NHS
University Hospitals Birmingham
NHS Foundation Trust

Annual Report and Accounts 2016/17

This annual report covers the period 1 April 2016 to 31 March 2017

University Hospitals Birmingham NHS Foundation Trust
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Annual Report 2016/17

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Performance report

1 Overview

University Hospitals Birmingham NHS Foundation Trust (UHB) is one of the highest performing healthcare organisations in Europe with a proven international reputation for its quality of care, information technology, clinical education and training and research. The Trust was established in 1995 and was among the first to be awarded foundation trust status by Monitor in July 2004.

UHB is a regional centre for cancer, has the second largest renal dialysis programme in the UK and has the largest solid organ transplantation programme in Europe. It also provides a series of highly specialist cardiac and liver services and is a major specialist centre for burns and plastic surgery. The Trust is also a regional Neuroscience and Major Trauma Centre and is world-renowned for its trauma care. UHB hosts the Royal Centre for Defence Medicine (RCDM) and has, since 2001 been the primary receiving hospital for all military patients that are injured overseas. This combined experience of treating trauma patients and military casualties has led to the development of pioneering surgical techniques in the management of ballistic and blast injuries, including bespoke surgical solutions for previously unseen injuries. As such, UHB has been designated as a Level 1 Trauma Centre and host of the UK's only National Institute for Health Research (NIHR) Surgical Reconstruction and Microbiology Research Centre (SRMRC).

The Trust employs more than 9,000 staff and is the largest single site hospital in the country. The £545m Queen Elizabeth Hospital Birmingham (QEHB) opened in 2010 and has 1,213 inpatient beds, 32 operating theatres and a 100-bed critical care unit, the largest co-located critical care unit in the world. Since the hospital opened the Trust has seen significant growth in demand from patients and GPs for its services and consequently has opened a further 170 beds in the Heritage Building (the original Queen Elizabeth Hospital), as well as a second Ambulatory Care facility and two theatres, to ensure capacity for the increase in the number of patients wishing to be treated at the Trust.

During 2016/17, the Trust has continued to focus on its vision 'to deliver the best in care'. This is underpinned by the Trust's values of honesty, innovation, respect and responsibility, and core purposes of excellent clinical quality, patient experience, workforce, and research and innovation.

In 2015, the Trust established the West Midlands Genomics Medicine Centre, in partnership with the University of Birmingham, as part of the national 100,000 Genomes Project to transform diagnosis and treatment for patients with cancer and rare diseases. In October 2016, as part of Birmingham Health Partners, the Trust officially opened the Institute of Translational Medicine (ITM), a new world-class clinical research facility located in the Heritage Building. The ITM will help to transfer the very latest scientific research findings into enhanced treatments for patients. Alongside the ITM the Trust has established a Centre for Rare Diseases and the ITM Imaging Centre, which saw its first patients in December 2016.

In August 2015, the Trust launched an innovative sexual health service, Umbrella, for Birmingham and Solihull, having been awarded a five-year contract as lead provider by Birmingham City Council and Solihull Metropolitan Borough Council. Working in partnership with the third sector, GPs and pharmacies, Umbrella is delivering better access to services and better outcomes to the people of Birmingham and Solihull.

In recent years, the Trust has been increasingly acknowledged as one of the most successful NHS foundation trusts and has therefore been asked to provide management support to a number of other trusts, for example, supporting George Eliot Hospital NHS Trust to leave special measures within a year. Since October and November 2015 respectively, UHB's Chief Executive and Chair have held Interim corresponding roles at Heart of England NHS Foundation Trust, along with other senior managers, to improve its clinical, financial and operational position.

UHB has continued to be one of the best performing foundation trusts in England in 2016/17, despite some significant challenges within Birmingham and the local health economy and the NHS as a whole. It continues to perform well against the majority of the national targets set by NHS Improvement (NHSI/formerly Monitor) and has outperformed its planned financial surplus. The Trust continues to offer high quality, safe care, with support from its well-proven monitoring systems, which have been developed in-house with input from clinical teams. In September 2016, UHB was named as a Global Digital Exemplar trust as part of new plans to fast-track digital development and improve the digital skills of the NHS workforce.

1.1 Details of overseas operations

The Trust has no permanent overseas operations but has continued its work to strengthen the Trust's international reputation and profile through:

- Delivering its international fellowship programme with international partners.
- Developing opportunities to share its expertise in new hospital commissioning overseas, particularly with Chinese partners (see below).
- Exploring the potential of providing education.
- Sales of Australasian Healthcare Evaluation Data system (A-HED) to Australia, New Zealand and Tasmania, through the Health Roundtable.

Innovating Global Health China Limited is a Hong Kong registered company, established as a Joint Venture between the Trust and Innovating Global Health SA (IGH), for the identification, development and pursuit of healthcare opportunities in China. The Trust and IGH each own 50% shareholdings in Innovating Global Health China Limited.

1.2 Royal Centre for Defence Medicine

University Hospitals Birmingham NHS Foundation Trust is the primary receiving hospital for military personnel injured overseas. The Royal Centre for Defence Medicine (RCDM), nested with the QEHB, works in partnership with UHB and a number of other NHS hospitals in the Birmingham area to support the operational patient pathway, with the majority of casualties receiving treatment at the QEHB.

Established in 2001, the RCDM's primary role is the focal point for the military reception of operational casualties. RCDM is one of the units commanded by the Defence Medical Group (DMG), which also includes the Defence Medical Rehabilitation Centre at Headley Court. DMG's role is to provide highly capable secondary healthcare personnel for operations and deliver the patient pathway. DMG sits under the command of Director Healthcare Delivery and Training, part of Headquarters Surgeon General.

RCDM is made up of approximately 380 uniformed personnel. Most fulfil a clinical role but around 50 personnel work in the Headquarters, with some working in academic positions throughout Birmingham. The combined experience of the military and medical staff and the civilian doctors, nurses and allied health professionals working together means UHB strives to deliver the best clinical care in the country. The hospital is at the leading edge in the medical care of trauma injuries and the experience gained by the staff working in this busy acute care environment provides the ideal training required for operations.

