry of the term of office of one of the Trust's existing Non-Executive Directors, Gurjeet Bains, a new Non-Executive Director, Jason Wouhra, was appointed. Both new Non-Executive Directors 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.

The Executive Appointments and Remuneration Committee of the Board appointed Cherry West as the new Executive Chief Operating Officer, taking over from Andrew McKirgan. 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 43, of the Annual Report and in the Remuneration 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 Chair) 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 External Auditor with effect from 1 January 2014. In July 2014, the Council of Governors re-confirmed their appointment for the audit of the accounts for the financial year ending on 31 March 2015.

The Trust's internal audit function is provided through a contract with an independent provider of internal audit services. KPMG LLP have been appointed as internal auditors for 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 50.

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 31 of the Annual Report and in Membership, page 56.

5.1.2 Compliance with the Code

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

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 15 Directors, excluding the Chair. Only seven of the eight 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.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 two new Non-Executive Directors. For these appointments, the Committee was chaired by the Chair of the Trust.

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. In 2013, Professor Michael Sheppard was re-appointed for a further three years, subject to annual re-appointment, taking his tenure of service up to eight 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 Chair 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.

D.2.3 *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.*

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. Non-Executive directors have not received any increase in remuneration in 2014/15.

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.

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

6.1 Overview

The Trust's Council of Governors continue to make a significant contribution to the success of the Trust and their commitment, support and energy is greatly valued.

The Council 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

Christine Beal resigned as a Public Governor (Edgbaston) on 1 April 2014 and was replaced by Anthony Ingold on the same date. Richard Crookes, Stakeholder Governor, resigned on 12 November 2014. A replacement is yet to be nominated. Elections for 2 Patient and 5 Public Governors were held in June 2014. Governors elected at these elections were appointed for terms commencing on 1 July 2014 and ending on 30 June 2017.

During this year, the Governors have been:

6.2.1 Patient

Shirley Turner
Ian Fairbairn (re-elected)
Aprella Fitch (re-elected)

6.2.2 Public (by Area and Parliamentary Constituency)

Birmingham Area	
Northfield	Edith Davies (re-elected)
	Sandra Haynes, MBE
Selly Oak	Valerie Reynolds
	Dr John Delamere (re-elected)
Hall Green	David Spilsbury
	Tony Mullins MBE (up to 30 June 2014)
	Elizabeth Hensel (from 1 July 2014)
Edgbaston	Prof. Ian Trayer (up to 30 June 2014)
	Anthony Ingold (from 1 April 2014)
	Bridget Mitchell (from 1 July 2014)

Birmingham Area	
Ladywood, Yardley, Perry Barr, Sutton Coldfield, Erdington & Hodge Hill	Graham Bunch (up to 30 June 2014)
	Sunil Handa (from 1 July 2014)
Rest of England Area	
Rest of England Area	John Cadle

6.2.3 Staff

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

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 (up to 12 November 2014)

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 six meetings in total. The Chair (the Rt Hon Jacqui Smith) attended all meetings.

Name of Governor	No. of meetings attended*
Graham Bunch	1 out of 1
Dr John Cadle	3
Edith Davies	5
Dr John Delamere	4
Ian Fairbairn	5
Aprella Fitch	All
Sunil Handa	5 out of 5
Sandra Haynes MBE	5
Elizabeth Hensel	5 out of 5
Anthony Ingold	4
Bridget Mitchell	5 out of 5
Tony Mullins MBE	0 out of 1
Valerie Reynolds	5
David Spilsbury	5
Prof Ian Trayer	1 out of 1
Shirley Turner	All
Stakeholder Governors	
Susan Barnett	2
Richard Crookes	0 out of 4
Prof Joanne Duberley	2
Air Marshal Paul Evans	2
Rabbi Margaret Jacobi	4
Staff Governors	
Helen England	1
Dr Tom Gallacher	3
Margaret Garbett	1
Patrick Moore	All
Susan Price	2**

*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, 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 e.g., Strategic Planning Group, Care Quality Group
- During the Reporting Period, two meetings, on 22 September 2014 and 11 March 2015, have been held between the Non-Executive Directors and Governors to facilitate the Governors in holding the Non-Executive Directors, individually and collectively, to account for the performance of the Board

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

7.1 Overview

During the reporting period, the Board of Directors comprised the Chair, seven Executive and seven Non-Executive Directors up to June 2014, when Catriona McMahon was appointed, bringing the number of Non-Executive Directors to eight. Gurjeet Bains, Non-Executive Director, retired at the end of her term of office and was replaced by Jason Wouhra.

Cherry West joined the Board as Executive Chief Operating Officer, taking over from Andrew McKirgan, who became Director of Partnerships.

Throughout the reporting period, Professor Michael Sheppard held the appointment of Deputy Chair. Gurjeet Bains held the appointment of Senior Independent Director until 30 November 2014, whereupon Catriona McMahon took over. 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: Rt Hon Jacqui Smith

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: Philip Norman
Executive Chief Operating Officer (interim): Andrew McKirgan (up to 31 August 2014)
Executive Chief Operating Officer: Cherry West (from 1 September 2014)
Executive Director of Strategic Operations: Kevin Bolger

Non-Executive Directors:

Gurjeet Bains (until 30 November 2014)
David Hamlett
Angela Maxwell
David Waller
Professor Michael Sheppard
Jane Garvey
Harry Reilly
Catriona McMahon (from 1 June 2014)
Jason Wouhra (from 1 December 2014)

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
Rt Hon Jacqui Smith	1 December 2013	3 years	30 November 2016
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 2014	3 years	30 September 2017
David Waller	1 October 2014	3 years	30 September 2017
Jane Garvey	1 December 2013	3 years	30 November 2016
Harry Reilly	1 December 2013	3 years	30 November 2016
Catriona McMahon	1 June 2014	3 years	31 May 2017
Jason Wouhra	1 December 2014	3 years	30 November 2017

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

Jason Wouhra is the Regional Chairman of Institute of Directors West Midlands and Angela Maxwell is a Member of the Regional Committee of the IoD.

7.2 Board meetings

The Board met regularly throughout the year, holding 9 meetings in total.

Directors	No. of meetings attended
Rt Hon Jacqui Smith	All
Dame Julie Moore	All
Mike Sexton	8
Tim Jones	8
Prof Michael Sheppard	All
Dr David Rosser	8
Philip Norman	8
Gurjeet Bains	5 out of 6*
Angela Maxwell	7
Kevin Bolger	All
David Hamlett	8
David Waller	7
Andrew McKirgan	All*
Jane Garvey	All
Harry Reilly	8
Cherry West	All*
Catriona McMahon	All*
Jason Wouhra	1 out of 3*

*While a member of the Board of Directors.

7.3 The Board of Directors composition

Rt Hon Jacqui Smith, Chair

Jacqui read Philosophy, Politics and Economics (PPE) at Hertford College, Oxford, gained a PGCE from Worcester College of Higher Education and became Britain's first women Home Secretary in 2007. 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 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, comprising the 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 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 and External Affairs to lead regional and national work supporting Trusts in special measures and further develop the Trust's international developments.

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 before being appointed to the role of Chief Operating Officer in June 2006. In September 2008 he was appointed to the newly-created role of Executive Director of Delivery which incorporates board level responsibility for Strategy, Research, Education and Workforce.

Tim is also an executive Director of Birmingham Health Partners, joint Theme Director for the West Midlands Academic Healthcare Science Network (AHSN) Digital Health programme, a member of Birmingham Smart City Commission, a board member of Birmingham Science City, Greater Birmingham & Solihull LEP Life science Employment and Skills Champion and the Industry Governor for Harborne Academy.

Philip Norman, Executive Chief Nurse

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.

Cherry West, Executive Chief Operating Officer

Cherry joined the Trust in August 2014, and is the lead for delivery of patient services and operational performance through the Trust's Clinical Divisions.

She trained in medical physics and started her NHS career as a Clinical Physiologist in London. Cherry also spent some time in clinical research, and health services research and evaluation before moving into general management in the late 1990s undertaking a range of operational roles.

Cherry has had a successful record in managing complex health services and has spent the majority of her career in large acute trusts leading operational delivery and numerous transformation and service redesign programmes. Immediately prior to her appointment at UHB, Cherry held the position of Chief Operating Officer at Portsmouth Hospitals NHS Trust. Before that, she held two divisional roles and was Executive Board member for eight years at the Norfolk and Norwich University Hospitals NHS Foundation Trust.

Qualifications include: MSc from University College London, MBA from Henley Management College and Diploma Health Planning and Management from Birkbeck College, University of London.

Non-Executive Directors

Professor Michael Sheppard, Deputy Chairman

Professor Sheppard was appointed a Non-Executive Director of the Trust in December 2007. 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 at the University of Birmingham. 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, and Vice Principal of the University of Birmingham. He is currently Chair of the Board of the West Midlands Academic Health Science Network and holds an Honorary Professor title at the University of Birmingham. 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.

Gurjeet Bains (left Trust on 30 November 2014)

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 50 Ambassadors for the 2012 Olympics. She was appointed as a Governor for Birmingham Metropolitan College in 2010. She was the board's Senior Independent Director, the key link between the Board of Directors and the Council of Governors.

Jane Garvey

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 £3.6million 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. She is also Chair of the Birmingham Rep Theatre.

Dr Catriona McMahon

Catriona is a physician with over 16 years' experience in pharmaceutical medicine. She worked for AstraZeneca in the UK as their Medical and Healthcare Affairs Director until December 2014. She has wide experience in Medical Affairs and Clinical Operations, in leading a complex Medical and Healthcare Affairs Directorate and in working as a national level board member in both the UK and Canada.

Catriona is passionate about the NHS, patient access to medicines and excellence in patient care. She was the Chair of the Medical Expert Network, a member of the Innovation Strategy Board and Reputation Strategy Group of the ABPI, and co-chair of the MISG Clinical Research Working Group until December 2014. In addition, she is a former member of the NICE Appeals Panel and NICE Neuroscience Guidelines Review Panel.

As well as her role as a Non-Executive and Senior Independent Director for UHB NHS Foundation Trust, she is owner of and an Executive Coach within her own Coaching business, specialising in supporting the development and delivery of senior leaders in the Healthcare and Life Science Sectors.

Catriona attended Edinburgh Medical School and, prior to joining the Pharmaceutical Industry, Catriona practised Anaesthetics and Critical Care Medicine in the NHS for nine years.

Harry Reilly

Harry who trained as an accountant with Deloitte in the mid-1970s, joined British Leyland Plc in 1982. His career in the automotive sector took him via Leyland Trucks, DAF Holland, Rover Group and BMW.

During that time Harry has taken the opportunity to take on broader management positions and when he moved to the Rover Group and BMW 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, immediately prior to its sale

by BMW. He subsequently joined Brintons as Finance Director and later Managing Director, tasked with turning around and rebuilding the group. 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 and more recently a Chinese/Canadian joint venture. 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 Waller

David is Chairman 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 and a partner in JWZ LLP and JWZ Investments LLP.

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.

Dr Jason Wouhra

After graduating with a BA in Law with Business Studies from Staffordshire University, Jason joined the family business, East End Food plc, in 1998 and manages its central Birmingham depot. His is currently Director and Company Secretary of the organisation, now one of the largest ethnic food businesses in the country with a turnover of around £180m. As Operations Director of the company's cash and carry arm, his remit includes HR, marketing, sales and CRM.

Jason is currently Chairman of the Institute of Directors for the West Midlands and represents the region's business leaders on a number of forums, including at a national level. He is also Chairman of the Library of Birmingham Advisory Board. Jason was previously Vice Chairman of the Black Country Local Enterprise Partnership. He is also an IoD-qualified chartered director.

He is a regional board member for the Prince's Trust in the West Midlands and works with another of the Prince's charities, Prime, which supports the over-50s. He sits on the boards of the universities of Aston, Birmingham and Wolverhampton. He works with Macmillan Cancer Care and Marie Curie and headed a Disasters Emergency Committee appeal that raised over £36k for the Philippines after the 2013 typhoon.

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 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 during 2014/15 were as follows:

Mr David Waller
Ms Gurjeet Bains (until 30 November 2014)
Ms Jane Garvey
Mr Harry Reilly
Dr Jason Wouhra (since 1 December 2014)

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

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, West Midlands Manufacturing Consortium Limited, Winning Moves Limited, Galtons and Associates; Partner – TacFast Systems UK LLP; Chairman – British American Business Council Midlands

Dr Jason Wouhra – Director & Company Secretary - East End Foods plc, Regional Chairman – Institute of Directors, Co-Chair – Advisory Board Library of Birmingham, Board Member – Aston University Development Board, Board Member – Birmingham University Ethnicity and Diversity Alliance; and Commissioner – Child Poverty Commission.

The Committee's principal support officer throughout the year was the Director of Corporate Affairs. The Chief Financial Officer, Chief Operating Officer, Chief Nurse, Deputy Director of Corporate Affairs and Head of Clinical Risk and Compliance, 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 five ordinary meetings took place during 2014/15 and were attended as follows:

Directors	No. of meetings attended
Gurjeet Bains	All*
David Waller	4
Jane Garvey	All
Harry Reilly	All
Jason Wouhra	All*

*While a member of the Audit Committee.

The action plan following the annual self-assessment of 2013/14 was addressed and all recommendations were implemented during the reporting year. The annual self-assessment for 2014/15 is under way and its findings will be reported to the Council of Governors' meeting in July 2015.

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 2014/15, the Audit Committee considered the following significant issues in relation to financial statements, operations and compliance:

- Risks to the financial statements, including:
  - Recognition of NHS revenue
  - Capital programme and valuation
  - Accruals and provisions
- Accounting treatment of real estate developments on and off site, including an annual revaluation of the Queen Elizabeth Hospital Birmingham, which led to a significant reversal of impairment in 2014-15, write-downs on the office buildings acquired in 2014-15 by the Trust and the disposal of the Selly Oak site
- The process for the preparation of the annual Reference Cost submission to ensure that the Trust has robust systems in place and is compliant with DH guidance
- IT Business Continuity and Disaster Recovery Plans – the Committee sought and obtained assurance from the Director of IT regarding the disaster recovery plans for each of the Trust's critical IT systems
- Key Financial Controls - fraud awareness, with particular regard to referral rates and false job adverts on the internet
- The Trust's research compliance framework which contains 151 regulatory requirements
- A review of the Trust's Assurance Framework, processes for validating compliance with CQC Essential (Fundamental) Standards and the process for preparing the Annual Governance Statement (AGS)
- The process for monitoring progress against Cost Improvement Plans and the impact on the Trust of potential weaknesses in the healthcare system, where the Trust is dependent upon various external bodies for assistance that may be struggling for resources, such as social services and community trusts
- Patient Property – the Committee sought assurance that the recommendations made in a previous report would be implemented in an effective and timely way so as to ensure that the Trust maintained a robust system to minimise the loss of patient property
- The Trust's Continuity of Services Risk Rating ("CoSRR") for the next financial year in the context of the proposed tariff and contract changes

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 2014/15, the Trust's External Auditor has been Deloitte LLP.

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 carries out a review of the effectiveness of the External Auditor following the completion of each annual audit, assessing the External Auditor's performance against an agreed framework and seeking the views of officers of the Trust, and reports 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.

Deloitte LLP external audit fee: £126,720.

Deloitte LLP provided the following non-audit services during 2014/15:

Statutory and audit-related work (to the subsidiaries): £21,120.
Counter Fraud Service: £48,961.

8.5 Independence of External Auditors

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

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

Deloitte LLP, the Trust's independent auditors, report 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

9.1 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 Chair 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
Rt Hon Jacqui Smith (Chair)
Dr John Delamere (Governor Vice-Chair)
Prof Ian Trayer (up to 30 June 2014)
Sandra Haynes (from 1 July 2014)
Ian Fairbairn
Dr Tom Gallacher
Richard Crookes (up to 30 June 2014)
Rabbi Margaret Jacobi (from 1 July 2014)

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

Members	No. of meetings attended
Rt Hon Jacqui Smith	All
Dr Tom Gallacher	2
Dr John Delamere	All
Ian Trayer	All*
Ian Fairbairn	All
Richard Crookes	All*
Sandra Haynes	All*
Rabbi Margaret Jacobi	All*

*While a member of the Committee.

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

9.2 Nominations Sub-Committee

During the reporting year the Executive Appointments and Remuneration Committee appointed a Nominations Sub-Committee on one occasion, to deal with the appointment of a new Chief Operating Officer, and consisted of: the Rt Hon Jacqui Smith, Dame Julie Moore and Prof. Michael Sheppard, assisted by Kevin Bolger, Executive Director of Strategic Operations and Julia Bridgewater, Chief Operating Officer at Central Manchester NHS FT – External Assessor.

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 and a further constituency – 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. Public members are drawn from those individuals who are aged 16 or over and:

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

Patient Constituency

Patient members are individuals who are:

- Patients or Carers who are aged 16 or over; and
- 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 31/03/15	%
Public	11,105	46
Patient	4,288	18
Staff	8,818	36
Total Membership	**24,211**	**100**

10.3 Membership Strategy

10.3.1 Membership Development 2014/15

During 2014/15 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 2014/15

In April 2014 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 2014, 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.

10.3.4 Forward Plan/Objectives 2015-16

The successful strategy employed in 2014/15 – ie, 'maintain numbers and replace churn' will be employed again in 2015/16.

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.

The objectives for 2015/16 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 2014/15

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 2014/15 have included:

- Monitor's New Role
- Hospitality Mortality
- Research
- NHS Finances
- Initial Discussion on 2015/16 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 talk given by Dr Tom Gallacher covering the training of Junior Doctors at QEHB

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

The Governors were also invited to attend meetings of the Pan Birmingham, Solihull & Black Country Governors, Chair & Company Secretaries Network. Two meetings have been held to date with varied agendas covering topics such as Governor involvement in Quality and Duty of Candour. Breakout discussion groups and lunch breaks have provided an opportunity for networking.

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
- intranet@QEHB - the intranet is constantly updated and improved
- In the Loop - staff receive weekly email updates on Trust news and developments
- There is a programme of corporate and local induction and orientation for new starters to improve long-term retention of staff
- There are monthly staff meetings with the Chief Executive and Executive Directors which any member of staff can attend. These meetings allow staff to be updated on key projects and/or matters of interest around the Trust. Staff are able to ask any questions that they may have.

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 2014 compared with 2013

2013		2014		Difference
UHB	National Average	UHB	National Average	
60%	46.9%	56%	43%	There was a 4% reduction in response rate however this response rate still falls within the top 20% for acute trusts

The staff survey results are presented in the form of key findings. This year there were 29 key findings in comparison to 28 in 2013.

There are two types of key findings:

- Percentage scores
- Scale summary scores between 1 and 5

Areas of improvement from 2013 survey

There are no areas of improvement from 2013.
Results have remained consistently good.

Areas of deterioration from 2013 survey

	2013	2014	Difference
KF27. Percentage of staff believing the trust provides equal opportunities for career progression or promotion	92%	87%	5% decrease

2014 Top 4 Ranking Scores

	2013		2014		Difference
	UHB	National Average	UHB	National Average	
KF15: % of staff agreeing they would feel secure raising concerns about unsafe clinical practice (higher score better)	N/A	N/A	80%	67%	This is a new key factor so no comparison is available from 2013.
KF20: % of staff feeling pressure in last 3 months to attend work when feeling unwell (lower score better)	24%	27%	19%	26%	5% decrease
KF18: % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months (lower score better)	27%	28%	23%	29%	4% decrease
KF3: Work pressure felt by staff (lower score better)	3.86	3.04	2.91	3.07	0.95 scale point decrease

2014 Bottom 4 Ranking Scores

	2013		2014		Difference
	UHB	National Average	UHB	National Average	
KF13. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	86%	90%	83%	90%	3% decrease
KF10. Percentage of staff receiving health and safety training in last 12 months	74%	76%	73%	77%	1% decrease
KF5. Percentage of staff working extra hours	72%	70%	72%	71%	No change
KF7. Percentage of staff appraised in last 12 months	86%	84%	84%	85%	2% decrease

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

11.4 Future priorities and targets

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

- Increase in Incident reporting, even though we are high-reporting Trust
- Reduction in staff experiencing discrimination
- Communication around what constitutes health and safety training

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.

Regulatory Ratings

12.1 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*
Governance Rating			Green	Green	Green

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 to *C. difficile* achievement 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. 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. difficil*e 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.

12.2 Monitor Risk Ratings in 2014/15

	Annual Plan 2014/15	Q1 2014/15	Q2 2014/15	Q3 2014/15	Q4 2014/15
Continuity of Service Rating	2*	2*	2*	2*	2* (based on self assessment)
Governance Rating	Green	Green	Green	Under Review	Green

In its Operational Plan for 2014/15 the Trust declared a risk to the achievement of the Cancer 62 day GP referral target and the Referral to Treatment Time (RTT) 18 week target for admitted patients due to the significant growth the Trust had seen in referrals which was leading to capacity problems and making delivery of these targets difficult. In addition ongoing risks to the 62 day cancer target, particularly resulting from late tertiary referrals from other providers, were highlighted.

In Quarter 1 2014/15 the Trust achieved all targets with the exception of cancer 62 day GP referral, cancer 31 day first treatment and RTT admitted. The Trust therefore retained its 'Green' governance rating.

In Quarter 2 2014/15 the Trust did not achieve the following targets: cancer 62 day GP referral, cancer 31 day first treatment, cancer 31 day subsequent surgery, cancer 2 week (all cancer), RTT to treatment time for admitted patients, total time in A&E. Monitor requested additional information from the Trust to gain assurance that the Trust was addressing these areas of performance. This information was supplied, including forecasts of when the Trust expected to sustainably achieve the RTT and cancer targets, which provided Monitor with the additional assurance it required and the Trust maintained its 'Green' governance rating.

In Quarter 3 2014/15 the Trust did not achieve the following targets: cancer 62 day GP referral, cancer 62 day referral from screening, cancer 31 day first treatment, cancer 31 day subsequent surgery and RTT admitted. Monitor decided to place the Trust's governance rating 'under review' following multiple breaches of the cancer targets and

requested additional information from the Trust to allow it to determine whether or not to commence a formal investigation into the Trust's governance. This additional information has been supplied. The Trust responded to Monitor with its detailed action plan and trajectories for each target showing that they would all be achieved from Quarter 2 2015/16. Monitor's decision as to whether to commence an investigation is awaited.

In Quarter 4 2014/15, the Trust did not achieve the same targets as Quarter 3 with the addition of cancer 31 day subsequent anti-cancer drug treatments and Total Time in A&E target. Monitor's response to this will be contingent on the outcome of its decision as to whether to conduct a formal investigation in response to the Trust's performance over Quarter 3.

12.3 Explanation of changes in regulatory regimes in 2014/15 and any impact this has had on the trust's ratings

Monitor introduced the Risk Assessment Framework (RAF) as a replacement for the previous Compliance Framework from 1 October. A revised version of the RAF was published in March 2015 but this does not include any material changes to the regime for acute Foundation Trusts.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 introduce a number of regulatory changes from April 2015 including requiring providers to follow new regulations called 'fundamental standards', which are clearer about the care that people should always expect to receive. There are also new requirements relating to the duty of candour, ensuring that directors are 'fit and proper' and on the publication of CQC ratings.

12.4 Details and actions from any formal interventions

There have been no formal interventions.

13. Public Interest Disclosures

13.1 Sickness absence

In 2014/15, the Trust recorded an annual average sickness absence, across all clinical and corporate divisions, of 3.81%; a slight increase from 3.79% in 2013/14. Trust management is working in partnership with Staffside to reduce this to 3.5%.

Staff can access over 20 topic areas for advice on guidance, from bereavement to exercise and weight loss via the staff portal, me@ qehb. 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 and 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 2014 – March 2015) include: 618 Violence and aggression incidents (down from 632 in 2013-14); 290 Inoculation injuries (318 in 2013-14); 120 Slips, trips and falls (129 in 2013-14); 75 Musculoskeletal (81 in 2013-14).

The violence and aggression incidents include 62 intentional assaults as validated to NHS Protect standards, this is a reduction from 72 in year 2013-14 219 verbal assaults. The national average for intentional assaults on staff as ratified by NHS Protect within the Acute sector is 20 assaults per 1000 staff employed, the figure for UHB is 7 assaults per 1000 staff employed, which is below half

the national average. 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 90% currently.

The Health & Safety Team oversaw the implementation of the Trust inoculation prevention strategy in line with UK and European legal requirements which included: the introduction of safer cannulas; introduction of safer devices for collecting blood samples; mandating the use of face protection for clinical tasks identified as higher risk of inoculation injury from splashes; increased monitoring of practice, with Directors Of Operations, Senior Nursing staff and the Health & Safety Team carrying out both planned and unannounced inspections and; the introduction of a Trust Procedure For Preventing Inoculation Injury. The number of reported inoculation incidents throughout the Trust reduced for the first time in five years.

The Health & Safety Team continued to provide training to staff with health and safety responsibilities enabling risk assessments to be completed level and low/ moderate category incidents to be managed locally. Training compliance is currently 94%, the highest compliance level since records began.

The Trust's Manual Handling and Ergonomics service has continued to provide a range of services including training (currently 88% compliance); specialised review and advice for management of some patients, especially bariatric patients; specialised review and advice for staff to manage musculoskeletal problems at work. The Trust is planning on review and upgrade of older hoists with a rolling programme over the next two 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 one Information Governance Serious Untoward Incident involving personal data that required reporting to the Information Commissioner's Office in 2014/15. For further details, please see the Annual Governance Statement.

The table below sets out a summary of other personal data related incidents in 2014/15.

Summary of other personal data related incidents in 2014/15		
Category	**Nature of incident**	**Total**
I	Loss/theft of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	11
II	Loss/theft of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	6
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	49
IV	Unauthorised disclosure	11
V	Other	29

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	119,072	400,089
Total bills paid within target	115,712	392,546
Percentage of bills paid within target	97.18%	98.11%

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%.

University Hospitals Birmingham NHS
NHS Foundation Trust

This annual report covers the period
1 April 2014 to 31 March 2015

Section 2 Remuneration Report 2014/2015

1. Annual Statement on Remuneration

The year ended 31st March 2015 was another challenging year for the Trust, as indeed it has been for many NHS providers. In addition to focussing on delivering high-quality healthcare to patients in the face of increasing demand, both in terms of numbers and complexity, as well as limited resources, the Trust has continued to provide support to challenged NHS Trusts and Foundation Trusts, and develop its commercial and international activities, in order to support the provision of NHS healthcare.

As a Committee, we remain focused on ensuring that the Trust has a strong, effective and motivated Board and Executive Team, whilst recognising that remuneration must reflect the public service ethos and be aligned with that of the staff of the Trust. In particular, we continue to focus on ensuring that the Executive Team has the capacity and capability to deal with the increasingly challenging issues of meeting greater demand for healthcare with limited resources, whilst supporting other NHS trusts and contributing to the health service in general.

Accordingly, 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 Senior Managers[1] 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 but affordable. The Committee considers that this is particularly so at present, when the demand for competent and effective senior leaders in the NHS is high, but the pool of suitable candidates is diminishing.

