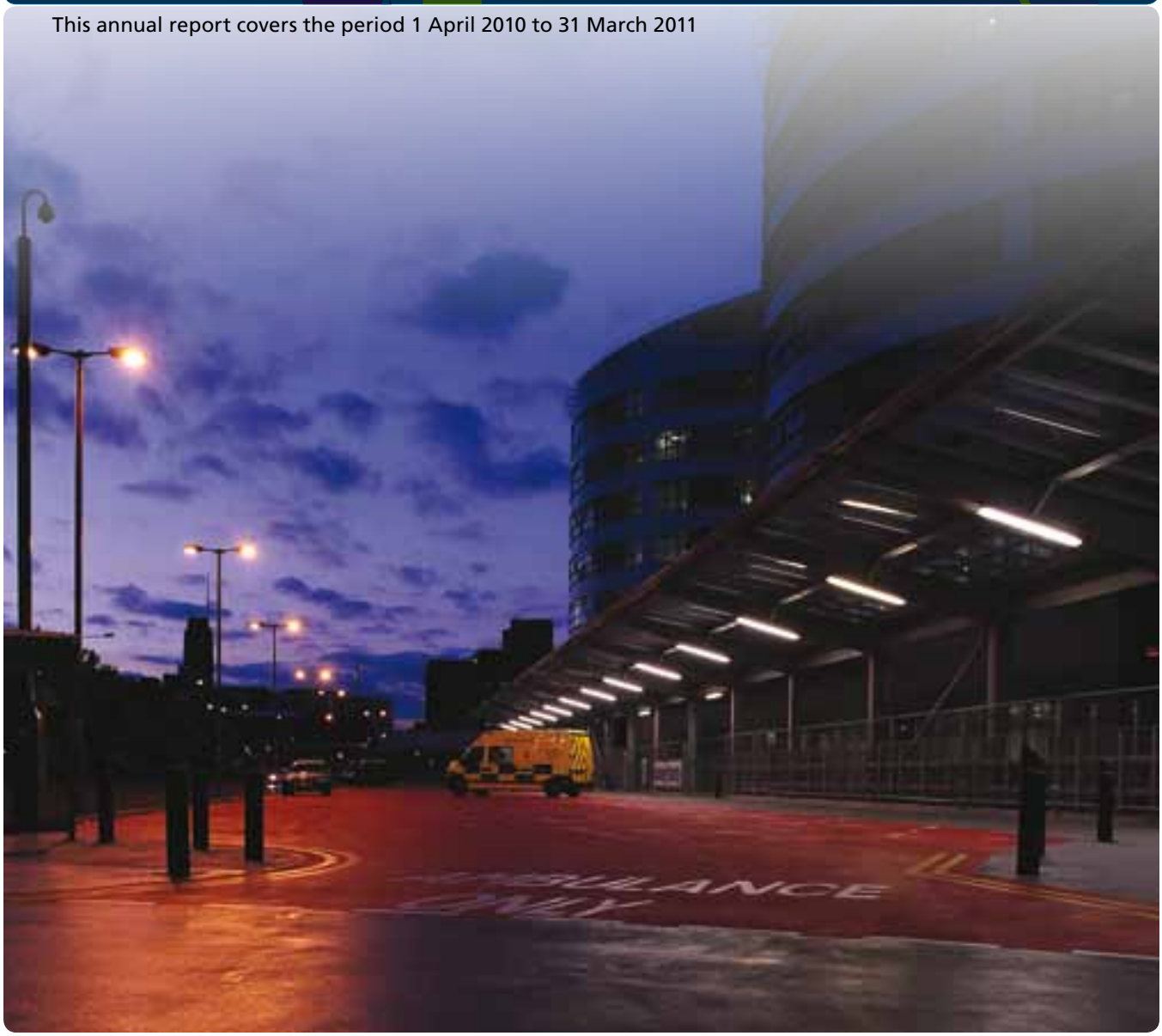
University Hospitals Birmingham
NHS Foundation Trust

Annual Report and Accounts 2010/2011

This annual report covers the period 1 April 2010 to 31 March 2011



University Hospitals Birmingham NHS Foundation Trust
Annual Report and Accounts 2010/11

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

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NHS Foundation Trust

Section 1 **Annual Report 2010/2011**

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Directors' Report

1. Overview

1.1 Names of persons who were Directors of the Trust

The Board is currently comprised as follows:

Chairman: Sir Albert Bore

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

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

1.2 Principal activities of the Trust

University Hospitals Birmingham NHS Foundation Trust is the leading university teaching hospital in the West Midlands. It provides traditional secondary care services to the South Birmingham catchment area. Specialist tertiary care is provided mainly across the West Midlands and a proportion of the Trust's activity is provided to patients who are referred from outside the region.

The Trust runs three hospitals, Queen Elizabeth Hospital Birmingham, the Queen Elizabeth and Selly Oak hospitals, which provide adult services to over 700,000 patients every year, from a single outpatient appointment to a heart transplant. The Trust is a regional centre for cancer, trauma, burns and plastics, and has the largest solid organ transplantation programme in Europe. It is also the UK's first and only NIHR Centre for Surgical Reconstruction and Microbiology.

The Trust employs around 6,900 staff and is two thirds the way through transferring services into Birmingham's first new acute hospital in 70 years. The move will be complete by November 2011.

The Trust had five clinical divisions with each division led by a management team consisting of a Divisional Director, Director of Operations, and an Associate Director of Nursing. This triumvirate structure is mirrored through all the clinical specialties.

1.3 Royal Centre for Defence Medicine

The Trust is host to the Royal Centre for Defence Medicine (RCDM), the primary function of which is to provide medical support to military operational deployments. It provides secondary and specialist care for members of the armed forces and incorporates a facility for the treatment of service personnel who have been evacuated from an overseas deployment area after becoming ill or wounded.

It is a dedicated training centre for defence personnel and a focus for medical research. The RCDM is a tri-service establishment, meaning that there are personnel from all three of the armed services. Defence personnel are fully integrated throughout both sites and treat both military and civilian patients. The Trust also holds the contract for providing medical services to military personnel evacuated from overseas via the "Aero med service".

1.4 Research and Development

The Trust is a leading UK centre for medical research and development thanks to its diverse portfolio of clinical trials. Our researchers play a vital role in advancing the treatment the Trust is able to deliver to its patients and in doing so they support the Trust's vision to deliver the best in care, help maintain its reputation for excellence and, most importantly, make a real difference to people's lives.

This strong track-record was further enhanced in January 2011 when the Queen Elizabeth Hospital Birmingham (QEHB) was announced as the host of a £20m national centre for research into treating trauma.

The new National Institute for Health Research (NIHR) Centre for Surgical Reconstruction and Microbiology involves the Department of Health, the Ministry of Defence, University Hospitals Birmingham NHS Foundation Trust and the University of Birmingham.

As the QEHB is the primary receiving hospital for all of Britain's serious military casualties, the new NIHR centre will be used to help bring military and civilian trauma surgeons and scientists together to share innovation in medical research and advanced clinical practice in the battlefield, benefiting all trauma patients in the NHS at an early stage of injury.

Research will focus initially on today's most urgent challenges in trauma, including:

- Identifying effective resuscitation techniques
- Surgical care after multiple injuries or amputation
- Fighting wound infections

Also in January 2011, Dr Simon Bowman, a consultant rheumatologist at Selly Oak Hospital, was awarded almost £1 million by Arthritis Research UK to research treatment for an auto-immune condition called Sjögren's syndrome.

Sjögren's syndrome affects around half a million people in the UK and causes the body to attack its own tissues, particularly the tear glands and salivary glands.

Dr Bowman, who ran a small pilot study into Sjögren's two years ago funded by the QEHB Charity, will now recruit up to 110 patients from hospitals around the country for a full-scale clinical trial, comparing the drug rituximab against a placebo.

A new study to assess the benefits of exercise for people with type 1 diabetes was launched in March 2011.

The research is being coordinated by the Wellcome Trust Clinical Research Facility, based at the Queen Elizabeth Hospital, and involves University Hospitals Birmingham NHS Foundation Trust (the Trust), the University of Birmingham, University of Bristol and University of Bath.

The study is being funded through the National Institute for Health Research (NIHR) under its Research for Patient Benefit Programme (RfPB) and will recruit over two years throughout the West Midlands and South West England. Birmingham has secured £249,000 of the total funding.

In November 2010, a Birmingham research team presented results at an international conference confirming that the use of copper on surfaces can improve hygiene in hospitals.

The QEHB Charity has continued to support research projects and awarded £1 million in grants to the Trust and University of Birmingham during 2010-11. The latest awards, in March 2011, totalled more than £521,000. A full summary of the Trust's R & D activities in the last 12 months is available on the website www.uhb.nhs.uk under Research.

2. Management Commentary

2.1 Trust Development and Performance in 2010/11 and Position at Year End

2.1.1 Strategic Planning

The Trust has continued to further develop its vision, values, and core purposes over the last year, in particular by implementing its Annual Plan for 2010/11 which was developed as year two of the Trust's Five-Year Strategy. Both the strategy and annual plan were developed with the objective of the Trust fulfilling its vision to deliver the best in care and the four core underpinning purposes (clinical quality, patient experience, education and training, and research and innovation). The Trust's values (honesty, responsibility, respect, and innovation) also played a significant role in the development of both the strategy and the plan as they provide the governance framework within which it will be delivered.

In addition both the annual plan and the five-year strategy were refreshed during the year to reflect the aims of the government White Paper: 'Equity and Excellence: Liberating the NHS'. The themes contained in the White Paper were strongly linked to those originally developed in the original strategy:

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

The Trust is therefore in a strong position to adapt to the new system that will be introduced with its focus on quality, efficiency, and patient engagement. Each level of both the strategy and the annual plan was analysed as part of the review following the publication of the White Paper and a number of strategic aims, enablers, and actions within the 2010/11 annual plan were revised. The strategic aims underlying each of the Trust's core purposes are now as follows:

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

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

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

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

2.2 Principal Risks and Uncertainties Facing the Trust

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

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

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

In terms of external regulatory requirements, although they were achieved in 2010/11, performance against the cancer targets remains a risk. As the Trust receives a high level of tertiary referrals due to the specialist services it provides, any referrals received late along the pathway make achievement of the targets more challenging. Infection control also remains a challenge.

The standard NHS contract carries a high level of risk due to the financial penalties that can be applied for a range of performance issues such as activity variance and under-achievement of targets. The Trust did however attain full achievement of all its CQUINs in 2010/11.

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

Although there may be further changes in the details as it passes through Parliament it is clear that the Health and Social Care Bill will result in fundamental changes to the NHS in England.

The following key areas of change relating to the new system are likely to have significant effects on the Trust's future position. These challenges were considered as part of the review of the five-year strategy following the publication of the White Paper and mitigating actions are being implemented to ensure that the risk to the Trust is minimised.

2.3.1 Information and Choice

The Government intends to involve patients more closely in their care and decision making and look to do this by increasing access to information and by utilising patient reported measures of satisfaction to drive policy and payment. The Trust is already a leader in this area and has been publishing quality and outcome information on the Trust's website to allow patients to make informed choices about their care. The Trust has also been piloting a system that allows patients with certain conditions to see healthcare information relating to their care on a secure website, myhealth@QEHB. There is significant potential for the Trust to share its expertise in health informatics with other providers, for example its Healthcare Evaluation Data (HED) system which allows the outcomes of different trusts to be compared.

It is clear that the further development of patient choice by giving patients a greater range of information could lead to significant changes in the Trust's referral patterns and levels of activity, particularly as choice of named consultant-led team is introduced for elective care by April 2011. Choice is also to be introduced for diagnostic testing and choice post diagnosis from 2011. The Trust will therefore need to be able to provide information on these services to allow patients to make an informed choice about their provider.

2.3.2 Patient and Public Involvement

The Government intends to introduce HealthWatch England in the forthcoming Health Bill to be an independent consumer champion. This will replace the current Local Involvement

Networks (LINks) and Overview and Scrutiny Committee and will form the local arm of the Care Quality Commission. The Trust has a long history of patient and public involvement, including supporting the work of LINks and it is important that the existing knowledge of the Trust and its services is not lost during the transition.

2.3.3 Improving Healthcare Outcomes and Payment for Performance

The Department of Health has developed an Outcomes Framework for the NHS which aims to measure the overall effectiveness of the NHS in improving outcomes. It is also linked to the development of Quality Standards by the National Institute for Health and Clinical Excellence (NICE) which set out what a high quality service for a particular condition will look like.

The Trust has already started to develop its information systems to allow the reporting of performance against both the Outcome Framework and NICE Quality Standards. In addition the Trust is seeking to develop the HED system to support other trusts in this area.

It is intended that payment is linked to this quality framework through a tariff and prices determined by the NHS Commissioning Board and Monitor, however, in the interim a number of changes are being introduced by the Department of Health. Key changes include the widening of CQUINs and Best Practice Tariffs and non-payment for readmissions. The Trust has therefore been strengthening its information and contracting systems to ensure that the financial risk associated with these changes is minimised.

2.3.4 Changes in Commissioning Arrangements

The Department of Health will devolve commissioning responsibility to GP practices, operating in consortia and facilitated by a range of third parties. In South Birmingham there are already three 'pathfinder' consortia established and the Trust has established both clinically-led and management relationships with these new bodies to ensure that strong working arrangements are developed in advance of the consortia being statutorily established in 2013.

The establishment of GP consortia is clearly a risk to the Trust as there is significant potential for commissioning intentions to change which could have a financial impact on the Trust. The Trust is therefore working with the pathfinder consortia to ensure that they have the information they need and are assured that the Trust offers high quality and efficient services.

In addition to the GP consortia the NHS Commissioning Board (NHSCB) will be responsible for commissioning specialised services. The detail of how this will operate in practice is not currently available but it is clear that the Trust will need to develop a similar working relationship with the NHSCB to ensure that the quality of its services is recognised and they continue to be commissioned.

2.3.5 Regulation

Monitor and the CQC will operate a joint licensing regime with CQC responsible for essential safety and quality and Monitor as the economic regulator. Clearly this is a fundamental change in both organisations' roles. It is therefore essential that the Trust retains its existing good standing with both regulators both during and after the transition period.

2.3.6 Changes to Commissioning and Funding for Education

The Government has indicated in its consultation 'Developing the Healthcare Workforce' that it intends to replace the current system of commissioning, funding and quality assuring the education of current and future healthcare professionals. Key changes that are proposed include the replacement of deaneries by Local Skills Networks, and the introduction of a tariff and levy for educational activities.

Although the proposals are currently relatively strategic it is clear that, as a teaching hospital,

these changes may have a significant effect on the Trust's educational activity and income. It is therefore vital that the Trust continues to play an active part in the development of policy in this area so that it can both influence policy and work to mitigate any potential negative effects.

2.4 Performance Governance Framework

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

During the year the Trust has continued to invest in its informatics capabilities, in particular by further developing its web-based dashboard which is used for both operational and performance management. Work has been undertaken to further expand the range of performance indicators available on the dashboard and for this information to be available in a timely manner to aid operational management. In addition the Trust has developed a role-based dashboard which enables operational staff to see all key information and indicators about the service they provide in one place and offers a system of alerts where deviation in performance is identified.

2.5 National Targets/Standards and the Standard NHS Contract

The financial year of 2010/11 was another very successful year for the Trust. It has successfully met or exceeded some very challenging targets.

The Trust has continued to place a particular focus on reducing infection rates. A total of 11 post-48 hour MRSA cases were reported against a trajectory of 11 and 145 C.difficile cases were reported against a trajectory of 164.

The Trust saw nearly half a million outpatients, 67,000 inpatients, 32,000 daycases, and 83,000 A&E attendances. The Trust continues to ensure equitable access to services and over 95% of patients were treated, admitted, or discharged from A&E in less than four hours over the course of the year. The Trust continued to meet the national 18-week referral-to-treatment target at Trust and specialty level and is already meeting the new 95th centile waiting times ahead of their introduction in April 2011. The Trust has also successfully delivered against all the national cancer waiting time targets in 2010/11.

This was the third year of the standard NHS contract. Contract performance is monitored and discussed on a monthly basis with NHS South Birmingham and, for specialised services, the West Midlands Specialised Commissioning Team on behalf of the 17 West Midlands PCTs. The Trust has successfully complied with the terms of the contract in 2010/11.

2.6 Clinical Quality and Patient Experience

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

The priorities contained within the 2010/11 Quality Report have shown improvement:

- Reducing errors (with a particular focus on medication errors)

- Time from prescription to administration of first antibiotic dose
- Venous thromboembolism (VTE) risk assessment on admission
- Improve patient experience and satisfaction
- Infection prevention and control

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

The milestones and outcomes contained within the CQUIN priorities have also been successfully delivered. In addition to those identified above the following goals are included:

- Introduction of an electronic observation chart
- Improving the management of patients who are at risk of falling
- Reducing the rate of central venous catheter associated bloodstream infections
- Reducing the rate of pressure ulcers acquired in hospital

2.7 Trust Development and Performance during 2010/11

In 2010/11 the Trust broadly met its objectives and successfully met or exceeded a number of very challenging targets, treating more patients than ever before.

	2009/10	2010/11	% change
Inpatient Finished Consultant Episodes	67,058	70,612	+5.3%
Day-cases (excluding renal dialysis regular day attenders)	31,825	29,232	-8.1%
Outpatient attendances	499,981	517,516	+3.5%
A&E Attendances	82,632	82,925	+0.4%
Total treatments	681,496	700,285	+2.8%

Over 95% of patients were treated, admitted, or discharged from A&E in less than four hours over the course of the year. The Trust has sustained some of the lowest inpatient and outpatient waiting times in the NHS and has met all the national targets for cancer.

2.8 Performance against Key Patient Targets

The Care Quality Commission discontinued its Periodic Review performance rating system in 2010/11 and therefore did not publish overall performance ratings for trusts for 2009/10. Instead it published benchmarking of individual trusts' performance in 2009/10 against a subset of the national indicators. The benchmarking showed the Trust to be in line with expected performance for all included indicators with the exception of three. The Trust's performance was much better than expected for two-week waits for breast symptoms, better than expected for the percentage of cancelled operations not treated within 28 days and worse than expected for 62 day cancer waits from consultant upgrade to treatment. Financially the Trust continues to perform against plan. Had the system of Periodic Review continued the Trust would have scored 'Excellent' for both Quality of Services and Quality of Financial Management in 2009/10.

The Trust's inpatient survey results showed an improvement which allowed the Trust to achieve its nationally mandated CQUIN for 2010/11. There was however a number of areas that still require improvement and an action plan has been developed to drive further improvement. The Trust has in place a formal committee, the Care Quality Group, which develops initiatives to enhance the patient experience and improve patient satisfaction.

The following table sets out performance against the Trust's main targets for 2010/11:

National targets and indicators included in Monitor's Compliance Framework for 2010/11

Target/indicator	Time Period	2010/11 Target	2010/11
Clostridium difficile (post-48 hour cases)	Apr 2010 – Mar 2011	164	145
MRSA (post-48 hour cases)	Apr 2010 – Mar 2011	11	11
62-day wait for first treatment from urgent GP referral: all cancers	Apr 2010 – Mar 2011	85%	86.5%
62-day wait for first treatment from consultant screening service referral: all cancers	Apr 2010 – Mar 2011	90%	93.9%
31-day wait from diagnosis to first treatment: all cancers	Apr 2010 – Mar 2011	96%	98.6%
31-day wait for second or subsequent treatment: surgery	Apr 2010 – Mar 2011	94%	97.9%
31-day wait for second or subsequent treatment: anti cancer drug treatments	Apr 2010 – Mar 2011	98%	99.9%
31-day wait for second or subsequent treatment: radiotherapy	Jan 2011 – Mar 2011	94%	100%
Two week wait from referral to date first seen: all cancers	Apr 2010 – Mar 2011	93%	96.0%
Two week wait from referral to date first seen: breast symptoms	Apr 2010 – Mar 2011	93%	98.4%
18-week maximum wait from point of referral to treatment (admitted patients)	Apr 2010 – Mar 2011	Not a target from July 2010	95.6%
18-week maximum wait from point of referral to treatment (non-admitted patients)	Apr 2010 – Mar 2011	Not a target from July 2010	98.7%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	Apr 2010 – Mar 2011	95%	97.6%
Screening all elective in-patients for MRSA	Apr 2010 – Mar 2011	100%	117.7%
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	Apr 2010 – Mar 2011	N/A	Certification made

2.9 Performance Monitoring and Improvement

The Trust has a robust performance monitoring system in place which contributes to driving improvements in the quality of care. The Trust performance framework includes all targets and indicators included in Monitor's Compliance Framework as well as other national targets from the NHS Operating Framework and local indicators considered to be priorities for the Trust. On a monthly basis, the Board of Directors and Executive Director level groups receive a performance report detailing progress against national and local targets.

The reports act as an assurance mechanism that targets are being achieved and where there is underachievement, that action is being taken to improve performance. The risk-based approach is taken to the performance management of national targets in particular. This approach aligns effectively with reporting target risks to Monitor.

2.10 Operational Efficiency

The efficiency of all services remains a high priority for the Trust and a number of initiatives were implemented in 2010/11 to make further improvements in this area.

As length of stay is an important marker of both patient experience and the efficiency of patient care, work has therefore continued to ensure pathways are streamlined, non-value added steps removed, and the patient experience improved. These have led to a reduction in pre-operative length of stay and consequently an increase in day-of-admission surgery rates. Work has also been undertaken to further increase daycase and ambulatory care rates. Almost all ambulatory care activity now goes through the Ambulatory Care unit in the QEHB which has seen steady increases in the number of patients treated per trolley each day.

There has been a particular focus over the year on reducing the number of patients who do not attend for their outpatient appointments. Work has included conducting a survey of patients who have missed appointments to find out the reasons why. The Trust has seen a small reduction in the percentage of patients who have not attended and will be trialling a reminder system which will pre-emptively remind patients of their upcoming appointment.

The Trust has also been testing the new models of care prior to the physical transfer to the new hospital. In 2010/11 there has been a particular focus on testing the systems and processes prior to the move of outpatients during 2011/12. This has involved piloting a number of the new systems proposed for the new hospital.

There has continued to be a focus on efficiency within theatres and this has resulted in the efficiency of the emergency theatres being the best it has ever been with theatre staff, anaesthetists and surgeons all working extremely well as a team. The recycling of theatre lists is managed on a daily basis to ensure full use of available capacity for both elective and emergency activity.

2.11 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 West Midlands gross domestic product. The Trust itself has a similar budget to Coventry City Council – one of the biggest local authorities in England – and is Birmingham's third largest employer, employing some 6,900 staff. The new Queen Elizabeth Hospital Birmingham is one of the region's largest capital projects and is adjacent to University of Birmingham, creating one of Europe's largest academic/medical complexes. It is a catalyst for the regeneration of south Birmingham.

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

2.11.1 Reducing Disadvantage

A key priority of the Trust has been to broaden access to the jobs and training it and Balfour Beatty - the builder of the new hospital - has to offer to unemployed people, particularly those living in the most disadvantaged parts of the city. Over the last five years the training projects now in the Hub have enabled almost 1,200 people to gain a job.

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

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

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

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

'Building Health' covers both healthcare and construction jobs arising from the new hospital and is aimed at the whole of the health and social care sector including private sector care homes.

The Learning Hub has taken the healthcare lead in the regional Single Public Sector Hub project. This major European Social Fund project led by Sandwell Council aims to provide an integrated training and brokerage service for unemployed people looking for a job in the public sector – in effect spreading the Learning Hub model across the public sector.

The Learning Hub introduced in December 2010 a new initiative - "Inspired"- which provides young people who are long-term patients with educational and vocational skills and mentoring support whilst being treated. This highly innovative project is being funded through the QEHB Charity.

Key stakeholders in the Learning Hub include JobCentre Plus, Birmingham City Council, further education colleges and Consort/Balfour Beatty, as well as the Trust and NHS partners.

During the past year the Trust helped train 40 apprentices and provide a further 40 placement opportunities for unemployed people under the Government's Future Jobs Fund initiative. Three quarters of those placed under Future Jobs Fund secured employment at the end of their placement.

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

The Learning Hub won the NHS Partnership of the Year award in December 2010, building on the 2009 West Midlands JobCentrePlus award for most innovative Local Employment partnership (LEP) and for the most outstanding contribution to LEPs. The Hub also gained a national Matrix excellence award for the quality of its information, advice and guidance.

2.11.2 Increasing Prosperity

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

The new 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 medical technology is integral to Advantage West Midlands' Regional Economic Strategy, the West Midlands Regional Competitiveness and Employment Programme, and the Birmingham Science City initiative and most recently the new Local Enterprise Partnership for Birmingham.

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

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

The Leukaemia Centre has undoubtedly helped develop a policy alignment around translational research in medicine.

Most recently the Trust has been a leading partner in a successful Health Innovation Education Cluster bid to the Department of Health. The Trust working with partners has also made a bid to be a national centre for proton therapy and is awaiting a decision by the Department of Health on the number of centres that will be established nationally.

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

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

2.12 Patient Care

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

The Trust continues to improve patient care through the work of the Care Quality group chaired by the Executive Chief Nurse. A number of patient-focused initiatives were developed last year in response to feedback from patients and carers. The Trust has monitored feedback via the patient advice and liaison contacts, complaints, compliments, and national surveys. Ward-based feedback is now well established at the point of care via an electronic bedside survey.

These surveys have assisted the Trust in measuring the success of its patient improvement measures including an increase in the number of patients who rated their overall care as excellent. There have also been increases in the number of patients who feel that they are involved in decisions about their care, are always treated with dignity and respect, given privacy when being treated and who respond that the hospital and ward are clean.

A 'Mystery Patient' programme has been introduced this year to help departments to respond to, and resolve issues raised by patients. This was initially trialled within the pharmacy dispensary, where a number of changes have been made to enhance the patient experience.

As a result of the feedback there has been a focus on areas that patients indicate they are most concerned with. For example, the Trust has changed its catering systems and supplier

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

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

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

The Trust's Infection Prevention and Control programme has continued to demonstrate excellent progress in the last year. Initiatives to standardise clinical practice has enabled the Trust to meet the national MRSA objective for 2010/11 and continue to improve performance year on year. In addition, the Trust has reduced cases of *Clostridium difficile* infection (CDI) by 21% in 2010/11. This year concludes the national three-year target for CDI which shows that the Trust has reduced the incidence of CDI by 61% over three years.

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

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

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

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

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

In response to its patients and to the Department of Health's campaign to virtually eliminate mixed sex accommodation, the Trust has made further changes to ensure that where possible patients will not share sleeping areas, that all toilet areas are clearly marked for male and female use and that privacy and dignity is maintained at all times. Almost all of the wards are now in the new hospital with the completion of the moves being in October 2011.

2.13 Public and Patient Involvement

2.13.1 Patient and Carer Councils

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

The purpose of the Councils is for patients, Foundation Trust members and the public to work in partnership with staff to improve the services provided to patients. All council members are also Foundation Trust members.

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

Both Councils have continued to use the 'Adopt-A-Ward' scheme to facilitate partnership working with ward staff to provide a patient perspective to improving the experience of patients and their relatives.

The work programme this year has concentrated on the move to the new hospital which opened in June 2010. Council members provided a huge amount of support to the move and were on site on the move days to talk to patients and helping patients, visitors and staff to find their way to wards and departments. Councils have also been involved with ongoing work on nutrition and hydration of inpatients, privacy and dignity, and patient experience data collection.

2.13.2 Young Person's Council

A Young Person's Council was established at the end of 2010 to provide a way of involving young people aged 16-25 years in the development and improvement of services within our hospitals to ensure they have the best possible experience.

The group have developed a credit-card size information booklet that provides useful telephone numbers and website addresses for support groups and help with specific issues relevant to this age group, including sexual health, housing, drug use, alcohol abuse and bullying.

The group are currently working on an interactive website for patients and their carers, and methods of gaining patient experience feedback.

2.13.3 Mystery Patient

Patient and Carer Council members have been involved in a new 'Mystery Patient' project in response to patient feedback for the pharmacy dispensary. The project has been very useful in highlighting key areas for improvement. Group members have worked with the staff in pharmacy to develop an action plan to address these.

Due to its success, it is planned to develop and expand this project in the next year to target areas that have been highlighted by patient, carer or visitor feedback.

2.13.4 Information Group

The group was established five years ago and provides a forum for involving patients and the public in reviewing and influencing the way in which information is provided in all formats. This ensures that all information within the Trust is produced in a way that is useful to patients, carers and the public, has a consistent style, and is in a non-jargonised language that falls in line with national NHS guidelines. This year the group has specifically been involved with:

- Review of the infection prevention and control leaflets
- Development of information for patients having radiotherapy
- Development of a text messaging service for the pharmacy dispensary

2.13.5 Local Involvement Networks (LINks): the Trust Working Group

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

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

A successful event to promote and publicise the work and support provided by over 25 patient and carer support and information groups was hosted by the group.

2.13.6 Patient/Carer Consultations

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

- NHS white papers including
  - Equity and Excellence
  - Greater Choice and Control
  - Information Revolution
  - Transparency in Outcomes Framework
- Birmingham Adult Care Strategy
- Procedures of Lower Clinical Value
- Overnight accommodation on wards for relatives

2.13.7 Increase in volunteers from the local community

The Trust had over 900 people registered as volunteers at the end of February 2010. A continued effort has been made to recruit from groups that would not traditionally be linked with hospital volunteering. The profile of volunteers is now:

- 30% male
- 35% black and Asian
- 34% under 30 years old
- 21% over 66 years old
- 15% employed

A Volunteer Committee was been established in February 2011 to formally involve volunteers in the development of the voluntary services within the Trust. The Committee are currently reviewing recruitment methods and development of support mechanisms for new volunteers.

Good working relationships have continued with the Birmingham Voluntary Services Council, and the Associate Director of Patient Affairs has been involved in the development of a Birmingham-wide strategy for volunteering.

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

2.14 Complaints

The Trust received 840 formal complaints in 2010/11, compared with 643 in 2009/10. The Trust had anticipated an increase in the number of complaints as a result of the move of services to the new hospital, in line with the experience of other trusts where there has been reorganisation across sites. In order to manage this and to provide the best possible complaints resolution service, the Trust has increased staff numbers in its Patient Services Department and continues to look at improvements to its complaint handling process. Complaints are acknowledged on receipt and contact is subsequently made with the complainants to agree a way forward including the preferred method of resolving their concerns (letter, meeting or telephone call) and an appropriate timescale.

Trends identified in complaints are analysed, assessed and reported to both the Chief Executive's Advisory Group and the Audit Committee. Across the year, the Trust responded fully to 93% of complaints within the timescale agreed with the complainant.

The main issues raised in complaints were:

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

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

- Review of ward staffing

- Introduction of ward-based hourly Care Rounds
- Customer care training

We were advised by the Parliamentary and Health Service Ombudsman that 15 enquiries had been received from people who wished to have further investigation of their complaints against the Trust. Of those, 10 have been assessed and will not be investigated, four are at the assessment stage and 1 has been accepted for investigation.