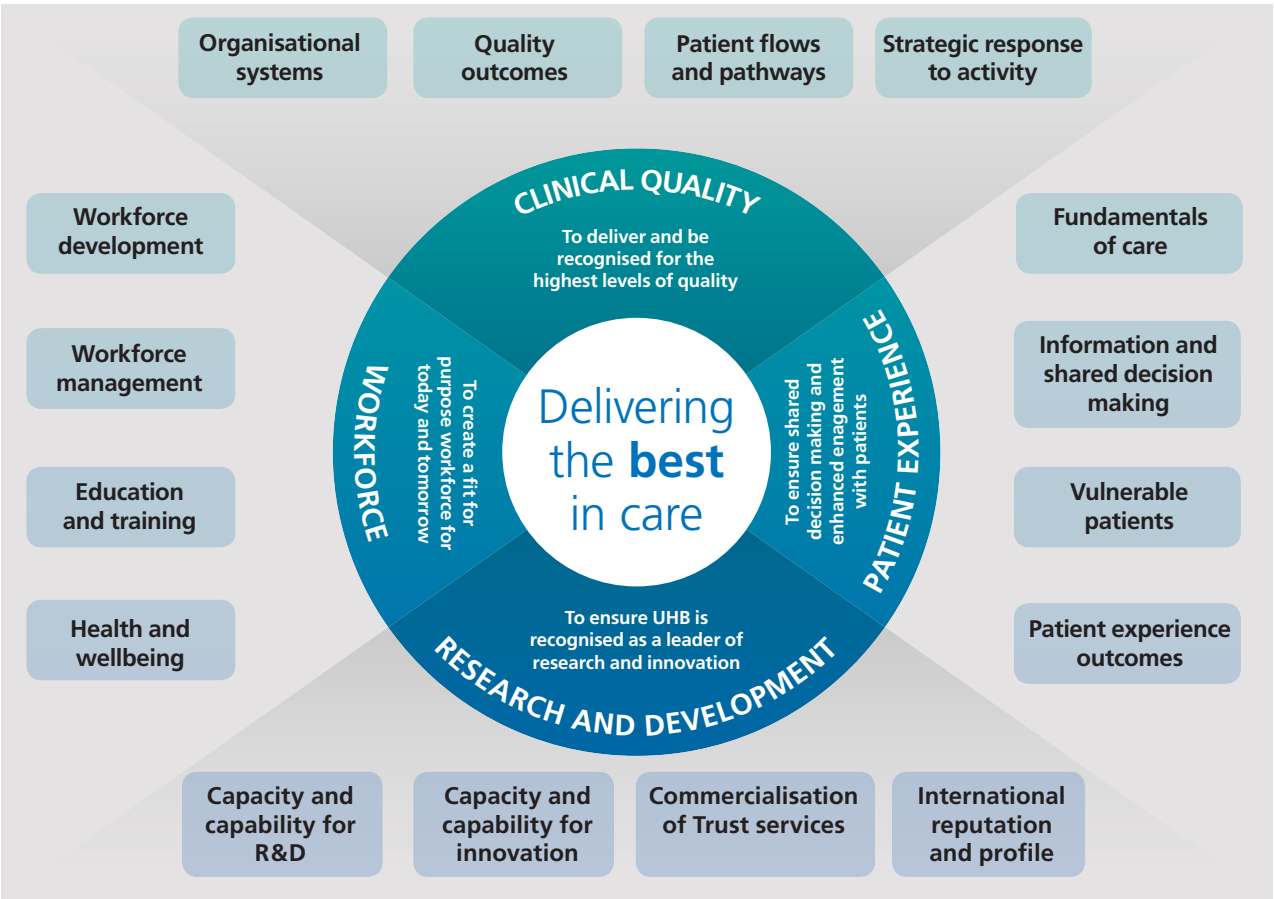
Military patients are treated on the ward most appropriate to their recovery. Service personnel and their families have the opportunity to use a Day Room on one of the trauma wards, which features welfare facilities to maintain their morale during their hospital stay. Families of patients can also stay at Fisher House, an 18-bedroomed home away from home for families of injured military personnel, during their recovery.

Whilst the NHS provides the treatment to meet the patient's immediate clinical needs, RCDM is uniquely enhanced to provide medical administrative and welfare support to service patients (and their families) admitted from operations. This 'military bubble' concept is necessary for the well-being of the operational casualty and is an integral part of the morale component of fighting power.

1.3 The Trust strategy

UHB continues to focus on its vision to deliver the best in care. This is underpinned by the Trust's values of honesty, innovation, respect, and responsibility and core purposes of excellent clinical quality, patient experience, workforce, and research and innovation.

The Trust's key strategic aims are detailed in the diagram below.



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

Core Purpose 1	Clinical Quality
Strategic Aim	To deliver and be recognised for the highest levels of quality.

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

Core Purpose 3	Workforce
Strategic Aim	To create a fit-for-purpose workforce for today and tomorrow.

Core Purpose 4	Research and Innovation
Strategic Aim	To ensure UHB is recognised as a leader of research and innovation.

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

1.4 Key issues, risks and uncertainties that could affect the foundation trust in delivering its objectives

The Trust has identified a number of key risks that could affect it in delivering its objectives which are included in its Board Assurance Framework:

- **Failure to deliver infection prevention and control trajectories leading to failure to maintain registration with the CQC or a breach of contract**
  Controls in place include: monthly review of risks and controls and compliance to mandatory training at Infection Prevention and Control Group; Root Cause Analysis (RCA) reviews of all *Methicillin Resistant Staphylococcus Aureus* (MRSA) and *Clostridium Difficile* Infection (CDI) cases; local review of CDI RCA and Executive Review of Trust apportioned cases of MRSA bacteraemia and CDI deaths.

- **Significant deterioration in the Trust's underlying financial position resulting in a deficit being reported in excess of planned levels and a reduced 'Use of Resources' score which forms part of the new Single Oversight Framework. This financial risk may be further compounded by the UK's exit from the EU**
  To mitigate the risk that the Trust's financial position has a material effect on quality, the Trust's Board of Directors regularly receives updates on the financial plan and the Trust continues to work with NHS Improvement (NHSI) and NHS England (NHSE) to influence the national tariff to ensure that it is paid appropriately to allow it to continue to offer high quality care. The Trust also has in place a robust contract monitoring process with its commissioners to mitigate the risk.

- **Risk of failure to deliver operational performancetargets including Sustainability and Transformation Fund trajectory due to capacity issues**
  Continued growth in activity challenges the Trust's ability to deliver the national targets, particularly the four-hour emergency care standard. Recently the existing Unscheduled Care Project has been reviewed and strengthened. Initiatives include the expansion of our Surgical Assessment Unit which allows for an increased number of conditions to bypass the Emergency Department. Emergency pathways which receive patients into assessment areas, where they would previously have attended the Emergency Department, now account for around 700 patients per month. We have also introduced new roles into the Emergency Department, such as physiotherapists, which shorten the patients' treatment pathway. Numerous other schemes that have been introduced are aimed at reducing attendances or signposting patients to alternative services such as urgent outpatient. The Trust has continued to undertake its annual capacity and demand modelling. This allows us to forecast demand and to establish the capacity requirements for out-patients, theatres and beds. Physical capacity is becoming a key constraint and so our focus has been to increase our productivity and efficiency where possible. In 2014/15, good progress was made to improve length of stay and improve our theatre efficiency. This year we will apply the same service improvement principles to outpatients.

- **Inability to recruit adequate numbers of sufficiently skilled, trained and competent staff including senior management due to insufficient supply and the UK's exit from the EU**
  Various workstreams are in place to mitigate this and an Executive-led Strategic Workforce Group oversees this work. The Operational Workforce Group and other groups escalate any risks to the Strategic Workforce Group for resolution.

- **Reduction in research funding and negative impact on contracts for equipment, consumables, services and finance generally as a result of the UK's exit from the EU**
  The Trust continues to monitor the political and legal landscape.

1.5 Case for Change

Following the decisions of the Boards of Directors of University Hospitals Birmingham (UHB) and Heart of England (HEFT) NHS Foundation Trusts in July 2016, a mandate was given to develop a Case for Change for the two organisations to become a single entity. The next step in this process is the submission of this notification document to the CMA in mid-April 2017.