Remuneration levels of Senior Managers of the Trust 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.

During the reporting year, the Committee reviewed the remuneration policy and the responsibilities and remuneration of the Senior Managers of the Trust (not including the Non-Executive Directors). Whilst the policy itself was considered appropriate, it had become apparent, through the recruitment of, first, an Executive Chief Nurse and, second, a Chief Operating Officer, that the levels of remuneration of Senior Managers were significantly lower than those paid elsewhere, to such an extent that it was affecting the ability of the Trust to recruit to these posts.

Executive team remuneration was comprehensively reviewed in 2005 and benchmarked against comparable trusts by Hay Consulting. At that time, salary levels were set slightly above mid-point for comparable trusts, in order to attract and retain the best people.

Since then, the composition of the Executive Team has changed and small adjustments to

[1] i.e.'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS foundation trust'. The Chief Executive has confirmed that, in addition to the Chair, the Executive and Non-Executive Directors, this covers the Director of Partnerships, the Director of Communications and the Director of Corporate Affairs.

remuneration have been made to ensure new posts were aligned with the 2005 review. Other than that, the Executive Team salaries have only been subject to inflationary pay increases in line with national agreements for NHS staff[2].

Comparative data was obtained from Shelford Group trusts and other local trusts. The Committee approved increases to the remuneration of members of the Executive Team, having had regard to:

- the review of the remuneration of the Executive Team in comparison to similar Trusts
- the ability of the Trust to recruit and retain high-performing Senior Managers
- The benefit the Trust has seen from having had a stable and cohesive team of Senior Managers
- Increased Responsibility - the re-allocation of the responsibilities of the Director of Projects to existing members of the Executive Team. In addition, Executive Team members have been heavily involved in the supporting of other trusts, through buddying and similar arrangements

Each Director has annual objectives which are agreed by the Chief Executive. Reviews on performance are quarterly. The Chair agrees the objectives of the CEO and associated performance measures. The Trust does not use performance-related pay mechanisms.

Non-Executive Directors' fees are reviewed regularly with advice taken from independent consultants where appropriate. There have been no changes to Non-Executive Directors' fees during the reporting period.

Overall, the Committee considers the remuneration policy and its application to be balanced and fair, fulfilling the aims of ensuring that the Trust retains the services of its Senior Managers, all of whom will have received tempting offers from other organisations, and is able to recruit when necessary.

The Rt Hon Jacqui Smith, Chair of the Executive Appointments & Remuneration Committee

Date: May 21 2015

[2]except for the three years ending March 2013, where there were no inflationary increases

2. Senior Managers' Remuneration Policy

The key goal of remuneration policy remains to recruit and retain competent and effective Senior Managers. This requires that the pay and benefits structure is competitive within the sector. The table below provides detail on each element of directors' remuneration packages for 2015/16:

2.1 Future policy table – Senior Managers (other than Non-Executive Directors)

Purpose and link to strategy	Operation (and changes if appropriate)	Maximum that could be paid in respect of that component
Salary Retains and motivates, takes account of complexity and scale of director's duties, and cognisance of market levels in the appropriate sector	Salary levels are set with reference to responsibilities and the need to retain and recruit. With regard to the latter, a comparison against similar roles in an appropriate comparator group is used (the comparator group comprises Shelford Group trusts and local trusts).	Senior Manager £000 Julie Moore 250 Mike Sexton 150 Dave Rosser 186 Tim Jones 150 Kevin Bolger 150 Philip Norman 150 Cherry West 150 Andrew McKirgan 125 Fiona Alexander 125 David Burbridge 125
Pension Provides post-retirement remuneration and ensures that the total package is competitive	Senior managers are eligible to become members of the NHS Pension Scheme. The benefits provided to Senior Managers through the NHS Pension Schemes are the same as for all other Trust employees. Where Senior Managers cease to accrue pensionable service in an NHS Pension Scheme due to reaching the lifetime allowance, they are entitled to a cash supplement equal to 10.5% of base salary. This policy remains unchanged from 2013/14	Dame Julie Moore withdrew from pensionable service on 31.03.2013 and Mike Sexton withdrew on 31.08.2014. No pensionable service in any NHS Pension Scheme has been accrued by these directors since these dates. They will receive a cash supplement of 10.5% of base salary in lieu of pension accrual.

2.2 Future policy table – Senior Managers (Non-Executive Directors)

The table below provides detail on each element of non-executive directors' (including the Chair) remuneration for 2015/16:

Purpose and link to strategy	Operation (and changes if appropriate)	Maximum that could be paid in respect of that component
Non-Executive Director fees Attracts, retains and motivates non-executive directors with the required knowledge, experience and ability	Non-executive directors are paid a fee each year. Some non-executive directors with additional responsibilities may receive an additional fee, although none do at present.	Chair 52,520 Non-Executive Director 13,837 Fees will be reviewed during the year ending 31 March 2016. Any increases will take into account salary increases awarded to the wider workforce.

Notes:
There are no benefits in kind, performance related pay, nor severance payments (2013/14 - £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 (2013/14 - £nil).

The Trust's governors and directors incur non-taxable expenses in association with activities that they undertake that support the objectives of the Trust. Information about expenses is set out below.

No new components of the remuneration package have been introduced.

Changes made to existing components of the remuneration package are set out above.

The Trust's general policy on remuneration is closely aligned to the Agenda for Change, NHS doctors' pay scales and national pay negotiations. The Trust does not operate any performance pay schemes or provide benefits in kind for any of its employees. Inflationary pay increases, if any, for Senior Managers will generally reflect the increases provided to other employees as a result of national negotiations. Thus the only differences between the Trust's policy on Senior Managers' remuneration and its general policy on employees' remuneration is that Senior Managers do not receive any form of automatic incremental increases such as are included within Agenda for Change.

2.3 Service contracts obligations

There are no obligations on the Trust contained or proposed to be contained in any Senior Managers' service contracts which could give rise to, or impact on, remuneration payments or payments for loss of office but which are not disclosed elsewhere in this remuneration report.

2.4 Policy on payment for loss of office

Senior Managers (other than Non-Executive Directors) are on substantive contracts with a notice period of six months. Non-Executive Directors are engaged on fixed term contracts of three years. The Contracts do not stipulate that there is any entitlement to compensation for loss of office.

There were neither termination payments nor compensation for loss of office made to Senior Managers during 2014/15.

2.5 Statement of consideration of employment conditions elsewhere in the foundation trust

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.

The Trust has not consulted with employees when preparing the senior managers' remuneration policy, but, if material changes are to be considered in future, will do so.

When reviewing Executive Team remuneration comparative data was obtained from Shelford Group trusts and other local trusts. These were used to set remuneration levels which would enable the Trust to recruit and retain key staff, whilst not being excessive. (Salary levels remain below average for Shelford Group trusts).

3. Pensions

All the Executive Directors are members of the NHS Pensions Scheme, with the exception of Dame Julie Moore and Mike Sexton. 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 73 and 74.

4. Annual Report on Remuneration

4.1 Service Contracts

Senior Managers (other than Non-Executive Directors) are on substantive contracts with a notice period of six months. There are no Senior Managers on fixed term contracts.

Name of Senior Manager	Date of Service Contract	Unexpired term	Details of Notice Period
Dame Julie Moore	04/03/2002	N/A	Six months
Mike Sexton	26/10/2006	N/A	Six months
Dave Rosser	01/12/2006	N/A	Six months
Tim Jones	13/06/2007	N/A	Six months
Kevin Bolger	15/06/2009	N/A	Six months
Philip Norman	28/10/2013	N/A	Six months
Cherry West	01/09/2014	N/A	Six months
Fiona Alexander	01/02/2006	N/A	Six months
David Burbridge	07/05/2007	N/A	Six months
Andrew McKirgan	01/09/2014	N/A	Six months

4.2 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 Chair, all other Non-Executive Directors and, for appointments of Executive Directors other than the Chief Executive, the Chief Executive. The Chair of the Committee is the Chair of the Trust.

The Executive Appointments and Remuneration Committee met four times in the year. Attendance was as follows:

Directors	No. of meetings attended
Rt Hon Jacqui Smith	All
Dame Julie Moore	All
Gurjeet Bains	1 out of 3*
Prof Michael Sheppard	3
Angela Maxwell	All
David Hamlett	All
David Waller	3
Jane Garvey	All
Harry Reilly	All
Catriona McMahon	All*
Jason Wouhra	All*

*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 and from remuneration comparative data (2013/14) obtained from Shelford Group trusts and other local trusts. 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.

4.3 Council of Governors' Remuneration and Nominations Committee for Non-Executive Directors

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

Details of membership and attendance of the Governors' Remuneration and Nominations Committee for Non-Executive Directors are set out on page 53.

There have been no changes to Non-Executive Directors' fees during the reporting period.

4.4 Disclosures required by Health and Social Care Act

Information on the Trust's policy on pay and on the work of the Executive Appointments and Remuneration Committee are set out above at Sections 2 and 4.2 respectively.

Information on the remuneration of the directors is set out at Sections 2 and 5.

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 2015			
	Number in Office	Number receiving expenses	Total £00
Directors	19	4	146
Governors	23	6	20

Year Ended 31 March 2014			
	Number in Office	Number receiving expenses	Total £00
Directors	19	2	37
Governors	23	5	27

4.5 Reporting high paid off-payroll arrangements

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 – for more than £220 a day and last longer than six months.

No. of existing engagements as of 31 March 2015	2
Of which...	
No. that have existed for less than one year at time of reporting	0
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	1

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 2014 and 31 March 2015	0
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	0
Of which...	
No. for whom assurance has been received	0
No. for whom assurance has not been received	0
No. that have been terminated as a result of assurance not being received	0

No off-payroll engagements are with board members of the Trust.

4.6 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 2014/2015

Name and Title	Year Ended 31 March 2015					
	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	240-245					240-245
Philip Norman Executive Chief Nurse	135-140				242.5-245	380-385
Dr David Rosser Executive Medical Director	95-100				67.5-70	165-170
Tim Jones Executive Director of Delivery	140-145				50-52.5	195-200
Mike Sexton Chief Financial Officer	150-155					150-155
Kevin Bolger Executive Director Strategic Operations	140-145				52.5-55	195-200
Andrew McKirgan, (changed from acting Chief Operating Officer to Strategic partnerships on Sept 1 2014)	120-125				20-22.5	145-150
Cherry West, Chief Operating Officer (commenced office Sept 1 2014)	95-100				130-132.5	225-230
Fiona Alexander Director of Communications	110-115				45-47.5	155-160
Morag Jackson, New Hospitals Project Director (left office October 14 2014)	65-70					65-70
David Burbridge Director of Corporate Affairs	110-115				65-67.5	175-180
Viv Tsesmelis Director of Partnerships (left office October 1 2014)	45-50					45-50
NON EXECUTIVE DIRECTORS						
Rt Hon Jacqui Smith Chair	50-55					50-55
Angela Maxwell	10-15					10-15
David Waller	10-15					10-15
Gurjeet Bains (left office June 30 2014)	5-10					5-10
Professor Michael Sheppard	10-15					10-15
Harry Reilly	10-15					10-15
Jane Garvey	10-15					10-55
David Hamlett	10-15					10-15
Dr Catriona McMahon (commenced office Oct 14 2014)	10-15					10-15
Jason Wouhra (commenced office Dec 1 2014)	0-5					5-10

Salary entitlements of senior managers – 2013/14

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 22/11/13)	80-85					80-85
Philip Norman Executive Chief Nurse (commenced office 22/11/13)	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 to 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 office 01/12/2013)	0-5					0-5
Jane Garvey (commenced office 01/12/2013)	0-5					0-5
David Hamlett	10-15					10-15

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 (2013/14: 100-105).

Cherry West commenced in the role of Chief Operating Officer on 1 September 2014. Andrew McKirgan moved to the role of Director of Strategic Partnerships on the same date, replacing Viv Tsesmelis who retired on 1 October 2014. Morag Jackson left the post of New Hospitals Project Director on 14 October 2014.

One non-executive also left in the reporting year having reached their maximum allowable term of office: Gurjeet Bains. Two new non-executives were appointed: Catriona McMahon and Jason Wouhra.

There are no benefits in kind, performance related pay, nor severance payments (2013/14 - £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 (2013/14 - £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 2015	Year Ended 31 March 2014
Band of Highest Paid Director's Total Remuneration (£ '000)	240-245	235-240
Median Total Remuneration	28,789	27,617
Ratio	8.4	8.5

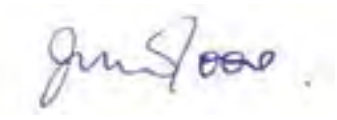
Total remuneration includes salary, performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions, the cash equivalent transfer value of pensions nor any other accrued pension benefits not yet taken.

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 2015	Total accrued pension related lump sum at age 60 at 31 March 2015	Cash Equivalent Transfer Value at 31 March 2014	Cash Equivalent Transfer Value at 31 March 2015	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder pension
	(bands of £2500)	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000	To nearest £100
Tim Jones, Executive Director of Delivery	0-2.5	5-7.5	45-50	130-135	685	764	60	N/A
Philip Norman, Executive Chief Nurse	10-12.5	30-32.5	45-50	145-150	628	844	200	N/A
Kevin Bolger, Executive Director Strategic Operations	0-2.5	5-7.5	55-60	175-180	1,164	1,279	84	N/A
Dr David Rosser, Executive Medical Director	2.5-5	7.5-10	60-65	185-190	1,032	1,144	84	N/A
David Burbridge, Director of Corporate Affairs	2.5-5	7.5-10	20-25	65-70	361	436	66	N/A
Fiona Alexander, Director of Communications	0-2.5	5-7.5	10-15	35-40	167	210	39	N/A
Cherry West, Chief Operating Officer	2.5-5	10-12.5	45-50	135-140	750	905	89	N/A
Andrew McKirgan, Director of Partnerships	0-2.5	2.5-5	35-40	110-115	569	616	31	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.



Dame Julie Moore, Chief Executive
Date: 21 May 2015

University Hospitals Birmingham
NHS Foundation Trust

This annual report covers the period
1 April 2014 to 31 March 2015

Section 3 **Quality Report 2014/2015**

Contents

Part 1: Chief Executive's Statement

University Hospitals Birmingham NHS Foundation Trust (UHB) has continued to focus on delivering high quality care and treatment to patients during 2014/15. In line with national trends, the Trust has seen unprecedented demand for its services with large increases in Emergency Department attendances and admissions which has put significant pressure on our ability to deliver planned treatments. The Trust's Vision is "to deliver the best in care" to our patients. 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. It is very pleasing to see that patients and staff would recommend the Trust as a place to be treated in the 'Friends and Family' tests. Furthermore, the number of formal complaints received remained stable and the number of compliments increased during 2014/15.

The Trust has made excellent progress in relation to two of the five priorities for improvement set out in last year's Quality Report: improving venous thrombo-embolism (VTE) prevention and completeness of observation sets. Performance for the remaining indicators – patient experience, reducing medication errors and infection prevention and control – has been mixed with some key achievements and further work required to improve performance in 2015/16. The Board of Directors has chosen to continue with four of the five priorities for improvement in 2015/16 and replace *Priority 1: Improving VTE Prevention* with a new priority proposed by the Trust's Council of Governors: *Reducing grade 2 hospital-acquired pressure ulcers*.

UHB's focused approach to quality, based on driving out errors and making incremental 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 2014/15 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 medication, Serious Incidents Requiring Investigation (SIRIs), serious complaints, infection incidents, incomplete observations and cross-divisional issues.

The national Sign up to Safety campaign was launched in 2014 and aims to make the NHS the safest healthcare system in the world. The ambition is to halve avoidable harm in the NHS over the next three years. Organisations across the NHS have been invited to join the Sign up to Safety campaign and make five key pledges to improve safety and reduce avoidable harm. University Hospitals Birmingham NHS Foundation Trust joined the Sign up to Safety campaign in November 2014. As part of the campaign, UHB has made five Sign up to Safety pledges which closely align with the content of the Quality Report and are included in section 3.7 of the report. UHB is now working on an action plan and process for monitoring progress over the next three years.

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. 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, Patient and Carer Council (Wards), General Practitioners (GPs) and local Clinical Commissioning Groups (CCGs).

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 has continued to publish monthly data during 2014/15 showing how each inpatient specialty is performing for a range of indicators on the dedicated *mystay@QEHB* website: infection rates, medication given, observations, clinical assessments and patient feedback.

The Trust's internal and external auditors provide an additional level of scrutiny over key parts of the Quality Report. The Trust's external auditor Deloitte has reviewed the content of the Trust's 2014/15 Quality Account and undertaken testing for three areas in line with the Monitor guidance on external assurance: 18 week referral to treatment times (unfinished pathways), 28 day readmissions and two local indicators. The Trust's Council of Governors selected two local pain indicators to be audited this year which will be measured as part of *Priority 3: Timely and complete observations including pain assessment* during 2015/16. No significant issues were identified with the content review or the testing for the 28 day readmission and two local pain indicators. Deloitte has however issued a qualified opinion on the 18 week referral to treatment time (unfinished pathways) indicator and the Trust is currently implementing the recommendations. The report provided by our external auditor is included in Annex 3 of the Quality Report.

The Trust was inspected in January 2015 by the Care Quality Commission (CQC) as part of the new, national inspection regime. The inspection involved around 60 inspectors observing the care and treatment provided across the Trust over 3 days, focusing on core services such as the Emergency Department and Critical Care, with an unannounced follow-up visit afterwards. The CQC focuses on assessing whether services are safe, effective, caring, responsive to people's needs and well led. The inspection included a Public Listening Event and voluntary drop-in sessions for various staff groups to provide feedback to the CQC. Trusts are given one of four overall ratings following inspection as well as separate ratings for each core service: Inadequate, Requires Improvement, Good or Outstanding. The Trust has been rated as Good overall with 85% of areas being rated as Good or Outstanding and 15% rated as Requires Improvement. The CQC found the Trust to be compliant with all Essential Standards and identified a small number of recommendations which will be taken forward during 2015/16.

The Five Year Forward View report was published in October 2014 and sets out the changes and investment required to deliver an improved, more sustainable NHS and implement new models of care. During 2014/15, the Trust successfully bid to become the prime provider for a new fully integrated sexual health treatment and prevention programme called Umbrella from August 2015. The contract will see UHB both providing and commissioning services for the people of Birmingham and Solihull through two central sites, satellite clinics and community clinics over the next five years.

2015/16 will be particularly challenging for UHB as we focus on delivering the best in care and achieving outcome/access targets alongside rising demand for our services and greater financial constraints. The Trust will continue working with commissioners, healthcare providers and other organisations to influence future models of care delivery and deliver further improvements to quality during 2015/16.

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.

Dame Julie Moore, Chief Executive

May 21, 2015

Section 3 | Quality Report

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

2.1 Priorities for Improvement

The Trust's 2013/14 Quality Report set out five priorities for improvement during 2014/15:

Priority 1: Improving VTE (venous thrombo-embolism) prevention
Priority 2: Improve patient experience and satisfaction
Priority 3: Electronic observation chart – completeness of observation sets (to produce an early warning score)
Priority 4: Reducing medication errors (missed doses)
Priority 5: Infection prevention and control

The Trust has made excellent progress in relation to two quality improvement priorities: improving venous thrombo-embolism (VTE) prevention and completeness of observation sets. There has however been mixed performance for patient experience, reducing medication errors and infection prevention and control during 2014/15.

The Trust received more compliments in 2014/15 compared to 2013/14 and the number of formal complaints received compared to activity remained stable. The improvement targets for the local patient survey questions were not achieved in 2014/15 for the majority of questions. The Trust has successfully maintained performance for missed antibiotics but performance for missed non-antibiotics deteriorated in 2014/15. The Trust missed the trajectory for zero Trust-apportioned MRSA bacteraemias but met the *C. difficile* infection trajectory during 2014/15.

The Board of Directors has chosen to continue with four of the five priorities for improvement in 2015/16 and replace priority 1 as follows:

No.	Priorities for Improvement	2014/15	2015/16	Detail
1	Improving VTE Prevention	Yes	No	Discontinued due to consistent high performance.
	Reducing grade 2 pressure ulcers	No	Yes	New priority proposed by Council of Governors to replace VTE.
2	Improve patient experience and satisfaction	Yes	Yes	Care Quality Group chose to keep the same questions due to performance issues and use scores to aid comparability with other trusts.
3	Timely and complete observations including pain assessment (previously called Electronic observation chart)	Yes	Yes	Changed to include pain assessment and timely administration of pain relief (analgesic medication).
4	Reducing medication errors (missed doses)	Yes	Yes	Remains a priority as non-antibiotic missed doses increased in 2014/15 rather than reduced as planned.
5	Infection prevention and control	Yes	Yes	Trajectories refreshed for 2015/16.

The improvement priorities for 2015/16 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 2014/15 as shown in the table below. The priorities for improvement in 2015/16 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 2015/16 were then finally approved by the Board of Directors in March 2015. The priorities for 2015/16 will finally be presented to the Trust Partnership Team and cascaded to all staff via Team Brief in May 2015.

Date	Group	Key Members
February 2015	Council of Governors	Chairman, Chief Executive, Executive Directors, Directors and Staff, Patient and Public Governors
February 2015	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 2015	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 2015	Chief Operating Officer's Group	Executive Chief Operating Officer, Deputy Chief Operating Officer, Directors of Operations, Divisional Directors, Director of Operational Finance, Deputy Chief Nurse, Director of Patient Services, Director of Estates and Facilities, Director of IT Services plus other Managers
March 2015	UHB Contract Review Meeting	Various managers and clinical staff from Birmingham and Cross-City Clinical Commissioning Group and UHB
May 2015	Trust Partnership Team	Executive Directors, Directors, Human Resources Managers, Divisional Directors of Operations, Staff Side Representatives
May 2015	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

The performance for 2014/15 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 2013/14.

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

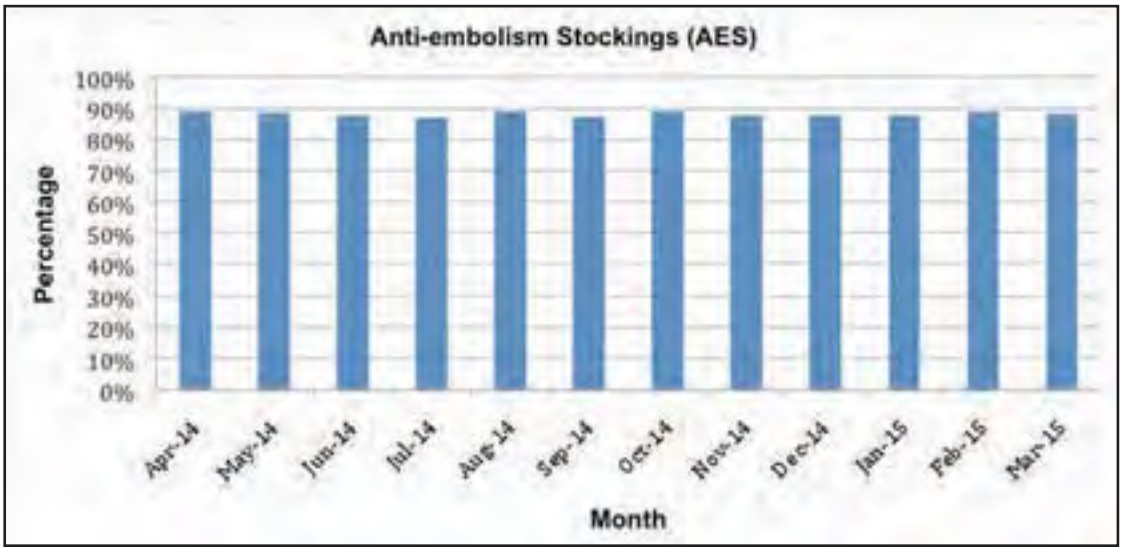
The Trust has achieved a VTE risk assessment completion rate of at least 98% since September 2010 and 99% or over since June 2012. This is above the national average of 96% for NHS acute providers as published on the NHS England website (January 2015).

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.

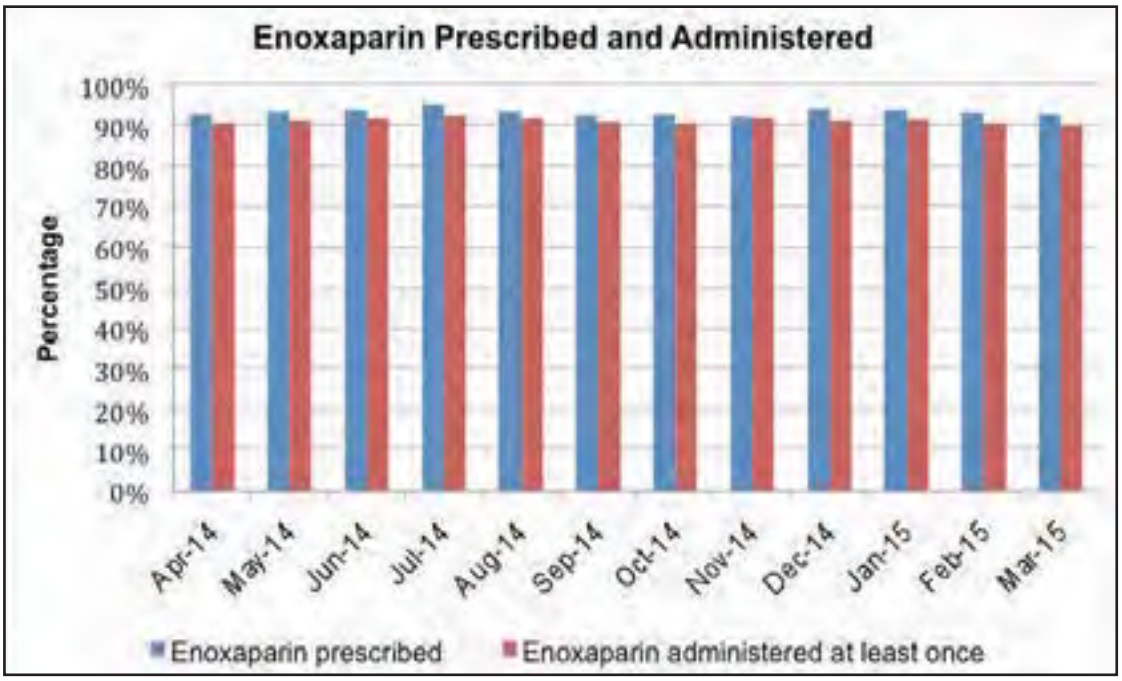
In the 2013/14 Quality Report, the Trust committed to maintaining performance for administration of anti-embolism stockings at 83% or above during 2013/14. Overall, 88.5% of anti-embolism stockings were administered at least once per episode during 2014/15.

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 around 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 2013/14 Quality Report, the Trust committed to maintaining performance for enoxaparin prescription at 90% or above during 2014/15. Overall, 93.5% of patients who required enoxaparin following VTE risk assessment were prescribed it within 12 hours in 2014/15. Of the patients who were prescribed enoxaparin, 91.3% were given it at least once. As with other forms of medication, there can be valid reasons why enoxaparin is not administered such as immediately prior to and after surgery to reduce the risk of bleeding.