2.15 Patient Advice and Liaison Service (PALS)

The Trust runs a Patient Advice and Liaison Service (PALS). There were 3,974 PALS contacts in 2010/11 of which 1,422 (36%) were related to issues/concerns raised. This compares with 2,702 PALS contacts the year before of which 1,301 (48 %) were related to issues/concerns raised. This equates to a 47% increase in PALS contacts overall but a 12% reduction in the percentage of issues/concerns in relation to the total number of PALS contacts. The main issues/concerns raised relate to Communication and Information, perceptions around Clinical Treatment and Outpatient appointments being cancelled or delayed. This has not changed from last year but differs slightly to Complaints for the same period where Attitude of Staff features more strongly than general Communication and Information issues.

2.16 Stakeholders, Partnerships, alliances/contractual arrangements

Significant progress has been made in developing stakeholder relations as set out in the table on the next page.

Local Health organisations	
South Birmingham PCT/ Birmingham & Solihull Cluster	Regular meetings between Chairs and CEOs and appropriate directors
	Primary secondary interface group
	Member of "system plan" group to develop QIPP plan for whole system
	Negotiation and implementation of Local Delivery Plan
	Quarterly finance and quality performance meetings
GPs/GP Consortia	Within South Birmingham, participating and leading work on Rheumatology, Pain and ENT redesigned pathways working in partnership on Diabetes redesign and community hub
	Early stages of discussion around provision of GI, TIA, Endoscopy and Community Infusions
	Working closely with the GPs at Sutton Medical Consulting Centre (Ashfurlong) to further develop the services provided in that locality, e.g. Ophthalmology Rapid Access Service, Neurology and Urology
	Discussions are ongoing and opportunities are being explored with Solihull GP Consortium
	Formed Clinical Interface Groups to progress service development/change programme, to reflect LDP settlement
	Established Associate Medical Director post to be the lead clinician with GP Consortia
	Developing data sharing protocols between 1° and 2°
	Introduced regular meetings between Trust Executive Team and GP Consortia Boards
Specialised Commissioning Agency	Chief Operating Officer continues to hold regular meetings with the head of the SCA
	Exploring potential of improving rehabilitation facilities
West Midlands SHA	Chair and CEO regularly meet their SHA counterparts
	Attending professional fora
	Trust developed an 18-week breach sharing protocol that has been adopted throughout the SHA
	Assisting the Quality Observatory
Heart of England Foundation Trust	Meeting of Executive teams has been held and agreement reached to co-operate on a number of issues including medical staff training and management development
	Ongoing discussions with regard to operational issues
Sandwell and West Birmingham Trust	Continued co-operation with SWBH on the Pan Birmingham Decontamination project
	COO holds meetings with SWBH Director of Strategy

Birmingham Children's Foundation Trust	The Trust is continuing to support BCH with its provision of tertiary paediatric care, where appropriate
	Regular operational meetings with Medical Director and Chief Operating Officer to ensure appropriate SLAs in place to support delivery of services
	Partner in Proton Therapy Centre project
	FD sits on Shared Services Group
Birmingham Women's Hospital NHS Foundation Trust	The Trust provides a number of services to the Women's eg. anaesthetics; critical care; finance; steam
	Regular meetings of Chairs and Executive Directors
West Midlands Ambulance Trust	Meeting of Chairs and Executive Directors has taken place
	Working together to improve turnaround times for patients
	Support the WMAs with patient transport
	Process developed to record the clinical handover of the patients so that we will be able to robustly monitor performance
Birmingham Community Trust	Agreed pathways for a number of different patient groups including fractured neck of femur and the elderly

National health bodies	
Monitor	Chair and CEO have met Monitor Chair on a number of occasions
	Quarterly finance and quality performance meetings to review quarter's performance against plan, national standards and declarations
	Regular discussions take place with the Trust's Relationship Manager
	The Trust Medical Director is a member of Monitor's working group developing Quality metrics
Care Quality Commission	Trust hosted visit by Head of Operations
	Pilot to be implemented re Learning Disabilities
	Hosted visit for CEO and Regional Director to new hospital
Department of Health	Ongoing discussions between key personnel at both organisations
	The Trust has agreed two secondments to DH to influence policy and to continue to play an active role in developing Connecting for Health
National Institute of Health Research	Partnership to deliver the UK's first and only Surgical Reconstruction and Microbiology Centre
Collaborative working	Have working relationships with a number of trusts and the Department of Health to deliver a variety of services

Non NHS contractual Partners	
Consort/Balfour Beatty	Relationships continue at all levels to ensure the delivery of the new hospital on time and on budget as well as health and safety issues
B-Braun	Meetings every two weeks at operational level with UHB Contracts to measure quality standards
	Quarterly Joint Management Board with the Pan Birmingham Collaborative and BBraun
University of Birmingham	Quarterly liaison meetings
	The Birmingham Clinical Research Academy has been developed
	Working with Business School to Develop MBA Programme
	Progress on ongoing discussions on various agendas are regularly reported to Board of Directors
	UoB are partner in Proton Therapy project
	Working in partnership to develop a proposal for medical devices testing
Ministry of Defence	The Trust has established a close working relationship with the Ministry of Defence, including Joint Medical Command (JMC) and the Defence Medical Services Department (DMSD)
	Under this arrangement the Trust also sub-contracts work to:
	- Birmingham City University
	- The University of Birmingham
	- The Royal Orthopaedic NHSFT
	- Heart of England NHSFT
	- Birmingham City and Sandwell NHST (incorporating Birmingham Eye Centre)
FMC Renal Services Limited	The Trust has worked closely with FMC in the planning of new satellite haemodialysis facilities. A 16-station purpose-built unit opened in Worcester in 2009 and a further unit in Woodgate Valley has just opened
	Both of the new satellite units have been designed with the flexibility to house community outpatient clinics which will be used by Renal Medicine and associated specialties
Advantage West Midlands/Science City	Government has announced the abolition of the Regional Development Agencies; Science City still aiming to provide strategic framework for innovation
	UHB chairs Science City Innovative Healthcare Group
	AWM grant (through European Regional Development Fund) for pan-European "Developing Centres of Excellence project focusing on translational research" varied to include e-prescribing
	AWM support for accessing European commission Framework 7 programme for research and development (which has a strong medical technology element)

Birmingham City Council	Member of citywide enablement forum
	Continuing planning relationship
	Improvement of public transport access to QE – working with BCC, Centro and West Midlands Travel
	Inward investment strategy – integrating medical technology, especially translational research and clinical trialling
	Regular attendance at overview and scrutiny committee
	Increasing working relationship with BCC on training for unemployed people as a result of BCC being passed additional responsibilities following the abolition of the Learning and Skills Council
	Worked with Social Services to develop an enablement service with therapy provided by UHB
Skills Funding Agency (replaced Learning and Skills Council)	UHB representation on the Birmingham and Solihull Employer Board
	Apprentice training funding
	SFA monitoring £2m Single Public Sector Hub contract for information, advice and guidance to unemployed people to a partnership where the Learning Hub leads on Healthcare for Birmingham and Solihull
JobCentre Plus	Continued effective working through the Learning Hub
	JCP gives financial support for Learning Hub, particularly auxiliary nurse training programmes
	UHB and JCP jointly chair pan-Birmingham Access to Employment Group focusing on LEP grant-aided schemes
	Future Jobs Fund (40 FJF posts delivered at UHB)
	Preliminary work on the Government's new Work Programme
Greater Birmingham and Solihull Local Enterprise Partnership	New body set up by the Government to provide a clear vision and strategic leadership to drive economic growth and job creation
	Medical technology, especially translational research and clinical trialling a priority for the LEP
	Initial meeting to discuss priorities and practical ways of joint working

3. Financial Review

On July 1, 2004 the Trust achieved Foundation Trust status under the Health and Social Care (Community Health and Standards) Act 2003, which brought with it not only a number of benefits and advantages for patients and the community as well as financial freedoms for the organisation, but also different operating and functioning requirements from those of a NHS trust.

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

The Trust began the financial year with two hospitals, the Queen Elizabeth (Edgbaston) and at Selly Oak. On 16 June 2010 the first phase of the new Queen Elizabeth Hospital Birmingham opened its doors to patients.

This transfer of services from Selly Oak and some of the older Edgbaston site buildings to Birmingham's first new acute hospital in 70 years, built under the private finance initiative scheme, will be completed in October 2011. The new hospital is on the same site as the original Queen Elizabeth hospital buildings and some services will continue to be provided from the latter's facilities.

3.1 Changes in accounting policies by the Trust in 2010/11

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 2011 and appropriate to NHS Foundation Trusts. This is the second set of full year results prepared in accordance with IFRS accounting policies. The previously reported 2009/10 financial statements have been restated where IFRS has required this; with the date of transition being 1 April 2009, which is the beginning of the comparative period for the year ended 31 March 2011.

There has been one significant amendment to accounting standards in 2010/11 affecting the Trust. Previously, leases of land could only be disclosed as operating leases but can now be classified as finance leases where risks and rewards transfer to the lessee. The Trust has therefore, disclosed the Edgbaston site land on the Statement of Financial Position (which is leased from Birmingham City Council), see note 14.3 to the financial statements.

The commencement of the new private finance initiative hospital has had a significant effect upon the presentation of the financial statements. All appropriate accounting policies and disclosures required by IFRS and HM Treasury have been made in the financial statements and are summarised in the following financial performance review.

3.2 Financial Performance

In line with recent years the Trust has again reported solid financial results for 2010/11. Total income has increased by 8.0% to £535.7 million 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 £1.0 million before any exceptional costs. The recurring surplus of £0.4m is after impairment to the Trust's existing estate of £0.6m. The non recurring 'exceptional costs' of £250.1m comprise restructuring costs of £7.1m associated with the transition to the new hospital and an impairment loss of £243.0m on the new building. This results in an overall retained deficit of £249.7m for the financial year.

The new hospital and existing estate impairments are a non-cash technical adjustment to the accounts (rather than an actual payment by the Trust) and are excluded by Monitor from the calculation of the Financial Risk Rating (FRR). The new hospital impairment arises from the difference between the value directly attributable to the construction of the new private finance initiative hospital (along with interest charges and fees) and the asset's fair value in operational use, as measured at 31 March 2011.

Therefore the organisation remains financially sound despite this accounting deficit. The recurring financial performance has resulted in the Trust achieving an overall Financial Risk Rating of 3 (out of 5) from Monitor.

3.3 Income and expenditure

The table below compares the original planned income and expenditure with the outturn position for 2010/11.

Summary income and expenditure – plan v. outturn

The Trust's Summarised Income and Expenditure (£M's)		
	Plan 2010/11	Outturn Position 2010/11
Income	511.0	535.7
Expenditure	-482.2	-507.8
EBITDA	**28.8**	**27.9**
Depreciation	-17.3	-16.5
Dividend	-0.0	-0.2
Interest receivable	0.6	0.3
Interest Payable	-11.3	-10.5
Operational Surplus	**0.8**	**1.0**
Impairments on existing property	0.0	-0.6
Recurring Surplus	**0.8**	**0.4**
Transition costs	-8.0	-7.1
Impairments on New Hospital	-260.5	-243.0
Retained Deficit	**-267.7**	**-249.7**

The largest component of the Trust's income is the provision of NHS healthcare, accounting for £414.8 million (77.4%) of the total. Non-NHS clinical income contributes a further £16.5 million (3.1%) and this includes private patients, provision of healthcare to the military and costs recovered from insurers under the Injury Cost Recovery scheme.

The Trust has a number of other income streams which are not linked directly to patient care. These include education levies which account for £34.7 million (6.4%) of the Trust's income in 2010/11 and funding associated with Research and Development (R&D) activities, which totals £21.4 million (4.0%). Education funding comprises the Service Increment for Teaching (SIFT), recognising the cost of training medical undergraduates from the University of Birmingham, the Medical and Dental Education Levy (MADEL) which supports the salary costs of post graduate doctors in training and support for Non-Medical Education and Training (NMET). R&D income includes grants from the National Institute of Health Research, support for the Wellcome Trust Clinical Research Facility, and funding for the Birmingham and Black Country Comprehensive Local Research Network, which is hosted by the Trust.

The balance of the Trust's income is attributable to services provided to other NHS bodies, trading activities and other miscellaneous items.

The main variances against plan in 2010/11 include additional healthcare income primarily for high cost drugs and devices paid for on a cost-per-case basis and additional healthcare activity from the Ministry of Defence. Both these sources carry corresponding expenditure commitments and therefore do not impact significantly on the Trust's bottom line surplus.

The largest item of expenditure is salaries and wages, accounting for £290.2 million, equivalent to 57.1% of total expenditure. Other significant components include £55.9 million on drugs (11.0%) and £67.3 million on Clinical Supplies and Services (13.3%).

Transition costs of £7.1 million have been incurred in 2010/11 and these relate to the exceptional restructuring costs associated with the one-off transfer to the New Hospital.

3.4 Capital Expenditure Plan

In 2010/11 the Trust incurred £23.2 million of capital expenditure on equipment, new facilities

and improvements to existing buildings. This is summarised below:

Category	Capital Invested £ Million
Brought Forward Programmes from 2009/10	0.7
IT Replacement, Modernisation, Infrastructure and additional capacity	1.3
Trust Buildings • Existing Estate • New Hospital	 1.4 4.2
	5.6
Trust Equipment • New Imaging Equipment • Replacement and other Equipment	 9.1 6.5
	15.6
TOTAL	**23.2**

The Trust's planned capital expenditure over the next three financial years (2011/12 to 2013/14) totals £29.5 million. This plan runs alongside the payments relating to the new hospital. It is not anticipated that there will be any requirement to borrow against the Prudential Borrowing Limit during these years.

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

3.5 Value for Money

The Trust's Financial Plan for 2010/11 included the delivery of cash-releasing efficiency savings of 3.5% against relevant budgets. In order to achieve this, a formal cost improvement programme (CIP) totalling £15.9m 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 cost CIP, further efficiency savings have been realised in the year through initiatives such as ongoing tendering and procurement rationalisation and a review of requests to recruit to both new and existing posts via the Workforce Approval Committee.

3.6 Private Patient Income (PPI)

PPI was £3.0 million which is within the authorised limit of 1.23%.

3.7 QEHB Charity

The charitable funds for the Trust are administered by QEHB Charity, a separate legal entity from the Trust. In 2009/10 the Trust received grants of £1.4 million from QEHB Charity.

3.8 Audit Information

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

3.9 External Auditors

The Trust's external auditors are KPMG LLP. The audit cost for the year is £132,618 of which £92,836 relates to statutory audit services, and £39,782 which relates to non-audit work.

The reappointment of external audit services from 2007/08 onwards was made by the Board of Governors, following a competitive tender exercise. In addition following a competitive tendering exercise from 1 April 2006, KPMG has also provided taxation advice to the Trust.

3.10 Pensions

The accounting policy for pensions and other retirement benefits are set out in note 1.3 to the financial statements and details of senior employees' remuneration can be found in the Remuneration Report in Section 2.

3.11 Going Concern

After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason the Trust has continued to adopt the Going Concern basis in preparing these accounts.

Julie Moore Date 2 June, 2011
Chief Executive

Governance

1. NHS Foundation Trust Code of Governance

IIn September 2006 Monitor, the independent regulator of Foundation Trusts, published the NHS Foundation Trust Code of Governance as best practice advice. The Code was revised and re-issued by Monitor in March 2010.

The purpose of the Code is to assist NHS foundation trust boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance. The Code is issued as best practice advice, but imposes some disclosure requirements. These are met by the Trust's Annual Report for 2010/11.

In its Annual Report, the Trust is required to report on how it applies the main and supporting principles of the Code.

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

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

1.1 Application of Principles of the Code

A. The Board of Directors

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

The Trust has a formal scheme of delegation which reserves certain matters to the Board of Governors or the Board of Directors and delegates certain types of decision to individual executive directors.

The Board of Directors has reserved to itself matters concerning Constitution, Regulation and Control; Values and Standards; Strategy, Business Plans and Budgets; Statutory Reporting Requirements; Policy Determination; Major Operational Decisions; Performance Management; Capital Expenditure and Major Contracts; Finance and Activity; Risk Management Oversight; Audit Arrangements; and External Relationships.

The Board of Directors remains accountable for all of its functions; even those delegated to the Chairman, individual directors or officers, and therefore it expects to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

All powers which are neither reserved to the Board of Directors or the Board of Governors nor directly delegated to an Executive Director, a committee or sub-committee, are exercisable by the Chief Executive or as delegated by her under the Scheme of Delegation or otherwise.

Details of the composition of the Board of Directors and the experience of individual Directors are set out in Board of Directors, page 30, of the Annual Report, together with information about the Committees of the Board, their membership and attendance by individual directors.

B. The Board of Governors

The Board of Governors is responsible for representing the interests of members, and partner organisations in the local health economy as well as in the governance of the Trust. It regularly feeds back information about the Trust, its vision and its performance to the constituencies and the stakeholder organisations.

The Board of Governors appoints and determines the remuneration and terms of office of the Chairman and Non-Executive Directors and the external auditors. The Board of Governors approves any appointment of a Chief Executive made by the Non-Executive Directors. The Chairman carries out annual appraisals of Non-Executive Directors, but the Board of Governors has the responsibility for terminating individuals i.e. as a result of poor performance, misconduct etc.

Details of the composition of the Board of Governors are set out in Governors, page 27 of the Annual Report, together with information about the activities of the Board of Governors and its committees.

C. Appointments and terms of office

The balance, completeness and appropriateness of the membership of the Board of Directors were reviewed during the year by the Executive Appointments and Remuneration Committee. The terms of appointment of the Chairman and three non-executive directors, David Ritchie, David Bailey and Michael Sheppard expired during the reporting year. All four having only served one term, were each re-appointed for further terms of three years by the Board of Governors, on a recommendation from the Board of Governors' Nomination Committee for Non-Executive Directors. Details of the composition of that Committee and its activities are set out on page 37 of the Annual Report. Details of terms of office of the Directors are set out in Board of Directors, page 30, of the Annual Report.

D. Information, development and evaluation

The Boards of Directors and Governors are supplied in a timely manner with information in an appropriate form and of a quality to enable them to discharge their respective duties. The information needs of both Boards are agreed in the form of an annual cycle and are subject to periodic review.

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

Both Boards regularly review their performance and that of their committees and individual members. Appraisals for all Executive and Non-Executive Directors (including the Chairman) have been undertaken and the outcomes of these have been reported to the Board of Governors or the Board of Directors as appropriate. The Board of Directors and the Audit Committee have each evaluated their performance.

E. Director Remuneration

Details of the Trust's processes for determining the levels of remuneration of its Directors and the levels and make-up of such remuneration are set out in the Remuneration Report in Section 2.

F. Accountability and Audit

KPMG LLP has been appointed by the Board of Governors as the Trust's External Auditor. The Trust has appointed RSM Tenon as internal auditors for the reporting year and has appointed Deloitte as internal auditors from 1 April 2011. The Board of Directors presents a

balanced and understandable assessment of the Trust's position and prospects, maintains a sound system of internal control and ensures effective scrutiny through regular reporting directly to the Board of Directors and through the Audit Committee.

G. Relations with Stakeholders

The Board of Directors recognises the importance of effective communication with a wide range of stakeholders, including members of the Trust. Details of interactions with Stakeholders are set out from page 16 of the Annual Report and in Membership, page 38.

1.2 Compliance with the Code

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

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

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

Prior to December 2008, the Board of Governors approved four-year terms of office for Non-Executive appointments. Since then, Non-Executive Directors have been appointed or re-appointed for terms of three years, in accordance with the Code. As a result of this, two of the Non-Executive Directors, Clare Robinson and Stewart Dobson have served for more than six years without being subject to annual re-election. Their current term will expire in September 2011.

E.2.3 The Board of Governors is responsible for setting the remuneration of Non-Executive Directors and the Chair. The Board of Governors should consult external professional advisers to market-test the remuneration levels of the Chairman and other Non-Executives at least once every three years and when they intend to make a large change to the remuneration of a Non-Executive Director.

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

Board of Governors

1. Overview

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

The Trust opted to have elected Governors representing patients, staff and the wider public, in order to capture the views of those who have direct experience of our services, those who work for us, and those that have no direct relationship with the Trust, but have an interest in contributing their skills and experience to help shape our future.

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

- 12 public Governors elected from the Parliamentary Constituencies in Birmingham
- 4 patient Governors elected by Patient members
- 5 staff Governors elected by the following staff groups:
  - Medical
  - Nursing (2)
  - Clinical Scientist/Allied Health Professional
  - Ancillary, Administrative and Other Staff
- 6 stakeholder Governors appointed by six of its key stakeholders

The change to the number of stakeholder governors came into effect on 12 January 2009. The changes to public and patient governors came into effect on 1 July 2009 and elections for all public and patient governor seats were held in June 2009. Governors appointed to public and patient seats at these elections were appointed for terms of either two or three years, commencing on 1 July 2009.

Elections for staff governors were held this year. No by-elections have been held.

During this year, the Governors have been:

1.1 Patient

Shirley Turner
Colin McAllister
Valerie Jones
Jamie Gardiner

1.2 Public (by Parliamentary Constituency)

Northfield
Margaret Burdett
Edith Davies

Selly Oak
Rita Bayley
John Delamere

Hall Green
David Spilsbury
Tony Mullins MBE

Edgbaston
John Coleman
Rosanna Penn
Ian Trayer

Ladywood
Shazad Zaman

Yardley
Kadeer Arif

Perry Barr & Sutton Coldfield
Joan Walker

Erdington & Hodge Hill
Monica Quach

1.3 Staff
Up to 30 June 2010

Professor John Buckels (Medical Class)

Paul Brettle (Clinical Scientist/Allied Health Professional)

Erica Perkins (Nursing Class)

Barbara Tassa (Nursing Class)

Anne Waller (Ancillary, Administrative and Other Staff)

From 1 July 2010 for terms of three years

Dr Tom Gallacher (Medical Class)

Susan Price (Clinical Scientist/Allied Health Professional)

Erica Perkins (Nursing Class)

Barbara Tassa (Nursing Class)

Patrick Moore (Ancillary, Administrative and Other Staff)

1.4 Stakeholder

Rabbi Margaret Jacobi, appointed by the Birmingham Faith Leaders' Group

Professor David Cox, appointed by South Birmingham Primary Care Trust Professor

Edward Peck, appointed by the University of Birmingham

Vice Admiral Raffaelli, appointed by the Ministry of Defence

Cllr James Hutchings, appointed by Birmingham City Council

Ms Ruth Harker, appointed by the South West Area Network of the Secondary Education Sector in Birmingham

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

Name of Governor	No. of meetings attended*
Rita Bayley	2 out of 5
Edith Davies	All
Valerie Jones	1 out of 5
Rosanna Penn	3 out of 3
Shirley Turner	All
Jamie Gardiner	4 out of 5
Colin McAllister	1 out of 5
Margaret Burdett	All
Kadeer Arif	2 out of 5
Shazad Zaman	None (out of 5)
Joan Walker	2 out of 5
John Delamere	4 out of 5
Monica Quach	2 out of 5
David Spilsbury	All
John Coleman	2 out of 2
Tony Mullins	All
Ian Trayer	4 out of 5
Stakeholder Governors	
Cllr James Hutchings	3 out of 5
Prof. David Cox	4 out of 5
Ruth Harker	4 out of 5
Rabbi Margaret Jacobi	2 out of 5
Vice Admiral Raffaelli	1 out of 5
Prof. Edward Peck	1 out of 5
Staff Governors	
Barbara Tassa	3 out of 5
Prof. John Buckels	0 out of 2
Dr Tom Gallacher	All
Patrick Moore	3 out of 3
Susan Price	All
Paul Brettle	1 out of 2
Anne Waller	0 out of 2
Erica Perkins	2 out of 5

*While a member of the Board of Governors.

1.5 Steps the Board of Directors, in particular the Non-Executive Directors, have taken to understand the views of the governors and members

- Attending, and participating in, Governor meetings and monthly Governor seminars
- Attending, and participating in, tri-annual joint Board of Governor and Director meetings to look forward and back on the achievements of the Trust
- Attendance and participation at the Trust's Annual General Meeting
- Governors and Non-Executive Directors are members of various working groups at the Trust eg. Patient Care Quality Group

1.6 Register of Interests

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

Board of Directors

1. Overview

Throughout the year, the Board of Directors comprised the Chairman, six Executive and seven Non-Executive Directors. The Chairman has been appointed for a second term of three years commencing 1 December 2010.

Stewart Dobson has been appointed as Deputy Chairman and Clare Robinson as Senior Independent Director. The Senior Independent Director is available to meet stakeholders on request and to ensure that the Board is aware of member concerns not resolved through existing mechanisms for member communications.

The Board is currently comprised as follows:

Chairman: Sir Albert Bore

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

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

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

NAME	Date of Appoint-ment/ Latest Renewal	Term	Date of end of term
Sir Albert Bore	1 December 2010	3 years	30 November 2013
Clare Robinson	25 September 2008	3 years	24 September 2011
Stewart Dobson	25 September 2008	3 years	24 September 2011
David Bailey	1 December 2010	3 years	30 November 2013
David Ritchie	1 December 2010	3 years	30 November 2013
Gurjeet Bains	1 December 2008	3 years	30 November 2011
Michael Sheppard	5 December 2010	3 years	4 December 2013
Angela Maxwell	1 July 2009	3 years	30 June 2012

The Board of Directors considers Clare Robinson, Stewart Dobson, David Bailey, David Ritchie, Gurjeet Bains and Angela Maxwell to be independent. With regard to Clare Robinson and Stewart Dobson, the Board of Directors has given special consideration to the issue of independence, given that Clare Robinson and Stewart Dobson have served as Non-Executive Directors for more than six years. Their current term will expire in September 2011.

2. Board meetings

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

Directors	No. of meetings attended
Sir Albert Bore	9
Julie Moore	All
Mike Sexton	All
Tim Jones	9
Stewart Dobson	All
Clare Robinson	9
David Ritchie	All
Prof Michael Sheppard	8
David Rosser	8
Prof David Bailey	9
Kay Fawcett	All
Gurjeet Bains	8
Angela Maxwell	All
Kevin Bolger	9

3. The Board of Directors composition

Sir Albert Bore, Chairman

Sir Albert Bore was elected Chairman of the Trust on 1 December 2006 and re-appointed for a further three years on 1 December 2010. He is the former leader of Birmingham City Council and the current leader of the council's principal opposition group (Labour). During his five years at the helm, Sir Albert was responsible for an annual budget of over £2.5billion and for shaping the strategic policy of the council. He also spearheaded key regeneration projects including Eastside and the Bullring. He holds a number of non-executive director positions including Performances Birmingham, responsible for Symphony Hall and the Town Hall, Optima Community Housing Association, Marketing Birmingham, National Exhibition Centre Limited and Birmingham Technology Ltd, the joint venture company developing and managing Birmingham Science Park Aston.

Julie Moore, Chief Executive

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

Julie was a member of the National Organ Donation Taskforces in 2007 and 2008 and in 2009 was a member of the Nuffield Trust Steering Group on New Frontiers in Efficiency.

She is a member of the International Advisory Board of the University of Birmingham Business School, an Independent Member of the Board of the Office for Strategic Co-ordination of Health Research (OSCHR), a member of the MoD/DH Partnership Board overseeing health care of military personnel, a member on the Commission on Living Standards undertaken by the Resolution Foundation and a Board Member of Marketing Birmingham, a strategic partnership to drive the inward investment strategy for the city. She is also a Fellow of the Royal Society of Arts.

Executive Directors

Kevin Bolger, Executive Chief Operating Officer

Kevin trained as a nurse at East Birmingham Hospital in the early eighties then worked in clinical haematology, respiratory and acute medicine before developing the Acute Assessment Unit. As a ward manager he gained a Masters in Business Administration. His career then moved away from clinical responsibilities into general management and operations including managing a variety of areas, from Theatres to Accident and Emergency. He moved to the Trust in 2001 as Group Manager for Neurosurgery and Trauma and after 12 months was promoted to Director of Operations for Division Three. In 2006 he moved to Division Two where he also became Deputy Chief Operating Officer. He was made Chief Operating Officer (Acting) in September 2008, responsible for the day-to-day running of the Queen Elizabeth and Selly Oak hospitals. His position became substantive in June 2009.

Kay Fawcett, Executive Chief Nurse

Kay qualified as a Registered General Nurse in 1980 and held a series of clinical posts before moving on to be a Clinical Teacher and then Nurse Tutor. She returned to clinical work as a Lecturer Practitioner and Emergency Care Manager in 1995. In 1998, Kay became an Operational Manager at the George Eliot Hospital NHS Trust before joining University Hospitals Birmingham in 2000 as Head of Nursing. She became Deputy Chief Nurse in 2002. In July 2005 took up post as Executive Director of Nursing for Derby Hospitals NHS Foundation Trust where she held responsibility for Nursing and Allied Health Professionals, Infection Prevention and Control, Governance and Risk. Kay rejoined the Trust in January 2008, when she was appointed as Executive Chief Nurse, with responsibility for Nursing, Facilities Management, Infection Prevention and Control and Business Continuity.

Tim Jones, Executive Director of Delivery

After graduating from University College Cardiff, with a joint honours degree in History and Economics, Tim joined the District Management Training scheme at City and Hackney Health Authority based at St Bartholomew's Hospital in London. He joined The Royal Wolverhampton NHS Trust in 1992 as Business Manager for Medicine before taking up his first post at University Hospitals Birmingham NHS Foundation Trust in 1995. In 1999 he became the first Divisional General Manager for Emergency Services before being appointed as the Deputy Chief Operating Officer in 2002. He was appointed as Chief Operating Officer in June 2006. In September 2008 he was appointed to a newly-created role of as Executive Director of Delivery. His key responsibilities are to lead on Strategy and Performance, Education, Research, Organisational Development, and Human Resources. He is also a board member of the NIHR Health Service Research Board and MidTech.

David Rosser, Executive Medical Director

David trained at University of Wales College of Medicine and did his basic specialist training in medicine and anaesthesia in South Wales before becoming a research fellow and lecturer in Clinical Pharmacology at University College London Hospital. He joined the Trust in 1996, became lead clinician for the Queen Elizabeth Intensive Care unit in December 1997 before becoming Group Director and then Divisional Director of Division One in 2002. Dr Rosser was also Senior Responsible Owner for Connecting for Health's e-prescribing programme, providing national guidance on e-prescribing to the Department of Health. Dr Rosser took up the role of Medical Director in December 2006.

Mike Sexton, Executive Director of Finance

Mike, who became FD in December 2006, spent five years in the private sector working for the accountancy firm KPMG and had a brief spell at the Regional Specialities Agency (RSA) before joining the Trust in 1995. Over the last 16 years he has held numerous positions including Head of Operational Finance and Business Planning, Director of Operational Finance and Performance and Acting Director of Finance. Mike is also the executive lead for commercial development, payroll, service and healthcare contracts, procurement, arts and charities.

Non-Executive Directors

Stewart Dobson, Vice Chairman

Stewart, who worked for 32 years as a lawyer for various large local authorities, joined the board in 2004. His work included over 13 years working for Birmingham City Council, mainly as the Director of Legal Services but finishing up as Acting Chief Executive. He retired from the City Council in 2002 and was the Chief Executive of Millennium Point and Thinktank, within the Eastside area of Birmingham, from 2003 to 2005. He now works as a local government consultant.