The Case for Change will continue to be developed, over the following months, with input from a wide range of staff, patients and stakeholders associated with the two trusts, into a Full Business Case, for consideration and decision by the Boards of Directors.

Historically, HEFT was a well-respected, financially healthy organisation that provided quality care: hospitals and services where patients chose to be treated and

where talented individuals chose to work. However, since 2012, HEFT has been unable to deliver the quality of care, operational and financial performance that its patients, staff and the public deserve.

The request by Monitor (now part of NHSI) for a UHB-led intervention to stabilise the rapid operational and financial decline, as well as the governance failures at HEFT, was the third attempt to put in place a recovery plan for the organisation.

Since October 2015, the interim executive management team has delivered the stability, structure, governance and financial leadership necessary to enable the clinicians to focus once again on delivering quality care for their patients. However, the current arrangement is not sustainable; the improvements, while significant, are not embedded, and delivering the full range of potential benefits is not deemed possible unless the organisations come together as a single, legal entity.

In considering the case for becoming a single legal entity, the Boards envisaged the following potential benefits. The new Trust could:

- Consolidate the extensive performance gains made to date at HEFT under a single Board that is widely recognised for its outstanding leadership.
- Deliver direct clinical benefits to patients through the integration of appropriate clinical services and electronic systems to standardise clinical practice, protocols and quality standards which, in turn, should reduce variation and improve patient safety and outcomes.
- Pool the best talent from both organisations and use staff more effectively across all sites, providing greater career and developmental opportunities for staff – and better retention of staff.
- Benefit from the integration of the administrative, education and training, financial and logistic and procurement services of both trusts. The new trust will, over time, be able to re-invest into the development and sustainment of clinical services and sites.
- Maximise the use of the experience of research and development, existing relationships with academic partners and the new combined, diverse patient population to become world leading in medical research and innovation.
- Create a more resilient organisation including financial sustainability, better able to influence and act as a supportive strategic partner within the Birmingham and Solihull (BSol) STP and the wider West Midlands' economy and healthcare market.

In developing the case to become a single legal entity, the Boards have emphasised the need to demonstrate clear clinical benefits and have involved clinical staff of both trusts throughout the process.

One organisation will create more equitable patient access to better quality and integrated healthcare across Birmingham, Solihull and South Staffordshire. The merged organisation will provide beneficial local and regional effects within the acute healthcare market and is aligned with regional and national healthcare strategies.

A Benefits Case has been developed from the "ground up" following engagement with over 130 clinicians and clinical managers within both trusts and with key stakeholders outside the organisations such as NHSI.

In addition to the clinical benefits, a preliminary review of IT has been undertaken and an infrastructure survey is underway. The introduction of a common Electronic Patient Record (EPR) system across the unified Trust will allow the same degree of quality monitoring currently enjoyed by UHB and will improve patient safety more widely across the combined catchment area.

1.6 Sustainability and Transformation Plan

Health and care leaders in Birmingham and Solihull are working together to develop a Sustainability and Transformation Plan (STP) to support a healthier future for the people the Trust serves.

The STP shows the system's thinking and proposals for the future of health and care services for Birmingham and Solihull. The delivery of the STP is being led by Dame Julie Moore, Chief Executive of UHB and Interim CEO at Heart of England NHS Foundation Trust. The organisations involved in the STP firmly believe that by working together in a way that they have not done before they can deliver great changes to the health and wellbeing of their communities.

The priorities of the Local Plan Board, formed from the leaders of local health and local authority organisations and also general practitioner representatives, are as follows:

- To develop community-based models of joined-up care. For defined communities the aim is to deliver improved access to local services for everyone when their need is urgent, and more supportive and consistent care which aims to keep people well for those who need more support including social care. The new models have not yet been agreed however they will involve collaborations between primary care, hospital staff, social care and voluntary and independent sectors.
- Through closer working between providers to develop a co-ordinated system of hospital services through Birmingham and Solihull which reduces differences which can't be explained, improves efficiency and delivers better outcomes.
- To focus upon the issues faced by children within Birmingham and Solihull, a Maternity, Children and Young People programme will be established. This will include links to other footprint plans as well as maximising the impact of the outstanding Children's Hospital influence within the city.
- To give those with mental health problems and the services supporting the same priority as other areas.
- To work with the West Midlands Combined Authority and our two local authority Health and Wellbeing Boards to improve the health and wellbeing of our population, particularly focussing on the wider determinants of health such as employment, education, housing and work.
- To work together on key enablers who will help us deliver better health and care including our approach to an accountable care system which will include new payments and measures of success as well as joint workforce developments, digitalisation and estates.

2 Financial Review

In 2004, the Trust achieved Foundation Trust status under the Health and Social Care (Community Health and Standards) Act 2003. As such, these annual accounts have been prepared under directions issued by the Foundation Trust regulator, NHS Improvement.

2.1 2016/17 Changes in accounting policies

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 2017 and appropriate to NHS Foundation Trusts. This is the seventh set of full year results prepared in accordance with IFRS accounting policies.

There have been no significant amendments to accounting standards during 2016/17 which have affected the Trust.

2.2 Financial performance

The Trust's total annual revenue increased by 6.6% up to £811.8 million in 2016/17, ensuring the Trust remains amongst the largest foundation trusts in the country. Like many NHS acute service providers, 2016/17 saw the Trust's financial position improve from a deficit to a surplus, partly as a result of new Sustainability and Transformation Funding (STF) allocated from NHS Improvement. The Trust delivered a real surplus (before asset revaluation accounting adjustments) of £10.0 million, comparing favourably with the planned surplus of £4.6 million. The bulk of the favourable variance is due to unplanned, non-recurring STF funding allocated to the Trust late in 2016/17 financial year.

The Trust's overall 2016/17 retained surplus increases up to £24.7 million once the £14.7 million impact of the annual QEHB building valuation is included. The increased building values for the Trust's Heritage and other buildings is included as an increase to reserves of £6.8 million. This is also shown in the consolidated Statement of Comprehensive Income. Both revaluation gains are technical accounting adjustments to the Trust accounts rather than actual cash transactions or flows of money.

2.3 Income and expenditure

The table below compares the revised planned income and expenditure with the outturn position for 2016/17.

Summary income and expenditure – plan v. outturn

Consolidated summarised income and expenditure	Plan 2016/17 £m	Actual 2016/17 £m
Operating income	780.7	811.3
Operating expenditure	-734.2	-759.3
EBITDA	**46.5**	**52.0**
Depreciation	-21.2	-21.2
Interest receivable	0.3	0.3
Interest payable	-22.1	-22.0
Corporation Tax	-0.1	0.1
Gain on disposal	0.7	0.2
Donated income	0.5	0.6
Surplus before impairment	**4.6**	**10.0**
Property revaluations	0	14.7
Retained surplus	**4.6**	**24.7**

The largest component of the Trust's income comes from the provision of NHS patient care services funded by NHS commissioners within England. This accounted for £659.0m (81%) of total income. Other patient care revenues contributed a further £16.7m (2%), which includes income for NHS patients treated from Scotland, Wales and Northern Ireland, private patients and costs recovered from insurers under the Injury Cost Recovery Scheme.