Initiatives implemented during 2014/15:

- Regular Junior Doctor review clinics continued during 2014/15 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

- The change made to the VTE risk assessment module in the Trust's Prescribing Information and Communication System (PICS) in January 2014 has been monitored to ensure the increase in performance was sustained. 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

Changes to Improvement Priority for 2015/16:

As performance has remained consistently high, the Trust has decided to discontinue this priority for improvement in 2015/16. Performance will continue to be monitored internally via the Clinical Dashboard, Thrombosis Group and regular Junior Doctor review clinics which focus on compliance with VTE risk assessment outcomes.

New Priority 1: Reducing grade 2 hospital-acquired pressure ulcers

This quality improvement priority was proposed by the Council of Governors and approved by the Board of Directors.

Background

Pressure ulcers are caused when an area of skin and the tissues below are damaged as a result of being placed under pressure sufficient to impair its blood supply (NICE, 2014). They are also known as "bedsores" or "pressure sores" and they tend to affect people with health conditions that make it difficult to move, especially those confined to lying in a bed or sitting for prolonged periods of time.

Pressure ulcers are painful, may lead to chronic wound development and can have a significant impact on a patient's recovery from ill health and their quality of life. They are graded from 1 to 4 depending on their severity, with grade 4 being the most severe:

Grade	Description
1	Skin is intact but appears discoloured. The area may be painful, firm, soft, warmer or cooler than adjacent tissue.
2	Partial loss of the dermis (deeper skin layer) resulting in a shallow ulcer with a pink wound bed, though it may also resemble a blister.
3	Skin loss occurs throughout the entire thickness of the skin, although the underlying muscle and bone are not exposed or damaged. The ulcer appears as a cavity-like wound; the depth can vary depending on where it is located on the body.
4	The skin is severely damaged, and the underlying muscles, tendon or bone may also be visible and damaged. People with grade 4 pressure ulcers have a high risk of developing a life-threatening infection.

(National Pressure Ulcer Advisory Panel, 2014)

UHB has seen a significant decrease in the number of hospital-acquired pressure ulcers during 2014/15, especially grade 3 and grade 4 ulcers. This is as a result of a number of initiatives:

- In April 2013, the Tissue Viability Service (TVS) was granted funding for additional specialist nurses which enables the Service to review every pressure ulcer that is reported as a grade 2, 3 or 4. This has allowed them to build up a clear idea of the true incidence of pressure ulcers, to assess educational requirements and tailor training to specific wards. It also means that the team can run a six-day service (a model of care not provided by any other regional providers)

- The Pressure Ulcer Action Group is a trust-wide group with a multi-disciplinary membership. The group hold monthly meetings chaired by the Deputy Chief Nurse, providing a forum to identify and address any key quality issues. Divisions complete action plans and present progress updates. There has been significant support from senior management which has ensured that ward staff are increasingly aware of how to prevent, identify, assess and manage pressure ulcers. The TVS provides a formal education programme on pressure ulcer prevention and treatment. Each clinical area has several Tissue Viability link nurses, and a member of the TVS is linked to each Division. All nursing staff are required to undergo mandatory pressure ulcer grading training

- UHB devised the "React to RED" preventative strategy: when a staff member identifies a potential pressure ulcer, they think "RED": Reposition, Equipment, Documentation

- The Waterlow assessment tool (an assessment of a patient's risk of developing a pressure ulcer) is recorded electronically in PICS, which means wards' use of this

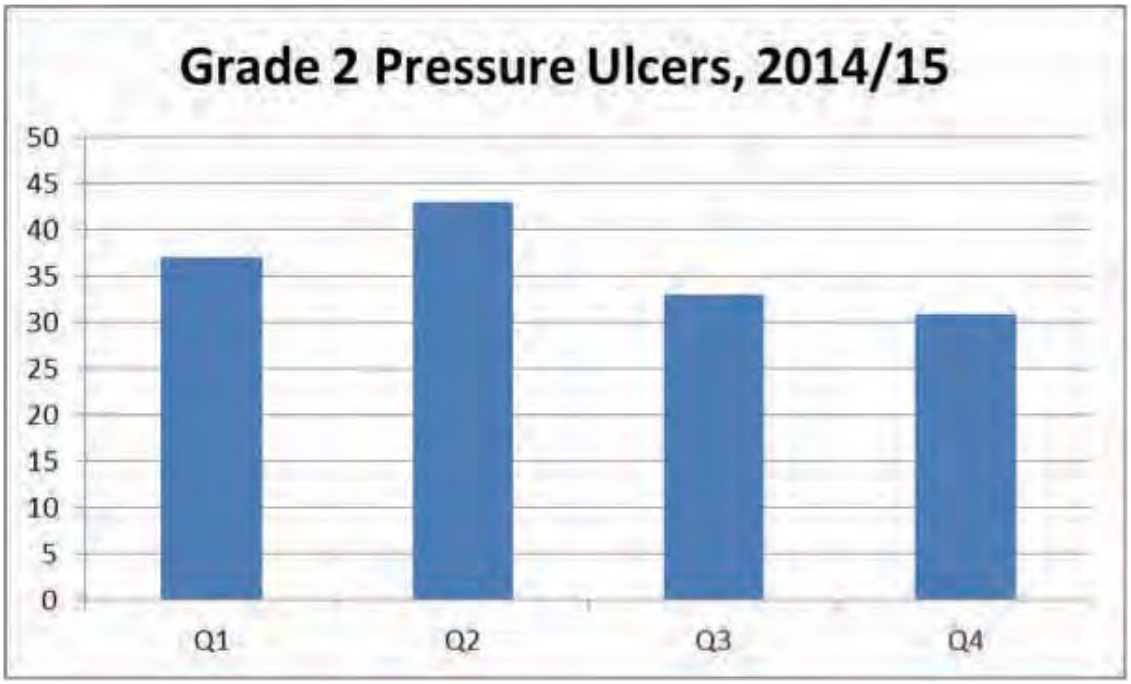
assessment tool can be easily monitored and reported. Repositioning is also recorded electronically

- The TVS are responsible for purchasing decisions for pressure relieving equipment, meaning choices are evidence-based, using the latest available research

As there are now fewer hospital-acquired grade 3 and grade 4 ulcers at UHB, the Trust has chosen to focus on reducing grade 2 ulcers. This in turn should reduce the number of grade 3 and grade 4 ulcers, as grade 2 ulcers will be less likely to progress.

Performance

For the period April 2014 to March 2015, there were 144 non device-related grade 2 pressure ulcers reported at UHB, against a trajectory of 143.



The 2015/16 reduction target agreed with Birmingham Cross City Clinical Commissioning Group (CCG) is 132 non device-related grade 2 pressure ulcers.

Initiatives to be implemented during 2015/16

To continue to build on the improvements seen in 2014/15, to further identify any common causes or reasons behind hospital-acquired pressure ulcers and to target training and resources accordingly.

How progress will be monitored, measured and reported:

- All grade 2, 3 and 4 pressure ulcers are reported via the Trust's incident reporting system Datix, and then reviewed by a Tissue Viability Specialist Nurse

- Monthly reports are submitted to the Trust's Pressure Ulcer Action Group, which reports to the Chief Nurse's Care Quality Group

- Data on pressure ulcers also forms part of the Clinical Risk report to the Clinical Quality Monitoring Group

- Staff can monitor the number and severity of pressure ulcers on their ward via the Clinical Dashboard

Priority 2: Improve patient experience and satisfaction

The Trust measures patient experience via feedback received in a variety of ways, including local and national patient surveys, the NHS Friends and Family Test complaints and compliments and online sources (e.g. NHS Choices). This vital feedback is used to make improvements to our services.

Patient Experience Data from surveys

Performance

During 2014/15, 25,960 patient responses were received to our local inpatient survey and 2265 responses to our discharge survey. The table below shows results to key questions for the past four financial years. The results show that since 2011/12 the Trust has made improvements across all areas of patient experience; however a slight decline was seen in completely positive responses during 2014/15, with an increase in partially positive responses and negative responses.

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

Methodology

From 2015/16 we are changing the way we report our patient experience results to match the national survey scoring method, which takes account of all responses received. This will allow transparency and comparison as well as simpler interpretation. In previous years we have reported the percentage of most positive responses received (calculated by dividing the number of positive responses, e.g. 'Yes, definitely', by the total number of applicable responses).

The data in the table for 2014/15 shows the new scoring system alongside the previous system for completeness.

The 2014 national survey scores for UHB have been included for information, but please note that these results are based on a smaller sample size than the local surveys (approximately 400, although this varies by question), hence the difference between the scores for each question.

Improvement target for 2015/16

The questions chosen for our improvement priority for 2014/15 included our lowest performing questions from our regular inpatient, outpatient, Emergency Department and discharge surveys. As we have not managed to show improvement in these areas during the year (see below table) we have decided to maintain this important improvement priority for 2015/16.

- Questions scoring 9 or above in 2014/15 are to maintain a score of 9 or above
- Questions scoring below 9 in 2014/15 are to increase performance by at least 5%, and/or achieve a score of 9

Results from local patient surveys

	Score		% most positive responses (local survey)		Target	No. responses (local survey)	UHB ranking in national survey compared to other Trusts	UHB National survey score (2014)
	2013/14	2014/15	2013/14	2014/15	2014/15	2014/15		
Inpatient survey								
1. Did you find someone on the hospital staff to talk about your worries or fears?	8.7	**8.4**	79.7%	**74.6%**	83.7%	10,913	About the same	6.1
2. Do you think that the ward staff do all they can to help you rest and sleep at night?	9.1	**8.8**	83.5%	**78.4%**	87.7%	14,633	Not applicable (local question)	
3. Have you been bothered by noise at night from hospital staff?	8.4	**8.1**	73.5%	**67.7%**	77.2%	14,697	About the same	8.2
4. Sometimes in hospital a member of staff says one thing and another says something quite different. Has this happened to you?	8.6	**8.6**	77.3%	**76.6%**	81.2%	25,610	About the same	8
5. Did the staff treating and examining you introduce themselves?	New for 2014/15	**8.9**	New for 2014/15	**80.3%**	New for 2014/15	22,724	Not applicable (local question)	
Outpatient survey*								
6. Was your appointment changed to a later date by the hospital?	9.2	**9.2***	80.6%	**81.1%***	84.6%	2,186	No recent national survey	
7. Did the staff treating and examining you introduce themselves?	8.6	**8.5***	78.0%	**73.1%***	81.9%	2,144		
8. Did a member of staff tell you about medication side effects to watch out for?	6.6	**6.6***	54.9%	**52.6%***	57.7%	422		
Emergency Department survey								
9. Were you involved as much as you wanted to be in decisions about your care and treatment?	8.1	**7.9**	68.8%	**67.4%**	72.2%	1,680	About the same	7.5
10. Do you think the hospital staff did everything they could to help control your pain?	8	**7.8**	70.3%	**69.6%**	73.8%	1,608	About the same	7.6
Discharge survey*								
11. Did a member of staff tell you about medication side effects to watch for when you went home?	5.9	**5.8***	47.3%	**48.3%***	49.7%	1,631	About the same	5.3
12. Did you feel you were involved in decisions about going home from hospital?	7.2	**7.0***	54.7%	**53.1%***	57.4%	2,085	About the same	7.2

*2014/15 data available for outpatient and discharge survey questions up to February 2015.

Friends and Family Question

The Trust has monitored performance for the Friends and Family Test question during 2014/15:

- How likely are you to recommend our (ward / emergency department / service) to friends and family if they needed similar care or treatment?

Patients asked the question could choose from six different responses as follows:

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

Patients staying overnight on an inpatient ward were asked on discharge from hospital. Those attending the emergency department were asked either on leaving, or afterwards via an SMS text message.

From 1st October 2014 the question was rolled out to include those attending as day cases and outpatients. Patients can choose to answer the question as they leave, or they can access the question online via the Trust website.

The required inpatient response rate target of 30% in Quarter 4 2014/15 has been met, and the additional target of 40% for March 2015 has also been met.

The response rate target for the A&E Friends and Family Test has proved challenging, but a sustained and collaborative focus has resulted in this target being met with a response rate for Quarter 4 of 20.8% against a target of 20.0%.

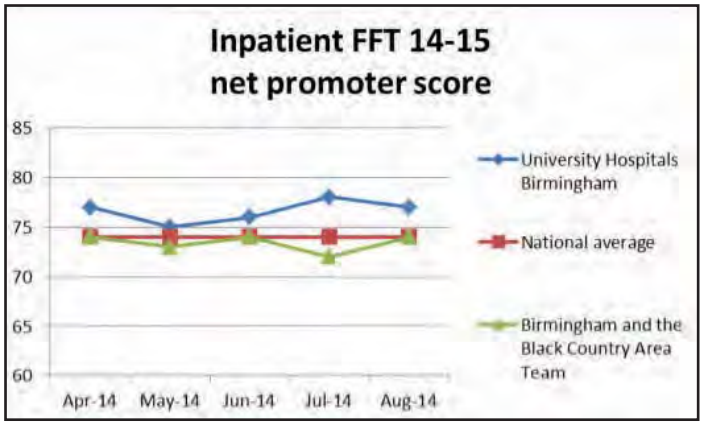
Methodology

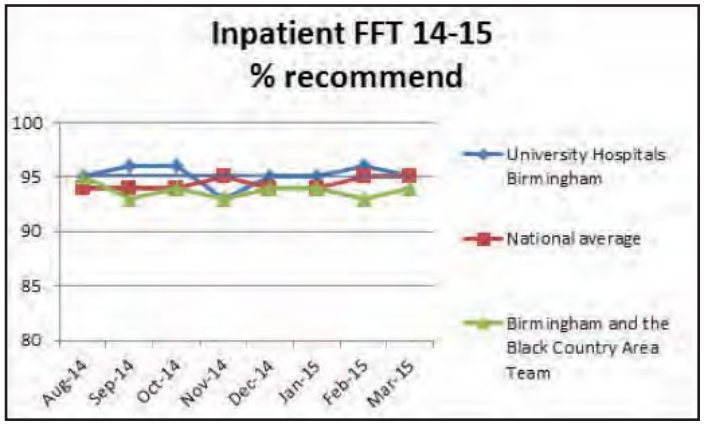
In 2014/15 there was a national change to the methodology for reporting results. From Quarter 3, rather than a net promoter score, results are shown as a percentage of those who 'would recommend' (those who answered 'extremely likely' or 'likely') and those who would not recommend' (those who answered 'unlikely' or extremely unlikely').

Although the net promoter score is no longer used, both ways of scoring are displayed in this report for completeness for the year.

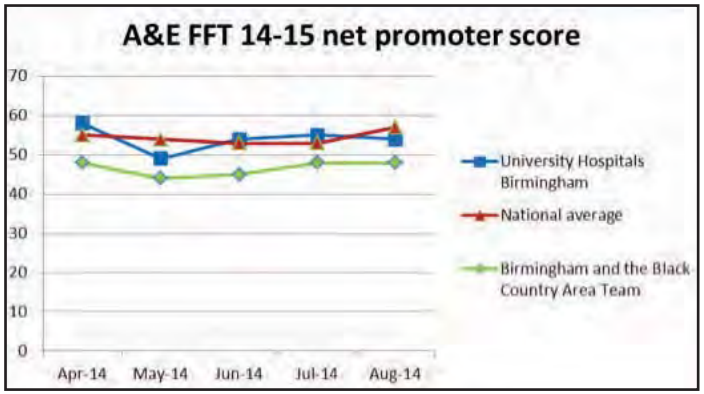
Performance and Response Rates

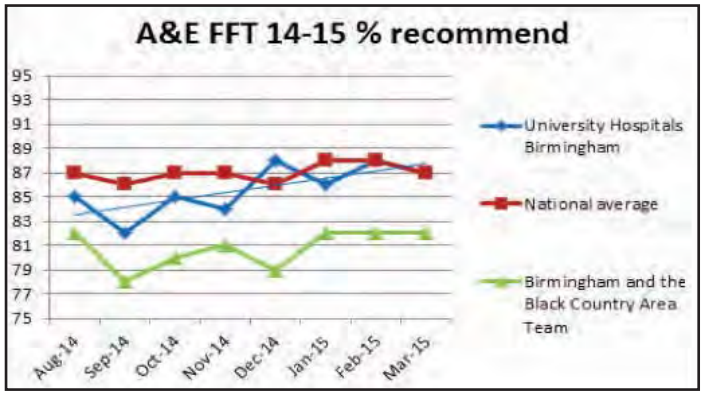
The charts below show comparisons for the net promoter scores, and the 'would recommend' percentages for the Friends and Family Test for Inpatients and for A&E. Two charts are shown for each area due to the change in scoring mechanism during the year.





Inpatients: During 2014/15 the Trust has maintained a score/positive recommendation rate that is equal to or above the national average, and above the Birmingham and Black Country regional score/positive recommendation rate.





A&E: During 2014/15 the Trust has increased its positive recommendation rate to fall in line with the national average, and has remained above the Birmingham and Black Country regional score/positive recommendation rate.

Complaints

The number of formal complaints received in 2014/15 was 654. A further 138 complaints were dealt with informally such as via a telephone call to resolve an appointment issue, without the need for formal investigation.

The top three main subjects of complaints received in 2014/15 related to clinical treatment (358), communication and information (83) and inpatient appointment delay/cancellation (80), matching the top three main subjects identified in 2013/14 complaints.

The rate of formal complaints received against activity across Inpatients, Outpatients and the Emergency Department has remained stable, despite an increase in activity in Outpatients and the Emergency Department.

	2011/12	2012/13	2013/14	2014/15
Total number of formal complaints	797	752	664	654

Rate of formal complaints to activity		2011/12	2012/13	2013/14	2014/15
Inpatients	FCEs*	118,504	126,309	132,280	127,204
	Complaints	434	428	379	371
	Rate per 1000 FCEs	**3.7**	**3.4**	**2.9**	**2.9**
Outpatients	Appointments**	544,876	585,488	729,695	752,965
	Complaints	289	214	200	201
	Rate per 1000 appointments	**0.5**	**0.4**	**0.3**	**0.3**
Emergency Department	Attendances	87,744	94,662	97,298	102,054
	Complaints	72	110	85	82
	Rate per 1000 attendances	**0.8**	**1.2**	**0.9**	**0.8**

* 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
Level of complaints around the attitude of Imaging staff towards patients/ carers.	Relatively low but persistent level of complaints. Impact on patients/ carers already anxious about a procedure.	Details of trend highlighted in the Patient Relations report to the relevant Divisional Clinical Quality Group. Highlighted in a report and email to the Group Manager for Imaging. Head of Patient Relations delivered a programme of bespoke customer care training to Imaging staff, incorporating anonymised examples of the feedback received.	No complaints received about Imaging staff attitude relating to experiences since the time of the training. The level of complaints around this will continue to be closely monitored.
Level of complaints around Urology, especially around cystoscopy procedures.	Delays and cancellations of appointments, delaying procedures.	Trend highlighted in a report and email to the divisional Associate Director of Nursing. Head of Patient Relations met with the Associate Director of Nursing to discuss content of complaints and associated trends. Actions have been taken to address the underlying issues. Additional theatre time allocated to the specialty. Private sector theatre capacity secured. Process refinements on the main Urology ward had resulted in an increased throughput of patients.	Waiting list for patients awaiting the specific procedure has been dramatically reduced; impacting positively on the patient experience and the level of complaints received about this issue, which will continue to be monitored.
Personal hygiene needs neglected.	Four complaints received around this subject in one month.	Each complaint investigated and response including apology provided. Findings reviewed by members of the senior divisional management team. Details sent to the Senior Clinical Educator (Nursing) with anonymised details of the cases for incorporation into training sessions with nursing staff. The anonymised scenarios developed have been used in a number of training sessions. Details also shared with the Lead Nurse for Standards.	Complaints around this issue significantly reduced but this issue will continue to be closely monitored.

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. All actions from individual complaints are captured on the Complaints database. A regular report is sent to each clinical division's senior management team with details of every complaint for their division with actions attached; highlighting any of those cases where any of the agreed actions remain outstanding.

Details of actions and learning from complaints are also shared in a wider Patient Relations report, which is presented at the relevant division's Clinical Quality Group meeting. This report provides detailed data on 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 Clinical Quality Committee, chaired by the Trust's Chairman, 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 meeting.

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 Teams' responsibility to ensure that following investigation of the complaint, appropriate actions are put in place to ensure that learning takes place and that every effort is made to prevent a recurrence of the situation or issue which triggered the complaint being considered "serious". A recent revision of the Terms of Reference for the Trust's Patient Safety Group allows for serious complaints, where there is potential for Trustwide learning, to be presented to the Group for consideration of how best to share that learning across the organisation.

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

PHSO Involvement	2011/12	2012/13	2013/14	2014/15
Cases referred to PHSO by complainant for investigation	16	16	16	23
Cases which then required no further investigation	8	9	3	2
Cases which were then referred back to the Trust for further local resolution	1	2	1	1
Cases which were not upheld following review by the PHSO	0	1	2	5
Cases which were partially upheld following review by the PHSO	1	1	3	9
Cases which were fully upheld following review by the PHSO	0	1	0	0

The total number of cases referred to the Ombudsman for assessment, agreed for investigation and ultimately upheld or partially upheld remain relatively low, in proportion to the overall level of complaints received by the Trust.

Nine cases were upheld or partially upheld by the Ombudsman in 2014/15, an increase on the three partially upheld in the previous year. Discussion with complaints leads elsewhere suggests that this trend is mirrored at many Trusts across the country, including the larger acute Trusts which form the Shelford Group. In every case, appropriate apologies were provided, action plans were developed where requested and the learning from the cases was shared with relevant staff. Among the learning identified and shared was a case where a chyle leak (a complication where there is a leak of fluid from the thoracic duct or one of the channels leading into it) had been conservatively managed by the surgical team. As a direct result of the complaint, a new protocol for the management of such leaks was developed and shared with the complainant and the Ombudsman.

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 collates and records 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 or customer care award nominations 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 recorded around nine per cent more compliments in 2014/15 than in 2013/14. 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	2012/13	2013/14	2014/15
Nursing care	356	424	**242**
Friendliness of staff	207	191	**142**
Treatment received	766	1,202	**1,743**
Medical care	92	79	**56**
Other	38	9	**17**
Efficiency of service	151	187	**104**
Information provided	10	27	**12**
Facilities	24	12	**12**
Totals:	**1,644**	**2,131**	**2,328**

Examples of compliments received during 2014/15:

Date received	Compliment
April 2014	I… found that the nursing staff were exceptionally professional and couldn't do enough for me. Also the cleanliness was outstanding. I was very pleased with the food on offer and menu choice. The Porter was excellent and managed to make me feel relaxed and calm prior to my operation.
May 2014	Thank you for making today as comfortable and stress-free as possible, I have nothing but the greatest respect for your thoroughly professional team. From the very first engagement to post procedure care, I was treated extremely well by all the fantastic staff at QEH.
July 2014	Heart filled thank you and gratitude to you all for looking after me and for your patience and continuous care around the clock.
August 2014	Not only did she listen when I was panicking to help put me at ease she explained to me the reasons to the long waiting times… treated my granddad as a patient, not a number. She knew who I was talking about instantly which showed a customer rapport.
September 2014	Everyone was kind and thoughtful, explained everything clearly and allayed any concerns I had.
October 2014	My experience… has been second to none. I have been treated with the utmost efficiency, respect, and compassion by each and every one of the team.
December 2014	Your compassion has changed a situation I was dreading, into something I hardly gave a second thought to, and I really thank you for that.
February 2015	Thanking you making my stay a very pleasant experience under the circumstance. Your friendly faces and smiles helped a great deal.
March 2015	The best ever ward! You saved the family from disaster, thank you all for your hard work and help. Without your help and service our dad wouldn't be alive.

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 a further 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. The majority of feedback received via this method is extremely positive.

Initiatives implemented in 2014/15:

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

- The NHS Friends and Family Test question was expanded to include day case patients and those attending as an outpatient

- Feedback around food has been consistently evaluated via a variety of different methods and a number of touch points along the patient journey. This has enabled the catering team to be very responsive around making improvements. In particular they have been able to take an individualised approach, working directly with clinical areas to look at bespoke solutions for particular groups of patients

- A number of clinical areas have reviewed their individual needs around patient experience feedback and have introduced innovative ways of collecting feedback and displaying results, these areas include Ambulatory Care, East Block Day Unit and Therapies

- The Trust's first Patient Experience Conference titled 'Listen, Involve, Learn, Improve' was held in October 2014, with delegates coming from all parts of the country to see examples of good practice from this Trust and other organisations. The conference received excellent evaluations and is planned to be repeated in 2016

- Patient Experience team members have spoken at a number of national conferences and have shared some of the good practice that is evident across the organisation. They also bring back ideas for innovative ways to improve patient experience

- The Admissions Lounge has started to telephone patients the day before their admission to talk them through the admissions process and ensure they understand what will happen on the day of admission. It is a good opportunity to reiterate important information e.g. when to stop eating and drinking etc. An added benefit to patients is that they have an opportunity to discuss any last minute queries or anxieties they may have

- The trust has embraced the #*hellomynameis* initiative, a significant amount of work has been carried out to ensure staff introduce themselves properly to patients, a question relating to this was added to all relevant patient experience surveys so this can be monitored and areas where improvement is needed are identified

- In order to further improve communication generally and enhance the ability of staff to communicate effectively, a task and finish group looked at information and training requirements for staff around communication skills and then developed a toolkit. This will continue to be evaluated via the patient experience feedback mechanisms in place

- Helping patients to rest and sleep in hospital has been challenging this year, following previous improvements a decline in positive feedback was noted, this resulted in a further

trust-wide audit being undertaken (final analysis awaited). The process and stock availability of sleep kits has been improved and there is now a process in place to audit their use, and evaluate the impact they have on the patient experience. Adding sleep kits to our electronic prescribing system (PICS) as a prescribing option has also supported the organisation in its drive to reduce the amount of inappropriate night sedation prescribing

Initiatives to be implemented in 2015/16

- A review of our patient experience dashboard and reporting processes
- Launch of a dedicated Carers page on the Trust website
- Further work to reduce noise at night to be undertaken
- Use of patient stories as a feedback mechanism
- Development on an internal buggy system to complement the external buggy

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

Priority 3: Timely and complete observations including pain assessment

Background

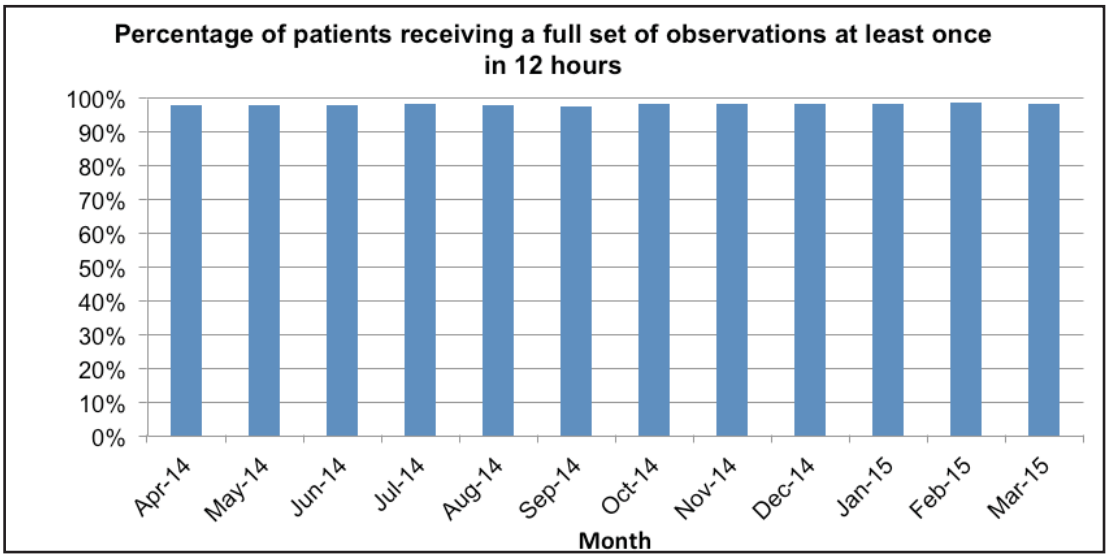
The Trust started to implement an electronic observation chart during 2010/11 within the Prescribing Information and Communication System (PICS) to record patient observations: temperature, blood pressure, oxygen saturation score, respiratory rate, pulse rate and level of consciousness.