Professor David Bailey

Professor David Bailey started his role as a new Professor at Coventry University's rapidly-expanding Business School on 1 May 2009. Prior to that, he was Director at the University of Birmingham's Business School. David has written extensively on globalisation, economic restructuring and policy responses, the auto industry, European integration and enlargement, and the Japanese economy. He has been involved in several major research projects and is currently leading an Economic and Social Research Council project on the economic and social impact of the MG Rover closure.

Gurjeet Bains

Gurjeet Bains, who joined the Trust as Non-Executive Director on 1 December 2008, is a qualified nurse and a successful businesswoman. After starting her first business in Peterborough in 1986 she later became a journalist for the Northampton Chronicle which eventually led her to join The Sikh Times, Britain's first English Punjabi newspaper as Editor in 2001. Her role expanded and she has since become Editor of Eastern Voice – a successful national newspaper, and has established herself in a prominent role at Birmingham-based Eastern Media Group. Aside from being the editor of two national newspapers, she became the first woman to chair the Institute of Asian Businesses (IAB). Gurjeet won the 'Business Woman of the Year' award in 1991 and was recently awarded with an Honorary Degree from Aston University. Currently Gurjeet is Chief Executive of Women of Cultures, an organisation which empowers women from ethnic minorities and is also a member of the Birmingham Chamber of Commerce and Industry Council and one of fifty Ambassadors for the 2012 Olympics. She was appointed as a Governor for Birmingham Metropolitan College in 2010.

Angela Maxwell OBE

Angela achieved prominence as one of the region's most dynamic entrepreneurs after she powered Fracino, the UK's only manufacturer of espresso and cappuccino machines from a £400,000 turnover in 2005 into a £2.6million world-class leading brand when she sold her interests in 2008. A former European adviser to UK Trade & Investment, a finalist in Businesswoman of the Year 2005, Angela is a Board member of Advantage West Midlands. Acuwomen, her latest enterprise, is the UK's first company to bring an all-women group of entrepreneurs under one roof. Angela is also an accredited business advisor for Business Link and UKTI. In 2010 Angela was awarded an honorary doctorate for business leadership from University of Birmingham and made an OBE for services to business. She recently co-launched Vibe Generation, specialists in intellectual property creation and product commercialisation.

David Ritchie CB

David Ritchie worked at a senior level in Government for a number of years most recently as Regional Director, Government Office for the West Midlands – the most senior official in the region. He was responsible for an annual budget approaching £1billion and around 300 staff, mostly engaged on the physical and industrial development of the region. He was also Chair of the Oldham Independent Review into the causes of the Oldham Race Riots in 2001. He is also a Trustee of the QEHB Charity.

Clare Robinson

Clare Robinson, who joined the board in 2004, is a highly experienced Chartered accountant and was appointed Senior Independent Director in 2008. She brings with her seven years experience as a Non-Executive Director at the Royal Orthopaedic Hospital NHS Trust where she was also Chair of the Audit Committee. Currently she is working as an independent Business Consultant including change management, strategic and operational reviews and management services.

Professor Michael Sheppard

Professor Sheppard was appointed a Non-Executive Director of the Trust in December 2007 and is Provost and Vice-Principal of the University of Birmingham. He graduated from the University of Cape Town with MBChB (Hons), and was later awarded a PHD in Endocrinology. His career at Birmingham began in 1982, when he was appointed as a Wellcome Trust Senior Lecturer in the Medical School. He then subsequently held the roles of the William Withering Professor of Medicine, Head of the Division of Medical Sciences, Vice-Dean and Dean of the Medical School. Michael's main clinical and research interests are in thyroid diseases and pituitary disorders. He holds honorary consultant status at the Trust, has published over 230 papers in peer reviewed journals and has lectured at national and international meetings, particularly the UK, Europe and the USA Endocrine Societies.

4. Directors' Interests

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

Audit Committee

1. Overview

The Audit Committee is a committee of the Board of Directors whose principal purpose is to assist the Board in ensuring that it receives proper assurance as to the effective discharge of its full range of responsibilities.

The Committee meets regularly and is chaired by Stewart Dobson. It comprises all the independent Non-Executive Directors of the Trust, with the external and internal auditors and other Executive Directors attending by invitation.

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

Directors	No. of meetings attended*
Clare Robinson	All
Gurjeet Bains	5
David Bailey	4
David Ritchie	All
Stewart Dobson	All
Michael Sheppard	3
Angela Maxwell	4

*While a member of the Audit Committee

The Audit Committee is responsible for the relationship with the group's auditors, and its duties include providing an independent and objective review of the Trust's systems of internal control, including financial systems, financial information, governance arrangements, approach to risk management and compliance with legislation and other regulatory requirements, monitoring the integrity of the financial statements of the Trust and reviewing the probity of all Trust communications relating to these systems.

The Audit Committee undertakes a formal assessment of the auditors' independence each year, which includes a review of non-audit services provided to the Trust and the related fees. The Audit Committee also holds discussions with the auditors about any relationships with the Trust or its directors that could affect auditor independence, or the perception of independence. Parts of selected meetings of the Audit Committee are held between the Non-Executive Directors and internal and external auditors in private.

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

2. Independence of External Auditors

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

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

b) Audit-related and advisory services - projects and engagements where the auditors may be best-placed to perform the work, due to:

- Their network within and knowledge of the business (e.g. taxation advice, due diligence and accounting advice) or
- Their previous experience or market leadership

c) Projects that are not permitted - projects that are not to be performed by the external auditors because they represent a real threat to the independence of the external auditor.

Under the policy:

- Statutory and audit-related work assignments do not require further approval from the Audit Committee or the Board of Governors. However, recognising that the level of non-audit fees may also be a threat to independence, a limit of £25,000 will be applied for each discrete piece of additional work, above which limit prior approval must be sought from the Board of Governors, following a recommendation by the Audit Committee.
- For advisory services assignments, the Trust's Standing Financial Instructions (SFIs) Procurement of Services should be followed and the prior approval of the Board of Governors, following a recommendation by the Audit Committee, must be obtained prior to commencement of the work. Neither approval of the Board of Governors nor a recommendation from the Audit Committee will be required for discrete pieces of work within this category with a value of less than £10,000, subject to a cumulative limit of £25,000 per annum.

3. Auditors' reporting responsibilities

KPMG LLP, our independent auditors, report to the Board of Governors through the Audit Committee. KPMG LLP's accompanying report on our financial statements is based on its examination conducted in accordance with UK Generally Accepted Accounting Practices and the Financial Reporting Manual issued by the independent regulator Monitor. Their work includes a review of our internal control structure for the purposes of designing their audit procedures.

Nominations Committee

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

The Nominations Committee for Non-Executive Directors is a sub-committee of the Board of Governors responsible for advising the Board of Governors and making recommendations on the appointment of new Non-Executive Directors, including the Chairman of the Trust. Its terms of reference, role and delegated authority have all been agreed by the full Board of Governors. The committee meets on an as-required basis.

The Nominations Committee for Non-Executive Directors comprises the Chairman and four Governors of the Trust. The Chairman chairs the committee, save when the post of Chairman is the subject of nominations, in which case the committee is chaired by the Governor Vice-Chair (Margaret Burdett). The other members of the committee for the year ended 31 March 2011 were Shirley Turner, Ian Trayer, Erica Perkins and Ruth Harker.

The Committee met twice during the year. All Committee members in office at the relevant times attended all Committee meetings with the exception of Ian Trayer and Ruth Harker who each attended one of the two meetings and Erica Perkins who did not attend either meeting.

During the year, the Committee oversaw the re-appointment of the Chairman and three Non-Executive Directors. The Committee approved the recommendation of the Executive Appointments and Remuneration Committee that, as each of them had served one term, they should be re-appointed for a further term of three years.

2. Nominations Sub-Committee

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

Membership

1. Overview

The Trust has three membership constituencies: public, staff and a patient constituency.

Public Constituency

The public constituencies correspond to the Parliamentary constituencies of Birmingham. Public members are drawn from those individuals who are aged 16 or over and:

(a) who live in the area of the Trust; and
(b) who are not eligible to become members of the staff constituency

Staff Constituency

The staff constituency is divided into four classes:

(a) medical staff
(b) nursing staff
(c) clinical scientist or allied health professional staff
(d) ancillary, administrative and other staff

Patient Constituency

Patient members are individuals who are:

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

(N.B. Following changes to the Constitution approved by the Board of Governors in September 2008, a patient who lives in the area of the Trust will not be eligible to be a Member of the Patients' constituency.)

2. Membership Overview by Constituency

Constituency	Total at 31/03/10*	%
Public	11,776	49.0
Patient	4,834	20.1
Staff	7,426	30.9
Total Membership	**24,036**	**100**

*Numbers correct up to 31 March 2011

3. Membership Strategy

3.1 Background

University Hospital Birmingham was a first wave NHS FT in 2004 and took the unusual step of adopting an 'opt-out' strategy around membership. This resulted in a membership of circa 100,000 members. Over the next three years (up until 2007/08) this figure reduced to circa 81,000, mainly due to deceased and 'gone away' members being removed from the database.

In July 2007 the Board of Directors and Board of Governors approved a new Membership Strategy to rationalise the membership to include only those who explicitly expressed a wish to be a member of the Trust and to recruit new members with whom the Trust could engage with in a meaningful way.

In November 2008 the Trust began developing a recruitment campaign which was subsequently launched at the beginning of April 2009.

In March 2009 the Trust had 18,070 members. By March 2010 some 7,794 new patients,

staff and members of the public had chosen to become a member of the Trust. Taking into consideration the 2,110 members who left the membership programme (due to death or moving away from the area) the net total number of members at the Trust as of March 31, 2010 was 23,754 – an increase of over 31%.

3.2 Membership development 2010/11

Since concluding the high-profile recruitment campaign, work has continued to ensure that members are actively engaged.

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

Over the past 12 months, significant work has been done with QEHB Charity to actively involve members in fundraising and supporting Trust events. In February 2011 the Charity began actively recruiting members through its own mailings and recruitment channels with a view to a more co-ordinated approach to gaining support.

A monthly email bulletin to members who have opted to receive email communications has been established and has proven very successful. The bulletin is used to inform members of forthcoming events and engagement opportunities i.e. 'drop-in' sessions and directs members through to the Trust's news pages on the Trust website. Increased attendance to members' Health Talks can be directly attributed to the email bulletins which are monitored by the database management provider.

In Autumn 2010, Governors' Drop-in sessions were introduced to community settings within Governors' constituencies to broaden the range of interaction they have with their membership and raise the profile of membership. Typical locations have been faith centres, libraries and health centres and these sessions have been well received by the public and Governors alike.

3.3 Ambassador Programme

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

Members are given the opportunity to become Ambassadors of the Trust through the Ambassador Programme. The role of an Ambassador is to promote the Trust, Foundation Trust Membership and recruit new members. Members are given training to enhance their communication and presentation skills and are provided with an in-depth working knowledge of membership.

The role of an Ambassador is to:

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

At present, the Trust's ambassadors are actively involved in promoting the Trust through presenting at community groups, fundraising for the Trust's charity, recruiting new members and giving feedback as 'mystery patients'.

3.4 Membership recruitment 2010/11

The Trust's Board of Directors had agreed the following objectives for 2010/11:

- To maintain the current number of members (ie. recruit circa 2,200 to replace the annual churn)
- To grow the membership by 5% (ie circa 1,100 members)

Between 1 April 2010-February 2011, 1,846 new members were recruited representing an increase of 7.8%. 1,508 members left the programme due to moving away from the area or dying, resulting in an overall increase in membership of 1.4%. The membership is representative of the constituencies served.

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

3.5 Recognition of the Trust's Membership Programme

Since launching an improved membership programme in 2009, the Trust has been approached by a number NHS trusts as well as the Foundation Trust Network, NHS Confederation and Monitor, to share its experience and knowledge. Regular requests are made for the Trust to present its Membership Strategy and its dynamic approach to member relations.

In 2010, the Trust was asked by Monitor to be interviewed as part of its at a study into best practice at recruiting and engaging members. Monitor invited UHB to share learnings of their rationalisation process and recruitment campaign.

3.6 Membership recruitment and engagement strategy 2011/12

Recruitment

The recruitment objectives for 2011/12 are to maintain the existing number of members by replacing those who have left and to ensure that the membership is representative. There are no plans to launch a major external recruitment campaign. It is more cost-effective to maintain and develop existing membership than recruit large numbers of new ones.

Continued analysis shows that new members frequently have existing relationships with the Trust. The recruitment of new members will therefore be conducted through well-established membership channels including:

- Leafleting internally
- Ambassadors
- Community groups
- Support groups
- Drop-in sessions
- In-house communication channels
- Existing members
- GP surgeries
- Trust website

Engagement

In order to maintain and further improve relationships with our membership, the engagement objectives for 2011/12 are:

- To continue to communicate with our members through the quartely publication Trust in the Future
- To survey existing members on Membership Engagement
- To embed the Ambassador Programme, ensuring that Ambassadors are involved in appropriate activities and contributing to the recruitment of new members
- To improve membership content on the Trust website
- To continue to deliver opportunities for members to engage with Governors both internally and externally
- To continue to include members on appropriate patient groups
- To actively promote the role of members within the Trust
- Continue work with QEHB Charity to increase membership opportunities amongst fundraisers

3.7 Engagement with members by Governors/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 alternating between the new Queen Elizabeth and Selly Oak hospitals. A mix of staff, patient and public governors 'set up camp' and talk to, advise, and take comments from staff, patients and visitors. These are then fed back to the Executive Directors for comment/action
- The Annual General Meeting
- Telephone, written or electronic communications co-ordinated through the Membership Office which then steers members to the appropriate Governor/ Director
- Website. Each Governor has their profile and details of the constituency they serve, published on the Trust website
- 'Trust in the Future' magazine – highlights work of Governors and opportunities to be involved in projects/patient experience groups
- Direct email and telephone number to the Membership Office who take any kind of membership query and then feed back into the Trust to action
- Chief Executive hotline – phone communication for queries, comments and ideas
- Governors attend community presentations held 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.
- Insideout – Trust newspaper distributed through the hospital sites

Staff Survey

1. Commentary

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

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

The Trust 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
- Inside Out – the Trust's monthly staff magazine, is available throughout the Trust
- Insight - the intranet is constantly updated and improved
- In the Loop - staff receive weekly email updates on Trust news and developments
- There is a programme of corporate and local induction and orientation for new starters to improve long-term retention of staff

2. Summary of Performance – NHS Staff Survey

2.1 NHS Staff Survey Response Rate 2010 compared with 2009

	2009		2010		Trust Improvement Deterioration
Response Rate	**The Trust**	**National Average**	**The Trust**	**National Average**	
	55%	55%	45%	52%	10% Decrease

2.2 Areas of improvement from 2009 survey

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

	2009	2010	Trust Improvement
Staff job satisfaction	3.51	3.61	0.10 scale point increase
Support from immediate managers	3.69	3.82	0.13 scale point increase
Perceptions of effective action from employer towards violence and harassment	3.60	3.73	0.13 scale point increase
Staff intention to leave jobs	2.45	2.28	0.17 scale point decrease (improvement)

2.3 Area of deterioration from 2009 survey

	2009	2010	Trust Deterioration
% of staff saying hand washing materials are always available	71%	62%	9% decrease

2.4 2010 Top 4 Ranking Scores

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

	2009		2010		Trust Improvement Deterioration
Top 4 Ranking Scores	The Trust	National Average	The Trust	National Average	
Effective team working	N/A*	N/A*	3.82	3.69	N/A*
Support from immediate managers	3.68	3.60	3.82	3.61	0.14 scale point increase (improvement)
Staff intention to leave jobs	2.44	2.51	2.28	2.53	0.16 scale decrease (improvement)
Quality of job design	3.50	3.39	3.56	3.41	0.56 scale point increase (improvement)

2.5 2010 Bottom 4 Ranking Scores

	2009		2010		Trust Improvement Deterioration
Bottom 4 Ranking Scores	The Trust	National Average	The Trust	National Average	
% of staff working extra hours	72%	66%	69%	66%	3% decrease (improvement)
% of staff experiencing discrimination in the last 12 months	N/A*	N/A*	15%	13%	N/A*
% of staff saying hand washing materials always available	70%	71%	62%	67%	8% decrease (deterioration)
% of staff having equality & diversity training in last 12 months	33%	35%	37%	41%	4% increase (improvement)

* Format of question has changed since 2009 survey so unable to compare scores between 2009 and 2010.

3. Future Priorities and Targets

3.1 Summary of Actions taken in response to 2009 Results

- E-learning package for diversity training launched
- Equality and diversity session now part of Corporate Induction
- Increase in conflict and resolution training courses for staff
- Prevention of bullying and harassment training courses provided for staff
- Pinpoint (personal alarms) issued to A&E staff

The Trust-wide action plan for 2011 has not yet been finalised but the proposed priorities for 2011 are as follows:

- Improve response rates
- Increase work on reducing the number of staff experiencing discrimination at work
- Investigate why staff are working extra hours
- Increase the % of staff receiving equality and diversity training
- Ensure hand washing materials are always available
- Involving Directorates in producing specific actions for their areas and monitoring these through directorate meetings
- To develop and implement an action plan for all of the above with the aim of improving the Trust's performance by the next reporting period

Regulatory ratings

1. Explanation of ratings

1.1 Finance Risk Rating

When assessing financial risk for the period 2010/11 Monitor assigned a risk rating using a scorecard which compared key financial metrics. The risk rating is intended to reflect the likelihood of a financial breach of the Authorisation.

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

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

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

1.2 Governance Risk Rating

Monitor's assessment of governance risk in 2010/11 was based predominantly on the NHS foundation trust's plans for ensuring compliance with its Authorisation, but also reflects historic performance where this may be indicative of future risk. As there is no longer a separate risk assessment for the provision of mandatory services, this in now incorporated within the governance risk assessment. Monitor therefore now considers eight elements when assessing the governance risk:

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

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

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

The tables below show the risk ratings for the Trust for Finance and Governance identified in the Annual Plan and the quarterly self-certifications in 2009/10 and 2010/11. Additional detail is provided where risks are declared and have a contribution to the risk ratings.

1.4 Risk Ratings in 2009/10

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

1.5 Risks Declared in 2009/10

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

In 2009/10, the Trust declared low risk ratings for finance and mandatory services. A risk was declared regarding achievement of the national 4 hour A&E target, resulting in a green Governance rating. As part of the quarterly self-certifications, risks were declared against the two-week, 31 day, and 62 day cancer targets. Again due to effective planning, the A&E and cancer targets were met for the full year.start of treatment cancer target, and the 62 day referral to treatment cancer target in quarter 4, however, Monitor did not include these in the assessment process to derive the Trust's governance rating.

1.6 Risk Ratings in 2010/11

	Annual Plan 2010/11	Q1 2010/11	Q2 2010/11	Q3 2010/11	Q4 2010/11
Financial Risk Rating	3	3	3	3	3
Governance Risk Rating	Amber-Green	Amber-Green	Green	Green	Green

1.7 Risks Declared in 2010/11

	Annual Plan 2010/11	Q1 2010/11	Q2 2010/11	Q3 2010/11	Q4 2010/11
Governance Risks Declared	Cancer - 62 day all Cancer - 62 day screening	Cancer 62 day day all	-	-	-

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

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

Achievement of the 62-day cancer target was declared as a risk in the 2010/11 Annual Plan due to the reliance of the Trust as a tertiary cancer centre on prompt referrals from neighbouring trusts to allow patients to be treated in a timely manner. In 2010/11 the Trust has continued to receive a high number of referrals of patients late along the pathway or indeed after the 62nd day which makes the target difficult or indeed impossible to achieve. the Trust. Particular work has been undertaken to ensure that full root cause analysis is undertaken of any breaches of the target to allow any potential improvement in pathways to be identified. The Trust has also been working with referring trusts and the Pan-Birmingham Cancer Network to share the learning from these cases and improve the affected pathways. Action continues to be taken to mitigate the impact of these issues and allowed the screening target to be met in each quarter and for the full year. The GP referral target was met in Quarters 2, 3 and 4 and for the full year.

1.9 Details and actions from any formal interventions

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

Public Interest Disclosures

1. Consultation

The Trust is committed to involving staff in decision-making and keeping them informed of changes and developments across the Trust. We work hard to ensure our staff are aware of the key priorities and issues affecting the Trust, this has been particularly important with the changes to the NHS and financial environment. Our visions and values are at the heart of everything we do and for our staff to 'Deliver the Best in Care' this has to mean their involvement in decisions and a commitment from Trust Management to meaningfully consult and communicate. This has never been more important with the opening of Queen Elizabeth Hospital Birmingham and the transformation of the workforce to ensure that new ways of working are implemented and embedded.

Our range of well-established communications channels includes a monthly team briefing from the Chief Executive and weekly publication 'In the Loop'. The Trust's corporate induction programme is a valuable source of information for new recruits, as is the Trust magazine, Inside Out. The Trust's intranet is also a central source for policies, guidance and online tools. For 2011/12, the Trust is developing a staff portal: me@QEHB so that they are able to directly access information which affects them individually and their work.

We work 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. The staff throughout the Trust are encouraged to voice opinions and get involved in developing services to drive continuous improvement.

2. Policies in relation to disabled employees and equal opportunities

Disabled employees have regular access to the Trust's Occupational Health Services including ergonomic assessment of the workplace to ensure that access and working environment is appropriate to their needs. Staff who become disabled whilst in employment have access to these services and are also supported in moving posts with appropriate adjustments, should it become inappropriate for them to continue in their original post.

The Trust also ensures that staff with disabilities are able to access training opportunities. When booking onto training courses staff are asked if they have any special needs or requirements. If this is the case, arrangements are made. This includes the use of hearing loop facilities. A number of courses are also provided which focus on equality and diversity issues, and this includes equality and diversity workshops, disability awareness training, equality impact assessment training, cultural awareness workshops, recruitment and selection and deaf awareness programmes. All new staff receive information on equality and diversity issues during their induction. In addition a facility in partnership with Learn Direct is provided for staff who wish to improve upon their literacy and numeracy skills.

The Trust is committed to the 'Positive about Disabled People' and was awarded the 'two ticks' symbol by Job Centre Plus which

recognises employers as having appropriate approaches to people with disabilities. This requires employers to meet the following standards:

1. To interview all applicants with a disability who meet the minimum criteria for a job vacancy and consider them on their abilities.

2. To ensure there is a mechanism in place to discuss at any time, but at least once a year, with disabled employees what can be done to make sure they can develop and use their abilities.

3. To make every effort when employees become disabled to make sure they stay in employment.

4. To take action to ensure that all employees develop the appropriate level of disability awareness needed to make the commitments work.

5. Each year to review the commitments and achievements, to plan ways to improve on them and let employees and the Employment Services know about progress and future plans.

The Trust's commitment to candidates with disabilities is outlined in its Information for Applicants which is attached to all job advertisements.

Managers are required to promote the recruitment of all diverse groups and are required to complete Equality and Diversity training.

The Learning Hub provides employment placement programmes for a six-week period for members of the local community who are looking for work. During this period trainees will be able to experience first hand job roles available within the hospital. They will also receive advice and guidance on life coaching skills, career guidance and job preparation, practical support and mentoring.

3. Public and patient involvement activities

Please see Public and Patient Involvement activities under Patient Care on page 12.

4. Sickness absence

The Trust recorded an annual average sickness absence of 4.28% across all clinical and corporate divisions. Trust management is working in partnership with Staffside to reduce this to 3% by 2013.

5. Cost allocation

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

6. Serious untoward incidents – Information Governance

The Trust has had no Information Governance Serious Untoward Incidents involving personal data as reported to the Information Commissioner's Office in 2010/11.

The table below sets out a summary of other personal data related incidents in 2010/11

Summary of Other Personal Data Related Incidents in 2010/11

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

III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	0
V	Other	9

7. Health and Safety

The staff incident rate for 2010/11 was 186 incidents per 1,000 staff. No Improvement Notices were issued by the Health and Safety Executive (HSE).

Whilst violence and aggression is the highest incident type reported (411) the majority of these fortunately relate to verbal rather than physical incidents. Inoculation injuries, of which there were 252, remain in the top three incident causation categories with impact incidents in third place at 153.

The HSE visited the Trust in November 2010 as part of its National Inspection Programme, specifically to look at the action the Trust is taking to reduce inoculation incidents. Following this visit a Short Life Working Group has been established, chaired by the Director of Corporate Affairs, and an action plan developed to ensure the implementation of safer working practices to reduce incidents. This group will also oversee compliance with the legal requirement to have safer needle devices in place by 2013. Moving and handling incidents are no longer in the top three categories (82) and this may be attributable to the additional moving and handling equipment that has been made available following the move to the new hospital in conjunction with training in local areas in its use.

A Health and Safety 'Starter Pack' that provides managers with templates and examples of how to undertake Risk Assessments has been issued to all wards and departments following the move to the new hospital and 'drop-in' training sessions provided locally to assist managers with the legal requirement to undertake assessments in their new environment.

Flu vaccination was made available to all frontline staff as close to their place of work as possible to reduce any disruption to services and this resulted in 29% of staff being vaccinated.

8. Countering fraud and corruption

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

The Trust policy is to apply best practice regarding fraud and corruption and that the Trust fully complies with the requirements made under the Secretary of State directions. The local counter fraud service is provided by its internal auditors (under a separate tender) and the counter fraud plan follows these directions. The Trust does not tolerate fraud and the plan is designed to make all staff aware of what they should do if they suspect fraud.

9. Better Payment Practice Code

	Number	£000
Total bills paid in the year	104,393	234,740
Total bills paid within target	103,156	232,928
Percentage of bills paid within target	98.82%	99.23%

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

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

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

11. Management costs

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

University Hospitals Birmingham
NHS Foundation Trust

Section 2 **Remuneration Report 2010/2011**

This annual report covers the period 1 April 2010 to 31 March 2011

Section 2 | Remuneration Report

1. Executive Appointments and Remuneration Committee

The Executive Appointments and Remuneration Committee is a sub-committee of the Board of Directors responsible for reviewing and advising the Board of Directors on the composition of the Board of Directors and appointing and setting the remuneration of Executive Directors. Its terms of reference, role and delegated authority have all been agreed by the full Board of Directors. The committee meets on an 'as-required' basis.

The Executive Appointments and Remuneration Committee's terms of reference empower it to constitute a sub-committee to act as a Nominations Committee to undertake the recruitment and selection process, including the preparation of a description of the role and capabilities required and appropriate remuneration packages, for the appointment of the Executive Director posts on the Board of Directors.

The Executive Appointments and Remuneration Committee comprises the Chairman, all other Non-Executive Directors and, for appointments of executive directors other than the Chief Executive, the Chief Executive. The Chairman of the Committee is the Chairman of the Trust.

The Executive Appointments and Remuneration Committee met twice in the year. The Nominations Sub-Committee met once during the year and all members were in attendance.

2. Executive Remuneration Policy

The Committee recognises that, in order to ensure optimum performance, it is necessary to have a competitive pay and benefits structure.

The remuneration policy was reviewed by the Committee in March 2010.

Executive Directors are on substantive contracts with a notice period of six months. Each Director has annual objectives which are agreed by the Chief Executive. Reviews on performance are quarterly. The Chairman agrees the objectives of the CEO and associated performance measures.

There were no termination payments to Senior Managers and the Contracts do not stipulate that there is any entitlement to them. No significant awards and no compensation for loss of office were made to Senior Managers during 2010/11.

3. Pensions

All the executive directors are members of the NHS Pensions Scheme. Under this scheme, members are entitled to a pension based on their service and final pensionable salary subject to HM Revenue and Customs' limits. The scheme also provides life assurance cover of twice the annual salary. The normal pension age for directors is 60. None of the Non-Executive Directors are members of the schemes. Details of the benefits for executive directors are given in the tables provided on pages 55 and 56.

4. Salary and Pension Entitlements of Senior Managers

A. Remuneration

Name and Title	Year Ended 31 March 2011			Year Ended 31 March 2010		
	Salary	Other Remuneration	Benefits in Kind	Salary	Other Remuneration	Benefits in Kind
	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100
SENIOR MANAGERS						
Julie Moore Chief Executive	210-215	0	0	210-215	0	0
Kay Fawcett Executive Chief Nurse	125-130	0	0	120-125	0	0
Dr David Rosser Executive Medical Director	85-90	95-100	0	85-90	95-100	0
Tim Jones Executive Director of Delivery	135-140	0	0	135-140	0	0
Mike Sexton Executive Director of Finance	135-140	0	0	135-140	0	0
Kevin Bolger Executive Chief Operating Officer	130-135	0	0	130-135	0	0
Fiona Alexander Director of Communications	100-105	0	0	95-100	0	0
Morag Jackson New Hospitals Project Director	115-120	0	0	115-120	0	0
David Burbridge Director of Corporate Affairs	95-100	0	0	90-95	0	0
Viv Tsesmelis Director of Partnerships (commenced office 01/04/2010)	95-100	0	0	0	0	0
Sam Chittenden Director of Strategic Developments (left office 1/11/2009) **	0	0	0	65-70	0	100
NON EXECUTIVE DIRECTORS						
Sir Albert Bore Chairman	50-55	0	0	50-55	0	0
Stewart Dobson	15-20	0	0	15-20	0	0
Angela Maxwell (commenced office 01/07/2009)	10-15	0	0	10-15	0	0
David Ritchie	10-15	0	0	10-15	0	0
Clare Robinson	15-20	0	0	15-20	0	0
Gurjeet Bains	10-15	0	0	10-15	0	0
Professor Michael Sheppard	10-15	0	0	10-15	0	0
Professor David Bailey *	10-15	0	0	10-15	0	0
Tony Huq (left office 30/06/2009)	0	0	0	0-5	0	0

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

B. Pension Benefits

Name and title	Real increase in pension at age 60	Real increase in pension related lump sum at age 60	Total accrued pension at age 60 at 31 March 2011	Total accrued pension related lump sum at age 60 at 31 March 2011	Cash Equivalent Transfer Value at 31 March 2010	Cash Equivalent Transfer Value at 31 March 2011	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
Julie Moore, Chief Executive	2.5-5	7.5-10	80-85	240-245	1,554	1,446	0	N/A
Mike Sexton, Executive Director of Finance	2.5-5	12.5-15	50-55	150-155	944	928	0	N/A
Tim Jones, Executive Director of Delivery	0-2.5	5-7.5	30-35	90-95	485	440	0	N/A
Kay Fawcett, Executive Chief Nurse	0-2.5	2.5-5	50-55	150-155	994	923	0	N/A
Kevin Bolger, Executive Chief Operating Officer	0-2.5	2.5-5	45-50	140-145	939	871	0	N/A
Dr David Rosser, Executive Medical Director	0-2.5	5-7.5	50-55	150-155	803	720	0	N/A
David Burbridge, Director of Corporate Affairs	0-2.5	2.5-5	15-20	45-50	241	236	0	N/A
Fiona Alexander, Director of Communications	0-2.5	2.5-5	5-10	15-20	79	83	4	N/A
Morag Jackson, New Hospitals Project Director	0-2.5	2.5-5	30-35	100-105	600	556	0	N/A

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

Details above are provided by the NHS Pensions Agency.