The Health and Social Care Act 2012 (the 'Act'), removed the requirement for foundation trusts to limit private patient revenue as a specified percentage of total revenue from activities. In its place, the Act requires that a foundation trust's principal activity is to deliver goods and services for the purposes of the National Health Service in England. Therefore, revenue from this principal activity must exceed 50% of total revenues. In 2016/17, total revenue in this category was 83.2% of total revenue, whilst private patient income of £3.9m represented 0.5%.

The Trust has a range of income streams which are not linked directly to patient care. These include education levies, which account for £30.6m (3.8% of the total income, such as the Service Increment for Teaching (SIFT), recognising the cost of training medical undergraduates from the University of Birmingham, the Medical and Dental Education Levy (MADEL), which supports the salary costs of post graduate doctors in training, and the Non-Medical Education and Training (NMET) levy.

Research and Development (R&D) activity funding totalled £25.6m (3.1% of total income). This includes grants from the National Institute of Healthcare Research (NIHR) to support the Wellcome Trust Clinical Research Facility.

As highlighted elsewhere in this report, Sustainability and Transformation Funding (STF) income totalled £20.6m during 2016/17 and a further £11.7m was generated from services provided by the Trust to other organisations. The balance of the Trust's income is attributable to trading activities and other miscellaneous items.

Within Trust expenditure, the largest category is salaries and wages totalling £405.1m (including Directors and Non Executives) which is equivalent to 52.9% of total operating expenditure. Other significant components include £228.1m on drugs and clinical supplies (29.8%), estates and premises costs of £21.2m (2.8%) and depreciation of £21.0m (2.7%).

2.4 Capital Expenditure Plan

During 2016/17, the Trust invested £15.0m of capital expenditure on medical equipment, ICT infrastructure and improvements to existing buildings:

Category	Capital Expenditure £million
IT Infrastructure replacement & modernisation (inc. Genomics project)	1.8
Trust Buildings	3.0
› QEHB building works and lifecycle	
› QE Site Heritage & offsite buildings	1.7
Trust Equipment	
› Replacement medical equipment	4.0
› New (growth) medical equipment	1.2
› Replacement CT & Linac scanners	2.8
› Donated Assets	0.6
Total	15.0

Planned capital investment in 2017/18 is currently estimated at £19.8million and includes plans for:

- Proactive replacement of medical equipment.
- Ongoing investment into IT infrastructure.
- Statutory maintenance works within Trust buildings.
- Contracted lifecycle works within the QEHB.
- Improvement works within the Clinical Haematology and Heritage buildings (both supported by external funding).
- Replacements for an existing Linear Accelerator and other imaging equipment.
- ICT Global Digital Exemplar systems investments (externally funded).

There is no single high value project requiring external approval within the current plan.

The Queen Elizabeth Hospital land is on a long-term lease from Birmingham City Council, due to expire 29 September 2932.

2.5 Value for Money

During 2016/17, the Trust delivered £16.6m of efficiency savings across all services. A formal cost improvement programme (CIP) target was set across all divisions and corporate functions. A database of projects was developed to monitor CIP delivery (both expenditure reductions and income generation schemes) during the year.

In addition to the annual CIP savings, further efficiencies are realised in year through initiatives such as ongoing tendering, contract renegotiation, product standardisation, bulk purchases and the use of local, regional and national purchasing frameworks. Weekly reviews of non-clinical recruitment requests are undertaken for new and existing posts through the Workforce Approval Committee.

2.6 QEHB Charity

The charitable funds for the Trust are administered by QEHB Charity, a separate legal entity from the Trust. In 2016/17, the Trust received grants of £0.8m and donated assets worth £0.6m from the QEHB Charity.

2.7 External Auditor

The Trust's external auditor is Deloitte LLP; the audit cost for the year was £103,000 for the Trust's statutory audit and £20,000 for the subsidiary companies audit. Other work undertaken by Deloitte LLP in year totalled £85,000, including £55,000 for local counter fraud work, £24,000 of audit fees for the 2016/17 quality report audit and £6,000 of 2015/16 audit fees.

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

2.8 Basis for the Accounts

The Trust has three operational wholly owned subsidiary companies;

- Pharmacy@QEHB Limited, which commenced trading in 2011, providing an Outpatients pharmacy service in the Queen Elizabeth Hospital Birmingham.
- UHB Facilities Ltd, which commenced trading in 2014, providing estate management services.
- Assure Dialysis Services Ltd, which commenced trading in 2014, providing renal dialysis services to the Trust.

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

These group 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 2017 and appropriate to NHS Foundation Trusts.

2.9 Going Concern

Based on the financial performance detailed in these financial statements and the financial plans submitted to NHS Improvement, the Trust is forecasting that its cash balances will remain sufficient to continue meeting its working capital requirements for the immediate future. Therefore, after making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, the Trust has continued to adopt the Going Concern basis in preparing these accounts.

3 Performance Analysis

3.1 What the foundation trust sees as its key performance measures and how it checks performance against those measures

The Trust continues to have a robust and effective framework in place to provide assurance around the quality of care it offers and to monitor organisational performance. The Board of Directors and Executive Director-level groups receive monthly performance reports which present performance against national and local targets and priorities. These reports adopt a risk-based approach to reporting to ensure that the consequences of under-achievement are highlighted to the Executive Team and Board of Directors, as well as the actions that are in place to improve performance. The framework provides a good level of assurance and supports effective decision-making. UHB also has a Clinical Quality Monitoring Group and a Care Quality Group in place led by the Executive Medical Director and the Executive Chief Nurse respectively. These groups report to the Board of Directors and provide additional assurance and effective accountability around clinical quality and the patient experience. Please see the Trust's Quality Account for further details.

Information on the Trust's key performance indicators, broken down by specialty, ward or department, as appropriate, is included in the Trust's programme of quarterly Performance Review. This includes performance data on infection control, cancer, referral to treatment time, diagnostics, emergency care, clinical quality and outcomes, safety, education and training, workforce availability, research and development and efficiency. Key national targets are progress-monitored through the monthly Chief Operating Officer's Group and Quarterly Performance Reviews

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

3.2 Development and performance of the Trust during the year and performance against key health care targets

The Trust, and the NHS as a whole, has faced a very challenging year with relentless increases in demand and reduced funding. The increase in attendances and admissions seen over the year, and particularly in the past six months, has affected performance against a number of key targets.

The Trust continued its robust approach to capacity planning to ensure it had sufficient capacity to deliver the 18-week referral to treatment time (RTT) target on a sustainable basis. Consequently, the target was achieved consistently throughout the year on an aggregate basis. The Trust has also achieved the six-week diagnostic target for over a year on a continual basis. There remain certain specialties where the national 62-day cancer standard was not achieved and for these, action plans are in place with progress monitored weekly. These are often complex pathways incorporating referrals from other hospitals. Often those patients will have undergone a series of investigations at the referring hospital and will be referred quite late in the pathway.