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 12-hour period.

All inpatient wards have been recording patient observations electronically since 2011/12. 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 2015/16.

Performance

In the 2013/14 Quality Report, the Trust committed to all wards achieving at least 98.0% for completion of observations by the end of 2014/15. The Trust has maintained performance during 2014/15 with an overall completion rate of 98.3%. The vast majority of the Trust's wards achieved at least 98% with some observations appropriately missed due to patients being off the ward, in theatre or at the end of their life when a complete set of observations may not be clinically appropriate.



Initiatives implemented in 2014/15:

- Wards performing below the 98.0% target for observation completion have continued to be reviewed at the Executive Care Omissions Root Cause Analysis meetings to identify where improvements could be made

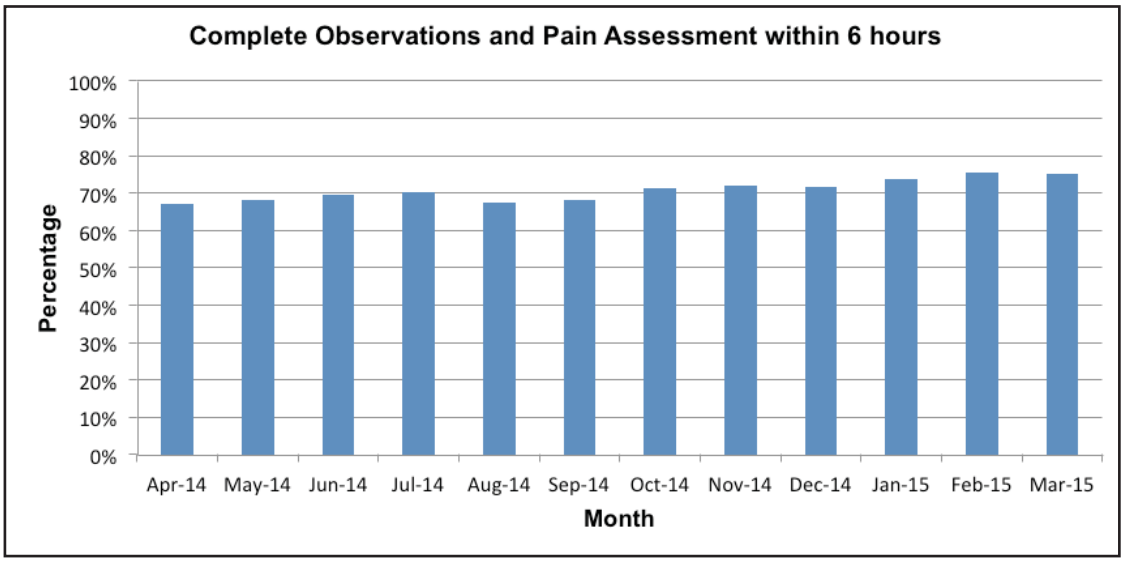
- Automatic incident reporting was implemented in September 2014 for 12 hour observation completion. If a patient receives an incomplete or late set of observations, PICS automatically notifies Datix, the Trust's incident reporting system. The Ward Sister is required to review any such incidents and implement remedial actions. Performance is monitored monthly via the Clinical Quality Monitoring Group chaired by the Executive Medical Director

- The minimum observation requirements have been agreed for Harborne ward which cares for patients who are waiting to be discharged from the Trust. A full set of observations, excluding blood pressure which can be distressing for patients with dementia for example, is required at least once every 24 hours on this ward

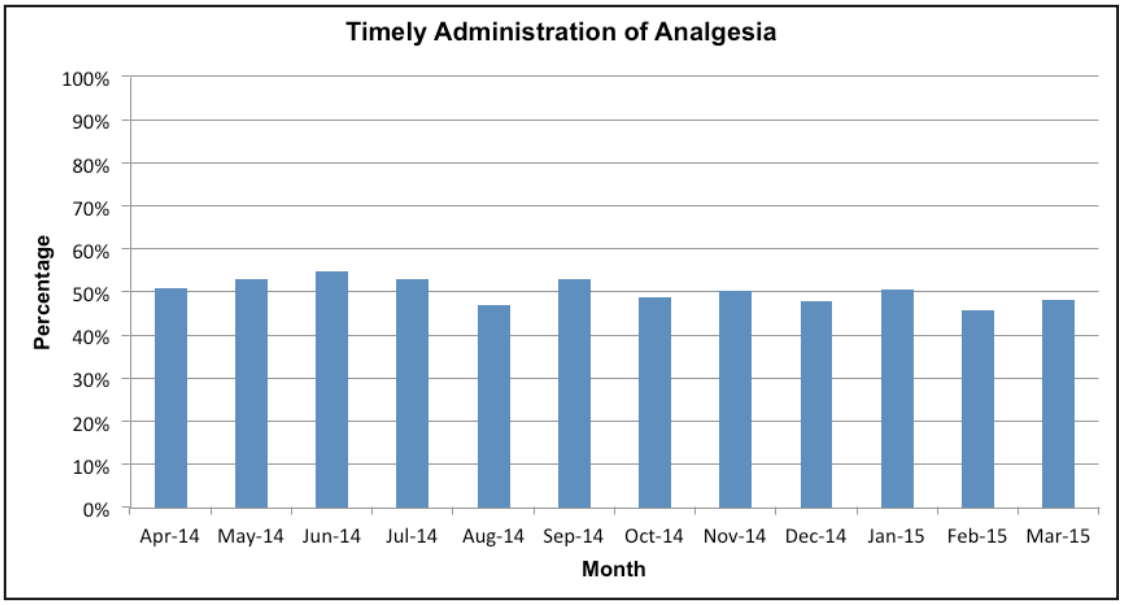
Changes to Improvement Priority for 2014/15:

The Board of Directors has chosen to tighten the timeframe for completeness of observation sets to within 6 hours of admission or transfer to a ward and to include pain assessment. Baseline data for 2014/15 is shown in the graph below: 71% of patients had a full set of observations plus a pain assessment done within 6 hours of admission or transfer to a ward during 2014/15.

This is a new indicator so a challenging improvement target of 85% has been set for the Trust to achieve by the end of 2015/16.



In addition, the Trust will monitor the timeliness of analgesic (pain relief) medication following a high pain score of 3. The pain score used at UHB runs from 0 (no pain) to 3 (severe pain at rest). Whenever a patient scores 3, they should be given analgesic medication within 30 minutes. The indicator also includes patients who are given analgesia within the 60 minutes prior to a high pain score to allow time for the medication to work. Baseline data for 2014/15 is shown in the graph below: 50% of patients received timely pain relief following a high pain score in 2014/15. This is a new indicator so an ambitious improvement target of 75% has been set for the Trust to achieve by the end of 2015/16.



Initiatives to be implemented in 2015/16:

- A change will be made to the electronic observation chart within the PICS to allow staff to more accurately record the reasons for incomplete observations. This will allow us to understand the reasons for incomplete or delayed observations in more detail and to focus on those observations which should not have been missed
- To implement a bespoke electronic observation chart for Critical Care within PICS
- The Clinical Dashboard will be reviewed and improved so that ward staff can see which of the six observations are being missed and when, plus how they compare to Trust-wide performance
- Wards performing below target for 6 hour observation completion and pain assessment or timely analgesia administration will be reviewed at the Executive Care Omissions Root Cause Analysis meetings to identify where improvements can be made
- Observation compliance will be monitored as part of the unannounced Board of Directors' 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

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 (PICS).

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.

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.

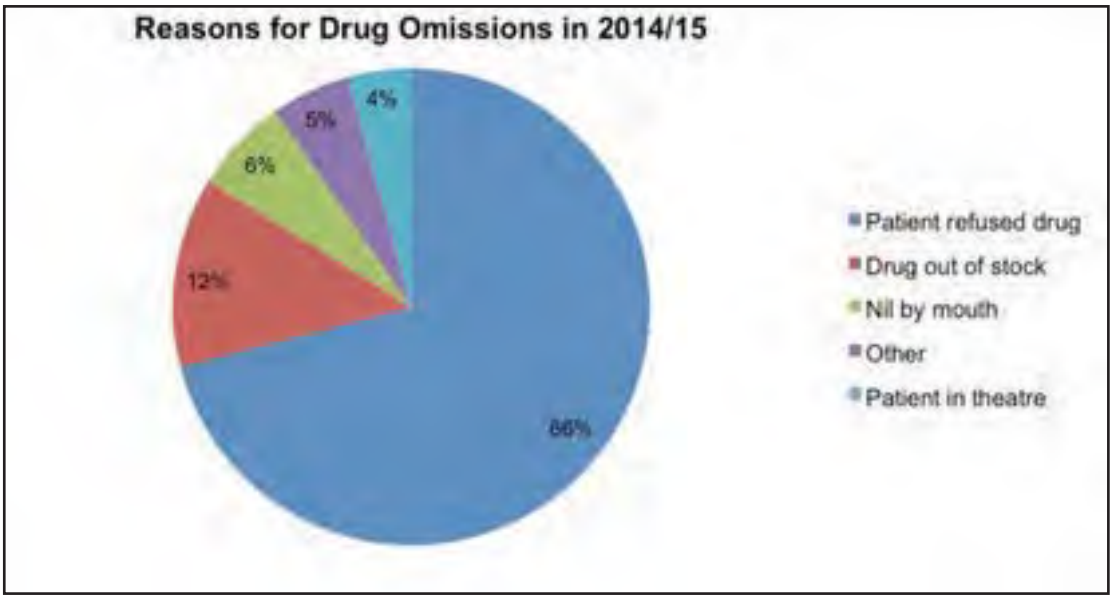
Performance

The graph below shows performance for missed antibiotics and non-antibiotics for the past seven years. In the 2013/14 Quality Report, the Trust committed to maintaining performance for missed antibiotics at around 4.0% which has successfully been achieved. The Trust was aiming to reduce the percentage of missed non-antibiotics by 10% in 2014/15 compared to 2013/14 however this has not been achieved. The percentage of missed non-antibiotics was 10.5% for 2014/15 and 9.3% for 2013/14. It is important to remember that some drug doses are appropriately missed due to the patient's condition at the time.

The pie chart below shows the main reasons recorded for missed antibiotic and non-antibiotic doses in 2014/15. The most common reason recorded for doses being missed was due to patients refusing their medication. Certain medications such as pain-relief, anti-sickness and other symptomatic treatments tend to be regularly prescribed in case patients require it which can result in a high number of patient refusals. Patients may also refuse medication because they do not like the side effects or the route of administration e.g., injection. Medical staff are expected to promptly review prescriptions where the patient has refused two or more doses. There may be a different way of giving the same medication to a patient or another medication which can be given instead.

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% again being recorded as being out of stock in 2014/15. '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 2015/16, the Trust will focus on trying to reduce missed non-antibiotics across the Trust particularly those due to patient refusals, medication being out of stock on the ward and nil by mouth. Wards which perform better than average will be asked to share best practice with others to ensure learning is widely known and acted upon.



Initiatives implemented during 2014/15:

- 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
- The Executive RCA group have begun to look at patients who had intermittent missed doses of non-antibiotics, where the reason was recorded as 'drug out of stock', this will continue in 2015/16

Changes to Improvement Priority for 2015/16:

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 2015/16 as this was not achieved in 2014/15.

Initiatives to be implemented in 2015/16:

- New reports will be developed to monitor consecutive missed doses of non-antibiotics, repeated patient refusals and intermittently out of stock medication
- Wards with the highest percentage of consecutive missed doses, patient refusals or out of stock medication 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 PICS to Pharmacy will be implemented for drugs which are recorded as out of stock
- The Clinical Dashboard will be reviewed and improved so that ward staff can easily see which non-antibiotics are being missed, when and by whom plus how they compare to Trust-wide performance

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 (PICS)
- 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 2014/15 was to have zero avoidable MRSA bacteraemia. During the financial year 2014/15, there were six MRSA bacteraemias apportioned to UHB.

All MRSA bacteraemias are subject to a post infection review by the Trust in conjunction with the Clinical Commissioning Group. MRSA bacteraemias are then apportioned to UHB, the Clinical Commissioning Group or a third party organisation, based on where the main lapses in care occurred. Trust-apportioned MRSA bacteraemias are also subject to additional review at the Trust's Executive Care Omissions Root Cause Analysis meetings chaired by the Chief Executive.

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

Time Period	2011/12	2012/13	2013/14	2014/15
Actual performance	4	5	5	6
Agreed trajectory	7	5	0	0

Clostridium difficile Infection (CDI)

The Trust's annual agreed trajectory was a total of 67 cases for 2014/15. The Trust uses a review tool with the local Clinical Commissioning Group to establish whether cases were avoidable or unavoidable, so that the Trust could focus on reducing avoidable (preventable) cases. The majority of the Trust's CDI cases were deemed to be unavoidable following this joint review.

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

Time Period	2011/12	2012/13	2013/14	2014/15
Actual performance	85	73	80	66
Agreed trajectory	114	76	56	67

Initiatives implemented in 2014/15:

- Maintained improvements in patient safety through a robust Infection Prevention and Control surveillance programme, including all alert organisms, urinary catheter associated infection, 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 2015/16:

For 2015/16, the zero tolerance approach to avoidable MRSA bloodstream infections with timely post infection reviews will continue as previously. For CDI, the national approach will expand on what was done at UHB during 2014/15 with a system of joint reviews with commissioners to assess cases where there have been "lapses in care" and those cases will count towards penalties based on breaching trajectory. For 2015/16 the UHB trajectory will be 63.

Initiatives to be implemented in 2015/16:

- Deliver further 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 CDI will be submitted monthly to Public Health England and measured against the 2015/16 trajectories
- Performance will be monitored 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
- Any death where an MRSA bacteraemia or CDI is recorded on part one of the death certificate will continue to 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 monitored by the Infection Prevention and Control Group and reported to the Board of Directors via the Patient Care Quality Reports and the Infection Prevention and Control Annual Report. Progress will also be shared with Commissioners

2.2 Statements of assurance from the Board of Directors

2.2.1 Information on the review of services

During 2014/15 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 2014/15 represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2014/15.

* 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 2014/15 33 national clinical audits and 5 national confidential enquiries covered relevant health services that UHB provides. During that period UHB participated in 87.9% 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 2014/15 are as follows: (see tables below). The national clinical audits and national confidential enquiries that UHB participated in during 2014/15 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 2014/15, 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.

National Clinical Audits

Audit UHB eligible to participate in	UHB participation 2014/15	Percentage of required number of cases submitted
Part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP)		
Inflammatory bowel disease (IBD)	Yes	75% of those completed, as of February 2015
Oesophago-gastric cancer	Yes	100%
Bowel cancer (NBOCAP)	Yes	100%
Adult cardiac surgery	Yes	100%
Heart failure	Yes	On target to be 100% by the data submission date
Myocardial infarction (MINAP)	Yes	N/A no required case target.
Cardiac rhythm management (Pacing / Implantable Defibrillators)	Yes	95% submission rate, 5% admitted due to patient choice of non-surgical management
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	100%
Lung Cancer	Yes	Data collection for 2014 is still ongoing via Somerset database
Chronic Obstructive Pulmonary Disease (COPD)	Yes	100%
Rheumatoid and early inflammatory arthritis	Yes	100%, 2-3 patients per week on average
National Diabetes Audit	Yes	N/A no required case target
Head and Neck Cancer (DAHNO)	Yes	100%
Falls and Fragility Fractures Audit Programme (FFFAP) – includes National Hip Fracture Database (NHFD)	Yes	Data collection due to commence May 2015
SSNAP (Sentinel Stroke National Audit Programme)	Yes	100% (more cases actually submitted than required)
National Emergency Laparotomy Audit (NELA)	Yes	Target 100%, submitted 97%
National Joint Registry	Yes	79% cases submitted to date, against a target of 75%
National Audit of Percutaneous Coronary Interventions (PCI)	Yes	100%

Audit UHB eligible to participate in	UHB participation 2014/15	Percentage of required number of cases submitted
Medical and Surgical Clinical Outcome Review Programme *(also known as NCEPOD, or Confidential Enquiries)*	Yes	See National Confidential Enquiries table below
National Audit of Dementia	Yes	Pilot began in January 2015. Data collection will take place in 2016 from April with local reporting in early 2017.
National Ophthalmology Audit	Yes	N/A no required case target confirmed
National Prostate Cancer Audit	Yes	100%
Not part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP)		
National Cardiac Arrest Audit	No	N/A
ICNARC - Adult Critical Care Case Mix Programme	No	Working towards 100% with a rectification plan in place which has been agreed by UHB CQMG and ICNARC.
PROMs	Yes	66.4% Pre-operative questionnaire completion for groin hernias and varicose veins as published on the HSCIC website. Data covers April-September 2014. Participation in PROMS by patients is voluntary.
Major Trauma - TARN (Trauma Audit and Research Network)	Yes	100%
CEM Mental Health (care in ED)	Yes	100%
CEM Older People (care in ED)	Yes	100%
Adult Community Acquired Pneumonia	Yes	100% (data collection underway, deadline 31/05/15)
Pleural Procedures	Yes	100%
National Comparative Audit of Blood Transfusion programme	No	N/A
British Society for Clinical Neurophysiology & Association of Neurophysiological Scientists: Standards for Ulnar Neuropathy at Elbow testing	No	N/A

National Confidential Enquiries (NCEPOD)

National Confidential Enquiries (NCEPOD)	UHB participation 2014/15	Percentage of required number of cases submitted
Acute pancreatitis	Yes	Data submitted, awaiting the questionnaires for the study.
Avoidable death review	Yes	100%
Sepsis	Yes	100%
Gastrointestinal Haemorrhage	Yes	100%
Lower Limb Amputation	Yes	100%

Percentages given are the latest available figures.

The reports of 13 national clinical audits were reviewed by the provider in 2014/15 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 808 clinical audits were registered with UHB's clinical audit team as having commenced or been completed at UHB during 2014/15.

The reports of 137 local clinical audits were reviewed by the provider in 2014/15 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).

2.2.3 Information on participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by UHB in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 11,400. The total figure is based on all research studies that were approved during 2014/15.

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	2012/13	2013/14	2014/15
Total number of projects registered with R&D	286	306	307
Out of the total number of projects registered, the number of studies which were abandoned	27	39	56
Trust total patient recruitment	**8,598**	**10,778**	**11,400**

The table below shows the number of projects registered in 2014/15 split by specialty:

Specialty	Number of projects registered
Accident & Emergency	2
Anaesthetics	4
Audiology	1
Breast Services	2
Burns & Plastics	3
Cardiac Surgery	1
Cardiology	20
Clinical Haematology	2
Critical Care	5
Dermatology	5
Diabetes	5
Emergency Medicine	1
Endocrinology	16
ENT	8
General Medicine	1
General Surgery	4
Genito-Urinary Medicine	6
GI Medicine	8
GI Surgery	1
Haematology	13
HIV	2
Imaging	6
ITU	2
Liver Medicine	24
Liver Surgery	2
Lung Investigation Unit	3
Neurology	15
Neuroradiology	2
Neurosurgery	6
Non-specific	37
Oncology	45
Ophthalmology	6
Oral Surgery and Orthodontics	1

Specialty	Number of projects registered
Palliative Care	1
Radiotherapy	2
Renal Medicine	13
Renal Services	1
Renal Surgery	1
Respiratory Medicine	9
Rheumatology	8
Stroke Services	5
Trauma	2
Urology	5
Vascular Surgery	1
Total	**307**

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

A proportion of UHB income in 2014/15 was conditional on 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 2014/15 and for the following 12 month period are available electronically at http://www.uhb.nhs.uk/quality.htm.

The amount of UHB income in 2014/15 which was conditional upon achieving quality improvement and innovation goals was £10.7m*. The Trust received £12.6m in payment in 2013/14. Final payment for 2014/15 will not be known until June 2015.

* This figure has been arrived at as a percentage of the healthcare income which will be included within the Trust's 2014/15 accounts and does not represent actual outturn (as an estimate has to be included for March 2015 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 2014/15.

UHB has participated in special reviews or investigations by the Care Quality Commission and the Birmingham Cross City Clinical Commissioning Group relating to the following areas during 2014/15 (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 2015 in taking such action (see table below).

Responding to Key National Recommendations

During 2014/15 the Trust responded to the consultation by the Department of Health on the new regulations to replace the CQC's Essential Standards with Fundamental Standards, as recommended by Sir Robert Francis. The new Fundamental Standards come into effect from 1 April 2015, in preparation for this the Trust has reviewed the new requirements and is putting in place appropriate actions to ensure it is complaint with the new requirements.

In response to the new and revised regulations that came into effect on 27 November, which sets out the new statutory duty of candour, the Trust is updating its policies and processes in order to comply with the new requirements. In February 2015 the Freedom to Speak Up review was published. In the report Sir Robert Francis sets out 20 Principles and Actions which aim to create the right conditions for NHS staff to speak up, share what works right across the NHS and get all organisations up to the standard of the best and provide redress when things go wrong in future. The proposed recommendations were discussed at the Patient Safety Group and work is underway to implement the relevant recommendations.

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.

Date	Type of inspection	Outcome	Actions taken
Birmingham Cross City - Clinical Commissioning Group			
07/07/14 & 03/09/14	Review of compliance with quality standards of care to ensure that all actions are taken to reduce harm form falls.	The report concluded that 'Overall the findings from the review have been very positive with no major concerns identified. The Trust has a very robust falls prevention agenda with engagement from the medical teams, therapy groups, pharmacy, all nursing groups and various other professionals. There is clear ownership right up at Trust board level that support the agenda and gain frequent assurances'.	There were some minor recommendations made which have been incorporated into an action plan and are monitored by the Lead Nurse for Falls.
20/10/14	Review of Radiology Services to review actions implemented within the department following a cluster of UHB radiology reported Serious Incidents (SIs) regarding delayed imaging/diagnosis.	CCG advised that there have not been any recent serious incidents in relation to delayed imaging/diagnosis indicating the new process is working well. No further actions were identified.	No further action required
12/11/14	Review of UHB's Duty of Candour and WHO checklist processes.	Reviewed our processes for both Duty of Candour and WHO checklist and considered that the Trust is compliant.	No further action required

Date	Type of inspection	Outcome	Actions taken
Care Quality Commission			
28/11/14	Unannounced inspection of Core Essential Standards.	Outcome 16: Assessing and Monitoring the Quality of Service Provision to follow up on previous inspection 22-24 July 2013. CQC report deemed the Trust fully compliant: People were safe and benefited from appropriate arrangements to assess their needs and plan, provide and regularly review care and treatment that met their needs and protected their rights. The provider had effective systems in place to identify, assess and manage risks to the health, safety and welfare of people using the service.	Continue to complete monthly audits and for these to be reviewed at the Care Quality Group.
28/01/15	Announced inspection of Core Essential Standards.	Overall the Trust was rated as Good with 85% of areas being rated as 'good' or 'outstanding' and 15% of areas rated as 'requires improvement'. The CQC found the Trust to be compliant with all the Essential Standards and identified a small number of recommendations.	The CQC report was published on 15 May 2015. The recommendations will be contained in an action plan and an appropriate lead and Director will be identified for each action. Overall compliance with the action plan will be monitored by the Director of Corporate Affairs' Governance Group and compliance will be reported to the Board of Directors via the quarterly compliance reports.

2.2.6 Information on the quality of data

UHB submitted records during 2014/15* 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:
99.0% for admitted patient care;
99.3% for out patient care; and
97.0% for accident and emergency care.

- which included the patient's valid General Medical Practice Code was:
99.9% for admitted patient care;
99.8% for out patient care; and
100% for accident and emergency care.

* Percentages shown are for the period April 2014 to

February 2015. Data for the whole year will be available by mid May 2015.

UHB Information Governance Assessment Report overall score for 2014/15 was 76% and was graded green (satisfactory).

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

	Diagnoses Incorrect		Procedures Incorrect	
	Primary	Secondary	Primary	Secondary
Digestive System Procedures and Disorders	3.0%	3.9%	4.1%	3.1%
Orthopaedic Non-Trauma Procedures	6.0%	12.4%	3.1%	20.6%

* CHKS undertook the Payment by Results clinical coding audit in 2014/15 on behalf of Monitor.

The results should not be extrapolated further than the actual sample audited. The two areas reviewed within the sample were Digestive System Procedures and Disorders and Orthopaedic Non-Trauma Procedures. The audit results were good and met Information Governance Standard Level 2, specifically related to Clinical Coding Audit. Whilst we cannot compare directly by specialty because only some trusts are audited and on different areas, overall we rate better than average for the trusts audited.

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 Trustwide patient administration system which will simplify data entry, increase validation and reduce duplication of data entry
- Ensuring continued compliance with the Information Governance Toolkit minimum Level 2 for data quality standards
- Reinforce the embedded data quality culture by ensuring senior staff are informed of the importance of data accuracy and the Trust Data Quality Policy
- Continue to reinforce the embedded data quality culture by challenging data at monthly executive forums and investigating any potential issues
- Implementation of a quality assurance programme ensuring key elements of information reporting including data assurance, presentation and validation
- Continue to improve the data quality in relation to 18 week referral to treatment time (RTT) through audit, validation and education of both clinical and non-clinical teams

2.3 Performance against national core set of quality indicators

A national core set of quality indicators was 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 2014/15 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

Section 3 | Quality Report

Part 3: Other Information

3.1 Overview of quality of care provided during 2014/15

The tables below show the Trust's latest performance for 2014/15 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 2013/14 Quality Report to enable patients and the public to understand performance over time.