5. Non-Executive Directors' remuneration

Non-Executive Directors' remuneration consists of fees which are set by the Board of Governors. The Board of Governors has established a committee, the Board of Governors Remuneration Committee for Non-Executive Directors, to advise the Board of Governors as to the levels of remuneration for the Non-Executive Directors. NED fees are reviewed each year with advice taken from independent consultants where appropriate. In addition to the Chairman (who does not attend when the committee considers matters relating to his own remuneration), the Committee comprised Margaret Burdett, Jamie Gardiner, Ian Trayer, John Buckels and James Hutchings, up until 30 June 2010, when Dr Tom Gallacher replaced John Buckels. The Committee met once during the year and all members, with the exception of Tom Gallacher, were in attendance.

Julie Moore, June 2, 2011
Chief Executive

University Hospitals Birmingham
NHS Foundation Trust

Section 3 **Quality Report 2010/2011**

This report covers the period 1 April 2010 to 31 March 2011

Contents

Part 1: Chief Executive's Statement

The Vision of University Hospitals Birmingham NHS Foundation Trust (UHB) is "to deliver the best in care" to our patients. Quality in everything we do supports this Vision in the overall Trust Strategy and the Corporate, Divisional and Specialty Strategies which underpin it. Clinical Quality and Patient Experience are two of the Trust's Core Purposes and provide the framework for the Trust's robust approach to managing quality.

UHB has made good progress in relation to all five quality improvement priorities for 2010/11 identified in last year's Quality Report: reducing medication errors, reducing delays in antibiotic delivery, completion of venous thromboembolism (VTE) risk assessments, improving patient experience and satisfaction and reducing infection. The Trust has chosen to continue with these priorities in 2011/12 to deliver further improvements for our patients alongside a new quality improvement priority: completeness of patient observations in the electronic observation chart.

That the Trust has managed to make significant improvements to the quality of care we provide during one of the biggest and most challenging hospital moves in NHS history, is a testament to the hard work and commitment of our staff. This is echoed in our excellent 2010 Staff Survey results which have shown a great improvement compared with previous years.

An essential part of driving up quality at UHB has been the scrutiny and challenge provided through proper engagement with staff and other stakeholders such as the Trust Board of Governors, the Birmingham Local Involvement Network and NHS South Birmingham. Clinical staff have continued to develop and use a wide range of specialty level quality indicators through the Trust's Quality and Outcomes Research Unit (QuORU), some of which are shown in Part 3 of this report.

A key part of UHB's commitment to quality is being open and honest with our staff, patients and the public, with published information not simply limited to good performance. The Quality web pages provide up to date information on the Trust's performance in relation to quality: http://www.uhb.nhs.uk/quality.htm. A wide range of information was published during 2010/11 including quarterly Quality Report updates, Trust-level patient experience data and performance for a greater number of specialty level indicators.

The Trust's focused approach to quality is driven by innovative and bespoke information systems which enable us to capture and use real-time data in ways which few other UK trusts are able to do. During 2010/11, UHB has started to review whole pathway mortality using the interactive Healthcare Evaluation Data (HED) tool developed last year and further improvements have been made within the Prescribing Information and Communication System (PICS). These are described in Parts 2 and 3 of this report.

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

During 2010/11, the Trust requested its internal auditors to review some of the processes through which data is extracted, checked and reported in different sections of the Quality Report: VTE risk assessment completion, reporting of falls and two of the specialty quality indicators. This review provided additional assurance over the accuracy of UHB's information reporting methods, with some minor recommendations for improvement which are being implemented.
On the basis of the processes the Trust has in place for the production of the Quality Report, I can confirm that to the best of my knowledge the information contained within this report is accurate.

Finally, the Trust's remaining services and departments will move into the new Queen Elizabeth Hospital Birmingham during 2011/12 which will allow us to continuously improve the quality of care we provide in a world-class environment.

Julie Moore, June 2, 2011
Chief Executive

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

2.1 Quality Improvement Priorities

2010/11

The Trust's 2009/10 Quality Report set out five key priorities for improvement during 2010/11:

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

Priority 2
Time from prescription to administration of first antibiotic dose

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

Priority 4
Improve patient experience and satisfaction

Priority 5
Infection prevention and control

The Trust has made good progress in relation to all five quality improvement priorities during 2010/11 with further improvements identified for 2011/12 as described below. The Board of Directors has chosen to continue with these improvement priorities for 2010/11 plus one additional one (shown in bold) as follows:

2011/12

Key Priorities:

Priority 1
Time from prescription to administration of first antibiotic dose

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

Priority 3
Improve patient experience and satisfaction

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

Ongoing Priorities:

Priority 5
Reducing medication errors (missed doses)

Priority 6
Infection prevention and control

The improvement priorities for 2011/12 were initially selected by the Trust's Clinical Quality Monitoring Group chaired by the Executive Medical Director, following consideration of performance in relation to patient safety, patient experience and effectiveness of care. These were then shared with the Trust's Governors and the Birmingham Local Involvement Network (LINk). The focus of the patient experience priority was decided by the Care Quality Group which is chaired by the Executive Chief Nurse and also has Governor representation. The priorities for 2011/12 were

then finally approved by the Board of Directors.

The performance in 2010/11 and the rationale for selection of each priority are provided in detail below. This report should be read alongside the Trust's Quality Reports for 2009/10 and 2008/09.

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

Performance

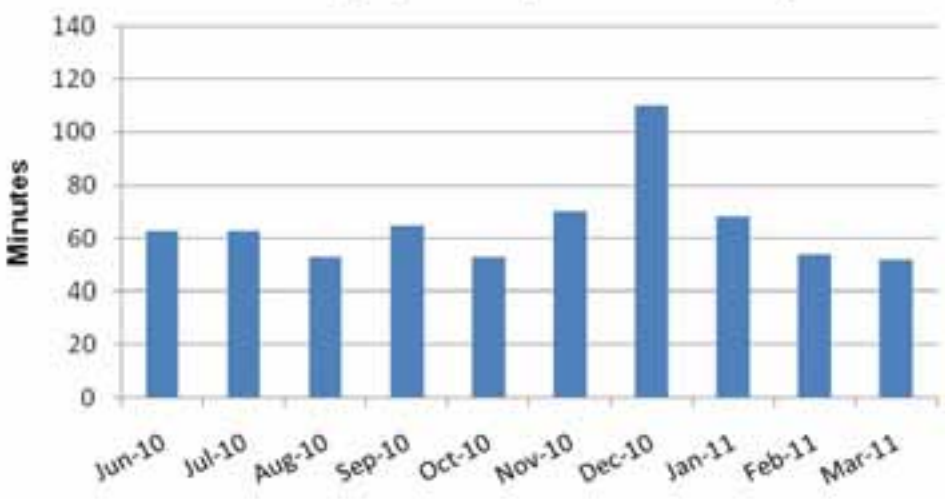
There is evidence within the clinical literature that rapid antibiotic delivery can reduce patient harm and improve outcomes. The recommended time from prescription to administration of first antibiotic dose for certain conditions should ideally be 60 minutes or less.

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

The Trust has now identified clinical exception rules with clinicians and refined the methodology for measuring performance against this indicator. Data has been collected from the Trust's electronic Prescribing Information and Communication System (PICS) for patients admitted with acute illnesses. This does not however include Emergency Department referrals where prescribing data is not yet captured electronically.

Performance data is shown in the graph below for June 2010 to March 2011. Improving performance for this priority has proved challenging during 2010/11. The actions the Trust has put in place during the year have now started to make a difference with February and March 2011 data in line with the target time of 60 minutes or less.

Trust Average (Median) Antibiotic Delay



Initiatives implemented in 2010/11:

- Education has been provided to various levels of medical staff around medication errors and the need to ensure timely antibiotic delivery to acutely sick patients
- A Pharmacy stock locator has been implemented within the Prescribing Information and Communication System. This is to enable nursing staff to locate drugs on another ward if needed so patients do not miss a drug dose
- Delayed antibiotics are being included in the monthly root cause analyses of selected missed dose cases by the Trust's Executive, divisional management and clinical teams to drive improvements in practice

New initiatives to be implemented in 2011/12:

- Plan for the implementation of the Prescribing and Communication System (PICS) into the Emergency Department to allow electronic prescribing data capture in the future
- Refinement of the indicator so that more patients are included; Emergency Department prescribing data to be added when it becomes available
- Add an alert into PICS to make sure nurse are aware of any one-off antibiotic doses prescribed outside of normal drug round times, particularly during the night

How progress will be monitored, measured and reported:

- Performance will continue to be measured and monitored at specialty and ward levels using PICS data and the Trust's usual reporting tools
- Progress will be monitored by the Clinical Quality Monitoring Group and reported in the quarterly Quality Report updates published on the Trust's quality web pages

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

Performance

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

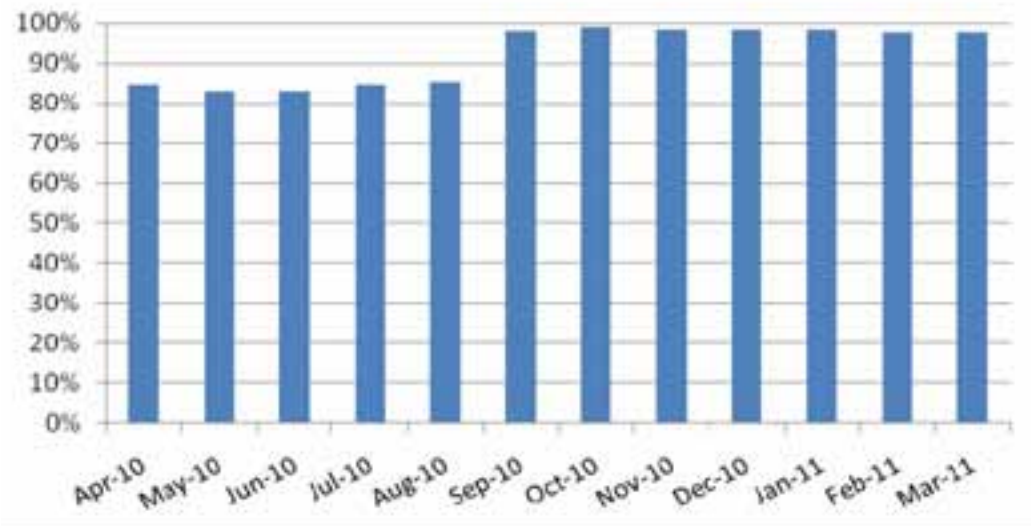
Whilst most other trusts have to rely on a paper-based assessment of the risk of VTE for individual patients, the Trust has been using an electronic risk assessment tool within the Prescribing Information and Communication System since June 2008 for all inpatient admissions. The tool provides tailored advice regarding preventative treatment based on the assessed risk.

The Trust's electronic VTE risk assessment tool has been revised to reflect the latest guidance from the National Institute for Health and Clinical Excellence (NICE). In order to comply with this guidance, new mandatory questions for all inpatients admitted acutely or electively have been included as part of the risk assessment tool. In addition, ambulatory care (day case) admissions have been examined to determine which patients also require a full risk assessment within our systems. Both of these changes have produced a big improvement in VTE risk assessment completion on admission.

The graph shows performance for 2010/11. The Trust has achieved a VTE risk assessment completion rate of over 97% since September 2010 which is well above the national average of 68.4%*. As the VTE risk assessment tool was revised in line with national guidance during 2010/11, data for previous years is not shown.

* This is the national average for all providers of NHS funded care for the period October to December 2010 as published on the Department of Health website.

VTE Risk Assessments Completed on Admission



Initiatives implemented during 2010/11:

- The Trust's electronic VTE risk assessment tool was revised to take into account the latest NICE guidance
- Preparatory work has been undertaken so that the electronic VTE risk assessment tool can be implemented within ambulatory care during early 2011/12

New initiatives to be implemented in 2011/12:

- PICS and the electronic VTE risk assessment tool will be implemented within ambulatory care during early 2011/12
- Improve compliance with the outcomes of completed VTE risk assessments so that patients are actually given the preventative treatment (compression hosiery and/or enoxaparin medication) they require

How progress will be monitored, measured and reported:

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

Priority 3: Improve patient experience and satisfaction

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

Performance

During quarter 1 2010/11, the Trust started monitoring the feedback received from patients via the electronic bedside and telephone surveys for the questions set out in the Trust's 2009/10 Quality Account Report. The last two questions relate to discharge and were added into the telephone survey in August 2010.

Patient Experience Data

Over 16,000 patients responded to the electronic patient survey during 2010/11 providing a wealth of information about their experience. The table below shows the patient experience data collected by UHB during 2009/10 and 2010/11. Data for questions 2-4 was collected from June 2010; data for questions 5-6 was collected from August 2010. The survey results show that the Trust has made improvements across a number of areas of patient experience and will continue to focus on delivering improvements across all elements during 2011/12.

		Performance					
Question	Answer	2009/10	2010/11	Q1 2010/11	Q2 2010/11	Q3 2010/11	Q4 2010/11
1. Have you been involved as much as you want to be in decisions about your care and treatment?	Yes	68.6%	73.4%	72.0%	73.0%	72.2%	75.7%
	Yes, to some extent	24.5%	20.9%	22.0%	20.8%	21.2%	19.5%
	No	6.8%	5.8%	6.0%	6.2%	6.6%	4.8%
2. Did you find someone on the hospital staff to talk about your worries and fears?	Yes, definitely		60.8%		62.4%	61.2%	58.6%
	Yes, to some extent		27.5%		25.5%	27.3%	29.6%
	No		11.8%		12.1%	11.5%	11.8%
3. Were you given enough privacy when discussing your care and treatment?	Yes, always		87.4%		86.7%	86.2%	89.0%
	Yes, sometimes		10.6%		11.0%	11.6%	9.4%
	No		2.0%		2.3%	2.3%	1.6%
4. Do you think that hospital staff do all they can to help control your pain?	Yes, definitely		80.8%		81.4%	80.0%	81.0%
	Yes, to some extent		16.0%		15.6%	16.6%	16.0%
	No		3.1%		3.0%	3.3%	3.1%

		Performance					
Question	Answer	2009/10	2010/11	Q1 2010/11	Q2 2010/11	Q3 2010/11	Q4 2010/11
5. Did a member of staff tell you about medication side effects to watch for when you went home?	Yes, completely		60.3%			59.0%	62.8%
	Yes, to some extent		12.2%			10.8%	10.9%
	No		27.5%			30.2%	26.3%
6. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	Yes		88.9%			88.2%	93.5%
	No		11.1%			11.8%	6.5%

The Trust's National Inpatient Survey results for 2010 are shown in Part 3 of this report.

Initiatives implemented during 2010/11:

- The outpatient telephone survey was implemented in July 2010, with around 70 surveys completed each month. The results are reported to the Care Quality Group
- More comprehensive reports on patient experience and satisfaction have been developed which provide detailed results by Division. These have enabled improvements to be made in relation to food, privacy and dignity and noise at night
- Patient survey data is analysed to ensure responses are representative of the patient population with regard to age, gender and ethnicity

Improving patient experience and satisfaction in 2011/12:

The Trust has chosen to focus on delivering improvements for 5 questions in the 2011 National Inpatient Survey. The questions have been selected because they form part of the nationally mandated Commissioning for Quality and Innovation (CQUIN) indicator for 2011/12:

1) Were you involved as much as you wanted to be in decisions about your care and treatment?
2) Did you find someone on the hospital staff to talk to about your worries and fears?
3) Were you given enough privacy when discussing your condition or treatment?
4) Did a member of staff tell you about medication side effects to watch for when you went home?
5) Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

In addition, the Trust will be focusing on delivering improvements for the following patient survey questions locally:

6) Do you think the hospital staff do all they can to help control your pain?
7) Overall how would you rate the hospital food you have received?
8) Have you been bothered by noise at night from hospital staff?
9) Sometimes in hospital a member of staff says one thing and another says something quite different. Has this happened to you?
10) Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

These questions have been selected by the Trust's Care Quality Group which has Governor representation.

New initiatives to be implemented in 2011/12:

- A Patient Experience Champion programme will be established to provide a framework within wards and departments to drive improvements through patient and carer feedback
- A paper questionnaire will be introduced in the Emergency Department alongside a facility for patients to provide feedback via on-line methods
- Implementation of an online patient survey to make it easier for patients to provide feedback
- Introduction of a discharge survey for patients using the Discharge Lounge
- Implementation of a 'Mystery Shopper' programme to audit customer care practices in various departments

How progress will be monitored, measured and reported

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

Complaints

In 2010/11 there was an increase of 30.6% in the number of complaints, compared with the previous year. This peaked during January 2011 and has since reduced. The Trust had anticipated an increase in the number of complaints as a result of the move of services to the new hospital, in line with the experience of other Trusts.

	2010/11	2009/10	2008/09
Total number of complaints	840	643	609
Response within agreed deadline	93%	92.2%	88%

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

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

* FCE = Finished Consultant Episode – which denotes the time spent by a patient under the continuous care of a consultant.
** Outpatients activity data relates to fulfilled appointments only and also includes Therapies (Physiotherapy, Podiatry, Dietetics, Speech and Language Therapy and Occupational Therapy)

Independent Reviews

Following local resolution, complainants may request an independent review; a function carried out since April 2009 by the Parliamentary and Health Service Ombudsman. Cases received by the Ombudsman will receive an initial assessment, following which they will either be accepted for investigation or will be refused. Cases that are accepted for investigation may be upheld or not upheld.

The Ombudsman report for 2009/10 showed that 66 requests had been received in relation to UHB. Of those, 7 were accepted for investigation. During 2010/11, the Ombudsman upheld 5 complaints relating to previous years. These cases resulted in further investigations by the Trust and publication of action plans to demonstrate learning outcomes.

Learning from Complaints

The Trust is continuing to learn from complaints and make real improvements to services for future patients. Some of the key improvements made as a result of complaints received during 2010/11 are detailed below.

Care Rounds

One of the trends identified following the move to the new hospital related to perceptions of nursing care on the new wards. The Trust has since introduced a system of Care Rounds across all 29 inpatient wards across the old and new hospital sites. Care Rounds involve nurses conducting hourly checks of patients where their concerns, comfort, hydration, nutrition, continence and environmental needs are assessed through direct interaction with the patient. These are then documented on a Care Round Checklist and actions taken to respond to issues as they arise.

Customer Care Training

In response to an increase in complaints relating to staff attitude and communication, the Trust has appointed a dedicated Customer Care Facilitator. Over 1,100 staff have received training in good customer care since January 2011 which includes staff in areas highlighted through complaints. A Customer Care Strategy has been developed and further training will be delivered during 2011/12.

Executive Root Cause Analysis (RCA) Meetings

Some of the more serious or complex complaints the Trust receives are now being reviewed at the monthly root cause analysis meetings attended by Executive directors, Divisional management and clinical teams.

Compliments

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

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

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

Compliment Subcategories	2010/11	2009/10	2008/9
Nursing care	309	92	11
Friendliness of staff	306	76	26
Treatment received	251	130	142
Medical care	122	21	9
Other	54	4	2
Efficiency of service	47	37	8
Information provided	17	3	1
Facilities	9	4	11
Comment	0	0	1
Totals:	**1115**	**367**	**211**

Examples of compliments received during 2010/11:

Date Received	Compliment
June 2010	"At all times she was treated with respect, with fairness, with open friendliness, with care. She received these from all members of staff, from the time she arrived… until she was discharged… to her home"
July 2010	"Astounded by the excellent nursing and medical care"
August 2010	"Thank you to the doctors and especially the nursing staff on days and nights who looked after me when I was ill during the first days of my 12 day stay on the ward. All staff made my stay that bit more bearable and I shall eternally be grateful. Thank goodness for the NHS. "
August 2010	"Every single person I encountered during my stay, was extremely professional and caring, every time"
January 2011	"The treatment was excellent, and all the staff, too many to name individually, were absolutely magnificent"
January 2011	"Your skills and dedication are breath taking! Your patience and care were invaluable during a very difficult time of my life. Thank you for getting me through the hardest part of my treatment"

Date Received	Compliment
February 2011	"Everyone associated with my treatment and care has been a credit to their profession. I really cannot thank them enough"
March 2011	"It is an extremely efficient service, you all made me feel very relaxed during a difficult time for me"

Feedback received through NHS Choices website:

The Trust has a system in place to routinely monitor feedback posted on external websites such NHS Choices/Patient Opinion. Feedback is forwarded to the relevant department manager for information and action. A response is posted to each comment received acknowledging the comment and providing generic information when appropriate. The response also promotes the Patient Advice and Liaison Service (PALS) as a mechanism for obtaining a more personalised response or to ensure a thorough investigation into any issues raised. The number of comments posted this way is relatively small but numbers are beginning to show a slight increase.

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

Current Status

The Trust has implemented an electronic observation chart during 2010/11 within the Prescribing Information and Communication System (PICS). 69% of inpatient wards are now using the electronic chart to record patient observations rather than the paper charts.

A full set of patient observations includes: 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 (Scottish 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 observation sets which are complete. The Trust's baseline performance was 79% for 2010/11 for those wards which were using the electronic observation chart in PICS. The Trust is aiming to roll out the electronic observation chart to the remaining wards and for at least 82% of all observation sets to be complete by the end of 2011/12.

New initiatives to be implemented in 2011/12:

- Roll out of the electronic observation chart to the remaining inpatient wards
- Add this indicator to the Clinical Dashboard to enable clinical staff to monitor and benchmark performance against other similar wards

How progress will be monitored, measured and reported:

- Progress will be measured using PICS data from the electronic observation charts
- Progress will be monitored at ward, specialty and Trust levels through the Clinical Dashboard and other reporting tools
- Progress will be reported monthly to the Clinical Quality Monitoring Group and quarterly to the Board of Directors through the quarterly Quality Report updates

Ongoing Priorities

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

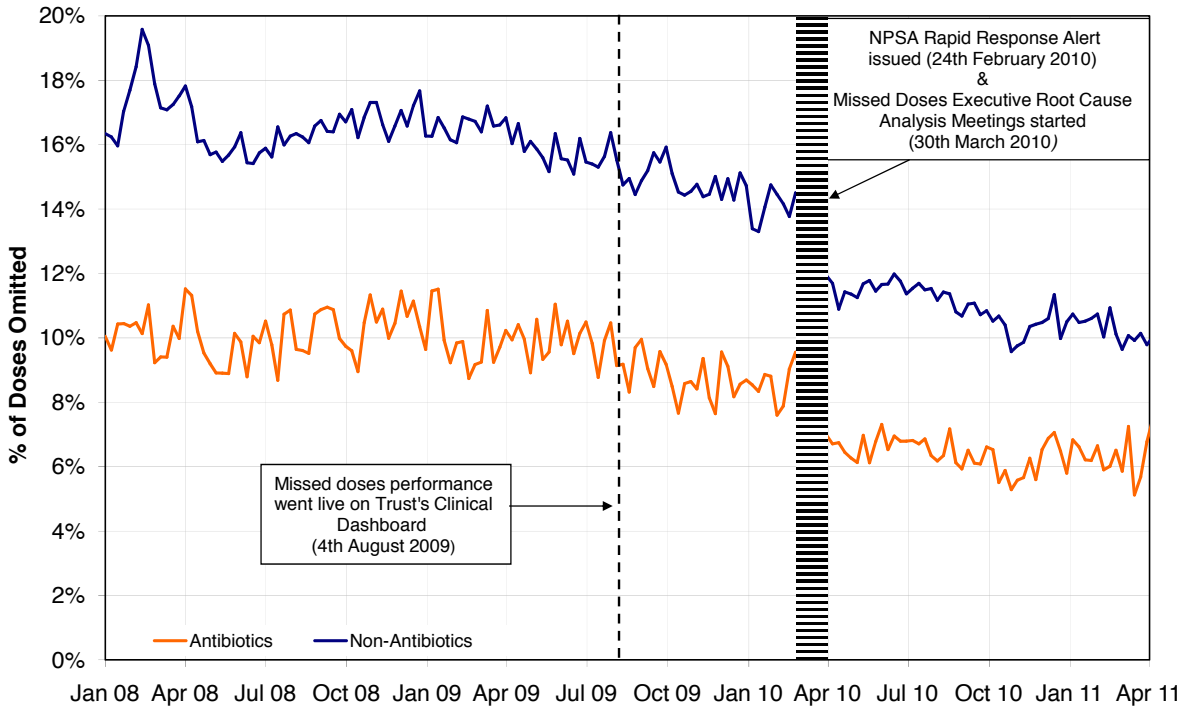
Performance

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

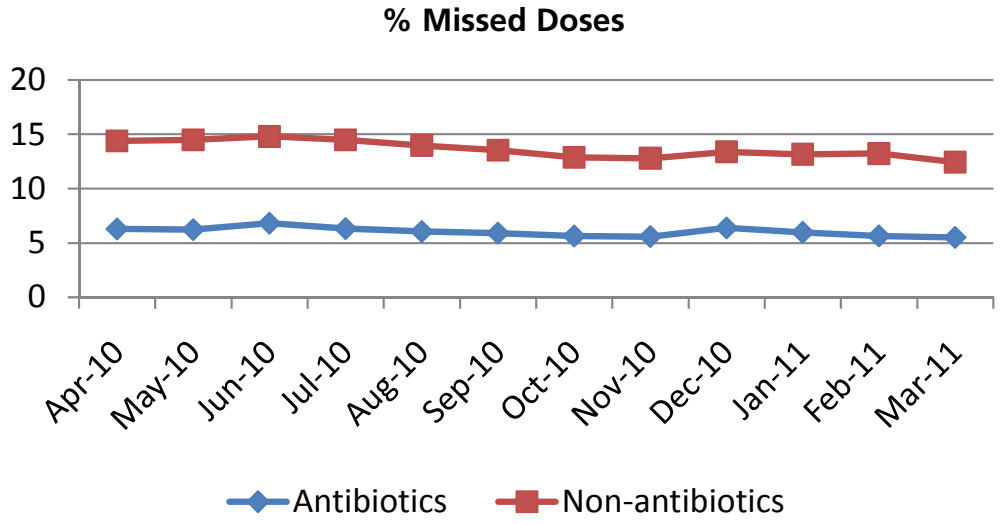
The graph shows that the Trust has delivered significant and sustained reductions in the percentage of omitted antibiotics and non-antibiotics. The biggest step change improvements occurred when the Trust began reporting missed doses data on the Clinical Dashboard in August 2009 and the Executive root cause analysis (RCA) meetings were introduced at the end of March 2010.

The Trust has also made further significant reductions in the percentage of omitted antibiotic and non-antibiotic drug doses during 2010/11, although the rate of decline has now slowed as expected. UHB is aiming to make further reductions during 2011/12, particularly for non-antibiotics. It is however important to remember that some drug doses are appropriately missed due to the patient's condition at the time. The Trust will therefore be evaluating its target reductions in 2011/12 to ensure they are appropriate, in the absence of any national agreement on what constitutes an expected level of drug omissions.

Missed Doses Performance by Week January 2008-April 2011



Missed Doses Performance by Month April 2010-March 2011



Initiatives implemented during 2010/11:

- Monthly Executive root cause analysis (RCA) meetings have continued during 2010/11, covering a wide range of omitted drugs and associated medication issues
- A nurse pause function has been introduced in the Prescribing Information and Communication System. This allows nursing staff to pause a limited number of symptomatic medications such as analgesics and laxatives as soon as they are not required
- Training and education has been given to both nursing and medical staff around the prescribing and administration of antibiotics and non-antibiotics
- The default screen which opens when nurses and medical staff log into PICS has been changed to the drug chart to focus attention on missed doses

Initiatives to be implemented in 2011/12:

- Evaluation of reduction targets for antibiotics and non-antibiotics for 2011/12
- The Trust will be focusing on improving prescribing practice and communication between medical and nursing staff
- Monthly Executive RCA meetings will continue with enhanced monitoring of action plans to ensure improvements are sustained

How progress will be monitored, measured and reported

- Progress will continue to be measured at ward, specialty, divisional and Trust levels using information recorded in the Prescribing Information and Communication System. This includes automatic email alerts to different levels of management staff where specialty performance is outside agreed targets
- Omitted drug doses will continue to be communicated daily to clinical staff via the Clinical Dashboard (which displays real-time quality information at ward-level) and monitored at divisional, specialty and ward levels
- Performance will continue to be reported to the Chief Executive's Advisory Group, the Chief Operating Officer's Group and the Board of Directors each month to ensure appropriate actions are taken
- Progress will also be reported in the quarterly Quality Report updates published on the Trust's quality web pages

Priority 6: Infection prevention and control

Performance

The Trust concluded 2010/11 under the agreed trajectory for *C. difficile* infections for 2010/2011. All staff have contributed to this improvement through a consistent focus on patient assessment, rapid isolation, appropriate hand hygiene, environmental decontamination and prudent antimicrobial prescribing.

The Trust met the agreed MRSA trajectory of 11 cases for 2010/11. The Trust will need to continue to reduce infection rates during the coming year to meet the challenging trajectories for 2011/12.

	Time Period					
Infection Type	Actual 2010/11 Number	Agreed Trajectory for 2010/11	Actual 2009/10 Number	Agreed Trajectory for 2009/10	Actual 2008/09 Number	Agreed Trajectory for 2008/09
C. difficile infection (post-48 hour cases)	145	164	178	348	357	526
MRSA bloodstream infections	11	11	13	30	35	48

Initiatives implemented during 2010/11:

- Enhanced cleaning with vapour decontamination is used for patients with diarrhoea which has tested positive for the *C. difficile* toxin and multi-drug resistant Acinetobacter
- MRSA screening has been expanded to cover all emergency and non-emergency patients admitted to UHB
- An improved root cause analysis (RCA) process has been developed for reviewing MRSA bacteraemias and *C. difficile* infections to ensure improvements are sustained

Initiatives to be implemented in 2011/12:

- Monthly reporting of other infections including meticillin-sensitive Staphylococcus aureus (MSSA) bacteraemias and Escherichia coli (E. coli) bacteraemia to the Health Protection Agency (HPA) will start during 2011/12
- Reduce the incidence of surgical site infection across all types of surgery
- Reduce the incidence of urinary catheter associated infection
- Reduce the incidence of blood culture contamination
- Minimise the risk from healthcare associated infections to patients through better management of invasive devices
- Ensure learning from healthcare associated infections is captured and disseminated across the Trust to minimise recurrence and improve patient safety

How progress will be monitored, measured and reported:

- The number of MRSA and *C. difficile* infections will be measured against the 2011/12 trajectories
- Performance will be monitored daily via the

Clinical Dashboard and daily/weekly email alerts

- All MRSA bloodstream infections will continue to be reported as serious incidents requiring investigation (SIRIs) to NHS South Birmingham
- Root cause analyses will continue to be undertaken for MRSA bloodstream infections and *C. difficile* infections
- Performance will be reported monthly to the Trust's Infection Prevention and Control Committee and the Board of Directors
- Progress will also be reported in the quarterly Quality Report updates published on the Trust's quality web pages

2.2 Statements of assurance from the Board of Directors

2.2.1 Information on the review of services

During 2010/11 the University Hospitals Birmingham NHS Foundation Trust* provided and/or sub-contracted 61 NHS services.

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

The income generated by the NHS services reviewed in 2010/11 represents 100% per cent of the total income generated from the provision of NHS services by the Trust for 2010/11.

In line with the Transforming Community Services Programme, the Trust will be integrating sexual health services from Heart of Birmingham Teaching Primary Care Trust as of 1 April 2011. Performance indicators will be developed and monitored during 2011/12 and considered as part of the Trust's 2011/12 Quality Report.