There are two key national target groupings where the Trust has seen below target performance in 2016/17. These are A&E (Emergency Department) and Cancer:

Total Time in A&E

For the whole of 2016/17, the Trust continued to see very significant growth in emergency admissions through the Emergency Department. This significantly affected flow out of the department, as there was not always an inpatient bed available for patients who needed admission. Consequently, performance against the Total Time in A&E target was affected and the target was not achieved in any month. A significant increase in delayed transfers of care (more than double) during Quarters 3 and 4 further impacted on hospital

	2014/15	2015/16	2016/17	2015/16 difference	2016/17 difference
Inpatient FCEs	127,255	129,531	135,216	2%	4%
OPD attendances	759,489	789,040	817,407	4%	3%
ED attendances	102,054	108,463	115,226	6%	6%
Total	**988,798**	**1,027,034**	**1,067,849**	**4%**	**3%**

flow and this, coupled with the ongoing increases in A&E demand, led to a further deterioration in four-hour wait performance. The number of delayed transfers of care improved marginally in February 2017 and as a result of improved hospital flow, A&E performance started to show signs of improvement.

The Trust has a joint action plan in place with its lead commissioner, Birmingham CrossCity Clinical Commissioning Group (CCG), to address the issues of increased attendances and hospital flow. Actions are focussed on the SAFER bundle which aims to improve hospital flow and achieve earlier discharge.

There were four patients who waited in A&E for more than 12 hours before being admitted to an off-site mental health bed during 2016/17. Root Cause Analysis (RCA) investigations were completed for all cases and no UHB-attributable delays were identified. Findings were shared with the mental health provider, CCG and NHS England.

Cancer

The Trust continued to perform below the 85% national standard for 62-day urgent GP referrals in 2016/17, although the remaining cancer targets were achieved each quarter.

The Trust has continued to see large numbers of tertiary referrals on the 62-day cancer pathway. National breach sharing rules were introduced in October 2016 which reduced the impact of some late referrals on Trust performance. However, the new rules require the Trust to treat late tertiary referrals within 24 days (instead of the 31 days previously allowed) which is extremely challenging for some tumour sites where ongoing investigations are required.

A 62-day recovery plan is in place and has been agreed with commissioners. The main focus areas are working with other trusts on streamlined pathways to reduce the number of late referrals and processes that reduce delays within the Trust, such as the introduction of one-stop services and straight-to-test pathways.

3.3 Progress towards targets as agreed with local commissioners and other key quality improvements

As part of the contract the Trust holds with its host commissioner Birmingham CrossCity CCG and NHS England for the provision of services, the Trust is required to report its performance against a number of targets in its monthly Service Quality Performance Report. Other quality improvements are detailed in the Trust's Quality Account.

Apart from those targets included in NHSI's Single Oversight Framework that were not achieved, as detailed above, the Trust achieved all targets for the full year 2016/17 with the following exceptions:

MRSA

The Trust has seen four cases of MRSA bacteraemia over the year; half the number seen in the previous year. These have each been subject to root cause analysis and any issues identified addressed. The Trust has also agreed a comprehensive MRSA reduction plan with its commissioners with actions around staff training, appropriate antimicrobial use and the identification of patients at risk of developing infection. As part of this plan, actions are also being implemented to improve performance on the Saving Lives audit programme.

Operations cancelled on the day of surgery and cancelled operations not rearranged within 28 days

The increase in emergency admissions the Trust has seen has resulted in an increase in cancelled operations due to a lack of capacity. An enhanced tracking process is now in place to ensure breaches of the 28-day guarantee are avoided wherever possible. Improvements have occurred as a result of this.

Nursing Assessments

The requirement for all relevant nursing assessments (observations, including pain, falls, Waterlow, MUST) to be undertaken within six hours of admission or transfer to a ward has been given to all nursing staff. This has standardised the approach to these assessments. Improvements in performance were seen for all nursing assessment indicators in 2016/17.

Delayed Transfers of Care

The Trust introduced a complex discharge hub in June 2015, following which there was a sustained reduction in the number of delayed transfers of care each month. However, during 2016, a number of local authority assessment beds and nursing home beds were closed across the city and this led to an increase in the number of beds occupied by a patient with a delayed transfer of care reaching an all-time high of 2,564 bed days over the month of January 2017. The commissioner purchased additional community beds in the latter part of Quarter 4 and delayed transfers began to reduce as a result.

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

The Trust continues to focus on delivering high quality care and treatment to patients. The Trust's vision remains 'to deliver the best in care' to our patients. Its Core Purposes – Clinical Quality, Patient Experience, Workforce and Research and Innovation – provide the framework for the Trust's well-established approach to managing quality which it will continue to implement and develop over the coming year. Its approach is based on reducing the potential for errors and making incremental but significant improvements driven by innovative and bespoke information systems which allow it to capture and use real-time data in ways which few other NHS trusts or foundation trusts are able to do.

Key to the Trust's quality improvement is the programme of Executive Root Cause Analysis and Board of Directors' Governance Visits. A wide range of identified omissions in care continue to be reviewed at the regular Executive Care Omissions Root Cause Analysis (RCA) meetings chaired by the Chief Executive. Cases are selected for review from a range of sources, including an increasing number put forward by senior

medical and nursing staff: wards selected for review, missed or delayed medication, Serious Incidents (SIs), serious complaints, infection incidents, incomplete observations and cross-divisional issues. As the Trust works towards a merger, by acquisition, with Heart of England NHS Foundation Trust (HEFT), a joint meeting with HEFT is now in place, as well as a meeting for UHB alone. This provides an added element of independent scrutiny.

The Trust's Executive Medical Director is the named executive lead for Clinical Quality. He chairs the Trust's Clinical Quality Monitoring Group where all aspects of clinical quality are monitored, discussed, challenged and driven forward. A monthly report to the Board of Directors or Clinical Quality Committee ensures that the Board is informed and able to take action, if required, in relation to matters of clinical quality.

3.5 Regulatory Action

The last full inspection by the Care Quality Commission took place in January 2015 with the report published in May 2015. This inspection assessed the Trust's full range of services against the five key questions the CQC uses:

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

The CQC gave the Trust an overall rating of 'Good' with 'Good' ratings in the four of the five main domains (Safe, Effective, Caring and Responsive) and an 'Outstanding' rating for well-led.

The CQC subsequently undertook a focussed inspection of Cardiac Services in December 2015, following the release of national audit data that showed the Trust to be an outlier for in-hospital survival rates. The inspection identified some concerns around the leadership, culture and governance of the service.

Prior to the CQC inspection, the Cardiac Surgery specialty had already identified that improvements were required and the Executive Medical Director had established a programme to bring these about. This programme, now called the Cardiac Quality Improvement Project, was aimed at addressing the majority of the concerns subsequently identified by the CQC. As a result of the CQC inspection, the Trust was required (under a formal Section 31 CQC notification) to undertake two specific actions. These were completed to the satisfaction of the CQC, who also acknowledged that the data submitted to them showed an improvement in outcomes and consequently removed the Section 31 notice on 25 May 2016. Subsequently, the CQC has returned the service to routine monitoring by NHS England as the commissioner of the service.

3.6 Consultation

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

UHB's range of well-established communication channels includes a bi-monthly team briefing from the Chief Executive and a weekly online publication called 'In the Loop'. The Trust magazine, news@QEHB, and the corporate induction programme are valuable sources of information for new recruits. The Trust's intranet is also a central source for policies, guidance and online tools. Staff are able to directly access information which affects them individually, e.g. payslips, training records, absence records, via the Trust's staff portal me@QEHB. There is also a section called AskHR which contains frequently-asked HR questions, template letters and links to the Trust's Policies and Procedures. The portal is available 24 hours a day so staff and managers can access it whenever they need to and get advice outside normal office hours.