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

The latest available data for 2014/15 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	2012/13	2013/14	2014/15	Peer Group Average (where available)
1(a). Patients with MRSA infection/ 100,000 bed days (includes all bed days from all specialties) *Lower rate indicates better performance*	**1.41**	**1.04**	**1.21**	**0.84**
Time period	2012/13	2013/14	April 2014 – January 2015	April 2014 – January 2015
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). Patients with MRSA infection/ 100,000 bed days (aged >15, excluding Obstetrics, Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	**1.42**	**1.04**	**1.21**	**0.99**
Time period	2012/13	2013/14	April 2014 – January 2015	April 2014 – January 2015
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	2012/13	2013/14	2014/15	Peer Group Average (where available)
2(a). Patients with *C. difficile* infection /100,000 bed days (includes all bed days from all specialties) *Lower rate indicates better performance*	**20.31**	**20.76**	**16.98**	**13.38**
Time period	2012/13	2013/14	April 2014 – January 2015	April 2014 – January 2015
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). Patients with *C. difficile* infection /100,000 bed days (aged >15, excluding Obstetrics, Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	**20.44**	**20.89**	**17.01**	**16.34**
Time period	2012/13	2013/14	April 2014 – January 2015	April 2014 – January 2015
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	2012/13	2013/14	2014/15	Peer Group Average (where available)
3(a,i) Patient safety incidents (reporting rate per 100 admissions) *Higher rate indicates better reporting*	**10.4**	**10.7**	**16.7**	**8.7**
Time period	2012/13	2013/14	2014/15	Oct 2013 - March 2014
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(a,ii) Patient safety incidents (reporting rate per 1000 bed days) *Higher rate indicates better reporting*	Not available (new measure)	Not available (new measure)	**47.2**	**35.9**
Time period			2014/15	April - September 2014
Data source(s)			Datix (incident data), Trust admissions data	Calculated from data on NRLS website (Organisational Patient Safety Incidents Workbook)
Peer group				Acute (non specialist) hospitals

Indicator	2012/13	2013/14	2014/15	Peer Group Average (where available)
3(b) Never Events *Lower number indicates better performance*	**0**	**2**	**3**	*Not available*
Time period	2012/13	2013/14	2014/15	
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*	**64.4%**	**71.1%**	**81.0%**	**73.7%**
Time period	2012/13	2013/14	2014/15	April - September 2014
Data source(s)	Datix (incident data)	Datix (incident data)	Datix (incident data)	NRLS website (Organisational Patient Safety Incidents Workbook)
Peer group				Acute teaching hospitals
4(b) Percentage of patient safety incidents reported to the National Reporting and Learning System (NRLS) resulting in severe harm or death *Lower % indicates better performance*	**0.27%**	**0.24%**	**0.12%**	**0.5%**
Time period	2012/13	2013/14	2014/15	April - September 2014

Indicator	2012/13	2013/14	2014/15	Peer Group Average (where available)
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)	**9,536**	**9,828**	**16,222**	**4,196**
Time period	2012/13	2013/14	2014/15	April - September 2014
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

3(a,i) & 3(a,ii): NHS England recently changed the methodology for calculating incident reporting rates from 'per 100 admissions' to 'per 1000 bed days', so both measures are presented here for completeness. For 2015/16 onwards, UHB will report against the new measure of 'per 1000 bed days'.

The NHS England definition of a bed day ("KH03") differs from UHB's usual definition. For further information, please see this link: http://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/

NHS England have also reduced the number of peer group clusters (trust classifications), meaning UHB is now classed as an 'acute (non specialist)' trust and is in a larger group. Prior to this, UHB was classed as an 'acute teaching' trust which was a smaller group.

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 2015/16. The Trust's incident reporting rate has therefore 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 three Never Events in 2014/15: a guide wire was left in situ, a swab was retained after a procedure and an incorrect site was biopsied. All incidents have been investigated as serious incidents and remedial actions put in place to prevent recurrence.

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	2012/13	2013/14	2014/15	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*	**12.65%** **England: 13.39%**	**12.86%** **England: 13.50%**	**13.50%**	**13.53%** **England: 13.82%**
Time period	2012/13	2013/14	April 2014 – January 2015	April 2014 – January 2015
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*	**12.62%** **England: 12.75%**	**12.85%** **England: 12.89%**	**13.48%**	**13.11%** **England: 13.26%**
Time period	2012/13	2013/14	April 2014 – January 2015	April 2014 – January 2015
Data source(s)	HES data	HES data	HES data	HES data
Peer group				University hospitals
5(c). Emergency readmissions within 28 days of discharge (%) *Lower % indicates better performance*	**9.87%**	**10.25%**	**10.68%**	*Not available*
Time period	2012/13	2013/14	2014/15	
Data source(s)	Lorenzo	Lorenzo	Lorenzo	
Peer group				

Indicator	2012/13	2013/14	2014/15	Peer Group Average (where available)
6. Falls (incidents reported as % of patient episodes) *Lower % indicates better performance*	**2.2%**	**2.1%**	**2.2%**	*Not available*
Time period	2012/13	2013/14	2014/15	
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*	**8.7%**	**8.5%**	*Not available*
Time period		2013/14	April 2014 - February 2015	
Data source(s)		SSNAP data	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*	**96.4%**	**89.0%**	**94.7%**	*Not available*
Time period	2012/13	2013/14	2014/15	
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.

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.

7: Stroke in-hospital mortality – data is one month in arrears due to the nature of the indicator methodology.

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. During 2014/15 there was a small adjustment to the methodology of this indicator, resulting in a very small change to the indicator results.

Patient experience indicators

The results of the 2014 National Inpatient Survey reported that the Trust was 'better' than other Trusts in four questions: specialists having all required information from referrer, being given written or printed information about what you should/should not do after leaving hospital, being given clear written or printed information about medicines and being asked to give views on the quality of care. We scored about the same as other trusts in all other questions. This is an improvement on 2013 when the Trust was 'about the same' as other trusts in all questions.

Patient survey question	2012/13	Comparison with other NHS trusts in England (2012/13)	2013/14	Comparison with other NHS trusts in England (2013/14)	2014/15	Comparison with other NHS trusts in England (2014/15)
9. Overall were you treated with respect and dignity	**8.9**	**About the same**	**9.1**	**About the same**	**9.2**	**About the same**
Time period & data source	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	2014, Trust's Survey of Adult Inpatients 2014 Report, Care Quality Commission	2014, Trust's Survey of Adult Inpatients 2014 Report, Care Quality Commission
10. Involvement in decisions about care and treatment	**7.5**	**About the same**	**7.5**	**About the same**	**7.7**	**About the same**
Time period & data source	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	2014, Trust's Survey of Adult Inpatients 2014 Report, Care Quality Commission	2014, Trust's Survey of Adult Inpatients 2014 Report, Care Quality Commission
11. Did staff do all they could to control pain	**8.0**	**About the same**	**7.9**	**About the same**	**8.1**	**About the same**
Time period & data source	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	2014, Trust's Survey of Adult Inpatients 2014 Report, Care Quality Commission	2014, Trust's Survey of Adult Inpatients 2014 Report, Care Quality Commission

Patient survey question	2012/13	Comparison with other NHS trusts in England (2012/13)	2013/14	Comparison with other NHS trusts in England (2013/14)	2014/15	Comparison with other NHS trusts in England (2014/15)
12. Cleanliness of room or ward	**9.3**	**About the same**	**9.3**	**About the same**	**9.2**	**About the same**
Time period & data source	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	2014, Trust's Survey of Adult Inpatients 2014 Report, Care Quality Commission	2014, Trust's Survey of Adult Inpatients 2014 Report, Care Quality Commission
13. Overall rating of care	**8.2***	**About the same**	**8.3***	**About the same**	**8.3**	**About the same**
Time period & data source	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	2014, Trust's Survey of Adult Inpatients 2014 Report, Care Quality Commission	2014, Trust's Survey of Adult Inpatients 2014 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	Target	Performance		
		2012/13	2013/14	2014/15
C. difficile infection (post-48 hour cases)	2012/13: 76 2013/14: 56 2014/15: 67	73	80 (16 cases judged avoidable)	**66** (17 cases judged avoidable)
62-day wait for first treatment from urgent GP referral: all cancers	85%	86.2%	79.5%	**73.8%**
62-day wait for first treatment from consultant screening service referral: all cancers	90%	95.2%	95.3%	**89.3%**
31-day wait from diagnosis to first treatment: all cancers	96%	97.2%	95.9%	**91.9%**
31-day wait for second or subsequent treatment: surgery	94%	96.8%	96.2%	**82.9%**
31-day wait for second or subsequent treatment: anti cancer drug treatments	98%	99.8%	99.3%	**98.5%**
31-day wait for second or subsequent treatment: radiotherapy	94%	99.3%	95.1%	**98.0%**
Two week wait from referral to date first seen: all cancers	93%	96.3%	97.1%	**95.1%**
Two week wait from referral to date first seen: breast symptoms	93%	98.2%	97.1%	**99.9%**
18-week maximum wait from point of referral to treatment (admitted patients)*	90%	94.9%	91.4%	**88.9%***
18-week maximum wait from point of referral to treatment (non-admitted patients)	95%	99.1%	98.1%	**96.1%**
18-week maximum wait from point of referral to treatment (incomplete pathways)	92%	95.7%	94.6%	**93.6%****
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	95%	94.95%	95.2%	**94.8%**
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A	Certification made	Certification made	**Certification made**

* The target for an 18-week maximum wait from point of referral to treatment for admitted patients was subject to a national 'managed fail' sanctioned by Monitor and NHS England for 8 months of 2014/15.

** This indicator was audited by the Trust's external auditor Deloitte as part of the external assurance arrangements for the 2014/15 Quality Report. Further detail about their findings is provided below.

1. Unknown clock starts

The Trust is required to report performance against three indicators in respect of 18 week Referral-to-Treatment targets. For patient pathways covered by this target, the three metrics reported are:

- "admitted" – for patients admitted for first treatment during the year, the percentage who had been waiting less than 18 weeks from their initial referral
- "non-admitted" – for patients who received their first treatment without being admitted, or whose treatment pathway ended for other reasons without admission, the percentage for the year who had been waiting less than 18 weeks from the initial referral
- "incomplete" – the average of the proportion of patients, at each month end, who had been waiting less than 18 weeks from initial referral, as a percentage of all patients waiting at that date

The measurement and reporting of performance against these targets is subject to a complex series of rules and guidance published nationally. However, the complexity and range of the services offered by the Trust mean that local policies and interpretations are required, including those set out in the Trust Access Policy. As a specialist tertiary provider, receiving onward referrals from other trusts, a key issue for our Trust is reporting pathways for patients who were initially referred to other providers.

Under the rules for the indicators, the Trust is required to report performance against the 18 week target for patients under its care, including those referred on from other providers. Depending on the nature of the referral and whether the patient has received their first treatment, this can either "start the clock" on a new 18 week treatment pathway, or represent a continuation of their waiting time which begun when their GP made an initial referral. In order to accurately report waiting times, the Trust therefore needs other providers to share information on when each patient's treatment pathway began.

Although providing this information is required under the national RTT rules, and there is a standardly defined Inter Provider Administrative Data Transfer Minimum Data Set to facilitate sharing the required information, the Trust does not usually receive this information from referring providers. This means that for some patients the Trust cannot know definitively when their treatment pathway began. The national guidance assumes that the "clock start" can be identified for each patient pathway, and does not provide guidance on how to treat patients with "unknown clock starts" in the incomplete pathway metric.

The Trust's approach in these cases, where information is not forthcoming after chasing the referring provider, is to treat a new treatment pathway as starting on the date that the Trust receives the referral for the first time. Rather than spend a significant amount of time chasing clock starts for tertiary referrals, the main focus is on recording receipt of the referral and ensuring timely appointments are made. This approach means that all patients are included in the calculation of the reported indicators, but may mean that the percentage waiting more than 18 weeks for treatment is understated as we cannot take account of time spent waiting with other providers which has not been reported by them. Due to how data is captured, it is not practicable to quantify the number of patients this represents for the year. However, the findings of the audit overall indicated the Trust was more likely to be overstating the number of breaches than understating them. An internal audit carried out by the Trust in December also found waiting time was more likely to be overstated than understated overall. Both audits recognised the positive patient safety features in place to ensure that any incomplete data entry does not result in patients being missed for RTT purposes.

The absence of timely sharing of data by referring providers impacts the Trust's ability to monitor and manage whether patients affected are receiving treatment within the 18 week period set out in the NHS Constitution, and requires significant time and resource for follow-up.

2. Data assurances

Data assurances and actions for improvement

The assurance work undertaken by Deloitte LLP in respect of the Quality Report 2014/15, led to a qualified conclusion in relation to the data quality of the

incomplete pathway indicator for 18-weeks Referral to Treatment. This finding is consistent with many other providers.

The Trust has put in place an action plan to address these concerns. This plan includes a review of the procedures required to achieve good data quality at the point of entry. In addition, the plan outlines initiatives to enhance skills and training of the clinical and administrative teams who are involved with RTT pathway management. By getting this right first time, we will reduce the validation burden down-stream.

The Trust's Service Improvement Team completed a detailed and larger audit involving 800 patients across admitted, non admitted and unfinished 18 week pathways during 2014/15 at the request of the Executive Chief Operating Officer. At any one time, UHB has around 30,000 patients on an 18 week pathway. The findings of this audit concluded that the Trust was putting patients onto an 18 week pathway and then removing them through validation rather than risk not tracking large numbers of patients. The Trust is currently implementing a number of actions in response to the internal review many of which are consistent with the Deloitte recommendations.

3.3 Mortality

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

UHB proactively contacted the CQC in December 2014 relating to a Burns diagnosis groups for which there appeared to be a higher than expected mortality rate. This diagnosis group was 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)

The Health and Social Care Information Centre (HSCIC) first published data for the Summary Hospital-level Mortality Indicator (SHMI) in October 2011. This is the national hospital mortality indicator which replaced 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 Summary Hospital-level Mortality Indicator should be interpreted with caution as no single measure can be used to identify whether hospitals are providing good or poor quality care[3]. 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 Trust's latest SHMI is 102.21 for the period April – December 2014 which is within tolerance. The latest SHMI value for the Trust, which is available on the HSCIC website, is 95.81 for the period April – June 2014. This is within tolerance.

The Trust has concerns about the validity of the Hospital Standardised Mortality Ratio (HSMR) which was superseded by the SHMI but it is included here for completeness. UHB's HSMR value is 98.95 for the period April 2014

3 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.
4 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.
5 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.

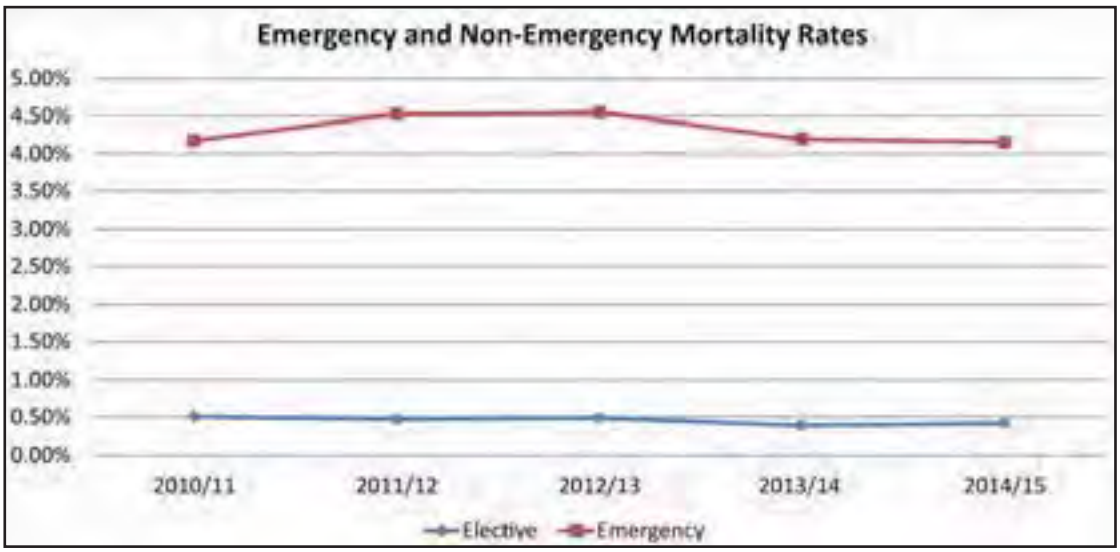
– January 2015 as calculated by the Trust's Health Informatics team. The validity and appropriateness of the HSMR methodology used to calculate the expected range has however been the subject of much national debate and is largely discredited[45]. The Trust is continuing to robustly monitor mortality in a variety of ways as detailed above.

Crude Mortality

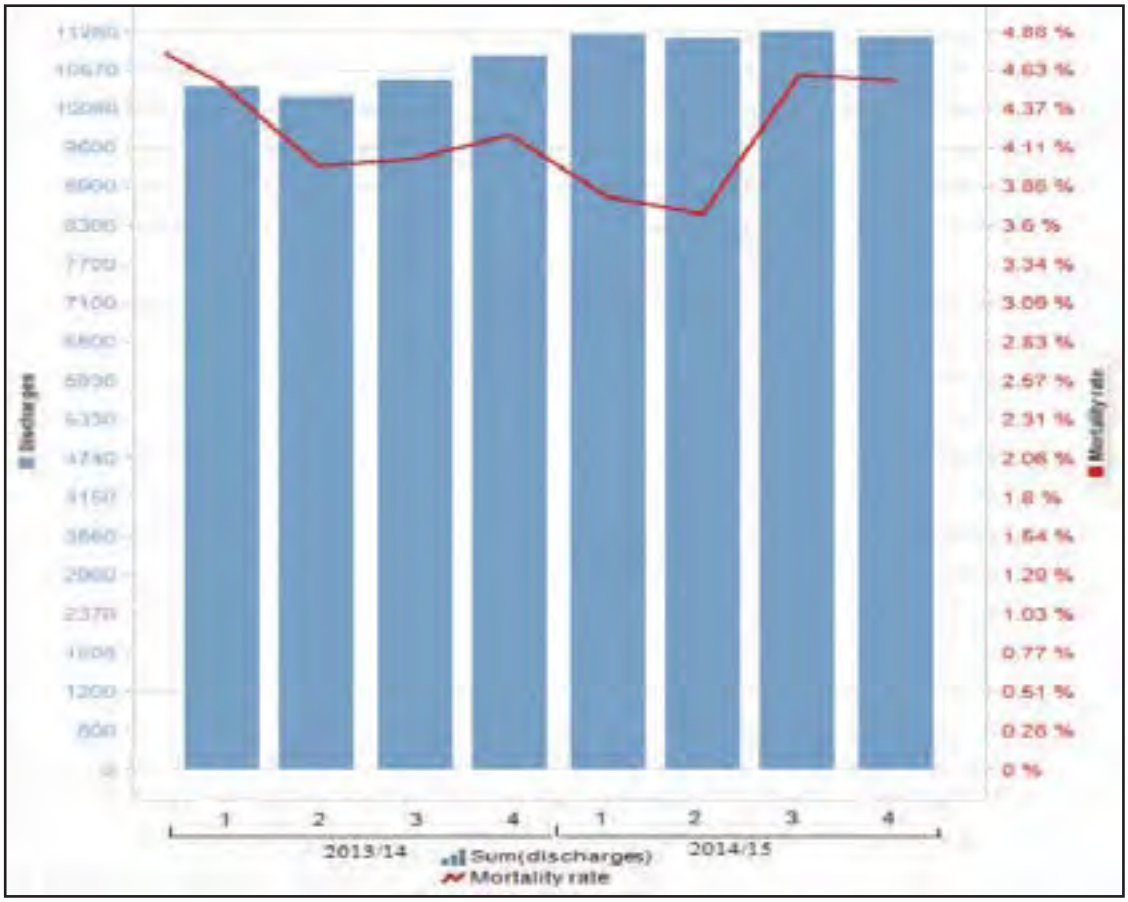
The first graph shows the Trust's crude mortality rates for emergency and non-emergency (planned) patients. The second graph below shows the Trust's overall crude mortality rate against activity (patient discharges) by quarter for the past two calendar years. The crude mortality rate is calculated by 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 for 2014/15 (3.045%) is very similar to 2013/14 (3.052%).

Emergency and Non-emergency Mortality Graph



Overall Crude Mortality Graph



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; and has been updated to include changes introduced in the Care Act 2014

UHB has continued to ensure that safeguarding of adults at risk remains a high priority within the Trust. The aim of safeguarding 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. Level 2 Adult safeguarding training has been mandatory for all patient-facing staff in 2014/15. Factsheets on numerous types of abuse are now available to support staff and a patient information leaflet for adults is available in all clinical areas. Two study days for Clinical Champions (one from each clinical area) have been held to improve knowledge across the Trust. A new domestic abuse page is available on the intranet for all staff.

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 2014/15: http://www.uhb.nhs.uk/reports.htm.

3.5 Staff Survey

The Trust's Staff Survey results for 2014 show that performance was average or better for 25 of the 29 key findings and below average for 4 key findings, when compared to other acute trusts. The results are based on responses from 467 staff which represents a small decrease in response rate from 60% last year to 56% this year, however this response rate is in the highest 20% of acute trusts in England.

The results for the key findings of the Staff Survey which most closely relate to quality of care are shown in the table below. UHB performed in the highest (best) 20% of trusts for staff recommending the Trust as a place to work or receive treatment (see Question 3 in the table below). It is disappointing to see that the Trust is again in the lowest (worst) 20% of trusts reporting errors, near misses or incidents witnessed in the last month (see Question 4 in the table below). This does not accord with the Trust's high incident reporting rate and the high percentage of no harm incidents reported (see indicators 4(a) and 4(c) in section 3.1 of this report). UHB will continue to encourage staff to report all incidents including minor incidents and near misses.

Key Finding from Staff Survey	2012/13	2013/14	2014/15	Comparison with other acute NHS trusts 2014/15
1. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver Time period & data source	**86%** Trust's 2012 Staff Survey Report, Department of Health	**85%** Trust's 2013 Staff Survey Report, NHS England	**82%** Trust's 2014 Staff Survey Report, NHS England	**Highest (best) 20%**
2. Percentage of staff agreeing their role makes a difference to patients Time period & data source	**94%** Trust's 2012 Staff Survey Report, Department of Health	**94%** Trust's 2013 Staff Survey Report, NHS England	**90%** Trust's 2014 Staff Survey Report, NHS England	**Average**
3. Staff recommendation of the trust as a place to work or receive treatment Time period & data source	**3.93** Trust's 2012 Staff Survey Report, Department of Health	**4.04** Trust's 2013 Staff Survey Report, NHS England	**3.95** Trust's 2014 Staff Survey Report, NHS England	**Highest (best) 20%**
4. Percentage of staff reporting errors, near misses or incidents witnessed in the last month Time period & data source	**92%** Trust's 2012 Staff Survey Report, Department of Health	**86%** Trust's 2013 Staff Survey Report, NHS England	**83%** Trust's 2014 Staff Survey Report, NHS England	**Lowest (worst) 20%**
5. Percentage of staff agreeing feedback from patients / service users is used to make informed decisions in their directorate / department Time period & data source	New question for 2014 survey	New question for 2014 survey	**61%** Trust's 2014 Staff Survey Report, NHS England	**Above (better than) average**

Notes on staff survey

Key Finding 3: Possible scores range from 1 to 5, with a higher score indicating better performance.
Key Finding 5: This is a new question for the 2014 Staff Survey, and has replaced the previously reported question about hand-washing materials being available, which is no longer in the Staff Survey.

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 2014/15 includes 74 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 improved performance for 34% of the indicators during 2014/15 with support from the Quality and Informatics teams. Performance for 43% stayed about the same (including 6 indicators which were already scoring the maximum and continued to do so). Performance for 15% deteriorated during 2014/15. The remaining 8 indicators were new or updated during 2014/15 so previous years' data is not available for comparison. The majority of the 75 indicators have a goal; 55% of those with a goal met them in 2014/15.

Table 1 shows performance for selected specialty quality indicators where the most notable improvements have been made during 2014/15. 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 selected indicators where performance has deteriorated during 2014/15. Performance for the Dermatology indicator has improved greatly since September 2014 however the performance shown is for the year to date.

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 12 - Mar 13	Percentage Apr 13 - Mar 14	Numerator Apr 14 - Mar 15	Denominator Apr 14 - Mar 15	Percentage Apr 14 - Mar 15	Data Sources
Imaging	Proportion of Inpatients who have report turnaround time of less than or equal to 4 days for MRI	>85%	90.0%	92.2%	4305	4438	97.0%	CRIS
Surgery – Emergency	Perianal abscess operations should take place on the day of admission or the next day	>90%	90.7%	85.8%	101	107	94.4%	Lorenzo
Upper Gastrointestinal Medicine	Emergency patients admitted with gall stone diseases who had an ultrasound within 24 hours of admission	>90%	62.6%	74.6%	174	208	83.7%	Lorenzo PICS

Table 2

Specialty	Indicator	Goal	Percentage Apr 12 - Mar 13	Percentage Apr 13 - Mar 14	Numerator Apr 14 - Mar 15	Denominator Apr 14 - Mar 15	Percentage Apr 14 - Mar 15	Data Sources
Dermatology	Suspected cancer cases seen within 2 weeks by a Consultant	>93%	97.9%	97.9%	1595	1950	81.8%	Lorenzo Somerset
Imaging	GP direct access patients who have report turnaround time of less than or equal to 7 days for plain imaging	>99%	97.7%	92.6%	27279	31937	85.4%	CRIS
Pathology	Turnaround time: Urine within 48 hours	>90%	82.0%	79.9%	35577	50164	70.9%	Telepath

3.7 Sign up to Safety

The national Sign up to Safety campaign was launched in 2014 and aims to make the NHS the safest healthcare system in the world. The ambition is to halve avoidable harm in the NHS over the next three years. Organisations across the NHS have been invited to join the Sign up to Safety campaign and make five key pledges to improve safety and reduce avoidable harm. University Hospitals Birmingham NHS Foundation Trust joined the Sign up to Safety campaign in November 2014. As part of the campaign, UHB has made the following five Sign up to Safety pledges:

1. Put safety first.

Commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally.

We will:

- reduce medication errors due to missed drug doses
- improve monitoring of deteriorating patients through completeness of observation sets
- reduce hospital acquired grade 3 and 4 pressure ulcers
- reduce harm from falls
- reduce the risk of venous thrombo-embolism through increased prescription and administration rates of prophylactic medication for those patients who require it

2. Continually learn.

Make their organisations more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe their services are.

We will:

- better understand what patients are telling about us about their care through continuous local patient surveys, complaints and compliments
- review the Clinical Dashboard to ensure clinical staff have the performance and safety information they need to improve patient care

3. Honesty.

Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

We will:

- improve staff awareness and compliance with the Duty of Candour
- communicate key safety messages through regular staff open meetings and Team Brief
- make patients and the public aware of safety issues and what the Trust is doing to address them

4. Collaborate.

Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

We will:

- work closely with our partners to:
  - make improvements for patients in relation to mental health and mental health assessment.
  - develop clearer and simpler pathways around delayed transfers of care, safeguarding, end of life care and falls.
  - implement electronic solutions such as the 'Your Care Connected' project to improve patient safety by sharing key information

5. Support.

Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.