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

** The Trust has appropriately reviewed the data available on the quality of care for all its services. Due to the sheer volume of electronic data the Trust holds in various information systems, this means that UHB uses automated systems and processes to prioritise which data on the quality of care should be reviewed and reported on. These are described further in Part 3 of this report.

Data is reviewed and acted upon by clinical and managerial staff at specialty, divisional and Trust levels by various groups including the Clinical Quality Monitoring Group chaired by the Executive Medical Director.

2.2.2 Information on participation in clinical audits and national confidential enquiries

During 2010/11 42 national clinical audits and 2 national confidential enquiries covered NHS services that UHB provides.

During 2010/11 UHB participated in 88% 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 2010/11 are as follows: (see table over the page)

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

The national clinical audits and national confidential enquiries that UHB participated in, and for which data collection was completed during 2010/11, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (see table over the page).

Audit type	Audit UHB eligible to participate in	UHB participation 2010/11	Percentage of required number of cases submitted
Part of the National Clinical Audit and Patient Outcomes Programme	Head & neck cancer (DAHNO)	Yes	100% of appropriate cases submitted
	Bowel cancer (NBOCAP)	Yes	65.2%
	Oesophago-gastric (stomach) Cancer	N/A - No current submission required	N/A
	IBD (Inflammatory Bowel Disease) Audit	Yes	N/A The third round audit has commenced in stages. Organisational data collection from September to October 2010 (submitted), Clinical Data September 2010 to August 2011 (in progress), Patient Experience September 2010 to September 2011(in progress)
	Adult cardiac surgery	Yes	100%
	Heart failure	Yes	100%
	Adult cardiac interventions (e.g., angioplasty)	Yes	100%
	Myocardial Infarction (MINAP)	Yes	Not available – specific number not required
	Cardiac rhythm management (Pacing / Implantable Defibrillators)	Yes	100%
	Congenital heart disease (children and adults) / Paediatric cardiac surgery	Yes	100%
	National Kidney Care Audit: Patient Transport	Yes	Not available – specific number not required
	National Audit of Continence Care	N/A - no audit in 2010/11	N/A
	Lung cancer (LUCADA)	Yes	100%
	National Falls and Bone Health Audit	Yes	89%

Audit type	Audit UHB eligible to participate in	UHB participation 2010/11	Percentage of required number of cases submitted
	National Sentinel Stroke Audit	Yes	100%
	National Audit of Dementia	Yes	100% - Plus enhanced audits
	Mastectomy & Breast Reconstruction	N/A - no audit in 2010/11	N/A
	Carotid Endarterectomy Audit	Yes	52%
	National Diabetes Audit	Yes	N/A - The submission of 2010/11 data is not due until October.
	Pain Database Audit (pilot)	N/A - no audit in 2010/11	N/A - Pain database audit due to start March 2011.
	Hip Fracture Database	Yes	Not available – specific number not required

Audit type	Audit UHB eligible to participate in	UHB participation 2010/11	Percentage of required number of cases submitted
Not part of the National Clinical Audit and Patient Outcomes Programme	National Cardiac Arrest Audit (NCAA)	No	N/A
	Adult Critical Care Case Mix Programme - ICNARC	Yes	100%
	National Elective Surgery Patient Reported Outcome Measures (PROMS): 1. Hernia	Yes	For April 2009-October 2010: Pre-operative questionnaire participation by patients: 42.7% Post-operative questionnaire participation by patients: 64.5%
	National Elective Surgery Patient Reported Outcome Measures (PROMS): 2. Varicose Veins	Yes	For April 2009-October 2010: Pre-operative questionnaire participation by patients: 22.2% Post-operative questionnaire participation by patients: 53.2%
	Potential Donor Audit	Yes	100%
	Renal Registry	Yes	100%
	UK Transplant registry: 1. Cardiothoracic	Yes	100%
	UK Transplant registry: 2. Liver	Yes	100%

Audit type	Audit UHB eligible to participate in	UHB participation 2010/11	Percentage of required number of cases submitted
	UK Transplant registry: 3. Kidney	Yes	100%
	British Thoracic Society: 1. Adult Asthma	Yes	Not available – specific number not required
	British Thoracic Society: 2. Emergency Oxygen	Yes	Not available – specific number not required
	British Thoracic Society: 3. National Pleural Procedures audit	Yes	Not available – specific number not required
	British Thoracic Society: 4. COPD	Yes	Not available – audit deadline 1st April 2011
	British Thoracic Society: 5. Adult Community Acquired Pneumonia	Yes	Not available – specific number not required
	British Thoracic Society: 6. NIV (Adult)	Yes	Not available – specific number not required
	British Thoracic Society: 7. Bronchiectasis	Yes	Not available – specific number not required
	College of Emergency Medicine: 1. Renal colic	No	N/A
	College of Emergency Medicine: 2. Fever in children	Yes	100%
	College of Emergency Medicine: 3. Vital signs in majors	Yes	100%
	Parkinson's Disease Audit	No	N/A
	SINAP (Stroke Improvement National Audit Programme)	No	N/A

Audit type	Audit UHB eligible to participate in	UHB participation 2010/11	Percentage of required number of cases submitted
	National Comparative Audit of Blood Transfusion: 1. Repeat use of 'O' Negative blood audit	Yes	100%
	National Comparative Audit of Blood Transfusion: 2. Re-audit of the use of platelets	Yes	100%
	National Clinical Audit of Management of Familial Hypercholesterolaemia	Yes	100%
	Peripheral Vascular Surgery	No	N/A
	Severe Trauma – TARN (Trauma Audit and Research Network)	Yes	100%

National Confidential Enquiries

National Confidential Enquiries	UHB participation 2010/11	Percentage of required number of cases submitted
Cardiac Arrest	Yes	100%
Peri-Operative Care	Yes	100%
Surgery in Children	N/A	-

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

The Trust has introduced a process during 2010/11 for considering participation in new national audits to ensure those we participate in are both clinically useful and cost effective. Any decisions to not participate in a national audit are made by the Chief Executive.

The reports of 23 national clinical audits were reviewed by the provider in 2009/10 and UHB intends to take the following actions to improve the quality of healthcare provided:

Actions reported from national clinical audits include measures such as:

- improvement in data capture including multi-professional care recording
- streamlining of patient care pathways

- appointment of new staff and changes to staff roles for improved training
- education and knowledge
- creating and updating patient information
- continued use of data for benchmarking purposes

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

At UHB a wide range of local clinical audit is undertaken in clinical specialties and across the Trust. A total of 706 clinical audits were registered with UHB's clinical audit team as having commenced or been completed at UHB during 2010/11.

The reports of 314 local clinical audits were reviewed by the provider in 2010/11 and UHB intends to take the following actions to improve the quality of healthcare provided:

This figure indicates that the results of 314 clinical audits were reported within clinical areas and those reports were submitted to UHB's clinical audit team. At UHB, staff undertaking clinical audit are required to report any actions that should be implemented to improve service delivery and clinical quality. A list of examples of specific actions reported can be viewed on the Quality web pages: http://www.uhb.nhs.uk/quality.htm. These include measures such as:

- updating patient information
- reviewing or developing new protocols or guidelines for staff
- arranging training or education sessions in order to increase staff awareness of required standards
- making changes to staff roles
- implementing new care plans or assessment tools for patients
- purchasing equipment

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

2.2.3 Information on participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by UHB that were recruited during that period to participate in research approved by a research ethics committee was 7300.

The table over the page shows the number of clinical research projects registered with the Trust's Research and Development (R&D) Team during 2010/11. 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.

Total number of projects registered with R&D in this period	181
Out of the total number of projects registered in this period the number of studies currently abandoned	13

Projects registered during this period broken down into disciplines	Registered	Abandoned
Cancer		
(Oncology:32; Haematology:4; Imaging:3; Clinical Biochemistry:2; Endocrinology:2; Radiotherapy: 2; Breast Services:1; ENT:1; Liver Medicine:1; Neuropsychology:1; Oral Surgery:1; Renal Medicine:1; Urology:1)	52	6
Heart and Vascular Disease		
(Cardiology:4; Cardiac Surgery:3; Endocrinology:3; Renal Medicine:2; Renal Surgery:2; Anaesthetics:1; Haematology:1; Rheumatology:1; Vascular Surgery:1)	18	1
Inflammation and Infection		
(Liver Medicine:8; Genito-Urinary Medicine:4; Haematology:4; Rheumatology:4; Neurology:3; Renal Medicine:3; Respiratory Medicine:3; Burns & Plastics:2; Oncology:2; Anaesthetics:1; GI Surgery:1; Trauma:1; Vascular Surgery:1)	37	2
Molecular & Genetic Basis for Disease		
(Diabetes:7; Endocrinology:6; Anaesthetics:3; Oncology:3; Renal Medicine:3; Haematology:2; Pharmacology:2; Respiratory Medicine:2; Burns & Plastics:1; GI Medicine:1; Neurology:1; Ophthalmology:1; Urology:1; Multi-disciplinary:1)	34	2
Neurosciences and Aging		
(Neurology:5; Audiology:4; Geriatric Medicine:4; Elderly Care:3; Endocrinology:2; Haematology:1; ITU:1; Neurosciences:1; Neurosurgery:1; Pain Service:1; Physiotherapy:1; Psychology:1; Oncology:1; Other:1)	27	1
Transplantation		
(Haematology:3; Liver Medicine:3; Renal Medicine:2; Cardiac Surgery:1; Critical Care:1; GI Surgery:1; Renal Surgery:1; Other:1)	13	1
Total	**181**	**13**

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

A proportion of UHB income in 2010/11 was conditional upon achieving quality improvement and innovation goals agreed between UHB and NHS South Birmingham, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2010/11 and for the following 12 month period are available online at http://www.uhb.nhs.uk/quality.htm.

The amount of UHB income in 2010/11 which was conditional upon achieving quality improvement and innovation goals was £5.96m* and the Trust received £5.96m** in payment.

* This figure has been arrived at as a percentage of the healthcare income which will be included within the Trust's 2010/11 accounts and does not represent actual outturn (as an estimate has to be included for Month 12 income). The actual figure will not be known until June 2011 when we will have a final position as reconciled with the HCS (Healthcare Commissioning Services). Also whilst we have received payment throughout the year as each month has been agreed with HCS, final payment of CQUIN monies will not take place until the June 2011 reconciliation point.

** Final payment is however subject to verification with NHS South Birmingham for the last two quarters of 2010/11.

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

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

The Care Quality Commission has not taken enforcement action against UHB during 2010/11.

UHB has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2010/11: review of services for people who have had a stroke and their carers.

This review looked at the pathway of care provided to people who experienced a stroke or a 'mini-stroke' (called a transient ischemic attack) and their carers. The review looked at different types of services involved in stroke care across the area covered by NHS South Birmingham and was not therefore limited to the care provided by UHB. The review focused in particular on transition of care from hospital to community settings, long term support and patient and carer information.

UHB intends to take the following action to address the conclusions or requirements reported by the Care Quality Commission:

- The results of the CQC review have been analysed by the medical and nursing stroke leads. Actions required across the pathway have been integrated into the existing Stroke Action Plan which aims to improve stroke performance more widely during 2011/12
- Work with community services and local Commissioners to develop an Early Supported Discharge (ESD) service for stroke patients. UHB has conducted an audit and identified that around half of the Trust's stroke patients would benefit from such a service
- Continue monitoring 30-day stroke mortality and readmissions through the Clinical Quality Monitoring Group chaired by the Executive Medical Director

UHB has made the following progress by 31 March 2011 in taking such action: the actions are in progress as described above.

2.2.6 Information on the quality of data

UHB submitted records during 2010/11 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: 96.8% for admitted patient

care; 98.1% for outpatient care; and 93.9% for accident and emergency care

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

UHB Information Governance Assessment Report overall score for 2010/11 was 77% and was graded green.

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

- Inclusion of a Data Quality Improvement Plan, based on specified key data items, within the 2011/12 Contract currently under negotiation
- Investigate the feasibility of creating a Coding Academy for the West Midlands
- The new role of Data Quality Specialist has been created and will be used to facilitate the implementation of data quality initiatives and compliance with the Data Quality Policy across the Trust
- Maintaining Level 2 compliance with the Information Toolkit Data Quality Initiatives and working towards Level 3 compliance

UHB was not subject to the Payment by Results clinical coding audit during 2010/11 by the Audit Commission.

Part 3: Other information

3.1 Overview of quality of care provided during 2010/11

The tables following show the Trust's performance for 2010/11 and the last two financial years for a selection of indicators for patient safety, clinical effectiveness and patient experience. The Board of Directors has chosen to include the same selection of indicators as reported in the Trust's previous Quality Reports to enable patients and the public to understand performance over time.

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

The latest available data for 2010/11 is shown on the following pages and has been subject to the Trust's usual data quality checks by the Health Informatics team. Benchmarking data has also been included where possible. Performance has been monitored and challenged during the past year by the Clinical Quality Monitoring Group and the Board of Directors. In addition, the Trust has reported on performance against these indicators during the past year in the Quality Report updates published on its quality web pages: http://www.uhb.nhs.uk/quality.htm

3.2 Performance of Trust against selected indicators

3.2.1 Patient safety indicators

Indicator	2010/11	Peer Group Average (where available)	2009/10	2008/09
1(a). MRSA: Patients with MRSA infection/10,000 bed days (includes all bed days from all specialties) *Lower rate indicates better performance*	0.31	0.21	0.42	1.15
Time period	April 2010 - December 2011	April 2010 - December 2011	2009/10	2008/09
Data source	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	HPA Website
Peer group		Acute trusts in West Midlands SHA		
1(b). MRSA: Patients with MRSA infection/10,000 bed days (aged >15, excluding Obstetrics Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	0.32	0.24	0.43	1.15
Time period	April 2010 - December 2011	April 2010 - December 2011	2009/10	2008/09
Data source	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	HPA (MRSA data), HES data (bed days)
Peer group		Acute trusts in West Midlands SHA		

Indicator	2010/11	Peer Group Average (where available)	2009/10	2008/09
2(a). *C. difficile*: Patients with *C. difficile* infection/1,000 bed days (includes all bed days from all specialties) *Lower rate indicates better performance*	**0.48**	**0.33**	**0.53**	**1.03**
Time period	April 2010 - December 2011	April 2010 - December 2011	2009/10	2008/09
Data source	Trust C.diff data reported to HPA, HES data (bed days)	Trust C.diff data reported to HPA, HES data (bed days)	Trust C.diff data reported to HPA, HES data (bed days)	HPA Website
Peer group		Acute trusts in West Midlands SHA		
2(b). *C. difficile*: Patients with *C. difficile* infection/1,000 bed days (aged >15, excluding Obstetrics Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	**0.48**	**0.38**	**0.59**	**1.03**
Time period	April 2010 - December 2011	April 2010 - December 2011	2009/10	2008/09
Data source	Trust C.diff data reported to HPA, HES data (bed days)	Trust C.diff data reported to HPA, HES data (bed days)	Trust C.diff data reported to HPA, HES data (bed days)	HPA (C.diff data), HES data (Bed days)
Peer group		Acute trusts in West Midlands SHA		

Indicator	2010/11	Peer Group Average (where available)	2009/10	2008/09
3. Patient safety incidents (reporting rate per 100 admissions) *Higher rate indicates better reporting*	**11.3**	**6.1**	**9.7**	**10.7**
Time period	2010/11	April - September 2010	2009/10	2008/09
Data source	Datix (incident data), Trust admissions data	Based on data provided in NPSA NRLS report	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data
Peer group		Acute teaching organisations		
4. Percentage of patient safety incidents which are no harm incidents *Higher % indicates better performance*	**81.3%**	**73.5%**	**89.9%**	**89.2%**
Time period	2010/11	April - September 2010	2009/10	2008/09
Data source	Datix (incident data)	Based on data provided in NPSA NRLS report	Datix (incident data)	Datix (incident data)
Peer group		Acute teaching organisations		

Notes on patient safety indicators

1(a), 1(b), 2(a), 2(b): The data shown for 2009/10 and 2008/09 differs to that shown in previous Quality Reports. This is due to a change in the method and data source used to calculate bed days.

3: The data shown for 2009/10 and 2008/09 differs to that shown in previous Quality Reports. This is due to a change in the method of calculation which uses admissions data rather than episodes; an admission is classed as the first episode of care.

4: The data shown for 2009/10 and 2008/09 differs to that shown in previous Quality Reports. This is due to a change in the method of calculation which now includes near miss as well as no harm incidents. The decrease in 2010/11 is largely due to the reporting of all grades of pressure ulcer as incidents. The Trust began reporting pressure ulcers in April 2010 and they now account for 11.5% of reported patient safety incidents which are classed as harm.

3.2.2 Clinical effectiveness indicators

Indicator	2010/11	Peer Group Average (where available)	2009/10	2008/09
5(a). Readmissions: Readmission rate (Medical and surgical specialties - elective and emergency admissions aged >15)% *Lower % indicates better performance*	**5.84%**	**5.30%**	**5.63%**	**Not available**
Time period	April-November 2010	April-November 2010	2009/10	
Data source	HES data	HES data	HES data	
Peer group		University hospitals		
5(b). Readmissions: Readmission rate (all specialties) % *Lower % indicates better performance*	**5.84%**	**4.89%**	**5.62%**	**Not available**
Time period	April-November 2010	April-November 2010	2009/10	
Data source	HES data	HES data	HES data	
Peer group		University hospitals		
6. Falls (incidents reported as % of elective and emergency admissions) *Lower % indicates better performance*	**2.5%**	**Not available**	**2.0%**	**2.0%**
Time period	2010/11		2009/10	2008/09
Data source	Datix (incident data), Trust admissions data		Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data

Indicator	2010/11	Peer Group Average (where available)	2009/10	2008/09
7. Percentage of stroke patients (infarction) on aspirin, clopidogrel or warfarin *Higher % indicates better performance*	**100%**	**99.3%**	**99.7%**	**98%**
Time period	2010/11	2009	2009/10	2008/09
Data source	Trust PICS data	Cleveland Clinic website	Trust PICS data	Trust PICS data
Peer group		Cleveland Clinic, Ohio, U.S.A.		
8. Percentage of beta blockers given on the morning of the procedure for patients undergoing first time coronary artery bypass graft (CABG) *Higher % indicates better performance*	**92.6%**	**98.0%** **NB This data is for all surgery patients with heart conditions who were on betablockers and is based on a sample of cases.**	**93.3%**	**86.6%**
Time period	2010/11	July 2009 - June 2010	2009/10	2008/09
Data source	Trust PICS data	Cleveland Clinic website	Trust PICS data	Trust PICS data
Peer group		Cleveland Clinic, Ohio, U.S.A.		

Notes on clinical effectiveness indicators

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

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

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

7: Aspirin, clopidogrel or warfarin are given to reduce the likelihood of recurrent stroke or transient ischaemic attack (TIA) in patients who have already suffered a stroke. Any patients who are identified as not having been given aspirin, clopidogrel or warfarin during their stay are followed up to ensure they have been discharged on these drugs if clinically appropriate.

8: Beta blockers are given to reduce the likelihood of peri-operative myocardial infarction and early mortality. This indicator relates to patients already on beta blockers and whether they are given beta blockers on the day of their operation. All incidences of beta blockers not being given on the day of operation are investigated to understand the reasons why and to reduce the likelihood of future omissions.

3.2.3 Patient experience indicators

Patient survey question	2010/11	Comparison with other NHS trusts 2010/11	2009/10	Comparison with other NHS trusts 2009/10	2008/09	Comparison with other NHS trusts 2008/09
9. Overall were you treated with respect and dignity	88	Intermediate 60% of trusts	89	Intermediate 60% of trusts	88	Intermediate 60% of trusts
Time period & data source	Trust's 2010 Inpatient Survey Report, Care Quality Commission		Trust's 2009 Inpatient Survey Report, Care Quality Commission		Trust's 2008 Inpatient Survey Report, Care Quality Commission	
10. Involvement in decisions about care and treatment	69	Intermediate 60% of trusts	70	Intermediate 60% of trusts	70	Intermediate 60% of trusts
Time period & data source	Trust's 2010 Inpatient Survey Report, Care Quality Commission		Trust's 2009 Inpatient Survey Report, Care Quality Commission		Trust's 2008 Inpatient Survey Report, Care Quality Commission	
11. Did staff do all they could to control pain	79	Worst performing 20% of trusts	80	Worst performing 20% of trusts	85	Intermediate 60% of trusts
Time period & data source	Trust's 2010 Inpatient Survey Report, Care Quality Commission		Trust's 2009 Inpatient Survey Report, Care Quality Commission		Trust's 2008 Inpatient Survey Report, Care Quality Commission	

Patient survey question	2010/11	Comparison with other NHS trusts 2010/11	2009/10	Comparison with other NHS trusts 2009/10	2008/09	Comparison with other NHS trusts 2008/09
12. Cleanliness of room or ward	89	Intermediate 60% of trusts	84	Worst performing 20% of trusts	83	Intermediate 60% of trusts
Time period & data source	Trust's 2010 Inpatient Survey Report, Care Quality Commission		Trust's 2009 Inpatient Survey Report, Care Quality Commission		Trust's 2008 Inpatient Survey Report, Care Quality Commission	
13. Overall rating of care	78	Intermediate 60% of trusts	78	Intermediate 60% of trusts	78	Intermediate 60% of trusts
Time period & data source	Trust's 2010 Inpatient Survey Report, Care Quality Commission		Trust's 2009 Inpatient Survey Report, Care Quality Commission		Trust's 2008 Inpatient Survey Report, Care Quality Commission	

Notes on patient experience measures:

9-13: The scores included in the table above are benchmark scores rather than percentages, calculated by converting responses to particular questions into scores. For each question in the survey, the individual responses were scored on a scale of 0 to 100. The higher the score for each question, the better the trust is performing.

3.3 Performance against key national priorities

Key National Priorities	Time Period for 2010/11	2010/11	2010/11 Target	2009/10	2009/10 Target
Clostridium difficile (post-48 hour cases)	Apr 2010 – Mar 2011	145	164	178	348
MRSA (post-48 hour cases)	Apr 2010 – Mar 2011	11	11	13	30
62-day wait for first treatment from urgent GP referral: all cancers	Apr 2010 – Mar 2011	86.5%	85%	85.4%	85%
62-day wait for first treatment from consultant screening service referral: all cancers	Apr 2010 – Mar 2011	93.9%	90%	92.6%	90%
31-day wait from diagnosis to first treatment: all cancers	Apr 2010 – Mar 2011	98.6%	96%	97.4%	96%
31-day wait for second or subsequent treatment: surgery	Apr 2010 – Mar 2011	97.9%	94%	96.6%	94%
31-day wait for second or subsequent treatment: anti cancer drug treatments	Apr 2010 – Mar 2011	99.9%	98%	99.1%	98%
31-day wait for second or subsequent treatment: radiotherapy	Jan 2011 – Mar 2011	100%	94%	Target introduced in January 2011	
Two week wait from referral to date first seen: all cancers	Apr 2010 – Mar 2011	96.0%	93%	94.6%	93%
Two week wait from referral to date first seen: breast symptoms	Apr 2010 – Mar 2011	98.4%	93%	98.6% (Jan – Mar 2010)	93%
18-week maximum wait from point of referral to treatment (admitted patients)	Apr 2010 – Mar 2011	95.6%	Not a target from July 2010	95.4%	90%
18-week maximum wait from point of referral to treatment (non-admitted patients)	Apr 2010 – Mar 2011	98.7%	Not a target from July 2010	98.5%	95%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	Apr 2010 – Mar 2011	97.6%	95%	98.5%	98%

Key National Priorities	Time Period for 2010/11	2010/11	2010/11 Target	2009/10	2009/10 Target
Screening all elective in-patients for MRSA	Apr 2010 – Mar 2011	117.7%	100%	121.8%	100%
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	Apr 2010 – Mar 2011	Certification made	N/A	Certification made	N/A

* Data includes patients who attended South Birmingham GP Walk In Centre (Katie Road) from July 2009.
** Some patients are screened more than once for MRSA.

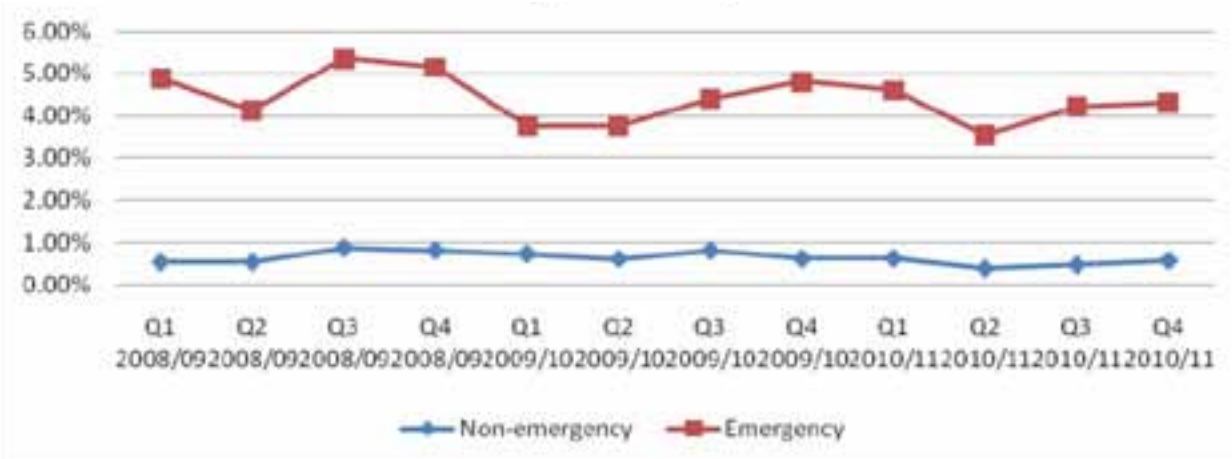
3.4 Mortality

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

UHB did not receive any formal mortality outlier notifications from the Care Quality Commission during 2010/11. The Trust has not included comparative information due to concerns about the validity of single measures used to compare trusts.

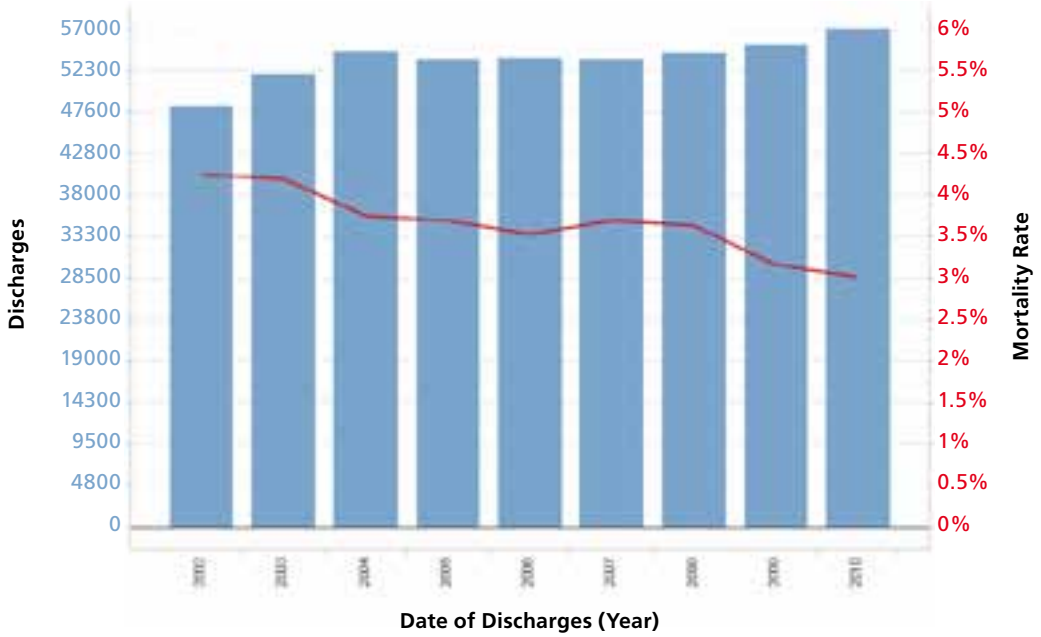
The graph below shows the non-emergency and emergency mortality rates by quarter for the last three financial years. Although the Trust is generally treating more elderly patients and patients with complex conditions, mortality continues to remain stable.

Non-emergency and Emergency Mortality Rates 2008/09-2010/11



Non-emergency and emergency mortality has slightly decreased despite an increase in the complexity of patients and increased activity during 2010/11 as shown in the graph below.

The graph shows the Trust's crude mortality rate against activity (patient discharges) for each of the past 9 calendar years.



3.5 Staff Survey

The Trust's Staff Survey results for 2010 have shown significant improvement compared to 2009, with over half of the findings in the highest 20% of acute trusts. The results are based on responses from 370 staff which represents a 45% response rate; the national response rate was 52%. The results for the Staff Survey questions which most closely relate to quality of care are shown in the table below. The main focus for 2011/12 will be on improving the response rate and the availability of handwashing materials across the Trust.

	2010/11	Comparison with other acute NHS trusts 2010/11	2009/10
1. Percentage feeling satisfied with the quality of work and patient care they are able to deliver	**79%**	**Highest (best) 20%**	**83%**
Time period & data source	Trust's 2010 Staff Survey Report, Care Quality Commission		Trust's 2009 Staff Survey Report, Care Quality Commission
2. Percentage agreeing their role makes a difference to patients	**93%**	**Highest (best) 20%**	**93%**
Time period & data source	Trust's 2010 Staff Survey Report, Care Quality Commission		Trust's 2009 Staff Survey Report, Care Quality Commission
3. Staff recommendation of the trust as a place to work or receive treatment	**3.81**	**Highest (best) 20%**	**3.79**
Time period & data source	Trust's 2010 Staff Survey Report, Care Quality Commission		Trust's 2009 Staff Survey Report, Care Quality Commission
4. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	**95%**	**Average**	**95%**
Time period & data source	Trust's 2010 Staff Survey Report, Care Quality Commission		Trust's 2009 Staff Survey Report, Care Quality Commission
5. Percentage of staff saying hand washing materials are always available	**62%**	**Below (worse than) average**	**71%**
Time period & data source	Trust's 2010 Staff Survey Report, Care Quality Commission		Trust's 2009 Staff Survey Report, Care Quality Commission

Notes on staff survey

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

3.6 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.

During 2010/11, the unit has continued to support clinical staff in the development of innovative quality indicators. Performance for a wide selection of the quality indicators developed by clinicians, Health Informatics and the Quality and Outcomes Research Unit was included in the Trust's 2009/10 Quality Report. The Trust focused on embedding these indicators within the specialties during 2010/11 and implemented a web-based tool to enable clinical staff to track performance on a monthly basis. The tool allows clinical staff to drill down to patient level data to facilitate validation, audit and research activity.

In addition, the Trust has significantly expanded the number of specialty quality indicator web pages during 2010/11 to enable patients and the public to track performance. These pages include graphs showing performance and explanatory text which are updated regularly.

Table 1 shows the performance for those specialty quality indicators where the most notable improvements have been made during 2010/11. The data has been checked by the appropriate clinical staff to ensure it accurately reflects the quality of care provided. Benchmarking data has been included where possible. Table 2 shows performance for those indicators where performance has deteriorated during 2010/11 compared with 2009/10. Some natural variation is to be expected, particularly for Haematology bone marrow transplant mortality. The specialties concerned will be focusing on these during 2011/12. Performance for the remaining 62 indicators has stayed about the same during 2010/11 and can be viewed on the Quality web pages: http://www.uhb.nhs.uk/quality.htm. The goals for all indicators have been reviewed by the clinicians involved to ensure they are both challenging and realistic for 2011/12.