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

3.7 Policies in relation to disabled employees and equal opportunities

Disabled employees have regular access to the Trust's Occupational Health Services including ergonomic assessment of the workplace to ensure that access and working environment is appropriate to their needs. Staff who become disabled whilst in employment have access to these services and are also supported in moving posts with appropriate adjustments, should it become inappropriate for them to continue in their original post. The Trust utilises organisations such as Access to Work, Autism West Midlands, Guide Dogs, Action for Blindness, and Action for Hearing for specialist advice to enable disabled staff to continue working at the Trust where possible.

The Trust also ensures that staff with disabilities are able to access training opportunities. When booking on to training courses staff are asked if they have any special needs or requirements. If this is the case, arrangements are made. This includes the use of hearing loop facilities.

A number of courses are also provided which focus on equality and diversity issues, and this includes equality and diversity workshops, disability awareness training, equality impact assessment training, cultural awareness workshops, recruitment and selection and deaf awareness programmes. All new staff receive information on equality and diversity issues during their induction. In addition a facility is provided for staff who wish to improve upon their literacy and numeracy skills. Support can also be utilised via the Learning Hub at the Trust.

The Trust is committed to the 'Positive about Disabled People' initiative and was awarded the 'two ticks' symbol by Job Centre Plus which recognises employers as having appropriate approaches to people with disabilities. This requires employers to meet the following standards:

- To interview all applicants with a disability who meet the minimum criteria for a job vacancy and consider them on their abilities.
- 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.
- To make every effort when employees become disabled to make sure they stay in employment.
- To take action to ensure that all employees develop the appropriate level of disability awareness needed to make the commitments work.
- 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.

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

3.8 Social and Community Issues

The Learning Hub provides a range of employability-based programmes which includes both classroom and work-based placements providing potential applicants with a more in-depth knowledge and understanding of careers within the NHS.

Once registered with the Learning Hub, clients will complete a two-week in-house programme including practical job search techniques along with Healthcare specific topics such as infection control, information governance and customer service, which will be of benefit to clients applying for roles within the NHS. During their time at the Hub, the Trust completes a DBS and Occupational Health check at no cost to the client and, on receipt of satisfactory clearances, they will be offered a three-week work-based placement in a chosen area of interest. Whilst completing training at the Hub, the client will receive ongoing mentoring and job search support for a period of up to 26 weeks.

The Learning Hub has supported 140 people into work over the past 12 months (1 April 2016 – 31 March 2017), of which 55% were 18-29 year-olds; a further 30 clients are awaiting a start date. Combined outputs to date demonstrate that the Learning Hub has supported 2,370 clients into employment from when the Trust began offering its employability programme.

3.9 Reducing Disadvantage

A key priority for the Trust has been to broaden access to the jobs and training healthcare has to offer to unemployed people, particularly those living in the most disadvantaged parts of the city.

In January 2016, UHB signed a contract with Birmingham City Council until July 2018 to be a named delivery partner within a city-wide initiative funded by European Social Funds and Youth Employment Initiative called Youth Promise Plus (YPP). The city-wide project aims to support 16,000 Birmingham and Solihull young people (15-29 years) who are NEET (Not engaged in Employment, Education or Training including unemployed and economically inactive) of which the Healthcare Consortium has committed to assisting 850. The project will support participants, where appropriate, with pathways to sustainable employment, education and training outcomes. A wider healthcare consortium was formed including all Birmingham and Solihull NHS trusts and UHB assumed the lead role within this consortium. The Learning Hub has the responsibility for the co-ordination and delivery of employability-based programmes and work experience.

To date, the Learning Hub has registered 370 clients onto various employability programmes, including the Prince's Trust 'Get into Hospitals' national programme. Of the 370 clients registered to date, 103 have been given an offer or have started employment and the Hub continues to work with those who have not yet secured an outcome.

Through YPP, the Learning Hub has developed strong relationships with various organisations who work with disadvantaged groups. These include Trident Reach (working with the homeless), Core Assets (working with care leavers), Prospects, APM (Advanced Personnel Management) and The Pioneer Group (who both deliver outreach advice and guidance within areas of high disadvantage). In particular the Learning Hub is looking to host one of Trident Reach's 'Intervention Workers' within the Trust to link with its own Young Persons Service by offering mentoring support and making appropriate referrals to provisions that will help their transition from unemployment back into work or education. It is hoped that this service will be in place for May 2017.

Although emphasis in 2016 has mainly been targeted towards younger NEET clients, the Learning Hub is also working closely with Job Centre Plus in applying to become an approved provider on their new purchasing site. They, too, are looking for innovative programmes for their 'clients furthest away from work'. At the end of 2016, the Trust gained provider status and, in 2017, will be working with JCP (Jobcentre Plus) to begin uploading offers of support. This will be open to all age groups.

The Trust operates a food collection point, where members of staff, patients and visitors can donate food items to help those in real need. Staff can use this resource by giving vouchers to patients who are in need of support. Working with the Narthex Centre in Sparkhill (the local Trussell Trust food bank), the Trust has received 786.3kg of food in donations from members of staff, patients and visitors. This is equal

to roughly 1,709 meals for those in need. Over the reporting period (2016/17), more than 133 people, including 26 children, were provided with a three-day emergency food parcel.

In October 2015, the Trust launched a clothing bank and, from May 2016, this has enabled staff to 'draw down' clothes for patients who are assessed as being in need upon their discharge. This year, 79 patients were provided with emergency clothing donations that have helped to support their discharge from hospital, while 152 clothing parcels have been provided to those in need as a result of referrals by professionals at the Trust. In total, in 2016/17, 2,905.9kg – almost three tonnes of clothing – was donated by Trust staff and visitors. This is equivalent to 5,800 clothes parcels for those in need in local communities.

3.10 Increasing Prosperity

The Trust is part of Birmingham Health Partners, a strategic alliance between the NHS and University of Birmingham, which sits at the centre of a regional population of over five million people. Accelerating patient access to new, innovative medicines and technologies is at the heart of what the organisation does. Locally, the Trust has worked hard to ensure life sciences are integral to the strategy and priorities of the Birmingham and Solihull Local Enterprise Partnership. The Trust is a regional centre for the national 100,000 Genomes Project, which aims to improve the prediction and prevention of disease, enable more new and precise diagnostic tests and allow personalisation of drugs and other treatments to specific genetic variants.

UHB is host to the Wellcome Trust's most successful NIHR clinical research facility, the largest solid organ transplantation programme in Europe, a national Biomedical Research Centre, the largest specialist cancer trials unit, a national centre for trauma research, the highly successful Centre for Clinical Haematology and the Royal Centre for Defence Medicine.

Excellent academics and clinicians working together, along with a very large and diverse catchment area, give Birmingham and the broader West Midlands a comparative advantage in translational research, in particular clinical trialling.