We will:

- improve the learning and feedback provided to staff from complaints and incident reporting
- enable Junior Doctors to understand how they are performing and how they can improve in relation to key safety issues such as VTE prevention through the Junior Doctor Monitoring System
- recognise staff contribution to patient safety through the Best in Care awards

The Trust will now turn the above actions into a safety improvement plan to show how we intend to save lives and reduce harm to patients over the next three years.

Further information about Sign up to Safety can be found on the NHS England website: http://www.england.nhs.uk/signuptosafety/

3.8 Glossary of Terms

Term	Definition
A&E	Accident & Emergency – also known as the Emergency Department
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
Analgesia	A medication for pain relief
Bacteraemia	Presence of bacteria in the blood
Bed days	Unit used to calculate the availability and use of beds over time
Benchmark	A method for comparing (e.g.) different hospitals
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)
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 Coding	A system for collecting information on patients' diagnoses and procedures
Clinical Dashboard	An internal website used by staff to measure various aspects of clinical quality
Clinical Quality Committee	A committee led by the Trust's Chairman which reviews clinical quality in detail
Commissioners	*See CCG*
Congenital	Condition present at birth
Contraindication	A condition which makes a particular treatment or procedure potentially inadvisable
CQC	Care Quality Commission
CQG	Care Quality Group - a UHB group chaired by the Chief Nurse, which assess the quality of care, mainly nursing

Term	Definition
CQMG	Clinical Quality Monitoring Group - a UHB group 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
Cystoscopy	A procedure where a camera is inserted into the bladder via the urethra
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)
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
FCE	Finished/Full Consultant Episode - 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 on the failings at Mid Staffordshire NHS Foundation Trust, published in February 2013
GI	Gastro-intestinal
GP	General Practitioner
HCS	Healthcare Commissioning Services
Healthwatch Birmingham	An independent group who represent the interests of patients and the public.
HES	Hospital Episode Statistics
HSCIC	Health and Social Care Information Centre
HSMR	Hospital Standardised Mortality Ratio
IBD	Inflammatory Bowel Disease
ICNARC	Intensive Care National Audit & Research Centre
Informatics	UHB's team of information analysts
IT	Information Technology
ITU	Intensive Treatment Unit (also known as Intensive Care Unit, or Critical Care Unit)
Lorenzo	Patient administration system
MINAP	Myocardial Ischaemia National Audit Project
Monitor	Independent regulator of NHS Foundation Trusts

Term	Definition
Mortality	A measure of the number of deaths compared to the number of admissions
MRI	Magnetic Resonance Imaging – a type of diagnostic scan
MRSA	Meticillin-resistant *Staphylococcus aureus*
Myocardial Infarction	Heart attack
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, temperature
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.
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
Plain imaging	X-ray
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
QuORU	Trust's Quality and Outcomes Research Unit
R&D	Research and Development
RCA	Root cause analysis
Readmissions	Patients who are readmitted after being discharged from hospital within a short period of time e.g., 28 days
Safeguarding	The process of protecting vulnerable adults or children from abuse, harm or neglect, preventing impairment of their health and development.
Safety Thermometer	A system for monitoring harm across NHS organisations

Term	Definition
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.
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
Trust assigned	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.
TVS	Tissue Viability Service
UHB	University Hospitals Birmingham NHS Foundation Trust
VTE	Venous thromboembolism – a blood clot

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 2014/15 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

	Previous Period (April 2013 – March 2014)	Current period (July 2013 – June 2014)				
			National Performance			
	UHB	UHB	Overall	Best	Worst	Comment
(a) Summary Hospital-level Mortality Indicator (SHMI) value	1.05	**1.03**	-	0.54	1.20	The Trust considers that this data is as described for the following reasons as this is the latest available on the HSCIC website.
(a) SHMI banding	2	**2**	-	1	3	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.
(b) Percentage of patient deaths with palliative care coded at diagnosis or specialty level	29.3	**30.5**	-	0	49.0	

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

	Previous Period (April 2013 – March 2014)	Current period (April – September 2014)				
			National Performance			
	UHB	UHB	Overall	Best	Worst	Comment
(i) Groin hernia surgery	0.068	**0.039**	0.081	0.125	0.009	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 data, 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.
(ii) Varicose vein surgery	-	-	0.100	0.142	0.054	
(iii) Hip replacement surgery	Not applicable to UHB					
(iv) Knee replacement surgery	Not applicable to UHB					

3. Readmissions to hospital within 28 days

	Previous Period (April 2010 – March 2011)*	Current period (April 2011 – March 2012)*				Comment
			National Performance			
	UHB	UHB	Overall (England)	Best (Acute teaching providers)	Worst (Acute teaching providers)	
(i) 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.
(ii) Patients aged 16 or over 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	

* The Trust has included the latest data available on the HSCIC website.

4. Responsiveness to the personal needs of patients

	Previous Period (2012/2013)	Current period (2013/14)				
			National Performance			
	UHB	UHB	Overall	Best	Worst	Comment
Trust's responsiveness to the personal needs of its patients – average weighted score of 5 questions from the National Inpatient Survey (Score out of 100)	72.4	**72.2**	68.7	84.2	54.4	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 2015/16 (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

	Previous Period (2013)	Current period (2014)				
			National Performance			
	UHB	UHB	Average score for 4th quartile	Best	Worst	Comment
Staff employed by, or under contract to, the Trust who would recommend the Trust as a provider of care to their family or friends. Performance shown is based on staff who agreed or strongly agreed.	82	**82**	67	93	35	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 performance for 2014 is consistent with 2013. 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

	Previous Period (Q2 2014/15)	Current period (Q3 2014/15)				
			National Performance			
	UHB	UHB	Overall	Best	Worst	Comment
Percentage of admitted patients risk-assessed for VTE	99.24%	**99.34%**	95.95%	100%	81.19%	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 few 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. Further details on UHB's VTE prevention performance are shown under Priority 1: *Improving VTE prevention* in this report.

7. *C. difficile* infection

	Previous Period (2012/13)	Current period (2013/14)				
			National Performance			
	UHB	UHB	Overall (England)	Best	Worst	Comment
C. difficile infection rate per 100,000 bed-days (patients aged 2 or over)	20.9	**21.9**	17.3	0	37.1	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. Patient Safety Incidents

	Previous Period (April – September 2012)	Current period (October 2012 – March 2013)				
			National Performance (Acute Teaching Providers)			
	UHB	UHB	Overall	Best	Worst	Comment
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 2014/15 Quality Report with Birmingham Cross City Clinical Commissioning Group, Healthwatch Birmingham and Birmingham Health & Social Care Overview and Scrutiny Committee.

Birmingham Cross City Clinical Commissioning Group, Healthwatch Birmingham and Birmingham Health & Social Care Overview and Scrutiny Committee have reviewed the Trust's Quality Report for 2014/15 and provided the statements below.

Statement provided by Birmingham Cross City Clinical Commissioning Group

University Hospitals Birmingham NHS Foundation Trust

Quality Account 2014/2015

Statement of Assurance from Birmingham CrossCity CCG May 2015

1.1 As coordinating commissioner Birmingham CrossCity CCG has welcomed the opportunity to provide this statement for the University Hospitals Birmingham NHS Foundation Trust's (UHB) Quality Account for 2014/15. The review of this Quality Account has been undertaken in accordance with the Department of Health guidance and Monitor's requirements. The statement of assurance has been developed in consultation with neighbouring CCGs, the Birmingham, Solihull and Black Country Area Team and the Birmingham CrossCity CCG Patient Council.

1.2 Ensuring high quality care for all is a fundamental component of improving patient outcomes and experiences, and therefore Birmingham CrossCity CCG is committed to working with providers such as UHB to drive forward best practice in respect to clinical quality, patient safety and patient experience. Hence during 2014/15 we have continued to work closely with the Trust's clinicians and managers, monitoring the delivery of care within clinical areas through undertaking Quality Assurance visits. We have also reviewed quality and performance through the monthly Clinical Quality Review Group meetings, addressing any issues around the quality and safety of patient care with the Trust, as and when they have occurred.

1.3 In reviewing this Quality Account we were disappointed that the Trust declined to include the locally agreed priorities for Quality Accounts into their Quality Account document for 2014/2015, for example information on Commissioning for Quality and Innovation (CQUINs) and equality performance. However, we acknowledge that the Trust produces this information in other formats regularly throughout the year as part of on-going performance reports.

1.4 We noted that the Trust has made considerable efforts to improve its services and the quality of the care it provides, notable examples include the excellent work that has taken place in respect to reducing avoidable harm from venous thrombo-embolism (VTE) and avoidable Grade 3 and 4 pressure ulcers. We are pleased that the Trust will now be focussing on reducing grade 2 hospital-acquired pressure ulcers as one of its targets for 2015/2016.

1.5 During 2014/2015 Friends and Family' test data indicates how patients and staff recommended the Trust as a place to be treated in. It was also positive that the number of formal complaints has remained stable. However whilst the Trust has seen an overall increase in the number of compliments received, there are two critical areas where

numbers of responses have declined: nursing staff and friendliness of staff.

1.6 We welcomed how the Trust had included examples of what patients had actually said within the compliments received and felt that this added a greater dimension to understanding of the patient's journey within the services the Trust provides.

1.7 We noted the examples of innovative practice such as the inclusion of sleep kits into the electronic prescribing system (PICS) as a prescribing option to reduce the amount of inappropriate night sedation prescribing, and were pleased to learn about the Trust's first Patient Experience Conference entitled 'Listen, Involve, Learn, Improve' which shared good practice from both the Trust and other organisations.

1.8 Whilst reviewing the Quality Account it was noted that there were some issues which were either not covered, or adequately explored. For example, frequent reference was made to the importance of investigation and learning lessons from adverse events, however the Trust did not offer any details of the learning from the three Never Events reported during 2014/15 and what measures had been taken to reduce the risks of future reoccurrence.

1.9 The Quality Account also contains details of the comprehensive range of audits and research projects that the Trust took part in during 2014/2015, however there are no specific details offered as to how such audit and research has impacted onto patient care and the key messages.

1.10 There was minimal reference to medicines management and how the Trust is learning from issues such as medication errors, and in a similar vein, safeguarding children is not mentioned. There was no reference to the children and young people who are seen in the Trust, despite the fact that the Emergency Department within the Trust was included in the CQC review of health services for Children Looked After and Safeguarding in September 2014.

1.11 There was also no detail offered in respect to how the Trust was working to tackle the issue of cancer waits, little mention in respect to staffing/workforce management and the delivery of the 6C's which supports the development of a nursing workforce which promotes: Care - Compassion – Competence – Communication – Courage – Commitment.

1.12 In response to discussions with the Trust, information has been included in the Quality Account on the Trust membership of the national Sign up to Safety Campaign. The Trust has made five pledges around:

- Putting safety first;
- Continually learning;
- Being honest and transparent when something goes wrong;
- Making improvements across all local services patients use;
- Being supportive.

These pledges are now being worked on to turn the actions into a Safety Improvement Plan.

1.13 In summary, we welcomed the opportunity to comment on the Trust's Quality Account which overall provided a balanced and accurate summary of the work of the Trust. The Quality Account provides description of a number of positive developments and innovative improvements made during the year, although in some areas the document lacked the necessary detail.

1.14 The Quality Account does however demonstrate the Trust commitment to making year on year improvement to patient experience and clinical quality, and we shall continue to work in partnership with the Trust to deliver the quality agenda in 2015/2016.

Barbara King
Accountable Officer
Birmingham CrossCity Clinical Commissioning Group

Statement provided by Healthwatch Birmingham

Comment from Healthwatch Birmingham regarding the University Hospitals Birmingham NHS Foundation Trust Quality Account 2014/15. 20 May 2015

We would firstly like to thank you for sending a copy of 2014/2015 Quality Account Report, highlighting your proposed vision and focus for quality improvement for UHB Trust.

Your vision to deliver best outcomes to patients sits well with our own philosophy of key principles, bringing quality to the forefront of practice.

Healthwatch Birmingham holds firm to this notion of thought and consider our dual role will be fundamental to the promotion of shaping future health services, through good consultation with the users of our services.

Your collective priorities for 2014/2015 reflect your strategic plans around governance. We are mindful that some of your priorities around quality have not been met and are now continuing with new initiatives set for the existing priorities. We trust that your predicted measures and outcomes around quality improvement will be met sufficiently in line with your CQC ratings and CQUIN agreed targets.

We would wish to draw reference to two of your five priorities in terms of responding to the overall quality.

It is refreshing to see improvements can be seen in Priority area 1 – Improving VTE Prevention. We trust that these improvements will be seen as a continuing feature of future research, and monitoring. We note that the trust has received a risk assessment rate of 98% allowing the trust to put mechanisms in place to reduce risks in this area. The assessment of risk allows the trust to monitor service provision levels against risk and level of improvement. During the process of reviewing your account information, we understand that the above priority is now replaced by a new priority; we too look forward to seeing similar decreases in cases and greater emphasis on risk elimination and preventative measures.

Under the four current tiers of managing quality set by the trust for this year; includes the quality management arrangements for governing patient experience. It is positive to see 'The Care Quality Board' is made up of key personnel including a patient representative member. We trust the long term arrangements of managing quality for patients, works in tangent with the recommendations of the Francis report, offering three main objectives of listening, understanding and responding to the needs of patients.

We welcome your new approach on the direct reporting protocols for addressing patient experience Priority 2 – Improve patient experience and satisfaction. The results from 'The Real Time Survey' highlight the need for this area to be addressed in a way that fully represents patient's feedback. The patient influx for the current year including inpatient, outpatient and A & E attendees appears to have increased in capacity. Your report references high levels of attendees for all three separate areas compared to previous years. It would therefore prove beneficial, if patient satisfaction levels were equally reflected in this transitional growth during the next reporting period. We particularly welcome the launch of the carer's page and website. The use of patient's satellites as a feedback mechanism allows progress to be monitored, measured and reported on, promoting 'Bespoke' services for the trust.

Alongside patient experience we have reviewed your complaints information, we note that responses to complaints and levels of satisfaction fluctuate. We see that there have been increases in cases referred to the Parliamentary Ombudsman. Although, some of these cases have been resolved at local level, we would hope for some redress to be taken in the future to address the way complaint handling is monitored, to prevent matters escalating to an external level unduly.

Thank you for providing an update on 'The Real Time Survey Model', we are aware this model is still being tested, we note that it is proving to be a highly effective model. Again, listening to patient's voice and building trust will be fundamental to the process of building wider participation forums; as is the need for building and restoring public confidence around these priorities.

We look forward to the transformation of your services and future integrated models of care delivery, which we believe will indeed govern the improvement of quality under your priorities. We are happy to see a number of initiatives implemented already, with a view of working through each priority; with agreed actions.

Thank you for giving us the opportunity to review the Trust's Quality Account.

Yours sincerely,
Candy
Candy Perry
Interim Director, Healthwatch Birmingham.

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

The Birmingham HOSC has indicated that it is not in a position to provide a statement on the 2014/15 draft Quality Report.

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 2014/15 and supporting guidance
- 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 2014 to May 2015
  - papers relating to Quality reported to the Board over the period April 2014 to May 2015
  - feedback from the commissioners dated 21/05/2015
  - feedback from governors dated 23/02/2015
  - feedback from local Healthwatch organisations dated 20/05/2015
  - feedback from Overview and Scrutiny Committee dated 12/05/2015
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 07/05/2015
  - the 2014 national patient survey 14/04/2015
  - the 2014 national staff survey 24/02/2015
  - the Head of Internal Audit's annual opinion over the trust's control environment dated 21/05/2015
  - CQC Intelligent Monitoring Report dated December 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) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

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

By order of the board

21/5/15 .....Date.....Chairman

21/5/15 .....Date.....Chief Executive

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

2014/15 limited assurance report on the content of the quality report and mandated performance indicators

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 2015 (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 2015, 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 2015 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 18 week referral to treatment – incomplete pathway; and
- Emergency readmissions within 28 days of discharge from hospital.

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

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by Monitor.

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

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified below:
  - board minutes for the period April 2014 to March 2015;

- papers relating to quality reported to the board over the period April 2014 to March 2015
- feedback from Commissioners, dated 21/05/2015;
- feedback from governors, dated 23/02/2015;
- feedback from local Healthwatch organisations, dated 20/05/2015;
- feedback from Overview and Scrutiny Committee, dated 12/05/2015;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 07/05/2015
- the national patient survey, dated 14/04/2015;
- the national staff survey, dated 24/02/2015;
- Care Quality Commission Intelligent Monitoring Report dated December 2014;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 21/05/2015; and
- any other information included in our review.

- 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 in 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;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- Reading the documents.

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

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can 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' and the explanation of the basis of preparation of the 18 week Referral-to-Treatment incomplete pathway indicator set out in the Quality Report which sets out the approach the Trust has taken to patients with "unknown" clock start dates.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Basis for qualified conclusion – 18 week Referral to Treatment Indicator
The "maximum time of 18 weeks from point of referral to treatment – patients on an incomplete pathway" indicator requires that the Trust accurately record the start and end dates of each patient's treatment pathway, in accordance with detailed requirements set out in national guidance.

During our sample testing, we found that:

- for a sample of our patient records' tested, one or both of the start and end date of treatment were not accurately recorded;
- for a sample of our patient records' tested, one or both of the start and end activity treatment were not accurately recorded; and

The "Performance against indicators included in the Monitor Risk Assessment Framework" section on page 162 of the Trust's Quality Report summarises the actions that the Trust is taking post year end to resolve the issues identified in its processes.

As a result of the issues identified, we have concluded that there are errors in the calculation of the "maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway" indicator for the year ended 31 March 2015. We are unable to quantify the effect of these errors on the reported indicator.

Qualified Conclusion
Based on the results of our procedures, except for the matters set out in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- 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 2014/15; 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
26 May 2015

University Hospitals Birmingham NHS
NHS Foundation Trust

This annual report covers the period
1 April 2014 to 31 March 2015

Section 4 **Consolidated Financial Statements 2014/2015**

Section 4 | Consolidated Financial Statements

University Hospitals Birmingham NHS Foundation Trust - Consolidated Financial Statements 2014/15

Contents

Foreword to the Financial Statements

University Hospitals Birmingham NHS Foundation Trust

These financial statements for the year ended 31 March 2015 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.

Signed.....
Dame Julie Moore
Chief Executive

21 May 2015

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 / her 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 NHS Foundation 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.

Signed.....

Dame Julie Moore
Chief Executive

21 May 2015

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

Opinion on financial statements of University Hospitals Birmingham NHS Foundation Trust

In our opinion the financial statements:

- **give a true and fair view of the state of the Group and Trust's affairs as at 31 March 2015 and of the Group's and 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.**

The financial statements comprise the Consolidated Statement of Comprehensive Income, the Consolidated and Trust Statement of Financial Position, the Consolidated and Trust Statement of Changes in Taxpayers' Equity, the Consolidated and Trust Statement of Cash Flows and the related notes 1 to 35. 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.

Qualified 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 except that we have qualified our conclusion on the Quality Report in respect of the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period indicator.

Going concern

We have reviewed the Accounting Officer's statement contained within the Strategic Report that the Group is a going concern. We confirm that

- we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified any material uncertainties that may cast significant doubt on the Group's ability to continue as a going concern.

However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Group's ability to continue as a going concern.

Our assessment of risks of material misstatement

The assessed risks of material misstatement described below are those that had the greatest effect on our audit strategy, the allocation of resources in the audit and directing the efforts of the engagement team:

Risk	How the scope of our audit responded to the risk
NHS revenue and provisions There are significant judgments in recognition of revenue from care of NHS patients and in provisioning for disputes with commissioners due to: • the complexity of the Payment by Results regime, in particular in determining the level of over performance and Commissioning for Quality and Innovation revenue to recognise; and • the judgemental nature of provisions for disputes, including in respect of outstanding over performance income for quarters 3 and 4. The Trust earns revenue from a wide range of commissioners, increasing the complexity of agreeing a final year-end position and increasing the significance of associated judgements. This risk refers to revenue from activities as shown in note 3 of £614,443,000, and accounting policies 1.2 and 1.28.	We evaluated the design and implementation of controls over recognition of Payment by Results income. We performed detailed substantive testing of the recoverability of overperformance income and adequacy of provision for underperformance through the year, and evaluated the results of the agreement of balances exercise. We challenged key judgements around specific areas of dispute and actual or potential challenge from commissioners and the rationale for the accounting treatments adopted. In doing so, we considered the historical accuracy of provisions for disputes and reviewed correspondence with commissioners.
Property valuations The Group holds property assets within Property, Plant and Equipment at a modern equivalent use valuation, as set out in note 1.5 and 1.28. The valuations are by nature significant estimates which are based on specialist and management assumptions, such as indices and estimated useful lives, and which can be subject to material changes in value. As at 31 March 2015 these assets are valued at £508,397,000 and are included in note 14.	We evaluated the design and implementation of controls over property valuations, and tested the accuracy and completeness of data provided by the Trust to the valuer. We used internal valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the Trust's properties, including through benchmarking against revaluations performed by other Trusts at 31 March 2015. We assessed whether the valuation and the accounting treatment of the adjustments were compliant with the relevant accounting standards, and in particular whether impairments should be recognised in the Statement of Comprehensive Income.

The description of risks above should be read in conjunction with the significant issues considered by the Audit Committee discussed on page 51.

Our audit procedures relating to these matters were designed in the context of our audit of the financial statements as a whole, and not to express an opinion on individual accounts or disclosures. Our opinion on the financial statements is not modified with respect to any of the risks described above, and we do not express an opinion on these individual matters.

Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

We determined materiality for the Group to be £5.9m, which is below 1% of revenue.

We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £117,000 as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit

Our group audit was scoped by obtaining an understanding of the Group and its environment, including group-wide controls, and assessing the risks of material misstatement at the Group level.

The focus of our audit work was on the Trust, with work performed at the Trust's head offices in Birmingham directly by the audit engagement team, led by the audit partner.

We performed specified audit procedures on all the Trust's trading subsidiaries, Pharmacy@QEHB Limited, UHB Facilities Limited and Assure Dialysis Services Limited, where the extent of our testing was based on our assessment of the risks of material misstatement and the materiality of the subsidiaries to the Group.

Our audit covered all of the entities within the Group, which account for 100% of the Group's net assets, revenue and surplus.

Our audit work was executed at levels of materiality applicable to each individual entity which were lower than group materiality.

At the Group level we also tested the consolidation process.

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

Annual Governance Statement, use of resources, and compilation of financial statements

Under the Audit Code for NHS Foundation Trusts, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit;
- the NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- proper practices have not been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

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.

Our duty to read other information in the Annual Report

Under International Standards on Auditing (UK and Ireland), we are required to report to you if, in our opinion, information in the annual report is:

- materially inconsistent with the information in the audited financial statements;
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Group acquired in the course of performing our audit; or
- otherwise misleading.

In particular, we have considered whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the annual report is fair, balanced and understandable and whether the annual report appropriately discloses those matters that we communicated to the audit committee which we consider should have been disclosed. We confirm that we have not identified any such inconsistencies or misleading statements.

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. We also comply with International Standard on Quality Control 1 (UK and Ireland). Our audit methodology and tools aim to ensure that our quality control procedures are effective, understood and applied. Our quality controls and systems include our dedicated professional standards review team.

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.

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.

Gus Mish (Senior statutory auditor)
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
Birmingham, United Kingdom
26 May 2015

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 2015 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 Auditor, KPMG LLP, and the External Auditor, Deloitte LLP, attend the Audit Committee meetings.

Both the Board of Directors and the Audit Committee receive reports that relate to clinical risks.

All new staff joining the Trust are required to attend Corporate Induction which covers 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 unannounced governance 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 and the Board of 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 regular exception 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, which includes information regarding Infection Prevention and Control Report. He is also responsible for the annual report regarding the National Inpatient Survey and the annual Safeguarding Adults and Children report.

The Executive Director Strategic Operations (and External Affairs) provides a six-monthly Emergency Preparedness Update Report to the Board.

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

The Executive Director of Delivery provides a Performance Indicators report to the Board of Directors each time it meets. The Clinical Quality Committee also receives a Performance Indicators report each time it meets which includes a more detailed analysis of a specific area of quality performance. The Board of Directors also approves the Monitor Quarterly Governance Declaration. In April the Executive Director of Delivery also provides an Annual Plan Year End Progress Update and the new Annual Plan for the year ahead. The Executive Director of Delivery also provided the Board of Directors with the Monitor 2 year Operational Plan in March 2014 and the 5 Year Strategic Plan in June 2014.

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 risk assessments
- Medico-legal claims and litigation
- Ad hoc risk issues brought to either the Speciality Meetings/departmental meetings, 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
- Reviews by external regulators
- 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 Board of Directors 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 Board Assurance Framework on a quarterly basis and the Audit Committee receives an annual report.

4.2 Risk Control

High level risks (both clinical and corporate) are reported directly to the Board of Directors through the BAF. 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 2014/15 and achieved a score of 75%, achieving Level 2 or above for all the requirements, which is satisfactory.

One serious incident was reported to the Information Commissioner's Office (ICO) in the period 2014 – 2015 via the Information Governance Incident Reporting Tool. This was a level 2 incident which involved a personal notebook containing patient identifiable information being stolen from a vehicle. The results of the investigation were reported to the ICO and no further action will be taken by the ICO.

Strategic Risks

The Board Assurance Framework (BAF) contains the organisation's major risks that may impact on the achievement of the Trust's overarching Strategic Priorities for 2014/2015. 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.

All the risks on the BAF have mitigation plans in place which are reviewed and updated every quarter by the Director responsible and subsequently reviewed by the Board of Directors. Timeframes for completion of the proposed actions are also provided to ensure actions to mitigate the risk are implemented in a timely manner. The key risks on the BAF are:

- Failure to maintain financial balance in future years due to the proposed tariff package for 2015/16 including a further Cost Improvement Plan 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. The Trust is currently planning for a significant deficit in 2015/16 due to the loss of CQUIN revenue under the Default Tariff Rollover and other income reductions imposed by commissioners. To date contracts have not been agreed with commissioners and high level discussions are continuing with NHS England to try to improve the funding position for main teaching hospitals therefore considerable uncertainty remains. This presents as a risk to the availability of resources but due to existing cash balances the Trust would reasonably expect to be able to meet its working capital requirements during the next 12 months and beyond, with modelling demonstrating that headroom exists under both the base case plan scenario and after applying downside sensitivities
- Present capacity issues are creating risks to tertiary patients, who need, for example, transplantation or complex cancer surgery, where the Trust is often the only realistic provider available, and who are waiting longer for their treatment due to the lack of ward beds. The shortage of capacity is directly related to the volume of routine secondary care work and the impact of external factors
- The inability to recruit sufficient numbers of sufficiently skilled, trained and competent staff due to insufficient supply

A potential future risk that may impact on the Trust could be changes in the regulatory framework for FTs, resulting from the change in government following the general election in May 2015. The Trust manages this potential 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.

The Trust is fully compliant with the NHS Foundation Trust condition 4. However, the Trust has identified a risk to the effectiveness of its governance framework from developments across the NHS regarding support to challenged trusts, which may require the development of board and committee structures in order to maintain effectiveness and clear reporting lines and accountabilities. The Trust will undertake regular reviews and seek external advice where appropriate.