Table 1

Specialty	Indicator	Goal	Numerator Apr 10-Mar 11	Denominator Apr 10-Mar 11	Percentage Apr 10-Mar 11	Percentage Apr 09-Mar 10	Percentage Apr 08-Mar 09	Data Source	Benchmarking (where available)
Cardiac Surgery	First-time isolated coronary artery bypass graft (CABG) - Patients discharged on angiotensin converting enzyme (ACE) inhibitors	100% of eligible patients	230	235	97.9%	89.6%	80.6%	PATS PICS	Not available
Dermatology	Proportion of suspected cancer cases seen within 2 weeks by a consultant	93%	1576	1594	98.9%	94.1%	95.3%	Cancer database	Not available
Max Fax	Percentage of emergency admissions with fractured mandible who have surgery same day or the next day	90%	170	216	78.7%	70.1%	74.3%	Lorenzo	Not available
Radiotherapy	85% of patients should commence treatment (first dose of radiotherapy) within 14 calendar days from CT scan. Note: Some of the patients not treated within the target timeframe had chosen to delay their treatment		2731	3298	82.8%	Jul 09 - Mar 10 78.5%	-	Radiotherapy database	Not available
Stroke Medicine	30 day mortality following stroke	>20%	45	423	10.6%	16.5%	16.7%	Lorenzo	Not available
Trauma & Orthopaedics	Proportion of patients who had surgery within 48 hours of admission for fractured neck of femur (fractured hip)	90%	223	279	79.9%	66.1%	60.9%	Lorenzo Galaxy	Not available

Table 2

Specialty	Indicator	Goal	Numerator Apr 10-Mar 11	Denominator Apr 10-Mar 11	Percentage Apr 10-Mar 11	Percentage Apr 09-Mar 10	Percentage Apr 08-Mar 09	Data Source	Benchmarking (where available)
Haematology	Bone Marrow Transplant-related mortality: During index (first) admission - autologous (patient's own bone marrow) transplants Within 100 days – autologous (patient's own bone marrow) transplants		 5 (Apr 10 – Dec 10) 5	 96 (Apr 10 – Dec 10) 73	 5.2% (Apr 10 – Dec 10) 6.8%	 0% 0%	 0% 3%	BMT database	Not available
Heart Failure	Percentage of heart failure patients discharged on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)	93%	237	359	66.0%	69.7%	71.6%	Heart Failure database PICS	Cleveland clinic 98% (July 09 - June 10) Average for all other US hospitals 94% (July 09 - June 10)
Imaging	Proportion of Outpatients who have report turnaround time of less than 5 days for CT		10032	14620	68.6%	74.0%	69.7%	CRIS	Not available
Imaging	Proportion of Outpatients who have report turnaround time of less than 5 days for MRI		5766	18316	31.5%	34.9%	31.3%	CRIS	Not available
Renal Surgery	Percentage of patients attending the low clearance clinic (which aims to get patients ready for dialysis) who had had an arteriovenous fistula (to create access for dialysis) made before starting haemodialysis. *The goal relates to those patients commencing haemodialysis who had chosen haemodialysis as their choice of treatment for end-stage renal failure.	80%*	38	60	63.3%	76.3%	73.5%	MARS Lorenzo	Not available
Urology	All patients admitted with acute retention to be discharged on alpha blockers (if not put on waiting list for transurethral resection of the prostate (TURP))	70%	35	76	46.1%	53.2%	48.6%	Lorenzo PICS	Not available

Notes on data sources:

BMT = Bone Marrow Transplant
Cleveland Clinic and US data = published on Cleveland Clinic website
CRIS = Radiology database
Galaxy = Theatres database
Lorenzo = Patient administration system
MARS = Renal database
PATS = Cardiac database
PICS = Prescribing Information and Communication System

3.7 Quality Web Pages

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

Information published includes:

- Quality Reports: this includes the Trust's annual Quality Reports plus quarterly progress reports
- Patient Experience Data: graphs showing Trust-level, electronic patient experience data collected locally through bedside televisions and telephone surveys
- Specialty Quality Indicators: graphs showing performance and explanatory text for specialty quality indicators which are updated monthly
- Other information: this includes some Annual Reports on specialised services such as HIV and national audit reports for example

The Trust is currently reviewing the content and layout of the Quality web pages to ensure they are user friendly and accessible. Further information and specialty quality indicator pages are likely to be added during 2011/12.

3.8 Healthcare Evaluation Data (HED) Tool

The Trust developed the interactive healthcare evaluation data (HED) tool during 2009/10 which enables clinical and managerial staff to evaluate the quality of healthcare delivery and operational efficiency in comparison to acute and mental health trusts in England.

The tool uses national Hospital Episode Statistics (HES) data and incorporates advanced methodologies which account for casemix and other variables, incorporate all care delivered and include anonymised patient level data.

The tool covers a number of different aspects of care delivery: activity, mortality, length of stay, DNAs (number of patients who did not attend their appointments), new to follow-up ratios and market share (GP referrals).

The Trust has taken part in the Department of Health's Technical Work Group to develop a more robust standardised mortality indicator to be used nationally called the summary hospital mortality indicator (SHMI). The new indicator will include deaths which occur out of hospital.

In line with the NHS Outcomes Framework, UHB has also focused on developing methodologies for reviewing whole pathway mortality for particular disease groups, rather than just in-hospital mortality.

3.9 Glossary of Terms

ACE	Angiotensin converting enzyme inhibitors
Acinetobacter	Acinetobacter is an environmental organism which can cause infection in susceptible patients such as those who are immuno-suppressed or seriously ill due to other causes
Ambulatory Care	Hospital admissions of less than 23 hours
Antiemetics	Anti-sickness medication
Autologous	This is a term used in blood transfusion and transplantation where the donor and recipient are the same person
Bed days	Unit used to calculate the availability and use of beds over time
BMT	Bone marrow transplant
Bronchiectasis	A lung condition which causes a persistent cough and an excess amount of sputum (phlegm) due to abnormal widening of the bronchial tubes (airways)
CABG	Coronary artery bypass graft procedure
CDI	*C. difficile* infection
Cleveland Clinic	The Cleveland Clinic, located in Ohio in the U.S.A., is a not-for-profit, multi-specialty academic medical centre that integrates patient care with research and education, and is widely regarded as being amongst the best healthcare providers in the U.S.A.
COPD	Chronic obstructive pulmonary disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation payment framework
CRIS	Radiology database
DAHNO	Data for Head and Neck Oncology (National Head and Neck Cancer Audit)
Datix	Database used to record incident reporting data
Daycase	Admission to hospital for planned procedure where patient does not stay overnight
DNAs	Patients who did not attend their appointments
E. coli	*Escherichia coli*
ENT	Ear, Nose and Throat
ESD	Early Supported Discharge
Foundation Trust	Not-for-profit, public benefit corporations which are part of the NHS and were created to devolve more decision-making from central government to local organisations and communities
Galaxy	Theatres database
GI	Gastro-intestinal
HCS	Healthcare Commissioning Services
HED	Trust's Healthcare Evaluation Data tool
HES	Hospital Episode Statistics
HPA	Health Protection Agency
Hypercholesterolaemia	Medical term for high cholesterol (fatty substance called a lipid) in the blood which can cause narrowing of the arteries, heart attack and stroke if left untreated
IBD	Inflammatory Bowel Disease

ICNARC	Intensive Care National Audit & Research Centre
ITU	Intensive Care Unit
LINk	Local Involvement Network
Lorenzo	Patient administration system
LUCADA	Lung cancer data
MARS	Renal database
Median	Data is ranked in order and then the middle value is selected
MINAP	Myocardial Ischaemia National Audit Project
Monitor	Independent regulator of NHS Foundation Trusts
MRSA	Meticillin-resistant *Staphylococcus aureus*
MSSA	Meticillin-sensitive *Staphylococcus aureus*
NBOCAP	National Bowel Cancer Audit Programme
NCAA	National Cardiac Arrest Audit
NCG	National Commissioning Group
Neck of femur	Hip
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NIV	Non-invasive ventilation
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning System
PALS	Patient Advice and Liaison Service
PATS	Cardiac database
PICS	Prescribing Information and Communication System
PROMS	Patient reported outcome measures
QuORU	Trust's Quality and Outcomes Research Unit
R&D	Research and Development
RCA	Root cause analysis
Readmissions	Patients who are readmitted to hospital after being discharged from hospital within the last 30 days
SEWS	Scottish Early Warning System
SHA	Strategic Health Authority
SHMI	Summary hospital mortality indicator
SINAP	Stroke Improvement National Audit Programme
SIRI	Serious incident requiring investigation
SUS	Secondary Uses Service
Symphony	A&E patient management system
TARN	Trauma Audit and Research Network
UHB	University Hospitals Birmingham NHS Foundation Trust
VTE	Venous thromboembolism

Annex 1: Statements from stakeholders

The Trust has shared its 2010/11 Quality Report with the commissioning Primary Care Trust, NHS South Birmingham, the Birmingham Local Involvement Network (LINk) UHB Action Group and Birmingham City Council Overview and Scrutiny Committee.

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

Statement provided by NHS South Birmingham:

Statement of Assurance from NHS South Birmingham 2011:

This statement from NHS South Birmingham as the lead commissioner for University Hospitals Birmingham Foundation Trust has been developed in consultation with key leads within NHS South Birmingham. The Quality Account for 2010/11, has been reviewed in line with the Department of Health guidance and we can confirm that to the best of our knowledge that this quality account is a fair and accurate reflection of the 2010/11 made against the identified quality standards.

University Hospitals Birmingham FT has undergone significant changes since summer of 2010 where majority of their services and departments have moved to the new Queen Elizabeth Hospital Birmingham. The move has posed challenges but has offered many opportunities in particular providing patients with an exceptional environment. NHS South Birmingham can therefore verify the reported MRSA and *Clostridium Difficile* infection rates within the Trust and acknowledges the improvements made during the last year from previous years.

This is a comprehensive technical account providing a detailed presentation of performance throughout the year including monitoring, measuring and reporting arrangements. There is evidence to support quality as a theme through all of the strategic developments within the account, inclusive of audit, performance and quality improvement. There is evidence of participation in clinical audits and examples of how this has led to service improvements. NHS South Birmingham is encouraged by the CEO's opening statement and it is positive that the Quality Account includes a range of feedback from different sources in relation to patient experience.

NHS South Birmingham have an on-going quality assurance monitoring process with the Trust which includes monthly contract meetings, quality reviews and quarterly performance meetings. To strengthen this process we have undertaken unannounced visits and themed reviews for 2010/11 and for the next contractual year we intend to undertake further reviews in particular around pathways of care. These monitoring mechanisms provide the NHS South Birmingham with a good understanding of the issues facing the Trust, its internal systems and processes that are in place to provide assurance. Given the significant challenges that lie ahead across South Birmingham's health economy and the new developments in commissioning we welcome our strengthened engagement with University Hospitals Birmingham Foundation Trust to deliver the quality agenda.

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

website, allowing continual publication of quality improvement throughout the year. The PCT also recommends that in future Quality Accounts, University Hospitals Birmingham FT need to consider how they reflect links to reducing health inequalities and quality for all.

In summary, the Quality Account provides a balanced view of the Trust's achievements throughout 2010/11 and has set clear priorities for quality improvement in 2011/12.

Statement provided by Birmingham LINk:

Birmingham LINk Report on University Hospitals Birmingham NHS Foundation Trust 2010/11 Quality Report

The Trust has shown evidence-based improvements and progress in relation to the five key priorities it had set in its 2009/10 Quality Report:

1. Reducing errors (with a particular focus on medicine errors).
2. Time from prescription to first antibiotic dose.
3. Venous thrombo embolism (VTE) risk assessment on admission (within 24 hours).
4. Improve patient experience and satisfaction.
5. Infection prevention and control.

Three of the above are selected again as key priorities:

1. Time from prescription to first antibiotic dose.
2. Completion of VTE (venous thromboembolism) risk assessments on admission.
3. Improve patient experience and satisfaction.

A new priority has been set:

4. Electronic observation chart- completeness of observation sets (to produce an early warning score).

This new priority would contribute significantly to patient safety by the identification of risk enabling early intervention.

Ongoing priorities are:

5. Reducing medication errors (missed doses).
6. Infection prevention and control.

The priorities can be justified evidentially. The Trust has been able to utilise robust data collection systems e.g. 16,000 electronic inpatient surveys, and a telephone outreach survey in which 70 patients a month were able to feedback on their care and experiences as patients. Five of the National Inpatient Survey questions have been focussed on as they are part of the nationally mandated Commission for Quality and Innovation (CQUINS) indicators for 2011/12.

There has been an increase in complaints which has coincided with the opening of the new hospital but this has been in line with the national picture for the opening of a new hospital. All complaints and quality issues are analysed regularly by the Trust and action plans formulated as indicated.

A wide range of evidence of very detailed evidence has been presented which shows the performance of the Trust in its range of activities. Mortality rates by speciality have been presented as well as other detailed information. It has not just focussed on areas of good performance, but published all data, favourable or otherwise because it has sufficiently well-developed metrics to do so. Other Trusts may not be able to furnish such rich data.

The Trust has engaged with and sought the views of the public and patients through a variety of mechanisms including the Governors, Patient Councils and Birmingham Local Involvement Networks (LINk). The Associate Director of Public affairs as the designated Communication Liaison Officer of the Trust has met regularly with the University Hospitals Foundation Trust Action Group of LINk and provided timely information and reports. The Trust has responded to questions and concerns raised and provided information and answers within an acceptable time-frame. There is an effective partnership between the Trust and LINk.

This year's Quality Report has, within the constraints of having to follow a prescribed

format, endeavoured to present information in a more user-friendly way and to simplify language and explain terminology. This is an improvement.

Birmingham LINk's, University Hospital Action Group Response to the Care Quality Accounts 2010/2011.
Submitted 13/05/2011

Annex 2: Statement of directors' responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) 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 2010/11
- 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 2010 to June 2011
  - Papers relating to Quality reported to the Board over the period April 2010 to June 2011
  - Feedback from the commissioners dated 19/05/2011
  - Feedback from governors dated 29/03/2011
  - Feedback from LINks dated 13/05/2011
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 05/05/2011
  - The 2010 national patient survey 04/2011
  - The 2010 national staff survey 16/03/2011
  - The Head of Internal Audit's annual opinion over the trust's control environment dated 05/05/2011
  - CQC quality and risk profiles dated 16/03/2011
- 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.monitornhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitornhsft.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

Albert Bore
Chairman

Date 2 June, 2011

Julie Moore
Chief Executive

Date 2 June, 2011

KPMG

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

We have been engaged by the Board of Governors of University Hospitals Birmingham NHS Foundation Trust to perform an independent assurance engagement in respect of the content of University Hospitals Birmingham NHS Foundation Trust's Quality Report for the year ended 31 March 2011 (the "Quality Report").

Scope and subject matter

We read the Quality Report and considered 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.

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2010-11 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor") and dated 31 March 2011.

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 content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual or is inconsistent with the documents.

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

- Board minutes for the period April 2010 to 8 June 2011;
- Papers relating to Quality reported to the Board over the period April 2010 to May 2011;
- Feedback from the Commissioners dated 18/05/2011;
- Feedback from Governors dated 29/03/11;
- Feedback from LINks dated 13/05/2011;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 05/05/2011;
- The latest national adult inpatient survey, dated April 2011;
- The latest national staff survey, dated 16/03/2011;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 05/05/2011; and
- CQC quality and risk profiles dated 16/03/2011

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

Independent Auditor's Report to the Board of Governors of University Hospitals Birmingham NHS Foundation Trust on the Annual Quality Report (continued)

This report, including the conclusion, has been prepared solely for the Board of Governors of University Hospitals Birmingham NHS Foundation Trust as a body, to assist the Board 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 2011, to enable the Board of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Governors as a body and University Hospitals Birmingham NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- Making enquiries of management;
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- Reading the documents.

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

Limitations

It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual dated 31 March 2011.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2011, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual.

Jon Gorrie

KPMG LLP

Chartered Accountants

Birmingham

Date 8 June 2011

University Hospitals Birmingham
NHS Foundation Trust

Section 4 **Annual Accounts 2010/2011**

This annual report covers the period 1 April 2010 to 31 March 2011

Section 4 | Annual Accounts

University Hospitals Birmingham NHS Foundation Trust
Financial Statements for the year ended 2010/11

Contents

Foreword to the Financial Statements

University Hospitals Birmingham NHS Foundation Trust

These financial statements for the year ended 31 March 2011 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.

Julie Moore,
Chief Executive

June 2, 2011

Statement of the Chief Executive's responsibilities as the accounting officer of University Hospitals Birmingham NHS Foundation Trust

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
- prepare the financial statements on a going concern basis

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable him to ensure that the accounts comply with the requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.

Julie Moore, Chief Executive

June 2, 2011

KPMG

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

We have audited the consolidated financial statements of University Hospitals Birmingham NHS Foundation Trust for the year ended 31 March 2011 which comprise the Consolidated Statement of Comprehensive Income, the Consolidated Statement of Financial Position, the Consolidated Statement of Changes in Taxpayers' Equity, the Consolidated Statement of Cash Flows and the related notes. These financial statements have been prepared under applicable law and the accounting policies set out in the Statement of Accounting Policies.

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

Respective responsibilities of directors and auditors

As described more fully in the Statement of Accounting Officer's Responsibilities on page 2 the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of affairs of the University Hospitals Birmingham NHS Foundation Trust Group as at 31 March 2011 and of the Group's income and expenditure for the year then ended; and

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

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

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

Matters on which we are required to report by exception

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

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

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

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 issued by Monitor.

Jon Gorrie for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
One Snowhill
Birmingham

2 June 2011

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 2011 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

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

3.2 Risk issues are reported through the Clinical Quality Framework and the Trust's Management Structures. Management and ownership of risk is delegated to the appropriate level from Director to local management teams through the Divisional Management Structure.

3.3 The Audit Committee monitors and oversees both internal control issues and the process for risk management. RSM Tenon (Internal Auditors) and KPMG (External Auditors) attend the Audit Committee meetings. Both the Board of Directors and the Audit Committee receive reports that relate to clinical risks.

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

4. The risk and control framework

4.1 The Board of Directors is responsible for the strategic direction of the Trust in relation to Clinical Governance and Risk Management. It is supported by the Audit Committee which provides assurance to the Board of Directors on risk management issues. Clinical governance is overseen directly by the Board of Directors, which, in addition to receiving reports, carries out regular unannounced clinical governance visits.

4.2 The Board of Directors has established an Investment Committee to provide the Board of Directors with assurance over investments, borrowings, and compliance with Trust treasury polices and procedures.

4.3 The Board of Directors approved the Trust's Risk Management Strategy and Risk Management Policy, (next review date is November 2011), which clearly defines risk management structures, accountability and responsibilities and the level of acceptable risk for the Trust. The Board of Directors reviewed and approved the Board Assurance Framework, identifying key risks that related to the Trust's corporate aims and objectives. The Board Assurance Framework is reviewed on a quarterly basis by Executive Directors who review the Annual Plan risks and the high level Divisional risks. The Board Assurance Framework is reviewed regularly by the Audit Committee, which then provides assurance to the Board of Directors.

4.4 The Trust was successfully assessed at level 2 against the NHSLA Risk Management Standards for Trusts (RMS) in February 2009 and the next assessment is in 2012.

4.5 Quality Governance Arrangements and Compliance with CQC registration

4.5.1 The Clinical Governance team (CGT) is responsible for liaising with manager leads for all parts of the CQC standards to review compliance using position statements initially completed in January 2010. The aim of this process is to ensure that any non-compliance against the standards is reported to the Board of Directors and action plans are produced to resolve compliance issues identified.

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

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

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

4.5.5 The Director of Corporate Affairs' Governance Group will provide assurance on the monitoring process by reviewing a sample of the standards and reporting

to the Audit Committee. Where any major concerns about compliance are identified, this will be reported to the Board of Directors as part of the Planning and Performance report.

4.6 Risk identification, evaluation and control

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

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

4.6.3 Risk Assessments, including Health and Safety and Infection Control Audits are undertaken throughout the Trust. Identified risks at all levels are evaluated using a common methodology based on the risk matrix contained in the Risk Management Standard AS/NZ 43360:1999.

4.6.4 Other methods of identifying risks are:

a) Complaints and Care Quality Commission reports and recommendations;
b) Inquest findings and recommendations from HM Coroners;
c) Health and Safety visits undertaken by Director of Operations of each Division;
d) Medico-legal claims and litigation;
e) Ad hoc risk issues brought to either the Divisional Clinical Quality Group meetings, Health, Safety and Environment Committee, Clinical Quality Monitoring Group, Care Quality Group or Safeguarding Group:
f) Incident reports and trend analysis;
g) Internally generated reports from the Health Informatics Team;
h) Internal and external audit reports; and
i) Regular Performance Reviews.

4.6.5 Identified risks are added to the Risk Registers and reviewed on a quarterly basis to ensure that action plans are being carried out and that risks are being added or deleted, as appropriate. High level risks identified by the Divisional Management Teams and corporate risks are reported regularly through Divisional Performance Reviews and the Audit Committee, through the Assurance Framework process.

4.6.6 The Audit Committee undertakes a detailed examination of the Assurance Framework and the associated risk management processes assessing whether there are any gaps in assurance or weaknesses in the effectiveness of controls. This is done on a quarterly basis.

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

4.6.8 Risks to information are managed and controlled in accordance with the Trust's Risk Management Policy and framework, through the Information Governance Group, chaired by the Director of Corporate Affairs, who has been appointed as the Senior Information Risk Officer. The Executive Medical Director, as Caldicott Guardian, is responsible for the protection of patient information, although all information governance issues are integrated through the Information Governance Group. The

Board of Directors has received a report regarding its systems of control for information governance. These include satisfactory completion of its annual self-assessment against the Information Governance Toolkit, mapping of data flows, monitoring of access to data and reviews of incidents.

4.6.9 The Trust completed the Information Governance Toolkit assessment for 2010/11 and achieved a score of 77%, achieving Level 2 or above for all the requirements, which is satisfactory.

4.7 The Trust's Major Risks

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

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

4.7.3 The Board Assurance Framework contains strategic level risks that may impact on the achievement of the Trust's overarching Strategic Priorities for 2011/2012. These are linked to the Annual Plan and the Care Quality Commission's Essential Standards; the risks will be reviewed by the Audit Committee, who provides assurance to the Board of Directors. This process ensures that the Board is informed about the most serious risks faced by the Trust.

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

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

4.8 Infection Prevention and Control

4.8.1 Infection control is a high priority risk. The Infection Prevention and Control Committee, chaired by the Executive Chief Nurse (Executive Director of Prevention and Control), meets on a monthly basis. In addition, key infection control indicators (MRSA/Clostridium difficile) are reported to the Board of Directors on a monthly basis. This data is also reported to Divisional Clinical Quality Groups for local follow up action.

4.8.2 The Board of Directors has reviewed, revised and enhanced its arrangements for ensuring that it is compliant with the Code of Practice on Healthcare Associated Infections (HCAI) and is assured that suitable systems and arrangements are in place to ensure that the code is being observed in this Trust, and that no significant lapses have been identified. Executive and Non-Executive members of the Board of Directors carry our regular visits to operational areas to observe compliance with infection control procedures.

4.8.3 There are clear policies and escalation procedures for the management of HCAI, which forms part of the Infection Prevention and Control Plan for the

Trust. This has been reviewed and updated throughout 2010/11. The Trust Action Plan makes clear reference to the Code of Practice and there are plans in place to continue the ongoing yearly improvement of performance within the Trust.

4.8.4 The Trust has an ongoing relationship with the Department of Health who have worked with the wider infection control team to review clinical practices and have given advice and practical help including training and an objective view of systems, including those relating to hotel services. The Infection Prevention and Control report is a standing item on the agendas for meetings of the Board of Governors, the Board of Directors and the Chief Executive's Advisory Group.

4.8.5 All Serious Incident Requiring an Investigation (SIRI). are reported to South Birmingham PCT, including MRSA bacteraemia and C difficile deaths.

4.9 How is Risk Management Embedded in the Organisation

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

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

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

4.9.4 When an incident occurs and there is a remaining risk, all practical and reasonable steps are taken to prevent re-occurrence. The line manager is responsible for the provision of primary support for staff involved in the incident and this is made available immediately. Any incidents which are considered to be 'serious' by the Risk Management Advisor are escalated to an appropriate Executive Director who decides whether the incident should be treated as a SIRI.

4.9.5 All SIRIs must be investigated using the RCA methodology. And are reported and managed in accordance with the national framework.

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

4.10 Involvement of Public Stakeholders

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

4.11 The Trust is fully compliant with the CQC essential standards of quality and safety and has been registered with CQC with no compliance conditions.

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

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

4.14 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.

6. Annual Quality Report

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

6.2 The content of the Trust's Quality Report for 2010-11 builds on the 2009-10 report and was agreed by the Clinical Quality Monitoring Group, chaired by the Executive Medical Director, and the Board of Directors with input from the Trust's Governors and Birmingham Local Involvement Network (LINk) UHB Action Group.

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

6.4 The quality improvement priorities and metrics identified in the Quality Report form part of the Trust's Annual Plan objectives for 2009-10, 2010-11 and 2011-12. In line with the Trust's commitment to transparency, the data included is not just limited to good performance and is publicly reported on a quarterly basis.

7. Review of effectiveness

7.1 As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the Internal Auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me.

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

regularly reviewed and plans to address any identified weaknesses and ensure continuous improvement of the system are put in place.

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

a) the maintenance of a view of the overall position with regard to internal control by the Board of Directors through its routine reporting processes and its work on Corporate risks maintained a view of the overall position;

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

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

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

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

7.4 The Board's review of the Trust's risk and internal control framework is supported by the Annual Head of Internal Audit opinion which states that "significant assurance can be given that there is a sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently". Whilst Internal Audit identified some weakness in the inconsistent application of controls, which could put the achievement of particular objectives at risk, based on the work they have undertaken on the Trust's system of internal control, they do not consider that there are any issues that need to be flagged as significant issues within this statement. For all weaknesses identified, agreed action plans have been established and are tracked via the Audit Committee to ensure that improvement is made.

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

8. Conclusion

8.1 There are no significant internal control issues I wish to report. I am satisfied that all internal control issues raised have been, or are being, addressed by the Trust through appropriate action plans and that the implementation of these action plans is monitored.

Julie Moore, June 2, 2011
Chief Executive

Income Statement

	Notes	Before non-recurring items £000	Material non-recurring items £000	Year Ended 31 March 2011 Total £000	Year Ended 31 March 2010 Total £000
Revenue	3 - 4	**535,705**	**-**	**535,705**	496,194
Operating expenses	5	**(524,934)**	**(250,055)**	**(774,989)**	(480,597)
Operating surplus		**10,771**	**(250,055)**	**(239,284)**	15,597
Finance costs					
Finance income	10	**358**	**-**	**358**	664
Finance expense	10	**(10,497)**	**-**	**(10,497)**	(47)
Net finance expense		**(10,139)**	**-**	**(10,139)**	617
Surplus / (deficit) for the year		**632**	**(250,055)**	**(249,423)**	16,214
PDC Dividends payable	11	**(231)**	**-**	**(231)**	(2,433)
Retained surplus / (deficit) for the year		**401**	**(250,055)**	**(249,654)**	13,781

Statement of Comprehensive Income

	Year Ended 31 March 2011 £000	Restated * Year Ended 31 March 2010 £000
Surplus for the year	**(249,654)**	13,781
Other comprehensive income		
Revaluation gains / (losses) on property	**(3,623)**	(16,617)
Receipt of donated assets	**1,607**	369
Transfers from donated asset reserve	**(704)**	(937)
Donated assets disposed of	**-**	-
Other recognised losses	**-**	-
Other comprehensive income for the year	**(2,720)**	(17,185)
Total comprehensive income for the year	**(252,374)**	(3,404)

All income and expenditure is derived from continuing operations.

* 2009/10 figures have been restated to reflect the adoption of the amendment to IAS 17 with effect from 1 April 2009 – see note 14.3 to the financial statements on page XLIV.

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

Statement of Financial Position

	Notes	31 March 2011 £000	Restated * 31 March 2010 £000	Restated * 1 April 2009 £000
Assets				
Non-current assets				
Intangible assets	13	**993**	1,023	897
Property, plant and equipment	14	**436,983**	170,451	180,946
Trade and other receivables	18	**2,864**	2,769	2,836
Other assets	19	**254**	30,249	16,535
		441,094	204,492	201,214
Current assets				
Inventories	17	**12,790**	10,851	9,601
Trade and other receivables	18	**53,909**	37,513	22,860
Other current assets	19	**41**	41	41
Cash and cash equivalents	20	**62,009**	96,290	97,793
		128,749	144,695	130,295
Total assets		**569,843**	349,187	331,509
Liabilities				
Current liabilities				
Trade and other payables	22	**(64,411)**	(62,604)	(47,058)
Borrowings	25	**(10,935)**	(68)	(84)
Provisions	29	**(3,280)**	(3,646)	(5,054)
Tax payable	23	**(6,340)**	(6,054)	(5,530)
Other liabilities	24	**(26,861)**	(27,469)	(19,042)
		(111,827)	(99,841)	(76,768)
Total assets less current liabilities		**458,016**	249,346	254,741
Non-current liabilities				
Borrowings	25	**(447,934)**	(7)	(75)
Provisions	29	**(1,700)**	(2,220)	(3,967)
Other liabilities	24	**(41,325)**	(27,688)	(27,864)
		(490,959)	(29,915)	(31,906)
Total liabilities		**(602,786)**	(129,756)	(108,674)
Net assets / (liabilities)		**(32,943)**	219,431	222,835
Taxpayers' equity				
Public dividend capital		**171,012**	171,012	171,012
Revaluation reserve		**103,916**	109,052	125,884
Donated asset reserve		**8,659**	7,735	8,197
Income and expenditure reserve		**(316,530)**	(68,368)	(82,258)
Total taxpayers' equity		**(32,943)**	219,431	222,835

* 2009/10 figures have been restated to reflect the adoption of the amendment to IAS 17 with effect from 1 April 2009 – see note 14.3 to the financial statements on page XLIV.