Key outcomes of all of this have been the award by Government, under its City Deal initiative, of £12m, matched by local partners, for the establishment of the Institute of Translational Medicine (ITM) in the Heritage Building; and the designation by Birmingham City Council of the area centred on the Queen Elizabeth Hospital Birmingham and the University of Birmingham as a Life Sciences Campus – one of six high-growth Economic Zones across the city. The ITM opened in the summer of 2015, on time and on budget, while land for a new Birmingham Life Sciences Park was purchased in March 2017 and will be developed by the University and its NHS partners in the coming year. UHB is also partner in two highly innovative projects funded through the European Regional Development Fund which aim to generate NHS "challenges" and engage with small and medium-sized enterprises in the region to provide solutions.

The potential prosperity benefit of this activity and investment to Birmingham and the West Midlands is huge. The ITM is operating in a "virtual" capacity and already creating real benefits in terms of care, finance and jobs.

The land vacated by the former Selly Oak Hospital has been sold and is currently being developed to offer significant regeneration as a key strategic housing site.

3.11 Environmental Issues

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

The Trust recognises that the NHS is a major contributor to CO_2 emissions.

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

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

3.12 Energy

The performance of the QEHB from April 2016 to December 2016 (inclusive) is 55.2 GJ/100m^3, which is only marginally above the Department of Health energy efficiency target of 35–55GJ/100m^3 with the design target being 54.621 GJ/100m^3. Thus actual performance is only 1% above the design target.

The latest available comparison data is for the third quarter of 2016/17. This shows a 33% saving in energy in that quarter compared to the equivalent quarter in 2007/08 (the baseline for NHS sustainability measurement). Taking the current year as a whole, the cumulative saving so far is 25.3% against the baseline.

The installation of solar panels on various roofs of the Heritage Building (original QE Hospital) is generating more electricity than was forecast and a number of LED replacement lights have been fitted in the Heritage Building site. Other energy/carbon conservation projects are being evaluated and will be implemented if viable and funding is available.

There has been limited progress in the development of an energy savings campaign but it is hoped that some will be made in 2017/18.

3.13 The Trust's Carbon Footprint

Treasury and NHS carbon reduction guidance relates to direct and indirect energy (Scopes 1 and 2) and official business travel (Scope 3). For UHB, the emissions for Scope 1 and 2 (energy consumed) for 2016/17 is estimated to be 33,000 tonnes of CO_2 equivalent. The Trust has achieved the NHS target of 10% reduction in CO_2 emissions between 2007 and 2016 for Scopes 1 and 2, having achieved an estimated saving of 19%, primarily through site rationalisation and conversion of the boiler house to gas from coal.

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

Note that all of the above data relate to the QEHB/ Heritage Building site and exclude all off site premises.

3.14 Physical Environment

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

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

In recent years the Trust has developed in excess of 16,000m^2 of land on the site for food production or habitat enhancement and continues to make progress with its Community Orchards and Gardens project, with local community partner The Trust Conservation Volunteers (TCV).

TCV, with funding from Mondeléz International, have funded a community worker post to focus on six key areas of the Community Orchards and Gardens. These areas are: a wildflower meadow, woodland walk, bee colony, patient fish pond garden, food growing spaces and orchard of fruit trees.

The community worker has helped to deliver over 50 sessions of wildflower or vegetable planting and gardens' maintenance with groups of volunteers from the Trust's Learning Hub and University of Birmingham, local residents and corporate groups from organisations such as the Royal Bank of Scotland, Barclays and Wilmott Dixon.

Eight Dawn Chorus walks have been popular with local residents, staff and visitors to the Trust, with species such as peregrine, kestrel, song thrush and greenfinch spotted on site. Insect biodiversity has also been encouraged with the creation of 'bug houses' at events for the children of patients and visitors.

Since April 2016, more than 10 tree planting sessions have seen over 80 new fruit trees, including varieties of plum, apple, and damson, added to the orchard. Once these have matured, it is envisaged that fruit will be distributed free to staff and visitors and via food bank partners.

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

- **Fruit and vegetable stall**
  As part of its sustainability and health and wellbeing strategies, the Trust wanted to make available to staff, patients, visitors and the wider community, fresh competitively priced fruit and vegetables to give everyone healthier options both at work and at home. The Trust generates a small income from the stall which is re-invested into Trust-wide health and wellbeing programmes.

- **Farmers' Market**
  The Farmers' Market was started in November 2012 and trades twice a month. It has grown from eight stalls to more than 20. Key to the establishment of the market was the desire to provide staff, visitors, patients and local people with access to local produce as well as supporting local businesses. Many of the businesses are regulars at the region's farmers markets, but others are new to selling their produce. Two stalls are run by social enterprises, Frost and Snow assisting homeless people and Park Lane Nurseries supporting people with mental health needs. The social enterprise aspect is important to UHB to continue support for the local communities which it serves in alternative ways, not just through healthcare provision.

3.15 Procurement

The Trust's Procurement Strategy is being reviewed to reflect a focus on sustainability regarding SMEs and other encouraged enterprises. One of the key elements of the strategy is 'Working with our Suppliers' and sustainability sits comfortably under this heading. The Trust is working with suppliers to deliver excellence through continued sustainable practice within the procurement team.

Procurement Excellence workshops are being developed and sustainability will be incorporated into the training programme.

The Procurement Department represented the Trust at the Innovation Engine Project SME workshop, delivered to West Midland-based SMEs in October 2014, focusing on the relationships they can build with contracting authorities including UHB Procurement for Trust bespoke contracts and other procurement partners including NHS Supply Chain and Crown Commercial Services, all of which champion the encouragement of SMEs in their sustainability policies.

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

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

member of the Shelford Group, the Trust is constantly looking at collaborative and best practice procurement solutions, to combat the financial challenges facing the organisation, and NHS, now and in the future.

3.16 Waste Recycling

The Trust has in place a comprehensive and successful waste recycling programme that, for the period April 2016 to March 2017, yielded 689 tonnes of reusable material, an increase of 24.38 tonnes (3.6%) on the previous 12 month period. The recycling programme continues to grow across the Trust with other Trust locations now benefiting from this service through the strategic placement of recycling bins to capture and maximise the volume of recyclable material. The Trust continues to recycle other material such as scrap metal, office/confidential paper, clothing, electrical and white goods, batteries and cardboard.

The Trust has recently reviewed and updated all applicable educational information in relation to waste management and has launched a scheduled "Dump the Junk initiative", following previous successful initiatives.

3.17 Transport

The Trust employs some 9,000 staff and, last year, treated over one million patients, with an estimated two million visitors. Consequently, the QEHB site is a major generator of traffic from across the city and beyond. Encouraging sustainable transport modes, specifically through a comprehensive Green Travel Plan, is a key part of the Trust's Sustainability Strategy and Action Plan.

All the targets set out in the Travel Plan produced in 2005 were achieved by 2010. Over the past year, the Trust has consolidated its Green Travel Plan, aimed at encouraging a further switch away from car travel, by re-invigorating staff to travel sustainably and informing new staff of the travel package offers available to them. The strategy commits the Trust to developing incentives for staff to minimise car use, increase the use of sustainable transport modes and to continue to work with stakeholders to promote sustainable travel. One key aspect of this plan, the introduction of eligibility criteria for staff car parking, was recently implemented across the Trust and has led to a significant reduction in the number of staff cars permitted to access the Trust premises. Between 2003 and 2016, there has been a 25% reduction in the number of single occupancy car journeys, which has been complemented by a 11% increase in staff commuting by public transport and a 2% increase in staff cycling to work.