The Compliance 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.

4.3 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 Speciality/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.

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 Patient and Carer Councils 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 Patient and Carer 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.

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

The Trust's Financial Plan for 2014/15 was approved by the Board of Directors in March 2014. Achievement of the Financial Plan relied on delivery of cash releasing efficiency savings of around £18.9m 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. Due to operational pressures the Trust has not fully achieved its planned surplus in 2014/15, but remains in overall surplus at a time when the majority of acute providers are in deficit.

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 2014/15 the Board of Directors have 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 the sickness absence, bank usage, external agency usage, vacancy rates, 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 2014/15, the Trust achieved all the targets included in the Framework with the exception of 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.

6. Quality Accounts

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

The content of the Trust's Quality Report for 2014/15 builds on the 2013/14 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 2014/15 were selected with input from the Council of Governors, Care Quality Group, Patient and Carer Council (Wards) and the Chief Operating Officer's Group.

The Trust uses the same systems and processes to collect, validate, analyse and report on data for the annual Quality Reports as it does for other clinical quality and performance information. Information is subject to regular review and challenge at specialty, divisional and 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 2014/15. 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 2014/15 Quality Report has been checked by all teams involved before being approved by the Trust Board of Directors. Data will also be subject to additional sign off by responsible Directors prior to publication. In line with the Trust's commitment to transparency, the data included is not just limited to good performance.

7. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the Internal Auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the External Auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, Internal Audit, the Foundation Secretary and External Audit. The system of internal control is regularly reviewed and plans to address any identified weaknesses and ensure continuous improvement of the system are put in place.

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

- the maintenance of a view of the overall position with regard to internal control by the Board of Directors through its routine reporting processes and its review of the Board Assurance Framework
- 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 Board's review of the Trust's risk and internal control framework is supported by the Annual Head of Internal Audit opinion. The opinion is based upon and limited to their work performed on the overall adequacy and effectiveness of the Trust's risk management, control and governance processes.

KPMG's Head of Internal Audit Opinion 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 2014/15 states that "significant with minor improvements assurance can be given on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control.

In 2014/15, the Trust's external auditor reviewed the effectiveness of some of the processes through which data is extracted and reported in the Quality Report. Deloitte reviewed the content of the Trust's 2014/15 Quality Account and undertook testing for three areas: 18 week referral to treatment times (unfinished pathways), 28 day readmissions and two local pain indicators. No significant issues were identified with the content review or the testing for the 28 day readmission and two local pain indicators.

8. Data Assurances and Actions for Improvement

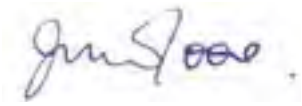
The assurance work undertaken by Deloitte LLP in respect of the Quality Report 2014/15, led to a qualified conclusion in relation to the data quality of the incomplete pathway indicator for 18-weeks Referral to Treatment. This finding is consistent with many other providers.

The Trust has put in place an action plan to address these concerns. This plan includes a review of the procedures required to achieve good data quality at the point of entry. In addition, the plan outlines initiatives to enhance skills and training of the clinical and administrative teams who are involved with RTT pathway management. By getting this right first time, we will reduce the validation burden down-stream.

The Trust's Service Improvement Team completed a detailed and larger audit involving 800 patients across admitted, non admitted and unfinished 18 week pathways during 2014/15 at the request of the Executive Chief Operating Officer. At any one time, UHB has around 30,000 patients on an 18 week pathway. The findings of this audit concluded that the Trust was putting patients onto an 18 week pathway and then removing them through validation rather than risk not tracking large numbers of patients. The Trust is currently implementing a number of actions in response to the internal review many of which are consistent with the Deloitte recommendations.

9. 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

21 May 2015

Consolidated statement of comprehensive income

		Year Ended 31 March 2015	Year Ended 31 March 2014
	Notes	Total £000	Total £000
Revenue	3 - 4	**733,333**	691,896
Operating expenses	5	**(705,078)**	(665,284)
Profit on disposal of land	14.3	**5,725**	-
Impairments reversed to operating revenue	14.2	**4,087**	23,993
Operating surplus		**38,067**	50,605
Finance costs			
Finance income	10	**307**	483
Finance expense	10	**(22,555)**	(22,045)
Net finance expense		**(22,248)**	(21,562)
Surplus before taxation		**15,819**	29,043
Taxation	12	**(172)**	(110)
Surplus after taxation		**15,647**	28,933
PDC Dividends payable	11	**-**	-
Retained surplus / (deficit) for the year		**15,647**	28,933
Other comprehensive income			
Gain from transfer by absorption from demising bodies	17	**-**	1,578
Revaluation gains on property, plant and equipment		**2,363**	6,755
Total comprehensive income for the year		**18,010**	37,266

All income and expenditure is derived from continuing operations.

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

A material element of the retained surplus for the year arises from the £5,725,000 (2013/14 - £nil) profit on disposal of the surplus land at Selly Oak, Birmingham. See note 14.3 to the financial statements on page XLIX.

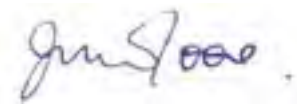
A material element of the retained surplus for the year arises from the £4,087,000 (2013/14 - £18,803,000) reversal of impairment in respect of the Trust's PFI 'Queen Elizabeth Hospital Birmingham' building valuation carried out in year. The remainder of the prior year reversal of impairment (2013/14 - £5,190,000) was due to refurbishment of old Queen Elizabeth site estate and has no equivalent in the current reporting year. See note 14.2 to the financial statements on page XLVIII.

The notes on pages XX to LXVI are an integral part of these financial statements.

Consolidated statement of financial position

	Notes	Group 31 March 2015 £000	Group 31 March 2014 £000	Trust 31 March 2015 £000	Trust 31 March 2014 £000
Assets					
Non-current assets					
Intangible assets	13	**717**	494	**717**	494
Property, plant and equipment	14	**508,397**	518,196	**506,947**	518,075
Trade and other receivables	20	**21,556**	3,065	**21,556**	3,065
Other assets	21	**-**	-	**-**	-
		530,670	521,755	**529,220**	521,634
Current assets					
Inventories	19	**15,462**	15,231	**13,811**	13,892
Trade and other receivables	20	**80,339**	55,876	**86,324**	60,637
Other current assets	21	**-**	-	**-**	-
Cash and cash equivalents	22	**51,268**	63,088	**49,496**	60,377
		147,069	134,195	**149,631**	134,906
Total assets		**677,739**	655,950	**678,851**	656,540
Liabilities					
Current liabilities					
Borrowings	26	**(12,629)**	(12,097)	**(12,629)**	(12,097)
Trade and other payables	23	**(113,199)**	(114,152)	**(115,847)**	(115,591)
Current tax liabilities		**(173)**	(109)	**-**	-
Provisions	29	**(772)**	(1,260)	**(772)**	(1,260)
Other liabilities	24	**(30,947)**	(16,965)	**(30,775)**	(16,965)
		(157,720)	(144,583)	**(160,023)**	(145,913)
Total assets less current liabilities		**520,019**	511,367	**518,828**	510,627
Non-current liabilities					
Borrowings	26	**(509,575)**	(522,204)	**(509,575)**	(522,204)
Provisions	29	**(2,468)**	(1,838)	**(2,222)**	(1,838)
Deferred tax liabilities	25	**(24)**	(17)	**-**	-
Other liabilities	24	**(10,813)**	(17,813)	**(10,813)**	(17,813)
		(522,880)	(541,872)	**(522,610)**	(541,855)
Total liabilities		**(680,600)**	(686,455)	**(682,633)**	(687,768)
Net assets / (liabilities)		**(2,861)**	(30,505)	**(3,782)**	(31,228)
Taxpayers' equity					
Public dividend capital		**180,663**	171,029	**180,663**	171,029
Revaluation reserve		**95,112**	113,496	**95,112**	113,496
Income and expenditure reserve		**(278,636)**	(315,030)	**(279,557)**	(315,753)
Total taxpayers' equity		**(2,861)**	(30,505)	**(3,782)**	(31,228)

The financial statements on pages XVII to LXVI were approved by the Board of Directors on 21 May 2015 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 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	-	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)**
Surplus for the year	-	-	15,647	**15,647**
Transfers in respect of assets disposed of	-	(20,747)	20,747	**-**
Public dividend capital received	9,634	-	-	**9,634**
Transfers between reserves	-	-	-	**-**
Revaluation gains	-	2,363	-	**2,363**
Total comprehensive income for the year	9,634	(18,384)	36,394	**27,644**
Balance at 31 March 2015	**180,663**	**95,112**	**(278,636)**	**(2,861)**

Trust	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	**Total**
	£000	£000	£000	**£000**
Balance at 1 April 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	-	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)**
Surplus for the year	-		15,449	**15,449**
Transfers in respect of assets disposed of	-	(20,747)	20,747	**-**
Public dividend capital received	9,634	-	-	**9,634**
Transfers between reserves	-	-	-	**-**
Revaluation gains	-	2,363	-	**2,363**
Total comprehensive income for the year	9,634	(18,384)	36,196	**27,446**
Balance at 31 March 2015	**180,663**	**95,112**	**(279,557)**	**(3,782)**

Consolidated statement of cash flows for the year ended 31 March 2015

	Notes	Group Year Ended 31 March 2015 £000	Group Year Ended 31 March 2014 £000	Foundation Trust Year Ended 31 March 2015 £000	Foundation Trust Year Ended 31 March 2014 £000
Cash flows from operating activities					
Operating surplus for the year		**38,067**	50,605	**37,685**	50,105
Depreciation and amortisation		**21,729**	20,275	**21,704**	20,250
Net reversals of impairments		**(2,250)**	(23,993)	**(2,250)**	(23,993)
Non-cash donations/grants credited to income		**(676)**	(2,474)	**(676)**	(2,474)
(Gain) / loss on disposal of property, plant and equipment		**(5,705)**	29	**(5,705)**	29
(Increase) / decrease in inventories		**(231)**	(1,793)	**81**	(1,445)
(Increase) / decrease in trade and other receivables		**(15,314)**	(17,746)	**(16,528)**	(19,674)
(Decrease) / increase in trade and other payables		**(2,018)**	15,662	**(757)**	15,702
Increase / (decrease) in other liabilities		**6,982**	(7,850)	**6,810**	(7,850)
Increase / (decrease) in provisions		**116**	(433)	**(130)**	(400)
Tax (paid) / received		**(101)**	(112)	**-**	-
Net cash generated from operating activities		**40,599**	32,170	**40,234**	30,250
Cash flows from investing activities					
Interest received		**317**	540	**318**	540
Payments to acquire property, plant and equipment		**(31,552)**	(11,631)	**(30,249)**	(11,574)
Receipts from sale of property, plant and equipment		**4,200**	-	**4,200**	-
Payments to acquire intangible assets		**(392)**	(178)	**(392)**	(178)
Net cash used in investing activities		**(27,427)**	(11,269)	**(26,123)**	(11,212)
Cash flows from financing activities					
Public dividend capital received		**9,634**	-	**9,634**	-
Capital element of finance lease obligations		**(38)**	(35)	**(38)**	(35)
Interest element of finance lease obligations		**(29)**	(31)	**(29)**	(31)
Capital element of PFI obligations		**(12,059)**	(11,966)	**(12,059)**	(11,966)
Interest element of PFI obligations		**(22,500)**	(21,981)	**(22,500)**	(21,981)
PDC dividends received / (paid)		**-**	-	**-**	-
Net cash used in financing activities		**(24,992)**	(34,013)	**(24,992)**	(34,013)
Net decrease in cash and cash equivalents		**(11,820)**	(13,112)	**(10,881)**	(14,975)
Cash and cash equivalents at 1 April		**63,088**	76,200	**60,377**	75,352
Cash and cash equivalents at 31 March	22	**51,268**	63,088	**49,496**	60,377

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 2014/15 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 2015, 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 2015. 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. The Trust has no joint ventures, joint operations nor any associate entities. 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.

All intra-group transactions, balances, income and expenses are eliminated on consolidation. 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 statement for the parent (the Trust) has not been presented.

The 2014/15 NHS Foundation Trust Annual Reporting Manual requires the consolidation of any NHS charity that meets the criteria of control under IFRS 10. The Queen Elizabeth Hospital Birmingham Charity is not considered to be a subsidiary of the Trust under IFRS 10 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.

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

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. 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 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 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 2012.

The Scheme Regulations 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.

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 employer.

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

1.4 Expenditure on other goods and services

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

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; or

- They form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

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

Valuation

All property, plant and equipment are stated initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

After recognition of the asset, property is carried at fair value using the 'Revaluation model' set out in IAS 16, in accordance with HM Treasury's Finance Reporting Manual. Property used for the Trust's services or for administrative purposes is carried at a revalued amount, being its fair value as determined at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are measured as follows:

- Land and non specialised buildings - existing use value

- Specialised buildings - depreciated replacement cost

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

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

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

Revaluation

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

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's

carrying value. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised.

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

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

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 scope 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 LVI. 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 LVI.

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 XLII.

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 XXXVIII.

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 LI.

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 1.3% 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 LX, 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 LX, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the entity's control; or

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

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 30 to the financial statements on page LX 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 and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the pre-audit version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.22 Research and Development

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

Research and development activity cannot be separated from patient care activity and is not a material operating segment within the Trust. It is therefore not separately disclosed.

1.23 Value Added Tax

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

1.24 Corporation Tax

The Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to disapply the exemption in relation to specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988).

Accordingly, the Trust is potentially within the future scope of income tax in respect of activities where income is received from a non public sector source.

The tax expense on the surplus or deficit for the year comprises current and deferred tax due to the Trust's trading commercial subsidiaries, see note 12 to the financial statements on page XLIII. 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 2015. 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 - critical accounting judgement

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 XLVIII. Future revaluations of the Trust's property may result in further material changes to the carrying values of non-current assets.

Provisions - key sources of estimation uncertainty

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 LIX.

1.29 Accounting standards, interpretations and amendments adopted in the year

All 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. The adoption of IFRS 10 'Consolidated Financial Statements' did not result in any change of presentation or disclosure as the Trust's wholly owned subsidiaries have previously been consolidated under International Accounting Standards.

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 2014-15:

- IFRS 9 'Financial Instruments' - recognition and measurement
- IFRS 13 'Fair Value Measurement'
- IFRS 15 'Revenue from Contracts with Customers'
- IAS 36 'Recoverable amount Disclosures' - (ammendment)
- IAS 19 'Employer contributions to defined benefit pensions schemes' - (ammendment)
- IFRIC 21 'Levies'
- Annual Improvements 2012
- Annual Improvements 2013

The Trust does not consider that these or any other standards, amendments or interpretations issued by the IASB, but not yet adopted by the European Union, will have a material impact on the financial statements. New and revised accounting standards are assessed for impact on the financial statements as they become applicable in the Treasury FReM.

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 XXXV. Other operating revenue is analysed in note 4 to the financial statements on page XXXVII 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 LXI, where individual customers within the public sector are considered material. The proportion of total revenue receivable from whole HM Government is 95.6% (2013/14 - 95.0%).

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, other healthcare support services are provided by separate trading companies:

Commercial subsidiaries -

There are three trading companies that are all wholly owned subsidiaries of the Trust: (i) Pharmacy@QEHB Limited provides an Outpatient Dispensary service, (ii) UHB Facilities Ltd provides a fully managed healthcare facility and (iii) Assure Dialysis Services Ltd provides renal dialysis healthcare. As trading companies, subject to additional legal and regulatory regimes (over and above that of the Trust), these activities are 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 these companies' revenues are inter group 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 2015	Healthcare services £000	Commercial subsidiaries £000	Inter-Group Eliminations £000	Total £000
Total segment revenue	733,822	28,333	(28,822)	733,333
Total segment expenditure	(705,949)	(27,951)	28,822	(705,078)
Total segment profit on disposal of land	5,725	-	-	5,725
Total segment reversal of impairment	4,087	-	-	4,087
Operating surplus	**37,685**	**382**	-	**38,067**
Net financing	(22,236)	(12)	-	(22,248)
PDC dividends payable	-	-	-	-
Taxation	-	(172)	-	(172)
Retained surplus - before non-recurring items	**15,449**	**198**	-	**15,647**
Non-recurring items	-	-	-	-
Retained surplus / (deficit)	**15,449**	**198**	-	**15,647**
Reportable Segment assets	678,851	9,079	-	687,930
Eliminations	-	-	(10,191)	(10,191)
Total assets	**678,851**	**9,079**	**(10,191)**	**677,739**
Reportable Segment liabilities	(682,633)	(8,158)		(690,791)
Eliminations	-	-	10,191	10,191
Total liabilities	**(682,633)**	**(8,158)**	**10,191**	**(680,600)**
Net assets	**(3,782)**	**921**	**-**	**(2,861)**

Year ended 31 March 2014	Healthcare services £000	Commercial subsidiaries £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)**

All activities are based in the UK.

3. Revenue from patient care activities

	Year Ended 31 March 2015 £000	Year Ended 31 March 2014 £000
By commissioner		
Foundation Trusts	**117**	168
NHS Trusts	**635**	501
NHS England	**353,955**	319,436
Clinical Commissioning Groups	**228,203**	224,989
Department of Health	**5,900**	-
Local Authorities	**8,514**	8,392
NHS Scotland, Wales and Northern Ireland	**8,249**	5,719
Private Patients	**3,912**	3,424
Overseas Patients	**713**	406
NHS Injury Cost Recovery scheme	**3,458**	3,695
Ministry of Defence	**787**	2,221
	614,443	568,951

The responsibility for commissioning nationally funded NHS healthcare 'specialist healthcare activity' lies with 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.

Healthcare activity income from the Ministry of Defence of £787,000 relates to the Trust contract with the Royal Centre for Defence Medicine (2013/14 - £2,221,000).

NHS Injury Cost Recovery scheme income, received from commercial insurance providers, is subject to a provision for impairment of receivables of 19.8% (2013/14 - 19.8%) to reflect expected rates of collection.

	Year Ended 31 March 2015 £000	Year Ended 31 March 2014 £000
By activity		
Elective	**111,649**	108,649
Non elective	**113,469**	106,827
Outpatients	**87,201**	83,776
A & E	**10,838**	10,399
Other NHS clinical	**282,416**	249,554
Private & overseas patients	**4,625**	3,830
Other non-NHS clinical	**4,245**	5,916
	614,443	568,951

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 Overseas visitors (patients charged directly by the Trust)

	Year Ended 31 March 2015	Year Ended 31 March 2014
	£000	£000
Income recognised this year	**713**	406
Cash payments received in-year	**225**	211
Amounts added to provision for impairment of receivables	**(158)**	(171)
Amounts written off in-year	**(73)**	(24)

3.2 Commissioner requested services

	Year Ended 31 March 2015	Year Ended 31 March 2014
	£000	£000
Commissioner requested services		
Revenue derived from NHS clinical activity in England	**597,324**	553,486
Non-commissioner requested services		
NHS Scotland, Wales and Northern Ireland	**8,249**	5,719
Non-NHS derived clinical activity	**8,870**	9,746
Other operating revenue (see note 4 to the financial statements)	**118,890**	122,945
	136,009	138,410
Total revenue	**733,333**	691,896
Commissioner requested services as a percentage of revenue	**81.45%**	80.00%

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 2015	Year Ended 31 March 2014
	£000	£000
Research and development	**24,260**	30,375
Education and training	**30,689**	32,130
Charitable and other contributions to expenditure	**1,526**	3,324
Non-patient care services to other bodies	**11,041**	11,891
Other revenue	**51,374**	45,225
	118,890	122,945

Other revenue includes PFI related income of £7,200,000 (2013/14 - £7,000,000); rental income of £2,277,000 (2013/14 - £2,175,000) due to the leasing of new hospital facilities by the University of Birmingham and Ministry of Defence; £4,184,000 from Clinical Excellence Awards (2013/14 - £4,214,000); recharges of £2,605,000 to the Ministry of Defence to fund the training expenditure of Nurses along with catering and car parking costs associated with the military contract (2013/14 - £2,449,000); £1,506,000 from the National Quality Assurance Service (2013/14 - £1,434,000); and funding of £1,734,000 (2013/14 - £3,166,000) 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 2015	Year Ended 31 March 2014
	Total	Total
	£000	£000
Services from Foundation Trusts	**6,467**	5,253
Services from other NHS Trusts	**975**	502
Services from CCGs and NHS England	**53**	10
Services from other NHS bodies	**-**	9
Purchase of healthcare from non NHS bodies	**14,366**	15,509
Directors' costs	**1,820**	1,769
Non executive directors' costs	**174**	160
Staff costs	**372,030**	353,095
Supplies and services - clinical	**192,433**	169,683
Supplies and services - general	**8,720**	9,654
Consultancy services	**1,875**	1,471
Establishment	**5,571**	5,496
Transport	**1,624**	1,559
Premises	**19,329**	19,504
Provision for Impairment of Receivables	**1,854**	211
Depreciation on property, plant and equipment	**21,491**	20,066
Amortisation on intangible assets	**238**	209
Impairments of property, plant and equipment	**1,837**	-
Loss on Disposal of property, plant and equipment	**20**	29
Audit services - statutory audit	**127**	123
Other auditor remuneration - taxation services	**-**	37
Other auditor remuneration - audit of subsidiaries	**20**	7
Other auditor remuneration - other services	**51**	-
Clinical negligence	**6,435**	5,418
Other	**47,568**	55,510
	705,078	665,284

Other expenditure includes £26,297,000 (2013/14 - £27,210,000) in relation to payments to the Trust's PFI partner for services provided; Research Grants distributed to other West Midlands NHS organisations of £4,560,000 (2013/14 - £14,928,000) due to the Trust acting as host body for the Comprehensive Local Research Network; Training, Courses and Conference fees of £4,118,000 (2013/14 - £4,222,000) and fees payable with regard to internal audit services of £157,000 (2013/14 - £161,000).

The Trust's contract with its external auditors, Deloitte LLP, provides for a limitation of the auditors liability of one million pounds sterling. The auditors remuneration - 'other services' fees of £51,000 (2013/14 - £nil) relate to the Local Counter Fraud Service.

6. Operating leases

6.1 As lessee

Payments recognised as an expense	Year Ended 31 March 2015	Year Ended 31 March 2014
	£000	£000
Minimum lease payments	**600**	949

Total future minimum lease payments	Year Ended 31 March 2015	Year Ended 31 March 2014
	£000	£000
Payable:		
Not later than one year	**651**	800
Between one and five years	**658**	558
After 5 years	**985**	1,125
Total	**2,294**	2,483

6.2 As lessor

Rental revenue	Year Ended 31 March 2015	Year Ended 31 March 2014
	£000	£000
Rents recognised as income in the period	**2,285**	2,249

Total future minimum lease payments	Year Ended 31 March 2015	Year Ended 31 March 2014
	£000	£000
Receivable:		
Not later than one year	**2,284**	2,248
Between one and five years	**8,393**	8,102
After 5 years	**21,216**	4,190
Total	**31,893**	14,540

7. Employee costs and numbers

7.1 Employee costs *

	Year Ended 31 March 2015			Year Ended 31 March 2014		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Short term employee benefits - salaries and wages	**298,805**	**276,970**	**21,835**	283,103	266,767	16,336
Short term employee benefits - social security costs	**23,410**	**23,410**	**-**	22,731	22,731	-
Post employment benefits - employer contributions to NHS pension scheme	**32,302**	**32,302**	**-**	30,311	30,311	-
Pension cost - other contributions	**9**	**9**	**-**	2	2	-
Termination benefits	**373**	**373**	**-**	256	256	-
Agency/contract staff	**19,456**	**-**	**19,456**	18,873	-	18,873
Revenue in respect of Salaries and wages where netted off expenditure	**(132)**	**(132)**	**-**	(156)	(156)	**-**
	374,223	**332,932**	**41,291**	355,120	319,911	35,209

7.2 Average number of persons employed

	Year Ended 31 March 2015			Year Ended 31 March 2014		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
Medical and dental	**1,112**	**1,059**	**53**	1,089	1,024	65
Administration and estates	**1,646**	**1,646**	**-**	1,521	1,521	**-**
Healthcare assistants and other support staff	**617**	**617**	**-**	639	639	**-**
Nursing, midwifery and health visiting staff	**3,214**	**3,214**	**-**	3,236	3,236	**-**
Scientific, therapeutic and technical staff	**1,157**	**1,157**	**-**	1,069	1,069	**-**
Bank and agency staff	**256**	**-**	**256**	223	**-**	223
	8,002	**7,693**	**309**	7,777	7,489	288

* The disclosure of employee costs does not include non-executive directors. Termination benefits are detailed in note 7.4 to the financial statements on page XLI.

7.3 Key management compensation

	Year Ended 31 March 2015	Year Ended 31 March 2014
	£000	£000
Salaries and short term benefits	**1,486**	1,417
Social Security Costs	**183**	187
Employer contributions to NHSPA	**151**	165
	1,820	1,769

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 2015						
< £10,000	-	-	-	-	-	-
£10,000 - £25,000	-	-	-	-	-	-
£25,000 - £50,000	3	99	-	-	3	99
£50,000 - £100,000	1	71	-	-	1	71
	4	170	-	-	4	170
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

The termination benefits disclosed all relate to compulsory redundancies. Of the disclosed termination payments none (2013-14 - none) were non-contractual payments requiring HMT approval.

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 (2013/14 - £nil).

8. Retirements due to ill-health

During the year to 31 March 2015 there were 7 early retirements from the Trust agreed on the grounds of ill-health (2013/14 - 7). The estimated additional pension liabilities of these ill-health retirements will be £502,865 (2013/14 - £601,813). 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 2015		Year Ended 31 March 2014	
	Number	**£000**	Number	£000
Trade				
Total trade bills paid in the year	**119,072**	**400,089**	109,237	332,302
Total trade bills paid within target	**115,712**	**392,546**	106,330	327,776
Percentage of trade bills paid within target	**97.18%**	**98.11%**	97.34%	98.64%
NHS				
Total NHS bills paid in the year	**6,667**	**180,804**	6,589	182,839
Total NHS bills paid within target	**6,056**	**177,814**	6,105	180,190
Percentage of NHS bills paid within target	**90.84%**	**98.35%**	92.65%	98.55%

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 (2013/14 - £nil) was charged to the Trust in the year for late payment of commercial debts.

10. Finance income and costs

	Year Ended 31 March 2015	Year Ended 31 March 2014
	£000	£000
Financing income		
Interest receivable	**307**	483
	307	483
Financing costs		
Interest on obligations under PFI contracts	**(22,500)**	(21,981)
Interest on obligations under finance leases	**(29)**	(31)
Other financing charges	**(26)**	(33)
	(22,555)	(22,045)
Net finance expense	**(22,248)**	(21,562)

11. Public dividend capital dividends

Public dividend capital ('PDC') dividends paid and due to the Department of Health amounted to £nil (2013/14 - £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 2015	Year Ended 31 March 2014
	£000	£000
Current tax expense		
Current year	**172**	109
Adjustments in respect of prior years	**(6)**	1
	166	110
Deferred tax expense		
Origination and reversal of temporary differences	**6**	2
Adjustments in respect of prior years	**-**	-
Reduction in tax rate	**-**	(2)
	6	-
Total tax expense recognised in income statement	**172**	110

Tax recognised in other comprehensive income is £nil (2013/14 - £nil).