The financial statements on pages XII to XV were approved by the Board of Directors on 2 June 2011 and were signed on its behalf by:

Julie Moore,
Chief Executive

June 2, 2011

Statement of Changes in Taxpayers' Equity

	Public Dividend Capital	Revaluation Reserve	Donated Asset Reserve	Income and Expenditure Reserve	**Total**
	£000	£000	£000	£000	**£000**
Balance at 1 April 2009	171,012	75,884	8,197	(82,258)	**172,835**
Adoption of amendment to IAS 17 (note 14.3)	-	50,000	-	-	**50,000**
Balance at 1 April 2009 as restated	171,012	125,884	8,197	(82,258)	**222,835**
Income for the year					
Surplus for the year	-	-	-	13,781	**13,781**
Other comprehensive income					
Transfers in respect of assets disposed of	-	(109)	-	109	**-**
Revaluation gains / (losses) on property	-	(16,723)	106	-	**(16,617)**
Receipt of donated assets	-	-	369	-	**369**
Transfers in respect of depreciation, impairment and disposal of donated assets	-	-	(937)	-	**(937)**
Total other comprehensive income	**-**	**(16,832)**	**(462)**	**109**	**(17,185)**
Total comprehensive income for the year	**-**	**(16,832)**	**(462)**	**13,890**	**(3,404)**
Balance at 31 March 2010 as restated	**171,012**	**109,052**	**7,735**	**(68,368)**	**219,431**
Income for the year					
Deficit for the year	-	-	-	(249,654)	**(249,654)**
Other comprehensive income					
Transfers in respect of assets disposed of	-	(1,492)	-	1,492	**-**
Revaluation gains / (losses) on property	-	(3,644)	21	-	**(3,623)**
Receipt of donated assets	-	-	1,607	-	**1,607**
Transfers in respect of depreciation, impairment and disposal of donated assets	-	-	(704)	-	**(704)**
Total other comprehensive income	**-**	**(5,136)**	**924**	**1,492**	**(2,720)**
Total comprehensive income for the year	**-**	**(5,136)**	**924**	**(248,162)**	**(252,374)**
Balance at 31 March 2011	**171,012**	**103,916**	**8,659**	**(316,530)**	**(32,943)**

Statement of Cash Flows for the year ended 31 March 2011

	Notes	Year Ended 31 March 2011 £000	Year Ended 31 March 2010 £000
Cash flows from operating activities			
Operating surplus for the year before non-recurring items		**10,771**	15,597
Non-recurring items		**(250,055)**	-
Operating surplus for the year		**(239,284)**	15,597
Depreciation and amortisation		**16,534**	10,840
Impairments		**243,557**	1,232
Loss on disposal of property, plant and equipment		**-**	51
Transfer from donated asset reserve		**(704)**	(937)
(Increase) / decrease in inventories		**(1,939)**	(1,250)
(Increase) / decrease in trade and other receivables		**(16,500)**	(14,576)
(Increase) / decrease in other assets		**41**	(13,714)
Increase / (decrease) in trade and other payables		**5,947**	12,038
Increase / (decrease) in taxation		**286**	524
Increase / (decrease) in other liabilities		**13,029**	8,251
Increase / (decrease) in provisions		**(930)**	(3,194)
Net cash generated from operating activities		**20,037**	14,862
Cash flows from investing activities			
Interest received		**354**	666
Payments to acquire property, plant and equipment		**(29,848)**	(14,760)
Receipts from sale of property, plant and equipment		**-**	-
Payments to acquire intangible assets		**(281)**	(103)
Net cash used in investing activities		**(29,775)**	(14,197)
Cash flows from financing activities			
Capital element of finance lease obligations		**(68)**	(84)
Interest element of finance lease obligations		**(4)**	(8)
Capital element of PFI obligations		**(15,541)**	-
Interest element of PFI obligations		**(10,449)**	-
PDC dividends received / (paid)		**(88)**	(2,445)
Other capital receipts		**1,607**	369
Net cash used in financing activities		**(24,543)**	(2,168)
Net decrease in cash and cash equivalents		**(34,281)**	(1,503)
Cash and cash equivalents at 1 April 2010		**96,290**	97,793
Cash and cash equivalents at 31 March 2011	20	**62,009**	96,290

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 2010/11 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the financial statements.

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 2011, 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.

The preparation of financial statements in conformity with IFRS requires the use of certain critical accounting estimates and judgements. An analysis and explanation of the critical accounting estimates and judgements used in producing this set of financial statements is made in accounting policy note 1.28.

Basis of consolidation

A subsidiary is an entity controlled by the Trust. Control exists when the Trust 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's consolidated financial statements include the financial statements of the Trust and all of its subsidiary undertakings at the reporting date. All intra-group transactions, balances, income and expenses are eliminated on consolidation.

An associate is an entity, being neither a subsidiary nor a joint venture, in which the Trust holds a long-term interest and where the Trust has a significant influence. The results of associates are accounted for using the equity method of accounting.

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, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The Scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying Scheme assets and liabilities. Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

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

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2011, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual

NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

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

Annual Pensions

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

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

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.

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 their final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the statement of comprehensive income at the time the trust commits itself to the retirement, regardless of the method of payment.

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

1.4 Expenditure on other goods and services

Recurring items

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

Non-recurring items

Non-recurring items are those items that are unusual because of their size, nature or incidence. The Trust's management consider that these items should be separately identified within their relevant operating expenses category to enable a full understanding of the Trust's results.

1.5 Property, plant and equipment

Recognition

Property, plant and equipment assets are capitalised where:

- They are held for use in delivering services or for administration purposes;
- It is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- They are expected to be used for more than one financial year;

- The cost of the item can be measured reliably;
- Individually they have a cost of at least £5,000; or
- They form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- They form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

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

Valuation

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

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

Land and non specialised buildings - existing use value

Specialised buildings - depreciated replacement cost

Valuations are carried out by a professionally qualified valuer in accordance with the Royal Institute of Chartered Surveyors (RICS) Valuation Standards, 6th Edition. The District Valuation Service has carried out the valuation of the Trust's property as at the reporting date. Where depreciated replacement cost has been used, the valuer has had regard to RICS Valuation Information Paper No. 10 'The Depreciated Replacement Cost (DRC) Method of Valuation for Financial Reporting', as supplemented by Treasury guidance. HM Treasury require the measurement of 'DRC' using the 'Modern Equivalent Asset' (MEA) estimation technique, see accounting policy 1.28 for details.

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

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

Revaluation

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

reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

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

1.6 Intangible assets

Expenditure on computer software which is deemed not to be integral to the computer hardware and will generate economic benefits beyond one year is capitalised as an intangible asset. Computer software for a computer-controlled machine tool that cannot operate without that specific software is an integral part of the related hardware and it is treated as property, plant and equipment. These intangible assets are stated at cost less accumulated amortisation and impairment losses. Amortisation is charged to the Statement of Comprehensive Income on a straight line basis.

1.7 Depreciation, amortisation and impairments

Freehold land and properties under construction are not depreciated.

Otherwise, depreciation and amortisation are charged on a straight line basis to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. The estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful economic lives or, where shorter, the lease term.

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

"In accordance with the FT ARM, 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 the donated asset reserve. Donated assets are valued, depreciated and impaired as described for purchased assets. Gains and losses on revaluations and impairments are taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to offset the expenditure. On the sale of donated assets, the net book value is transferred from the donated asset reserve to retained earnings.

1.9 Government grants

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

1.10 Leases

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

The Trust as lessee

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

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

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

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

The Trust as lessor

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

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

1.11 Private Finance Initiatives (PFI) transactions

Recognition

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

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

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

Valuation

The PFI assets are recognised as property, plant and equipment, when they come into use, in accordance with the HM Treasury interpretation of IFRIC 12. The assets are measured initially at fair value in accordance with the principles of IAS 17, HM Treasury guidance for PFI assets is the construction cost and capitalised fees incurred as at financial close, disclosed in the PFI contract. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16, as detailed in accounting policy note 1.5 'Property, plant and equipment - valuation'. For specialised buildings this is depreciated replacement cost.

The PFI asset's fair value at the reporting date and the impairment recognised are disclosed in notes 14.4 and 14.2 to the financial statements on pages XLV and page XLIII respectively.

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

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

Subsequent expenditure

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

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance expense and to repay the lease liability over the contract term. The annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is recognised under the relevant finance costs heading within note 10 to the financial statements on page XXXVII.

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 XXXII.

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 18 to the financial statements on page XLVII.

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

Other assets contributed by the Trust to the operator

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

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

1.12 Inventories

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

1.13 Cash and cash equivalents

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

1.14 Finance income and costs

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

1.15 Financial assets and financial liabilities

Recognition and de-recognition

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

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

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

Classification

Financial assets are classified as: 'financial assets at fair value through income and expenditure';

'held to maturity investments'; 'available for sale financial assets'; or as 'loans and receivables'.

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

Loans and receivables

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

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

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

Other financial liabilities

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

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

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

Impairment of financial assets

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

Accounting for derivative financial instruments

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

1.16 Trade receivables

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

1.17 Deferred income

Deferred income represents grant monies received where the expenditure has not occurred in the current financial year. The deferred income is included in current liabilities unless the expenditure, in the opinion of management, will take place more than 12

months after the reporting date, which are classified in non-current liabilities.

1.18 Borrowings

The Trust can borrow within the limits set by Monitor's Prudential Borrowing Code. The Trust's borrowings and position against its prudential borrowing limit are respectively disclosed in notes 25 and 26 to the financial statements on pages L and LI. The Trust has not utilised any loan or working capital facility, borrowing as at the reporting date consists of obligations under finance leases and the 'Queen Elizabeth Hospital Birmingham' Private Finance Initiative contract.

1.19 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the reporting date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.9% in real terms.

Clinical Negligence Costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed in note 29 to the financial statements on page LIV, but is not recognised in the Trust's financial statements.

Non-Clinical Risk Pooling

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

1.20 Contingencies

Contingent liabilities are not recognised but are disclosed in note 32 to the financial statements on page LVII, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the entity's control; or
- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 32 to the financial statements on page LVII where an inflow of economic benefits is probable.

1.21 Public Dividend Capital

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

A charge, reflecting the cost of capital utilised

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

1.22 Research and Development

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

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

1.23 Value Added Tax

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

1.24 Corporation Tax

The Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to disapply the exemption in relation to specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities where income is received from a non public sector source. HM Treasury have stated that corporation tax will be applied to Foundation Trusts from the financial year commencing 1 April 2011.

1.25 Foreign exchange

The functional and presentational currency of the Trust is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March 2011. Resulting exchange gains and losses for either of these are recognised in the Statement of Comprehensive Income in the period in which they arise.

1.26 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the financial statements in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.27 Losses and Special Payments

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

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover

had NHS foundation trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.28 Critical accounting judgements and key sources of estimation uncertainty

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

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

Modern equivalent asset valuation of property

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

Provisions

Provisions have been made for 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.

Employer and public liability claims are based on information received from the NHS Litigation Authority (NHSLA) which handles claims on behalf of the Trust, see accounting policy note 1.19 for details. For cases not yet concluded, provision is made for the 'excess' of each non-clinical case, according to the NHSLA view of the expected outcome.

Pension provisions due to early retirements and ill health are based on information received from NHS Pensions Scheme, see accounting policy note 1.3 for details. The calculation is based on current payments and the future life expectancy of recipients, using information supplied by Government statistics and discounted at the HM Treasury 'pensions rate' of 1.8% to reflect the future timing of payments.

Other provisions for legal and constructive obligations are made by Trust management where past events are known, settlement by the Trust is probable and a reliable estimate can be made.

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

1.29 Accounting standards, interpretations and amendments adopted in the year ended 31 March 2011

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

IFRIC 12 "Service Concession Arrangements" - requires assets built under the Private Finance Initiative (PFI) and their associated liabilities to be disclosed in the financial statements of NHS Foundation Trusts, where certain conditions are met. The Trust opened a new PFI hospital (the 'Queen Elizabeth Hospital Birmingham') on 15th June 2010 and as this infrastructure asset falls within the scope of a 'service concession' under IFRIC 12, this interpretation has been adopted as at the reporting date. See accounting policy note 1.11 for details of the material impact of this transaction on the financial statements.

Amendment to IAS 17 "Leases - classification of leases of land and buildings". Requires the classification of leased land as a finance lease, where the lease term is for several decades or more and at the end of the lease term no title can pass to the lessee, because substantially all risks and rewards are transferred to the lessee and the present value of the residual value of the leased asset is considered to be negligible. The material impact of this amendment is the reclassification of the land on the Queen Elizabeth Hospital Site, which is leased over 999 years, from an operating lease to a finance lease. The Trust has presented a restated Statement of Financial Position from the 31 March 2009, the beginning of the comparative period under IAS 1 "Presentation of Financial Statements". See note 14.3 to the financial statements on page XLIV for details.

IFRS 8 "Operating Segments - disclosure requirements". This standard amends the requirements for disclosure of segmental performance and does not have any effect on the Trust's overall reported results. See note 2 to the financial statements on page XXIX for details.

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

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

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

- IFRS 7 (amendment) 'Financial Instruments' - transfers of financial assets (effective 1 April 2012)
- IFRS 9 'Financial Instruments' - recognition and measurement of financial assets (effective 1 April 2013)
- IAS 12 (amendment) 'Income Taxes' - deferred tax, recovery of underlying assets (effective 1 April 2012)
- IAS 24 (revised) 'Related Party Disclosures' - government related entities (effective 1 April 2011)
- IFRIC 14 (amendment) 'Prepayments of a Minimum Funding Requirement' (effective 1 April 2011)
- IFRIC 19 'Extinguishing Financial Liabilities with Equity Instruments' (effective 1 April 2011)
- Annual Improvements to IFRSs 2010 (effective 1 April 2011)

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

2. Segmental Analysis

The Board (the Chief Operating Decision Maker as defined by IFRS 8 Operating Segments) has determined that the Trust operates one material business segment, which is the provision of healthcare services. The operating results of this segment are regularly reviewed by the Board.

Revenue from activities (medical treatment of patients) is analysed by customer type in note 3 to the financial statements below. Other operating revenue is analysed in note 4 to the financial statements on page XXXI and materially consists of revenues from healthcare research and development, medical education and the provision of services to other NHS bodies. Total revenue by individual customers within the whole of HM Government and considered material, is disclosed in the related parties transactions note 31 to the financial statements on page LV.

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

	Year ended 31 March 2011		Year Ended 31 March 2010	
	£000	**%**	£000	%
Revenue from whole HM Government	**501,423**	**93.6%**	477,656	96.3%
Revenue from non HM Government sources	**34,282**	**6.4%**	18,538	3.7%
	535,705	**100.0%**	496,194	100.0%

3. Revenue from Activities

	Year Ended 31 March 2011	Year Ended 31 March 2010
	£000	£000
Foundation Trusts	**120**	102
NHS Trusts	**326**	353
Strategic Health Authorities	**15,031**	13,570
Primary Care Trusts	**395,601**	374,900
Department of Health - other	**-**	88
NHS Scotland, Wales and Northern Ireland	**3,690**	4,791
Private Patients	**2,989**	2,799
NHS Injury Cost Recovery scheme	**2,813**	3,051
Ministry of Defence	**10,736**	9,170
	431,306	408,824

Healthcare activity income from the Ministry of Defence of £10,735,871 relates to the Trust contract with the Royal Centre for Defence Medicine (2009/10 - £9,169,814).

NHS Injury Cost Recovery scheme income is subject to a provision for impairment of receivables of 9.6% to reflect expected rates of collection.

3.1 Revenue from Activities

	Year Ended 31 March 2011	Year Ended 31 March 2010
	£000	£000
Elective	**98,226**	88,704
Non elective	**78,613**	80,948
Outpatients	**63,422**	51,788
A & E	**7,656**	7,032
Other NHS clinical	**166,851**	165,332
Private patients	**2,989**	2,799
Other non-protected clinical	**13,549**	12,221
	431,306	408,824

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

3.2 Private Patients

	Financial Year 2010/11	Base Year 2002/03
	£000	£000
Private patients	**2,989**	2,773
Total patient related revenue	**431,306**	225,193
Proportion (as percentage)	**0.69%**	1.23%

The Trust's Terms of Authorisation contain a private patient income cap (limit) of 1.23% of income earned from activities. This cap is based on actual results for reporting year 2002/03 as disclosed above and defined in section 44 of the National Health Service Act 2006. The private patient cap has not been breached. In February 2010 Monitor amended the definition of 'private patient income' which requires the revision of base year data under this wider definition where applicable. No additional private patient income has been identified and therefore the Trust has not restated the base year data.

4. Other Operating Revenue

	Year Ended 31 March 2011	Year Ended 31 March 2010
	£000	£000
Research and development	**21,430**	17,275
Education and training	**34,694**	28,799
Charitable and other contributions to expenditure	**1,420**	1,132
Transfers from donated asset reserve	**704**	937
Non-patient care services to other bodies	**10,970**	11,842
Other revenue	**35,181**	27,385
	104,399	87,370

Other revenue includes a one off contribution towards the construction of the new Queen Elizabeth Hospital Birmingham of £7,321,000 from the University of Birmingham due to their occupation of the new medical research facilities. Also included is rental income of £1,216,000 (2009/10 - £nil) due to the leasing of new hospital facilities by the University of Birmingham and Ministry of Defence; £4,174,000 from Clinical Excellence Awards (2009/10 - £4,391,000); recharges of £2,422,000 to the Ministry of Defence to fund the training expenditure of Nurses along with catering and car parking costs associated with the military contract (2009/10 - £5,377,000); £2,082,000 from the National Quality Assurance Service (2009/10 - £1,951,000); and funding of £2,441,000 (2009/10 - £1,998,000) 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

	Before non-recurring items	Material non-recurring items	Year Ended 31 March 2011 Total	Year Ended 31 March 2010 Total
	£000	£000	£000	£000
Services from Foundation Trusts	**2,321**	**-**	**2,321**	2,007
Services from other NHS Trusts	**5,416**	**13**	**5,429**	4,536
Services from PCTs	**1,507**	**-**	**1,507**	913
Services from other NHS bodies	**-**	**-**	**-**	135
Purchase of healthcare from non NHS bodies	**10,271**	**94**	**10,365**	9,551
Directors' costs	**1,672**	**-**	**1,672**	1,552
Non executive directors' costs	**164**	**-**	**164**	159
Staff costs	**288,405**	**2,366**	**290,771**	273,827
Supplies and services - clinical	**123,163**	**783**	**123,946**	116,116
Supplies and services - general	**6,542**	**245**	**6,787**	6,296
Consultancy services	**4,903**	**705**	**5,608**	4,086
Establishment	**4,540**	**131**	**4,671**	4,415
Transport	**893**	**539**	**1,432**	916
Premises	**20,585**	**2,098**	**22,683**	20,084
Provision for Impairment of Receivables	**640**	**-**	**640**	1,035
Depreciation on property, plant and equipment	**16,223**	**-**	**16,223**	10,593
Amortisation on intangible assets	**311**	**-**	**311**	247
Impairments of property, plant and equipment	**612**	**242,945**	**243,557**	1,232
Loss on Disposal of property, plant and equipment	**-**	**-**	**-**	51
Audit services - statutory audit	**93**	**-**	**93**	86
Other auditors remuneration - other services	**40**	**-**	**40**	82
Clinical negligence	**3,392**	**-**	**3,392**	3,501
Other	**33,241**	**136**	**33,377**	19,177
	524,934	**250,055**	**774,989**	480,597

Other expenditure includes £12,222,000 (2009/10 - £nil) in relation to payments to the Trust's PFI partner for services provided; Research Grants distributed to other West Midlands NHS organisations of £9,895,000 (2009/10 - £9,278,000) due to the Trust acting as host body for the Comprehensive Local Research Network; Training, Courses and Conference fees of £3,145,000 (2009/10 - £4,009,000) and fees payable to RSM Tenon with regard to internal audit and counter fraud services of £132,000 (2009/10 - £161,000).

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

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

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

5.1 Material non-recurring items

	Year Ended 31 March 2011 Total	Year Ended 31 March 2010
	£000	£000
Non-recurring operating expenses:		
Transition costs relating to relocation to the new PFI hospital (a)	**7,110**	-
Impairment of property - new PFI hospital (b)	**242,945**	-
	250,055	-

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

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

6. Operating leases

6.1 As lessee

Payments recognised as an expense	Year Ended 31 March 2011	Year Ended 31 March 2010
	£000	£000
Minimum lease payments	**1,100**	1,225

Total future minimum lease payments	Year Ended 31 March 2011	Year Ended 31 March 2010
	£000	£000
Payable:		
Not later than one year	**1,177**	1,041
Between one and five years	**1,921**	1,717
After 5 years	**1,917**	1,915
Total	**5,015**	4,673

6.2 As lessor

Rental revenue	Year Ended 31 March 2011	Year Ended 31 March 2010
	£000	£000
Rents recognised as income in the period	**1,523**	424

Total future minimum lease payments	Year Ended 31 March 2011	Year Ended 31 March 2010
	£000	£000
Receivable:		
Not later than one year	**1,910**	189
Between one and five years	**5,567**	432
After 5 years	**5,419**	1,111
Total	**12,896**	1,732

7. Employee costs and numbers

7.1 Employee costs

	Year Ended 31 March 2011			Year Ended 31 March 2010		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	£000	**£000**	**£000**	£000	£000	£000
Short term employee benefits - salaries and wages	**231,151**	**214,897**	**16,254**	219,346	204,210	15,136
Short term employee benefits - social security costs	**18,481**	**18,481**	**-**	17,463	17,463	-
Post employment benefits - employer contributions to NHS pension scheme	**25,421**	**25,421**	**-**	24,405	24,405	-
Termination benefits	**359**	**359**	**-**	187	187	-
Agency/contract staff	**17,390**	**-**	**17,390**	14,165	-	14,165
	292,802	**259,158**	**33,644**	275,566	246,265	29,301

7.2 Average number of persons employed

	Year Ended 31 March 2011			Year Ended 31 March 2010		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
Medical and dental	**907**	**842**	**65**	897	830	67
Administration and estates	**1,468**	**1,468**	**-**	1,470	1,470	-
Healthcare assistants and other support staff	**564**	**564**	**-**	581	581	-
Nursing, midwifery and health visiting staff	**2,389**	**2,389**	**-**	2,331	2,331	-
Scientific, therapeutic and technical staff	**1,134**	**1,134**	**-**	1,015	1,015	-
Bank and agency staff	**268**	**-**	**268**	232	-	232
	6,730	**6,397**	**333**	6,526	6,227	299

7.3 Key Management Compensation

	Year Ended 31 March 2011	Year Ended 31 March 2010
	£000	£000
Salaries and short term benefits	**1,351**	1,222
Social Security Costs	**154**	149
Employer contributions to NHSPA	**167**	181
	1,672	1,552

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 Termination of employment benefits

	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 2011						
< £10,000	9	33	-	-	9	33
£10,000 - £25,000	3	48	-	-	3	48
£25,000 - £50,000	1	35	-	-	1	35
£50,000 - £100,000	2	133	-	-	2	133
> £100,000	1	110	-	-	1	110
	16	**359**	**-**	**-**	**16**	**359**
Termination benefit by band - Year Ended 31 March 2010						
< £10,000	7	21	-	-	7	21
£10,000 - £25,000	4	63	-	-	4	63
£25,000 - £50,000	3	103	-	-	3	103
	14	**187**	**-**	**-**	**14**	**187**

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 (2009/10 - £nil).

8. Retirements due to ill-health

During the year to 31 March 2011 there were 9 early retirements from the Trust agreed on the grounds of ill-health (2009/10 - 8). The estimated additional pension liabilities of these ill-health retirements will be £483,904 (2009/10 - £580,494). 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 2011		Year Ended 31 March 2010	
	Number	**£000**	Number	£000
Trade				
Total trade bills paid in the year	**104,393**	**234,740**	95,539	201,652
Total trade bills paid within target	**103,156**	**232,928**	94,269	199,643
Percentage of trade bills paid within target	**98.82%**	**99.23%**	98.67%	99.00%
NHS				
Total NHS bills paid in the year	**4,937**	**90,237**	5,020	89,613
Total NHS bills paid within target	**4,688**	**85,495**	4,669	85,191
Percentage of NHS bills paid within target	**94.96%**	**94.74%**	93.01%	95.07%

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

9.2 The late payment of commercial debts (interest) Act 1998

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

10. Finance income and costs

	Year Ended 31 March 2011	Year Ended 31 March 2010
	£000	£000
Financing income		
Interest receivable	**358**	664
	358	664
Financing costs		
Interest on obligations under PFI contracts	**(10,449)**	-
Interest on obligations under finance leases	**(4)**	(8)
Other financing charges	**(44)**	(39)
	(10,497)	(47)
Net finance expense	**(10,139)**	617

11. Public dividend capital dividends

Public dividend capital ('PDC') dividends paid and due to the Department of Health amounted to £231,000 (2009/10 - £2,433,000). PDC dividends are calculated as a percentage (3.5%) of average net relevant assets. The Trust has negative taxpayers' equity as at the reporting date hence the significant reduction in PDC payable in the year.

12. Taxation

The activities of the Trust have not given rise to any corporation tax liability in the year (2009/10 - £nil).

13. Intangible assets

	Computer software - purchased	Licences and trademarks	Intangible assets under construction	Total
	£000	£000	£000	£000
Cost				
At 1 April 2009	1,057	164	59	1,280
Additions	103	-	-	103
Reclassifications	59	-	(59)	-
At 31 March 2010	**1,219**	**164**	**-**	**1,383**
Prior period adjustment *	-	-	270	270
At 31 March 2010 as restated	**1,219**	**164**	**270**	**1,653**
Additions	196	85	-	281
Reclassifications	255	15	(270)	-
At 31 March 2011	**1,670**	**264**	**-**	**1,934**
Amortisation				
At 1 April 2009	345	38	-	383
Charged for the year	214	33	-	247
At 31 March 2010	**559**	**71**	**-**	**630**
Charged for the year	271	40	-	311
At 31 March 2011	**830**	**111**	**-**	**941**
Net book value				
At 31 March 2011	**840**	**153**	**-**	**993**
At 31 March 2010 - restated	660	93	270	1,023
At 1 April 2009 - restated	712	126	59	897

* The prior period adjustment is due to £270,000 of additions in 2009/10 classified as property, plant and equipment, now reclassified as intangible software and licences. See note 14 to the financial statements on page XXXIX.

All intangible assets of the Trust 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 Trust's intangible assets and there is no revaluation reserve.

The estimated useful economic lives of the Trust'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 - 2010/11

	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 2010	72,500	59,050	1,348	3,381	69,082	119	12,497	5,165	223,142
Prior period adjustment *	-	4	-	(270)	(319)	(29)	(15)	(212)	(841)
At 31 March 2010 as restated	**72,500**	**59,054**	**1,348**	**3,111**	**68,763**	**90**	**12,482**	**4,953**	**222,301**
Additions purchased	-	479,652	-	561	15,825	-	1,184	143	497,365
Additions donated	-	-	-	5	1,602	-	-	-	1,607
Reclassifications	-	1,694	-	(2,512)	372	-	443	3	-
Transferred in from other non-financial assets **	-	30,963	-	-	-	-	-	-	30,963
Impairments charged to operating expenses	-	(243,557)	-	-	-	-	-	-	(243,557)
Impairments charged to revaluation reserve	(3,625)	(695)	-	-	-	-	-	-	(4,320)
Revaluation surpluses	-	(4,860)	(50)	-	-	-	-	-	(4,910)
Disposals other than by sale	-	-	-	-	(4,014)	-	-	(505)	(4,519)
At 31 March 2011	**68,875**	**322,251**	**1,298**	**1,165**	**82,548**	**90**	**14,109**	**4,594**	**494,930**
Depreciation									
At 31 March 2010	-	3,485	-	-	38,356	119	5,813	4,648	52,421
Prior period adjustment *	-	4	-	-	(319)	(29)	(15)	(212)	(571)
At 31 March 2010 as restated	**-**	**3,489**	**-**	**-**	**38,037**	**90**	**5,798**	**4,436**	**51,850**
Provided during the year	-	6,499	88	-	7,819	-	1,697	120	16,223
Revaluation surpluses	-	(5,519)	(88)	-	-	-	-	-	(5,607)
Disposals other than by sale	-	-	-	-	(4,014)	-	-	(505)	(4,519)
At 31 March 2011	**-**	**4,469**	**-**	**-**	**41,842**	**90**	**7,495**	**4,051**	**57,947**

	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
Net book value									
Owned	26,125	49,132	1,272	1,159	37,474	-	6,614	531	122,307
Donated	-	5,389	26	6	3,226	-	-	12	8,659
Private Finance Initiative	-	263,261	-	-	-	-	-	-	263,261
Finance Leased	42,750	-	-	-	6	-	-	-	42,756
At 31 March 2011	**68,875**	**317,782**	**1,298**	**1,165**	**40,706**	**-**	**6,614**	**543**	**436,983**
Analysis of property, plant and equipment									
Net book value									
Protected assets	42,750	309,096	-	-	-	-	-	-	351,846
Unprotected assets	26,125	8,686	1,298	1,165	40,706	-	6,614	543	85,137
At 31 March 2011	**68,875**	**317,782**	**1,298**	**1,165**	**40,706**	**-**	**6,614**	**543**	**436,983**

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

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

** Due to the opening of the Queen Elizabeth Hospital Birmingham and its subsequent recognition as an asset on 15 June 2010, £30,963,000 of construction work carried out prior to this date on the new PFI hospital was reclassified as property, plant and equipment from other non-financial assets, see note 19 to the financial statements on page XLVIII.

14. Property, plant and equipment - 2010/11

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost									
At 1 April 2009	42,500	92,815	3,156	5,592	62,160	119	10,677	5,240	222,259
Adoption of amendment to IAS 17 *	50,000	-	-	-	-	-	-	-	50,000
At 1 April 2009 as restated	**92,500**	**92,815**	**3,156**	**5,592**	**62,160**	**119**	**10,677**	**5,240**	**272,259**
Additions purchased	-	4,142	-	1,331	10,670	-	1,632	124	17,899
Additions donated	-	129	-	3	237	-	-	-	369
Reclassifications	-	2,755	-	(3,545)	602	-	188	-	-
Impairments charged to operating expenses	-	(1,232)	-	-	-	-	-	-	(1,232)
Impairments charged to revaluation reserve	(20,000)	-	(1,808)	-	-	-	-	-	(21,808)
Revaluation surpluses	-	(39,559)	-	-	-	-	-	-	(39,559)
Disposals other than by sale	-	-	-	-	(4,587)	-	-	(199)	(4,786)
At 31 March 2010	**72,500**	**59,050**	**1,348**	**3,381**	**69,082**	**119**	**12,497**	**5,165**	**223,142**
Depreciation									
At 1 April 2009	-	43,821	1,416	-	37,157	119	4,288	4,512	91,313
Provided during the year	-	2,892	106	-	5,735	-	1,525	335	10,593
Impairments charged to revaluation reserve	-	-	(1,522)	-	-	-	-	-	(1,522)
Revaluation surpluses	-	(43,228)	-	-	-	-	-	-	(43,228)
Disposals other than by sale	-	-	-	-	(4,536)	-	-	(199)	(4,735)
At 31 March 2010	**-**	**3,485**	**-**	**-**	**38,356**	**119**	**5,813**	**4,648**	**52,421**

	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
Net book value									
Owned	27,500	50,108	1,322	2,974	28,560	-	6,684	498	117,646
Donated	-	5,457	26	137	2,096	-	-	19	7,735
Finance Leased	45,000	-	-	-	70	-	-	-	45,070
At 31 March 2010 - restated	**72,500**	**55,565**	**1,348**	**3,111**	**30,726**	**-**	**6,684**	**517**	**170,451**
Analysis of property, plant and equipment									
Net book value									
Protected assets	45,000	26,665	-	-	-	-	-	-	71,665
Unprotected assets	27,500	28,900	1,348	3,111	30,726	-	6,684	517	98,786
At 31 March 2010 - restated	**72,500**	**55,565**	**1,348**	**3,111**	**30,726**	**-**	**6,684**	**517**	**170,451**

* Adoption of the amendment to IAS 17 results in the reclassification of the Queen Elizabeth Hospital 'QEH' site land from an operating lease to a finance lease, see note 14.3 to the financial statements on page XLIV.

14.1 Estimated useful economic lives

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

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

14.2 Valuation at the reporting date

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

The revaluation exercise resulted in a net impairment being charged to operating expenses, within the Income Statement.

Impairments of property, plant and equipment	**Year Ended 31 March 2011**
	£000
Impairments charged to Statement of Comprehensive Income	
Queen Elizabeth Hospital - new PFI facility	**242,945**
Trust owned property	**612**
	243,557

During the year the Trust opened the new Private Finance Initiative hospital (the 'Queen Elizabeth Hospital Birmingham'), which gave rise to an impairment resulting from the difference between the cost directly attributable to the construction (including interest charges and fees) and the fair value in operational use, as measured at 31 March 2011. The impairment is disclosed in non-recurring operating expenses within the Income Statement, see note 5 to the financial statements on page XXXIII.

The impairment to Trust owned property charged to operating expenses arose from the difference between the cost attributable to a refurbishment of office accomodation (the 'Wolfson' building) and the fair value of the asset in operational use, as measured at the reporting date and exceeding the available revaluation reserve balance to offset this charge.

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

Revaluation gains / (losses) on property, plant and equipment	Year ended 31 March 2011		
	Revaluation reserve	Donated asset reserve	**Total**
	£000	£000	**£000**
Surpluses / (deficits) due to revaluation of property recognised in other comprehensive income			
Land	(3,625)	-	**(3,625)**
Buildings	(56)	20	**(36)**
Dwellings	37	1	**38**
	(3,644)	**21**	**(3,623)**

14.3 Restatement under IFRS

The amendment to accounting standard IAS 17 'Leases - classification of leases of land and buildings' at the reporting date, has resulted in the following change to the disclosure of property, plant and equipment. The land on the Queen Elizabeth Hospital 'QEH' site is reclassified from an operating lease to a finance lease, because substantially all risks and rewards are transferred to the lessee:

	Land
	£000
Net book value	
At 1 April 2009 as previously reported	42,500
Adoption of amendment to IAS 17	50,000
At 1 April 2009 as restated	**92,500**
At 31 March 2010 as previously reported	27,500
Adoption of amendment to IAS 17	45,000
At 31 March 2010 as restated	**72,500**
Movements in 2009/10 recognised in other comprehensive income	(5,000)

The change in value of the 'QEH' site land at the respective prior reporting dates is due to revaluations of the carrying value to fair value.

The land previously disclosed at the prior reporting dates is the Selly Oak site whose freehold is owned by the Trust.

14.4 Assets held under finance leases and PFI arrangements

	PFI assets	Assets held under finance leases	Total
	£000	£000	£000
Cost			
At 1 April 2009	-	238	238
Adoption of amendment to IAS 17	-	50,000	50,000
At 1 April 2009 as restated	**-**	**50,238**	**50,238**
Additions	-	-	-
Impairments to revaluation reserve	-	(5,000)	(5,000)
Reclassifications	-	-	-
At 31 March 2010	**-**	**45,238**	**45,238**
Additions	478,544	-	478,544
Impairments to revaluation reserve	-	(2,250)	(2,250)
Transferred in from other non-financial assets	30,963	-	30,963
Impairments to operating expenses	(242,945)	-	(242,945)
At 31 March 2011	**266,562**	**42,988**	**309,550**
Depreciation			
At 31 March 2009	-	84	84
Charged for the year	-	84	84
At 31 March 2010	**-**	**168**	**168**
Charged for the year	3,301	64	3,365
At 31 March 2011	**3,301**	**232**	**3,533**
Net book value			
At 31 March 2011	**263,261**	**42,756**	**306,017**
At 31 March 2010	-	45,070	45,070
At 31 March 2009	-	50,154	50,154

The Private Finance Initiative asset is the new Queen Elizabeth Hospital Birmingham as detailed in note 28.1 to the financial statements on page LII. The impairment is detailed in note 14.2 above and the transfer in from other non-financial assets is detailed in note 19 to the financial statements on page XLVIII.

15. Capital commitments

Commitments under capital expenditure contracts at the end of the period, not otherwise included in these financial statements, were £7,018,000 (31 March 2010 - £10,257,000). This amount relates entirely to property, plant and equipment, there are nil contracted capital commitments for intangible assets. Included within these amounts are £6,437,000 (31 March 2010 - £5,996,000) for committed orders to purchase equipment for the new PFI Hospital.

16. Subsidiaries and investments

The Trust has two wholly owned subsidiary companies. 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. There are no equity or reserves attributable to minority interests and the amounts consolidated are drawn from the published financial statements of the subsidiaries whose reporting dates are the same as that of the Trust - 31 March 2011. 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.

'Pharmacy@QEHB Ltd', company no. 07547768, with a share capital comprising one share of £1 owned by the Trust. The company is preparing to trade as an Outpatients Dispensary service in the new 'Queen Elizabeth Hospital Birmingham' and has begun purchasing the necessary equipment, a cost of £32,130 paid to suppliers as at the reporting date. The Trust has provided the funding for the asset purchases of Pharmacy@QEHB Ltd and the £32,130 is disclosed on the Trust's own statement of financial position as a loan to subsidiary within trade and other receivables. The asset is disclosed within property, plant and equipment as an asset under construction in the consolidated financial statements.

Birmingham Systems (Healthcare) Ltd', 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, therefore there are nil assets and liabilities to consolidate into the Trust's financial statements.

The Trust has one investment comprising a 12% shareholding in a company 'Sapere Systems Limited', 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. Inventories

	31 March 2011	31 March 2010
	£000	£000
Materials	**12,787**	10,846
Work in progress	**-**	-
Finished goods	**3**	5
	12,790	10,851

Inventories carried at fair value less costs to sell where such value is lower than cost are nil (31 March 2010 - £nil).

The Trust expensed £122,025,000 of inventories during the year (2009/10 - £113,296,000). The Trust charged £13,000 to operating expenses in the year due to write-downs of obsolete inventories (2009/10 - £33,000).

18. Trade and other receivables

	Current		Non current	
	31 March 2011	31 March 2010	**31 March 2011**	31 March 2010
	£000	£000	**£000**	£000
NHS receivables	**35,010**	13,114	**-**	370
Receivables with other related parties	**10,887**	9,082	**-**	-
Commercial trade receivables	**3,475**	2,338	**-**	-
Provision for impaired receivables	**(2,263)**	(1,772)	**(304)**	(203)
PFI prepayments - lifecycle replacements	**14**	-	**-**	-
Prepayments	**2,164**	9,069	**-**	-
Accrued income	**1,061**	1,086	**-**	-
Other receivables	**3,561**	4,584	**3,168**	2,602
PDC receivable	**-**	12	**-**	-
	53,909	37,513	**2,864**	2,769

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 31 to the financial statements on page LIX.

Included within trade and other receivables are balances with a carrying amount of £12,692,000 (31 March 2010: £9,273,000) 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	Current		Non current	
	31 March 2011	31 March 2010	**31 March 2011**	31 March 2010
	£000	£000	**£000**	£000
By up to three months	**2,058**	2,131	**-**	-
By three to six months	**3,200**	1,655	**-**	-
By more than six months	**4,558**	3,091	**2,876**	2,396
	9,816	6,877	**2,876**	2,396

Provision for impaired receivables	Current		Non current	
	31 March 2011	31 March 2010	**31 March 2011**	31 March 2010
	£000	£000	**£000**	£000
Movement in the provision for impaired receivables				
Balance at 1 April	**1,772**	873	**203**	200
Increase in provision	**1,210**	1,429	**117**	84
Amounts utilised	**(48)**	(52)	**-**	(81)
Unused amounts reversed	**(671)**	(478)	**(16)**	-
	2,263	1,772	**304**	203
Aged analysis of impaired receivables				
By up to three months	**41**	591	**-**	-
By three to six months	**270**	107	**-**	-
By more than six months	**1,952**	1,074	**304**	203
	2,263	1,772	**304**	203

19. Other non financial assets

	Current		Non current	
	31 March 2011	31 March 2010	**31 March 2011**	31 March 2010
	£000	£000	**£000**	£000
PFI deferred assets - building works variations	**-**	-	**-**	29,955
PFI deferred assets - bullet payment	**41**	41	**254**	294
	41	41	**254**	30,249

Deferred assets - building works variations' arose from the Trust making direct payments to the PFI partner, for additional construction work to the new PFI hospital. Upon the opening of the Queen Elizabeth Hospital Birmingham and its subsequent recognition as an asset on 15 June 2010, the carrying value of the deferred asset of £30,963,000 was reclassified to property, plant and equipment. This amount being the sum of the balance at 1 April 2010 - £29,955,000 and the expenditure incurred during the year to 15 June 2010 - £1,008,000, see note 14 to the financial statements on page XXXIX.

Deferred assets - bullet payment' arises from the Trust making payments direct to the PFI partner for the provision of IT services. This payment made to the PFI partner will be amortised over the remaining 7 years of the contract.

20. Cash and cash equivalents

	31 March 2011	31 March 2010
	£000	£000
Cash and cash equivalents	**62,009**	96,290
Made up of		
Cash with Government Banking Service	**61,109**	95,897
Commercial banks and cash in hand	**900**	393
Current investments	**-**	-
Cash and cash equivalents as in statement of financial position	**62,009**	96,290
Bank overdraft - Government Banking Service	**-**	-
Bank overdraft - Commercial banks	**-**	-
Cash and cash equivalents as in statement of cash flows	**62,009**	96,290

21. Non-current assets held for sale

The Trust has no non-current assets held for sale (31 March 2010 - £nil).

22. Trade and other payables

	Current		Non current	
	31 March 2011	31 March 2010	31 March 2011	31 March 2010
	£000	£000	£000	£000
NHS payables	**12,467**	19,884	**-**	-
Amounts due to other related parties	**167**	540	**-**	-
Commercial trade payables	**18,293**	19,383	**-**	-
Trade payables - capital	**1,284**	5,555	**-**	-
Other payables	**1,308**	392	**-**	-
Accruals	**30,666**	16,370	**-**	-
Receipts in advance	**95**	480	**-**	-
PDC payable	**131**	-	**-**	-
	64,411	62,604	**-**	-

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 31 to the financial statements on page LIX. Included within NHS payables are NHS pension contributions of £3,218,000 (31 March 2010: £3,116,000).

23. Tax Payable

	Current		Non current	
	31 March 2011	31 March 2010	**31 March 2011**	31 March 2010
	£000	£000	**£000**	£000
Amounts due to other related parties	**6,340**	6,054	**-**	-

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

24. Other liabilities

	Current		Non current	
	31 March 2011	31 March 2010	**31 March 2011**	31 March 2010
	£000	£000	**£000**	£000
Deferred income	**26,815**	27,423	**38,694**	25,040
Deferred government grant	**46**	46	**2,631**	2,648
	26,861	27,469	**41,325**	27,688

25. Borrowings

	Current		Non current	
	31 March 2011	31 March 2010	**31 March 2011**	31 March 2010
	£000	£000	**£000**	£000
Obligations under finance leases	**7**	68	**-**	7
Obligations under Private Finance Initiative contracts	**10,928**	-	**447,934**	-
	10,935	68	**447,934**	7

The Private Finance Initiative obligation relates to the new Queen Elizabeth Hospital Birmingham as detailed in note 28.1 to the financial statements on page LII.

26. Prudential borrowing limit

	31 March 2011	31 March 2010
	£000	£000
Total long term borrowing limit set by Monitor	**561,100**	592,100
Working capital facility agreed by Monitor	**20,000**	1,000
	581,100	593,100
Long term borrowing at 1st April	**75**	159
Net actual borrowing / (repayment) in year - long term	**458,794**	(84)
Long term borrowing at 31st March	**458,869**	75
Working capital borrowing at 31st March	**-**	-

The Trust is required to comply and remain within a prudential borrowing limit. This is made up of two elements:

- the maximum cumulative amount of long term borrowing. This is set by reference to the four ratios test set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit.
- the amount of any working capital facility approved by Monitor.

Further information on the NHS Foundation Trust Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of NHS Foundation Trusts.

The long term borrowing limit set by Monitor is due to the new private finance initiative contract and the actual net borrowing is the non-current PFI obligation at the reporting date.

The ratio tests used to determine the maximum long term borrowing limit and the Trust's performance against them is set out below. As the Trust has a PFI scheme it is measured against Monitor's Tier 2 limits:

	Tier 2 Limits	31 March 2011	31 March 2010
Minimum dividend cover	> 1.0	76.9	11.7
Minimum interest cover	> 2.0	2.8	-
Minimum debt service cover	> 1.5	1.5	-
Maximum debt service to revenue	< 10%	3.5%	-

The Trust has achieved the four Tier 2 ratios laid down by Monitor in the Prudential Borrowing Code.

27. Finance lease obligations (other than PFI)

	Minimum lease payments		Present value of minimum lease payments	
	31 March 2011	31 March 2010	**31 March 2011**	31 March 2010
	£000	£000	**£000**	£000
Gross lease liabilities	**7**	80	6	76
Of which liabilities are due:				
Not later than one year	**7**	72	6	70
Later than one year, not later than five years	**-**	8	-	6
Later than five years	**-**	-	-	-
Net finance charges allocated to future periods	**-**	(5)	-	(4)
Net lease liabilities	**7**	75	**6**	72
Not later than one year	7	68	6	66
Later than one year, not later than five years	-	7	-	6
Later than five years	-	-	-	-

28. Private finance initiative contracts

28.1 PFI schemes on-statement of financial position

A contract for the development of the new hospital was signed by the Trust and its PFI partner on 14 June 2006. The purpose of the scheme is to deliver a modern, state of the art acute hospital facility on the QE site which is due to be fully operational in 2012. This is part of a wider PFI deal between the Trust, Birmingham & Solihull Mental Health Trust and a consortium led by Consort Healthcare (Birmingham) Limited. The ownership of the consortium entity is as follows:

Balfour Beatty Infrastructure Investments Ltd (40%), HSBC Infrastructure Fund (30%) and Royal Bank of Scotland Investments Ltd (30%).

The contracted value of the new PFI hospital is £584,600,000 (of which £484,889,000 is capital and £99,711,000 are fees and finance costs incurred prior to 15 June 2010). The 'Queen Elizabeth Hospital Birmingham' is being handed over in three phases:

- phase 1 on 15 June 2010 and phase 2 on 17 November 2010 were delivered on schedule and are complete as at the reporting date.
- phase 3 is scheduled for 11 October 2011 in the next reporting year.

As at the reporting date there were 122 formal contract variations which relate to the Trust. The cost of the approved variations have been included in the accounts where the work has been completed.

Total obligations for on-statement of financial position PFI contracts due:	31 March 2011	31 March 2010
	£000	£000
Gross PFI liabilities	**856,059**	-
Of which liabilities are due:		
Not later than one year	**28,429**	-
Later than one year, not later than five years	**119,646**	-
Later than five years	**707,984**	-
Net finance charges allocated to future periods	**(397,197)**	-
Net PFI liabilities	**458,862**	-
Not later than one year	**10,929**	-
Later than one year, not later than five years	**48,378**	-
Later than five years	**399,555**	-

The PFI obligation above is only that part of the unitary payment allocated to the finance lease rental, ie the annual finance expense and capital repayment of lease liability over the contract term. This apportionment of the unitary payment is described in accounting policy note 1.11 and the total unitary payment commitment, including annual service expense and lifecycle replacement is disclosed below:

The annual unitary payment for the reported year of £25,934,000 (2009/10 - £nil) reflects the phased opening of the new PFI hospital.

The Trust will be committed to the full unitary payment upon final handover and will then be committed till the contract expires on 14 August 2046, at which time the building will revert to the ownership of the Trust. The unitary payment is subject to change based on movements in the Retail Prices Index.

The Trust is committed to making the following unitary payments for on-statement of financial position PFI commitments during the next reporting year and until the contract expires:

Total commitments for on-statement of financial position PFI contracts due:	Unitary payments		Present value of unitary payments	
	31 March 2011	31 March 2010	31 March 2011	31 March 2010
	£000	£000	£000	£000
Of which commitments are due:				
Not later than one year	**44,013**	-	**44,013**	-
Between one and five years	**188,162**	-	**172,783**	-
After 5 years	**1,428,539**	-	**759,143**	-
Total PFI commitments	**1,660,714**	-	**975,939**	-

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

	Current		Non current	
	31 March 2011	31 March 2010	**31 March 2011**	31 March 2010
	£000	£000	**£000**	£000
Pensions relating to other staff	**33**	34	**134**	169
Legal claims	**1,335**	1,201	**1,566**	1,681
Other	**1,912**	2,411	**-**	370
	3,280	3,646	**1,700**	2,220

	Pensions relating to former directors	**Pensions relating to other staff**	**Legal claims**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
At 1 April 2010	-	203	2,882	2,781	**5,866**
Arising during the year	-	-	291	1,113	**1,404**
Used during the year	-	(34)	(148)	(1,924)	**(2,106)**
Reversed unused	-	(7)	(163)	(58)	**(228)**
Unwinding of discount	-	5	39	-	**44**
At 31 March 2011	**-**	**167**	**2,901**	**1,912**	**4,980**
Expected timing of cash flows:					
Within one year	-	33	1,335	1,912	**3,280**
Between one and five years	-	119	1,519	-	**1,638**
After five years	-	15	47	-	**62**

The provisions included under 'legal claims' are for personal injury pensions £1,653,000 (31 March 2010: £1,775,000), employers and public liability £355,000 (31 March 2010: £224,000) and other claims notified by the Trust's solicitors £893,000 (31 March 2010: £883,000). 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 £167,000 (31 March 2010: £203,000), disclosed as 'pensions relating to other staff' have been calculated on guidance received from the NHS Business Services Authority - Pensions Division.

The 'other' provisions include annual leave entitlement earned but not taken by employees at the period end £926,000 (31 March 2010: £802,000) and provisions in respect of NHS pay agreements £986,000 (31 March 2010: £1,514,000).

Provisions within the annual accounts of the NHS Litigation Authority at 31 March 2011 include £20,022,000 in respect of clinical negligence liabilities of the Trust (31 March 2010: £18,207,000).

30. Events after the reporting period

The phased handover of the new Queen Elizabeth Hospital to the Trust is detailed in note 28.1 to the financial statements on page LII. The first and second phases are complete at the reporting date, with that part of the asset in operational use recognised at fair value on the statement of financial position. As detailed in note 14.2 to the financial statements on page XLIII, the Trust has already recognised at the reporting date £509,507,000 of non-current assets with an associated impairment of £242,945,000 due to the completed handover of the first and second phases of the new hospital.

The third and final phase of the handover is scheduled to occur on 11 October 2011 in the subsequent reporting year ending 31 March 2012. The Trust believes £110,197,000 of non-current assets with an associated impairment of £49,060,000 will be recognised in this subsequent reporting year, due to the third and final phase of the new hospital achieving operational status.

On 24 March 2011, the Board of Directors approved that the Trust proceed with the proposed transfer of part of the staff and services in respect of the Community Sexual Health services of Heart of Birmingham Teaching PCT, subject to the resolution of a number of issues around finance and risk transfer. The transfer of these services is planned to take place on 1 April 2011.

The transfer is expected to increase income by £8,872,000 in the 2011/12 financial year and increase expenditure by an equivalent amount, therefore having no overall effect on the planned surplus. Net assets are expected to increase by £424,000 as a result of the transfer of equipment.

31. Related party transactions

University Hospitals Birmingham NHS Foundation Trust is a corporate body established by order of the Secretary of State for Health.

The Trust considers other NHS Foundation Trusts to be related parties, as they and the Trust are under the common performance management of Monitor - 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. These entities are listed below:

NHS in England	Receivables £'000	Payables £'000	Revenue £'000	Expenditure £'000
Birmingham East and North PCT *	-	(230)	152,733	(131)
South Birmingham PCT	12,685	-	128,209	(240)
West Midlands SHA	133	-	30,713	(5,008)
Heart of Birmingham Teaching PCT	304	(457)	25,163	(1,217)
Worcestershire PCT	2,735	(6)	19,591	(24)
Sandwell PCT	1,283	(493)	12,774	(328)
South Staffordshire PCT	1,478	-	10,522	-
Solihull PCT	522	-	7,920	
Dudley PCT	1,123	-	7,857	-
Warwickshire PCT	16	-	5,472	(2)
Walsall PCT	633	-	4,946	-
Herefordshire PCT	736	-	3,710	-
Shropshire PCT	1,427	-	3,668	-
Wolverhampton PCT	216	-	3,033	-
Coventry PCT	786	-	2,672	-
London SHA (National Commissioning Group)	118	-	15,057	-
Birmingham Women's FT	1,689	(367)	3,143	(930)
The Royal Orthopaedic Hospital FT	580	(887)	2,035	(238)
Birmingham Children's Hospital FT	404	(637)	1,353	(2,491)
Sandwell and West Birmingham NHS Trust	394	(403)	821	(2,937)
Birmingham Community Healthcare NHS Trust	2,050	(50)	649	(1,235)
Birmingham and Solihull Mental Health FT	259	(1,037)	437	(1,944)
Heart of England FT	593	(1,102)	348	(2,541)
NHS Pension Scheme	-	(3,218)	-	(25,421)
NHS Purchasing & Supply Agency	-	(785)	-	(12,100)
NHS Blood and Transplant Agency	30	(582)	556	(8,715)
West Midlands Ambulance Service NHS Trust	-	(473)	24	(4,437)
NHS Litigation Authority	-	-	-	(3,399)
NHS Business Services Authority	-	(187)	-	(2,184)
Other	4,816	(1,553)	24,720	(5,273)
	35,010	(12,467)	468,126	(80,795)

* The West Midlands Local Collaborative Commissioning Boards (LCCB) and Specialised Services Authority (SSA) are all administered by the Birmingham East and North Primary Care Trust.

Mr Kevin Bolger - an Executive Director of the Trust is the partner of Ms Michelle McLoughlin - an Executive Director of Birmingham Childrens Hospital NHS Foundation Trust. The Trust's formal Service Level Agreement with the Birmingham Childrens Hospital Foundation NHS Trust for the year ended 31 March 2011 has resulted in an income to the Trust of £2,042,000 and an expenditure of £319,000.

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

Other related parties	Receivables £'000	Payables £'000	Revenue £'000	Expenditure £'000
Ministry of Defence	8,639	-	14,369	(272)
Department of Health	20	-	17,765	(75)
Birmingham City Council	1,329	(166)	1,029	(1,838)
HM Revenue and Customs taxes	848	-		
Other	51	(1)	134	(461)
	10,887	(167)	33,297	(2,646)

The Trust has also received revenue and capital payments from the University Hospital Birmingham Charities. David Ritchie who was a Trustee of UHB Charities throughout 2010/11, was also a non-executive director of the Trust.

32. Contingencies

There are £144,000 of contingent liabilities at 31 March 2011 which relate to amounts notified by the NHSLA for potential employer and public liability claims over and above the amounts provided for in note 29 to the financial statements on page LIV (31 March 2010: £126,000). There are no contingent assets at the reporting date (31 March 2010: £nil).

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 comparison by category of the carrying amounts and the fair values of the Trust's financial assets and financial liabilities:

Carrying values and fair values of financial instruments	Notes	**Carrying Value 31 March 2011** **£000**	**Fair Value 31 March 2011** **£000**	Carrying Value 31 March 2010 £000	Fair Value 31 March 2010 £000
Current financial assets					
Cash and cash equivalentsw	1	**62,009**	**62,009**	96,290	96,290
Loans and receivables:					
Trade and receivables	1	**51,763**	**51,763**	28,432	28,432
		113,772	**113,772**	124,722	124,722
Non-current financial assets					
Loans and receivables:					
Trade and receivables	1	**2,864**	**2,864**	2,769	2,769
		2,864	**2,864**	2,769	2,769
Total financial assets		**116,636**	**116,636**	127,491	127,491
Current financial liabilities					
Financial liabilities:					
Finance leases	2	**7**	**7**	68	68
Private Finance Initiative contracts	2	**10,928**	**10,928**	-	-
Trade and other payables	1	**64,185**	**64,185**	62,124	62,124
Provisions under contract	1	**3,150**	**3,150**	3,517	3,517
		78,270	**78,270**	65,709	65,709
Non-current financial liabilities					
Financial liabilities:					
Finance leases	2	**-**	**-**	7	7
Private Finance Initiative contracts	2	**447,934**	**447,934**	-	-
Provisions under contract	1	**10**	**10**	371	371
		447,944	**447,944**	378	378
Total financial liabilities		**526,214**	**526,214**	66,087	66,087
Net financial assets / (liabilities)		**(409,578)**	**(409,578)**	61,404	61,404

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 page LII.

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 and PDC receivable which are not financial instruments, see note 18 to the financial statements on page XLVII
- Trade payables includes receipts in advance which is not a financial instrument, see note 22 to the financial statements on page XLIX
- Provisions includes liabilities incurred under legislation, rather than by contract - early retirements due to ill health or injury. These are not considered by HM Treasury to fit the definition of a financial instrument, see note 29 to the financial statements on page LIV

Risk management policies

The Trust's activities expose it to a variety of financial risks, though due to their nature the degree of the exposure to financial risk is substantially reduced in comparison to that faced by business entities. The financial risks are mainly credit and inflation risk, with limited exposure to market risks (currency and interest rates) and to liquidity risk.

Financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Investment Committee. The main responsibilities of the Trust's treasury operation are to:

- Ensure adequate liquidity for the Trust
- Invest surplus cash
- Manage the clearing bank operations of the Trust

(i) Credit risk

As a consequence of the continuing service provider relationship that the Trust has with primary care trusts (PCTs) and the way those PCTs are financed, the Trust is exposed to a degree of customer credit risk, but substantially less than that faced by business entities. In the current financial environment where PCT's must manage increasing healthcare demand and affordability within fixed budgets, the Trust regularly reviews the level of actual and contracted activity with the PCT's to ensure that any income at risk is discussed and resolved at a high level at the earliest opportunity available.

As a majority of the Trust's income comes from contracts with other public sector bodies, see note 2 to the financial statements on page XXIX, there is limited exposure to credit risk from individuals and commercial entities. The maximum exposures to trade and other receivables as at the reporting date, are disclosed in note 18 to the financial statements on page XLVII. The Trust mitigates its exposure to credit risk through regular review of receivables due and by calculating a bad debt provision.

In accordance with the Trust's treasury policy, the Trust's cash is held in current accounts at UK banks only. There are no cash or cash equivalent investments held, the result being to minimise the counter party credit risk associated with holding cash at financial institutions.

(ii) Inflation risk

The Trust's has exposure to annual price increases of medical supplies and services

(pharmaceuticals, medical equipment and agency staff) arising from its core healthcare activities. The Trust mitigates this risk through, for example, transferring the risk to suppliers by contract tendering and negotiating fixed purchase costs (including prices set by nationally agreed frameworks across the NHS) or reducing external agency staff costs via operation of the Trust's own employee 'staff bank'.

The unitary payment of the new 'Queen Elizabeth Hospital Birmingham' private finance initiative contract is subject to change based on movements in the Retail Prices Index (RPI), as disclosed in note 28.1 to the financial statements on page LII. For the reporting year the relevant RPI index was 219.2 (annualised rate of 3.7%) fixed at February 2010. 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 2011**		Year Ended 31 March 2010	
	£000	**£000**	£000	£000
	+1.0%	**-1.0%**	+1.0%	-1.0%
Retained surplus / (deficit)	**(317)**	**318**	-	-
Taxpayers' equity	**(317)**	**318**	-	-

(iii) Market risk

The Trust has limited exposure to market risk for both interest rate and currency risk:

Currency risk - the Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations nor investments and all Trust cash is held in Sterling at UK banks: Barclays bank and the Government Banking Service 'GBS'. The Trust therefore has minimal exposure to currency rate fluctuations.

Interest rate risk - other than cash balances, the Trust's financial assets and all of its financial liabilities carry nil or fixed rates of interest. Cash balances at UK banks earn interest linked to the Bank of England base rate. The Trust therefore has minimal exposure to interest rate fluctuations.

(iv) Liquidity risk

The Trust's net operating costs are incurred under annual service agreements with local Primary Care Trusts, which are financed from resources voted annually by Parliament. The Trust ensures that it has sufficient cash or committed loan facilities to meet all its commitments when they fall due. This is achieved by the Trust's compliance with the Prudential Borrowing Code made by Monitor, the Independent Regulator of NHS Foundation Trusts, detailed in note 26 to the financial statements on page LI. The Trust is not, therefore, exposed to significant liquidity risks.

(v) Capital management risk

The Trust's capital is 'Public Dividend Capital' (PDC) wholly owned and controlled by the Department of Health, there is no other equity. The 3.5% cost of capital - the 'PDC dividend' is disclosed in note 11 to the financial statements on page XXXVIII. Therefore, the Trust does not manage its own capital. Liquidity risk and the funding of the Trust's activities are described above.

34. Third Party Assets

The Trust held £2,963 of cash at 31 March 2011 (31 March 2010: £4,288) which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

35. Losses and Special Payments

There were 2,389 cases of losses and special payments (2009/10 - 2,091 cases) totalling £236,000 (2009/10 - £316,000) approved in the year.

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

NATIONAL HEALTH SERVICE ACT 2006

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

Monitor, the Independent Regulator of NHS Foundation Trusts, in exercise of powers conferred on it by paragraph 24 and 25 of schedule 7 to the National Health Service Act 2006, hereby directs that the keeping of accounts and the annual report of each NHS foundation trust shall be in the form as laid down in the annual reporting guidance for NHS foundation trusts with the NHS Foundation Trust Annual Reporting Manual, known as the FT ARM, that is in force for the relevant financial year.

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

Signed:
Name: David Bennett (Chairman) Dated: 28 February 2011

NATIONAL HEALTH SERVICE ACT 2006

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

Monitor, the Independent Regulator of NHS Foundation Trusts, with the approval of HM Treasury, in exercise of powers conferred on it by paragraph 25(1) of schedule 7 to the National Health Service Act 2006, (the 2006 Act) hereby gives the following Directions:

1. Application and Interpretation

(1) These Directions apply to NHS foundation trusts in England.

(2) In these direction "The Accounts" means:

for an NHS foundation trust in its first operating period since authorisation, the accounts of an NHS foundation trust for the period from authorisation until 31 March; or

for an NHS foundation trust in its second or subsequent operating period following authorisation, the accounts of an NHS foundation trust for the period from 1 April until 31 March.

"the NHS foundation trust" means the NHS foundation trust in question.

2. Form of accounts

(1) The accounts submitted under paragraph 25 of Schedule 7 to the 2006 Act shall show, and give a true and fair view of, the NHS foundation trust's gains and losses, cash flows and financial state at the end of the financial period.

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

(3) The Statement of Financial Position shall be signed and dated by the chief executive of the NHS foundation trust.

(4) The Statement on Internal Control shall be signed and dated by the chief executive of the NHS foundation trust.

3. Statement of accounting officer's responsibilities

(1) The statement of accounting officer's responsibilities in respect of the accounts shall be signed and dated by the chief executive of the NHS foundation trust.

4. Approval on behalf of HM Treasury

(1) These Directions have been approved on behalf of HM Treasury.

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

Signed:

Name: David Bennett (Chairman) Dated: 28 February 2011