Tax recognised directly in equity is £nil (2013/14 - £nil).

Reconciliation of effective tax rate	Year Ended 31 March 2015	Year Ended 31 March 2014
Operating surplus before taxation - subsidiary only *	**370**	467
Tax at the standard rate of corporation tax in the UK 23%	**177**	107
Current year impact of rate change	**-**	(2)
Adjustments in respect of prior years	**(6)**	1
Tax effect of expenditure not deductible	**1**	4
Total tax expense	**172**	110

* Liability for corporation tax only arises from the activity of the commercial subsidiaries whose combined operating surplus before taxation is disclosed in the segmental analysis note 2 to the financial statements on page XXXIII. 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 21% to 20%. The standard rate of corporation tax in the UK changed from 21% to 20% with effect from 1 April 2015.

13. Intangible assets

Group and Trust	Computer software - purchased	Licences and trademarks	Total
	£000	£000	£000
Cost			
At 1 April 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**
Additions	345	116	461
Disposals	(41)	-	(41)
At 31 March 2015	**2,315**	**448**	**2,763**
Amortisation			
At 1 April 2013	1,500	140	1,640
Charged for the year	154	55	209
Reclassifications	-	-	-
At 31 March 2014	**1,654**	**195**	**1,849**
Charged for the year	182	56	238
Disposals	(41)	-	(41)
At 31 March 2015	**1,795**	**251**	**2,046**
Net book value			
At 31 March 2015	**520**	**197**	**717**
At 31 March 2014	357	137	494
At 1 April 2013	348	147	495

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 - 2014/15

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 2014	69,350	436,001	1,424	940	94,849	11	16,314	3,761	622,650
Transfers by absorption - modified	-	-	-	-	-	-	-	-	-
Additions purchased / leased	1,950	20,089	-	1,146	8,117	-	1,248	67	32,617
Additions donated	-	-	-	-	607	-	-	-	607
Reclassifications	-	(12,444)	-	12,573	(129)	-	-	-	-
Reversal of impairments credited to operating income	-	4,087	-	-	-	-	-	-	4,087
Impairments charged to revaluation reserve	-	(1,837)	-	-	-	-	-	-	(1,837)
Revaluations	450	1,870	43	-	-	-	-	-	2,363
Disposals / derecognition	(26,125)	(1)	-	-	(1,075)	-	-	(1,220)	(28,421)
At 31 March 2015	**45,625**	**447,765**	**1,467**	**14,659**	**102,369**	**11**	**17,562**	**2,608**	**632,066**
Depreciation									
At 31 March 2014	-	32,243	248	-	57,054	3	11,648	3,258	104,454
Provided during the year	-	9,966	82	-	9,131	2	2,209	101	21,491
Disposals / derecognition	-	-	-	-	(1,056)	-	-	(1,220)	(2,276)
At 31 March 2015	**-**	**42,209**	**330**	**-**	**65,129**	**5**	**13,857**	**2,139**	**123,669**
Net book value									
Owned	2,625	63,498	1,115	2,223	32,231	6	3,705	436	105,839
Donated	-	6,263	22	6	4,688	-	-	33	11,012
Government granted	-	435	-	12,430	-	-	-	-	12,865
Private Finance Initiative	-	335,360	-	-	-	-	-	-	335,360
Finance Lease	43,000	-	-	-	321	-	-	-	43,321
At 31 March 2015	**45,625**	**405,556**	**1,137**	**14,659**	**37,240**	**6**	**3,705**	**469**	**508,397**

The land disposal disclosed above is the sale of the surplus Selly Oak land which was sold to Persimmon plc for residential housing, see note 14.3 to the financial statements on page LIX for details.

14. Property, plant and equipment - 2014/15

Trust	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 2014	69,350	436,001	1,424	940	94,728	11	16,314	3,761	622,529
Transfers by absorption - modified	-	-	-	-	-	-	-	-	-
Additions purchased / leased	1,950	20,089	-	-	7,932	-	1,225	67	31,263
Additions donated	-	-	-	-	607	-	-	-	607
Reclassifications	-	(12,444)	-	12,573	(129)	-	-	-	-
Reversal of impairments credited to operating income	-	4,087	-	-	-	-	-	-	4,087
Impairments charged to revaluation reserve	-	(1,837)	-	-	-	-	-	-	(1,837)
Revaluations	450	1,870	43	-	-	-	-	-	2,363
Disposals / derecognition	(26,125)	(1)	-	-	(1,075)	-	-	(1,220)	(28,421)
At 31 March 2015	**45,625**	**447,765**	**1,467**	**13,513**	**102,063**	**11**	**17,539**	**2,608**	**630,591**
Depreciation									
At 31 March 2014	-	32,243	248	-	57,054	3	11,648	3,258	104,454
Provided during the year	-	9,966	82	-	9,106	2	2,209	101	21,466
Disposals / derecognition	-	-	-	-	(1,056)	-	-	(1,220)	(2,276)
At 31 March 2015	**-**	**42,209**	**330**	**-**	**65,104**	**5**	**13,857**	**2,139**	**123,644**
Net book value									
Owned	2,625	63,498	1,115	1,077	31,950	6	3,682	436	104,389
Donated	-	6,263	22	6	4,688	-	-	33	11,012
Government granted	-	435	-	12,430	-	-	-	-	12,865
Private Finance Initiative	-	335,360	-	-	-	-	-	-	335,360
Finance Lease	43,000	-	-	-	321	-	-	-	43,321
At 31 March 2015	**45,625**	**405,556**	**1,137**	**13,513**	**36,959**	**6**	**3,682**	**469**	**506,947**

The land disposal disclosed above is the sale of the surplus Selly Oak land which was sold to Persimmon plc for residential housing, see note 14.3 to the financial statements on page XLIX for details.

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 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.

14.1 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 a previous impairment being credited to operating revenue, within the consolidated statement of comprehensive income.

Impairments of property, plant and equipment		**Year Ended 31 March 2015 £000**
(Impairments) / reversals of impairments to consolidated statement of comprehensive income		
Queen Elizabeth Hospital - PFI facility	1	**4,087**
Trust owned property	2	**(1,837)**
		2,250

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 2015 compared to 31 March 2014. The reversal of impairment is disclosed on the face of the consolidated statement of comprehensive income on page XVI.

2 The valuation of the newly purchased Regent Court and Yardley Court offices gave rise to an impairment due to the difference between the fair value, at the reporting date, compared to the purchase price and subsequent refurbishment works carried out.

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 XVIII.

Revaluation gains / (losses) on property, plant and equipment	31 March 2015	31 March 2014
Group	**£000**	£000
Surpluses / (deficits) due to revaluation of property recognised in other comprehensive income		
Land	**450**	-
Buildings	**1,870**	6,651
Dwellings	**43**	104
	2,363	6,755

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

14.3 Profit on the disposal of property, plant and equipment

The sale of the surplus land at Selly Oak, Birmingham to Persimmon plc for residential housing (completed on 31 March 2015), gave rise to a profit on disposal of £5,725,000 resulting from the difference between the purchase price of £31,850,000 and the book value of £26,125,000 (fair value in operational use at the date of contract completion). The profit on disposal is disclosed on the face of the consolidated statement of comprehensive income on page XVI. Included within the purchase price is cash received as at the reporting date of £4,200,000 and the remainder of £27,650,000 is disclosed within trade receivables, see note 20 to the financial statements on page LI for details.

14.4 Assets held under finance leases and PFI arrangements - Group

	PFI assets	Assets held under finance leases	Total
	£000	**£000**	**£000**
Cost			
At 1 April 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**
Additions	884	-	884
Revaluations	-	250	250
Disposals / derecognition	(1)	-	(1)
Reversal of impairments credited to operating income	4,087	-	4,087
At 31 March 2015	**366,182**	**43,699**	**409,881**
Depreciation			
At 1 April 2013	16,585	286	16,871
Charged for the year	6,932	46	6,978
At 31 March 2014	**23,517**	**332**	**23,849**
Charged for the year	7,305	46	7,351
At 31 March 2015	**30,822**	**378**	**31,200**
Net book value			
At 31 March 2015	**335,360**	**43,321**	**378,681**
At 31 March 2014	337,695	43,117	380,812
At 1 April 2013	325,379	43,138	368,517

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

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 £5,813,000 (31 March 2014 - £1,503,000). 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 2015.

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 XXXIII.

UHB Facilities Limited

The company is registered in the UK, company no. 08642236, with a share capital comprising one share of £1 owned by the Trust. The company commenced trading on the 10 October 2014 as a provider of a managed healthcare facility, see note 2 to the financial statements on page XXXIII.

Assure Dialysis Services Limited

The company is registered in the UK, company no. 08642238, with a share capital comprising one share of £1 owned by the Trust. The company commenced trading on the 1 January 2015 as a provider of renal dialysis healthcare, see note 2 to the financial statements on page XXXIII.

Birmingham Systems Limited

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

Investments

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

17. Mergers

The Trust has had no gains or divestments of NHS healthcare activity (from or to other NHS organisations respectively) during the reporting year. In the prior year 2013/14 - the Trust acquired the Community Sexual Health service for the city of Birmingham, for which no consideration was paid. The property, plant and equipment was transferred on 1 April 2013, a gain of £1,543,000 and is detailed in note 14 to the financial statements on page XLVII.

18. Non-current assets held for sale

The Trust has no non-current assets held for sale at the reporting date (31 March 2014 - £nil).

19. Inventories

	Group		Trust	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000	£000	**£000**	£000
Consumables	**8,251**	8,838	**8,251**	8,838
Drugs	**7,203**	6,384	**5,552**	5,045
Finished goods	**8**	9	**8**	9
	15,462	15,231	**13,811**	13,892

Inventories carried at fair value less costs to sell where such value is lower than cost are nil (31 March 2014 - £nil).

The Group expensed £103,342,000 of inventories during the year (2013/14 - £162,314,000). The Group charged £257,000 to operating expenses in the year due to write-downs of obsolete inventories (2013/14 - £248,000).

20. Trade and other receivables

Current	Group		Trust	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000	£000	**£000**	£000
NHS receivables	**41,057**	31,581	**41,057**	31,581
Receivables with other related parties	**3,850**	5,870	**3,850**	5,870
Commercial trade receivables	**12,086**	3,944	**17,897**	9,303
Provision for impaired receivables	**(3,417)**	(1,711)	**(3,417)**	(1,711)
PFI prepayments - lifecycle replacements	**7,649**	5,314	**7,649**	5,314
Prepayments	**2,887**	3,437	**2,876**	3,431
Accrued income	**213**	669	**213**	698
Other receivables - revenue	**7,014**	6,772	**7,199**	6,151
Other receivables - capital	**9,000**	-	**9,000**	-
	80,339	55,876	**86,324**	60,637

Non current	Group		Trust	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000	£000	**£000**	£000
Provision for impaired receivables	**(718)**	(757)	**(718)**	(757)
	3,624	3,822	**3,624**	3,822
Other receivables	**18,650**	-	**18,650**	-
	21,556	3,065	**21,556**	3,065

Other receivables - capital of both Group and Trust are the amounts owed by Persimmon plc which are due from the sale of the surplus land at Selly Oak, Birmingham detailed in note 14.3 to the financial statements on page XLIX. The timing of the future payments are contractual obligations and have been discounted (at 3.5%) to reflect the time value of the cash at the reporting date:

At 31 March 2015	Within one year £000	Between one and two years £000	Between two and three years £000
Commercial trade receivable - Persimmon	**9,000**	**11,836**	**6,814**

The land sale contract protects the Trust against the potential of credit risk associated with this material financial instrument by enacting a charge over the land, in proportion to the sale value not yet received in cash. Once the full sale value of £31,850,000 has been received, the security over the land will be discharged.

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 LXI.

Included within trade and other receivables of both Group and Trust are balances with a carrying amount of £14,631,000 (31 March 2014: £11,592,000) 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 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000	£000	**£000**	£000
Not past due date	**87,264**	47,349	**93,249**	52,110
By up to three months	**4,247**	3,553	**4,247**	3,553
By three to six months	**908**	1,011	**908**	1,011
By more than six months	**9,476**	7,028	**9,476**	7,028
	101,895	58,941	**107,880**	63,702

Provision for impaired receivables	**Group**		**Trust**	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000	£000	**£000**	£000
Balance at 1 April	**2,468**	2,479	**2,468**	2,479
Increase in provision	**3,847**	1,823	**3,847**	1,823
Amounts utilised	**(187)**	(222)	**(187)**	(222)
Unused amounts reversed	**(1,993)**	(1,612)	**(1,993)**	(1,612)
	4,135	2,468	**4,135**	2,468

Aged analysis of impaired receivables	Group		Trust	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000	£000	**£000**	£000
By up to three months	**950**	58	**950**	58
By three to six months	**332**	11	**332**	11
By more than six months	**2,853**	2,399	**2,853**	2,399
	4,135	2,468	**4,135**	2,468

21. Other non financial assets

The Trust has no non-financial assets as at the reporting date (31 March 2014 - £nil).

22. Cash and cash equivalents

	Group		Trust	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000	£000	**£000**	£000
Cash and cash equivalents				
Made up of				
Cash with Government Banking Service	**963**	519	**963**	519
Commercial banks and cash in hand	**50,305**	62,569	**48,533**	59,858
Current investments	**-**	-	**-**	-
Cash and cash equivalents as in statement of financial position	**51,268**	63,088	**49,496**	60,377
Bank overdraft - Government Banking Service	**-**	-	**-**	-
Bank overdraft - Commercial banks	**-**	-	**-**	-
Cash and cash equivalents as in statement of cash flows	**51,268**	63,088	**49,496**	60,377

23. Trade and other payables

Current	Group		Trust	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000	£000	**£000**	£000
NHS payables	**5,988**	9,206	**5,988**	9,206
Amounts due to other related parties	**5,498**	4,489	**5,498**	4,489
Commercial trade payables	**41,582**	41,432	**41,789**	41,295
Trade payables - capital	**2,373**	1,308	**2,321**	1,307
Taxes payable	**7,367**	7,385	**7,354**	7,376
Other payables	**1,336**	1,479	**3,745**	2,993
Accruals	**44,422**	45,252	**44,519**	45,324
Receipts in advance	**4,633**	3,601	**4,633**	3,601
	113,199	114,152	**115,847**	115,591

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 LXI. Included within amounts due to other related parties are NHS pension contributions of £4,565,000 (31 March 2014: £4,342,000).

Non current trade and other payables are nil (31 March 2014 - £nil).

24. Other liabilities

Current	Group		Trust	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000	£000	**£000**	£000
Deferred income	**18,947**	16,965	**18,775**	16,965
Deferred government grant	**12,000**	-	**12,000**	-
	30,947	16,965	**30,775**	16,965

Non current	Group		Trust	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000	£000	**£000**	£000
Deferred income	**10,813**	16,413	**10,813**	16,413
Deferred government grant	**-**	1,400	**-**	1,400
	10,813	17,813	**10,813**	17,813

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 2013	17	-	17
Charge / (credit) to the income statement	-	-	-
At 31 March 2014	**17**	**-**	**17**
Charge / (credit) to the income statement	7	-	7
At 31 March 2015	**24**	**-**	**24**

* Liability for corporation tax only arises from the activity of the commercial subsidiaries, 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 2015	31 March 2014
	£000	£000
Deferred tax assets	-	-
Deferred tax liabilities	**24**	17
Net non current deferred tax liability	**24**	17

26. Borrowings

Group and Trust	Current		Non current	
	31 March 2015	31 March 2014	31 March 2015	31 March 2014
	£000	£000	£000	£000
Obligations under finance leases	**40**	38	**312**	352
Obligations under Private Finance Initiative contracts	**12,589**	12,059	**509,263**	521,852
	12,629	12,097	**509,575**	522,204

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 LVI.

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 (31 March 2014 - £nil). In 2013/14 Monitor introduced a new financial reporting framework (the 'Continuity of Services Risk Rating') whose Liquidity ratio excluded all working capital facilities therefore, the Trust has no requirement for such a facility.

27. Finance lease obligations (other than PFI)

Group and Trust	Minimum lease payments		Present value of minimum lease payments	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000	£000	**£000**	£000
Gross lease liabilities	**466**	533	**389**	438
Of which liabilities are due:				
Not later than one year	**67**	67	**67**	67
Later than one year, not later than five years	**266**	266	**231**	231
Later than five years	**133**	200	**91**	140
Net finance charges allocated to future periods	**(114)**	(143)	**(100)**	(124)
Net lease liabilities	**352**	390	**289**	314
Not later than one year	**40**	38	**40**	38
Later than one year, not later than five years	**194**	180	**168**	155
Later than five years	**118**	172	**81**	121

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%), InfraRed Infrastructure Yield Fund (30%) and Infrastructure Investments Holdings Limited, a subsidiary of HICL Infrastructure Company Limited (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 2015	31 March 2014
	£000	£000
Gross PFI liabilities	**835,503**	864,574
Of which liabilities are due:		
Not later than one year	**29,210**	29,071
Later than one year, not later than five years	**111,979**	113,749
Later than five years	**694,314**	721,754
Net finance charges allocated to future periods	**(313,651)**	(330,663)
Net PFI liabilities	**521,852**	533,911
Not later than one year	**12,589**	12,059
Later than one year, not later than five years	**49,503**	49,682
Later than five years	**459,760**	472,170

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 £52,163,000 (2013/14 - £50,809,000). 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 2015	31 March 2014	31 March 2015	31 March 2014
	£000	£000	£000	£000
Of which commitments are due:				
Not later than one year	**52,676**	52,163	**52,676**	52,163
Between one and five years	**210,704**	208,652	**193,485**	189,028
After 5 years	**1,389,461**	1,427,614	**784,408**	732,937
Total PFI commitments	**1,652,841**	1,688,429	**1,030,569**	974,128

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

Group and Trust	Unitary payments		Present value of unitary payments	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000	£000	**£000**	£000
Of which commitments are due:				
Not later than one year	**14,898**	14,535	**14,898**	14,535
Between one and five years	**63,412**	61,866	**54,723**	56,048
After 5 years	**618,818**	635,262	**221,853**	326,143
Total service expense commitments	**640,028**	711,663	**291,474**	396,726

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	Current		Non current	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000	£000	**£000**	£000
Pensions relating to other staff	**41**	30	**380**	65
Legal claims	**528**	662	**2,088**	1,773
Other	**203**	568	**-**	-
	772	1,260	**2,468**	1,838

	Pensions relating to other staff	**Legal claims**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**
At 1 April 2014	95	2,435	568	**3,098**
Arising during the year	356	661	203	**1,220**
Used during the year	(31)	(218)	(217)	**(466)**
Reversed unused	-	(287)	(351)	**(638)**
Unwinding of discount	1	25	-	**26**
At 31 March 2015	**421**	**2,616**	**203**	**3,240**
Expected timing of cash flows:				
Within one year	41	528	203	**772**
Between one and five years	154	437	-	**591**
After five years	226	1,651	-	**1,877**

Trust	Current		Non current	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000	£000	**£000**	£000
Pensions relating to other staff	**41**	30	**380**	65
Legal claims	**528**	662	**1,842**	1,773
Other	**203**	568	**-**	-
	772	1,260	**2,222**	1,838

Trust	**Pensions relating to other staff**	**Legal claims**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**
At 1 April 2014	95	2,435	568	**3,098**
Arising during the year	356	415	203	**974**
Used during the year	(31)	(218)	(217)	**(466)**
Reversed unused	-	(287)	(351)	**(638)**
Unwinding of discount	1	25	-	**26**
At 31 March 2015	**421**	**2,370**	**203**	**2,994**
Expected timing of cash flows:				
Within one year	41	528	203	**772**
Between one and five years	154	437	-	**591**
After five years	226	1,405	-	**1,631**

The provisions included under 'legal claims' are for personal injury pensions £1,957,000 (31 March 2014: £1,884,000), employers and public liability £301,000 (31 March 2014: £399,000) and other claims notified by the Trust's solicitors £112,000 (31 March 2014: £152,000). 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 £421,000 (31 March 2014: £95,000), disclosed as 'pensions relating to other staff' have been calculated on guidance received from the NHS Business Services Authority - Pensions Division.

The Group provision includes an amount of £246,000 (31 March 2014: £nil) in respect of UHB Facilities Ltd and a tenant's dilapidations contractual commitment for the Rabone Lane site.

Provisions within the annual accounts of the NHS Litigation Authority at 31 March 2015 include £32,517,000 in respect of clinical negligence liabilities of the Trust (31 March 2014: £24,773,000).

30. Contingencies

There are £140,000 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 LIX (31 March 2014: £132,000). The same potential claims result in £17,000 of contingent assets at the reporting date (31 March 2014: £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 £000	Payables £000	Revenue £000	Expenditure £000
NHS in England				
NHS Birmingham Crosscity CCG	1,152	107	95,693	-
NHS Birmingham South And Central CCG	1,743	-	65,394	-
NHS Dudley CCG	298	-	7,054	-
NHS Redditch And Bromsgrove CCG	137	35	9,276	-
NHS Sandwell And West Birmingham CCG	984	-	21,242	-
NHS Solihull CCG	-	19	6,775	-
NHS South Worcestershire CCG	425	-	3,996	-
NHS Walsall CCG	104	8	4,550	-
NHS England (specialised commissioning)	15,442	207	351,906	648
Health Education England	1,026	4	31,994	49
Birmingham Women's NHS Foundation Trust	1,276	363	4,766	371
The Royal Orthopaedic Hospital NHS Foundation Trust	207	246	2,712	427
Birmingham Children's Hospital NHS Foundation Trust	1,107	405	3,311	1,786
Birmingham Community Healthcare NHS Trust	566	404	2,798	268
Department of Health	9,900	-	22,707	6
West Midlands Ambulance Service NHS Foundation Trust	-	2	59	4,526
NHS Litigation Authority	-	15	-	6,437
Other	6,690	4,173	39,005	6,144
	41,057	5,988	673,238	20,662
Other related parties - Whole of Government Accounts				
Ministry of Defence	347	362	6,459	1,272
NHS Pension Scheme	9	4,565	-	32,302
Birmingham City Council	439	42	8,142	5,056
NHS Wales	2,223	15	7,709	73
HMRC	1,314	7,564	-	23,423
	832	514	5,347	8,524
	5,164	13,062	27,657	70,650

The Trust has also received revenue and capital payments from the University Hospital Birmingham Charities totalling £1,526,000 (2013/14 - £3,324,000).

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 following directors of the Trust are also board members of the trading subsidiaries, roles as stated:

Trust director	Pharmacy@ QEHB Ltd	UHB Facilities Ltd	Assure Dialysis Ltd
Mike Sexton	chair	non-executive	-
Kevin Bolger	non-executive	-	-
Philip Norman	-	-	clinical lead
Dr David Rosser	-	-	non-executive
David Burbridge	co. secretary	co. secretary	co. secretary

The three trading subsidiaries do 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 and payables includes the following:

The Trust's receivables include £5,810,000 (31 March 2014 - £5,388,000) owed by and payables include £3,066,000 (31 March 2014 - £1,831,000) owed to Pharmacy@QEHB Ltd. The Trust's revenue includes £659,000 (31 March 2014 - £491,000) received from and expenditure includes £28,163,000 (31 March 2014 - £18,290,000) paid to Pharmacy@QEHB Ltd.

The Trust's receivables include £1,283,000 (31 March 2014 - £nil) owed by and payables includes £nil (31 March 2014 - £nil) owed to UHB Facilities Ltd. The Trust's revenue includes £11,000 (31 March 2014 - £nil) received from and expenditure includes £nil (31 March 2014 - £nil) paid to UHB Facilities Ltd.

The Trust's receivables include £35,000 (31 March 2014 - £nil) owed by and payables includes £nil (31 March 2014 - £nil) owed to Assure Dialysis Services Ltd. The Trust's revenue includes £1,000 (31 March 2014 - £nil) received from and expenditure includes £nil (31 March 2014 - £nil) paid to Assure Dialysis Services Ltd.

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 2015	31 March 2014	**31 March 2015**	31 March 2014
	Notes	**£000**	£000	**£000**	£000
Current financial assets					
Cash and cash equivalents	1	**51,268**	63,088	**49,496**	60,377
Loans and receivables:					
Trade and receivables	1	**69,803**	47,125	**75,799**	51,892
		121,071	110,213	**125,295**	112,269
Non-current financial assets					
Loans and receivables:					
Trade and receivables	1	**21,556**	3,065	**21,556**	3,065
		21,556	3,065	**21,556**	3,065
Total financial assets		**142,627**	113,278	**146,851**	115,334
Current financial liabilities					
Other financial liabilities:					
Finance leases	2	**40**	38	**40**	38
Private Finance Initiative contracts	2	**12,589**	12,059	**12,589**	12,059
Trade and other payables	1	**101,199**	103,166	**103,860**	104,614
Provisions under contract	1	**616**	1,119	**616**	1,119
		114,444	116,382	**117,105**	117,830
Non-current financial liabilities					
Other financial liabilities:					
Finance leases	2	**312**	352	**312**	352
Private Finance Initiative contracts	2	**509,263**	521,852	**509,263**	521,852
Provisions under contract	1	**246**	-	**-**	-
		509,821	522,204	**509,575**	522,204
Total financial liabilities		**624,265**	638,586	**626,680**	640,034
Net financial assets / (liabilities)		**(481,638)**	(525,308)	**(479,829)**	(524,700)

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 LVI and LVII 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 LI
- Trade payables includes receipts in advance and PDC payable which are not financial instruments, see note 23 to the financial statements on page LIV

- 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 LIX

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 XXXIII, there is reduced 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 LII, including details of the amounts owing on the sale of surplus land. 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 LVII. For the reporting year the relevant RPI index was 254.2 (annualised

rate of 2.7%) fixed at February 2014. 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 2015		Year Ended 31 March 2014	
	£000	£000	£000	£000
	+1.0%	-1.0%	+1.0%	-1.0%
Retained surplus / (deficit)	(508)	508	(470)	470
Taxpayers' equity	(508)	508	(470)	470

(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 LV. 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 XLII. 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 2014: £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 2015		Year Ended 31 March 2014	
	Number	£000	Number	£000
Losses				
Cash losses	**13**	**8**	19	6
Bad debts and claims abandoned	**178**	**102**	140	53
Damage to property and stores losses	**-**	**-**	4	54
	191	**110**	163	113
Special payments				
Compensation payments	**1**	**-**	2	20
Ex gratia payments	**193**	**23**	229	172
	194	**23**	231	192
Total losses and special payments	**385**	**133**	394	305

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

Signed:

Name: David Bennett (Chief Executive) Dated: December 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: or

for an NHS foundation trust in its final period of operation and which ceased to exist as an entity during the year, the accounts of an NHS foundation trust for the period from 1 April until the end of the reporting period; or

"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

Signed:

Name: David Bennett (Chief Executive) Dated: December 2014