The Trust has also, in conjunction with the City Council, the University of Birmingham, Birmingham Women's NHS Foundation Trust and Birmingham and Solihull Mental Health NHS Foundation Trust, launched a Green Travel District (GTD) as part of Birmingham's medium-term transportation strategy 'Birmingham Connected'. This aims to promote and enable a vision where people are put before cars, where residents, workers and visitors can safely walk, cycle or take public transport, leading to less congestion, less pollution and healthier, safer, more productive communities.

Dame Julie Moore, Chief Executive
18 May 2017

Accountability report

1 Directors' report

1.1 Overview

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

1.2 Audit Information

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

1.3 Pensions

The accounting policy for pensions and other retirement benefits are set out in note 1.3 to the financial statements and details of senior employees' remuneration can be found in the Remuneration Report in Section 2, pages 56 and 57.

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

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

1.5 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.

1.6 Better Payment Practice Code

	Number	£000
Total bills paid in the year	131,657	439,370
Total bills paid within target	130,050	435,656
Percentage of bills paid within target	98.78%	99.15%

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.

1.7 The Late Payment of Commercial Debts (Interest) Act 1998

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

1.8 Management costs/political donations

Management costs, calculated in accordance with the Department of Health's definitions, are 4%. There were no donations made to any political parties during the financial year.

1.9 Names of persons who were Directors of the Trust during the reporting period

The Board is currently comprised as follows:

- Chair: Rt Hon Jacqui Smith
- Chief Executive: Dame Julie Moore
- Chief Financial Officer: Mike Sexton
- Executive Medical Director: Dr David Rosser
- Executive Director of Delivery: Tim Jones
- Executive Chief Nurse: Philip Norman
- Executive Director of Strategic Operations: Kevin Bolger
- Executive Chief Operating Officer: Cherry West

Non-Executive Directors:

- David Hamlett
- Angela Maxwell
- David Waller
- Professor Michael Sheppard (resigned on 31/07/16)
- Jane Garvey
- Harry Reilly
- Catriona McMahon
- Jason Wouhra

1.10 Patient Care

1.10.1 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, which includes Trust Governors within its membership.

A number of patient-focused initiatives were developed during the year in response to feedback from patients and carers (many of whom are members of the Trust) – including planning a move to more flexible visiting times, which come into effect on 1 April 2017, following consultation with patients and staff.

During the year, the Trust has continued to monitor feedback via a variety of different methods, including patient advice and liaison contacts (PALS), complaints, compliments, friends and family test, and local and national surveys to drive service improvement. Ward-based feedback is well established at the point of care

via an electronic bedside survey. These surveys have assisted the Trust in benchmarking the success of its patient improvement measures against the results of the National Patient Survey. A ward-level dashboard is also in place allowing staff to see their own patient experience results and then act on any issues.

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

Trust Governors are encouraged to contribute to gaining patient feedback by participating in inpatient and outpatient Governor 'drop ins' and by becoming members of the Patient and Carer Councils.

All volunteers, Patient and Carer Council members and members of staff are members of the Foundation Trust and play a vital part in helping the Trust to shape its services and make improvements for patients.

More information on how the Trust involves its members can be found in the Membership section of this report.

1.10.2 Infection prevention and control

The Trust continues to have a robust Infection Prevention and Control programme in place and, whilst significant improvements have been made, challenges have been seen over the last year, especially in relation to *Clostridium Difficile* Infection (CDI), where the Trust will end the financial year above the agreed trajectory. Microbiology colleagues have been tracking the national CDI trend and, for the first time in recent years, this is increasing across the region. In relation to *Methicillin Resistant Staphylococcus Aureus* (MRSA) and other infections, improvements continue to be seen.

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

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

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

During 2016/17, the Trust has focused on patients 'feeling well looked after', as survey results show that patients deem this to be a very important aspect for them in reporting a good experience of their hospital stay. Feedback has, overall, been very positive when patients are asked this question and, by probing into what patients mean when they give positive or negative feedback relating to this, the Trust has been able to build further intelligence around what needs to happen to make patients feel well looked after. Unsurprisingly, it is the little, but important, things that are often easy to achieve, for example, taking time to talk to patients, or making them more comfortable, asking if they have any concerns, or if there is anything they need.

This work has also helped to validate the important role that ancillary staff play in the patient experience: housekeepers, porters and domestic assistants all contribute to the overall experience of patients and, by training and engaging with them, these groups of staff are being helped to understand the impact of their interactions. There is scope for more to be explored and actioned around this.

The Trust has made progress in understanding more about when and how patients are given conflicting information. By probing further, though face-to-face feedback, it has been able to establish more of the interactions when this happens, and also some of the ward processes, for example staff handovers and ward rounds, that can contribute to this. By sharing this information and mirroring pockets of good practice, it is hoped to see further improvements in this aspect of experience.

Discharge management continues to be a high priority for the Trust, with a number of further changes implemented to make the process more efficient and to further improve the patient experience. The Discharge Pharmacy continues to support more timely discharge and improve the patient experience. Allowing patients to collect medication on their way out of hospital empowers patients and enables them to increase their involvement in the discharge process. It also helps to reduce unnecessary delays on the wards, whilst also facilitating appropriate education and advice at the point of medication being dispensed.

The Discharge Lounge (which was re-launched following its successful relocation into the Heritage Building) provides a quiet, comfortable environment for patients to await discharge, freeing up ward beds and supporting effective capacity management. A clinical pharmacy technician based in the Discharge Lounge supports patient counselling on medicines and provides additional patient educational support. An additional bonus is a pick-up point right outside the entrance to the lounge. Further work has been undertaken to promote the benefits of the Discharge Lounge to both staff and patients/carers. This has resulted in an increased use of the facility and has enabled the lounge to improve its reputation as a positive element of the patient journey and an efficient part of the discharge process. Feedback about the lounge from patients and carers is very positive overall.

With some patient feedback citing delays in obtaining a clinic appointment, and also delays on the day of appointment in outpatient clinics, the work streams set up to look at the whole outpatient experience have made progress in a number of areas. The signage review and replacement of temporary signs is nearing completion, as part of this some further improvements have been made to areas with signs that were being reported through feedback as confusing or inappropriately positioned. Negative feedback regarding

signage has reduced through the variety of feedback mechanisms used by patients/visitors. As part of an audit of individual outpatient specialties, the outpatient team are obtaining some targeted patient experience feedback from specific clinics alongside a review of capacity management. This will greatly assist the teams in identifying where to target their actions to improve, not only the flow, but the experience for patients using their services.

Visiting times have been reviewed and a new, more flexible approach to visiting is currently being implemented. Patients and staff were consulted about what they thought would work well and the changes reflect this, so are expected to be embedded successfully. This will be revisited to ensure optimum patient and staff experience.

During 2016/17 the Trust has replaced its stock of overnight guest beds with beds that are more robust, comfortable and easy to clean in line with infection prevention and control guidelines. All wards have at least one guest bed, with areas who have more carers staying being given the option to have two or more to meet their needs. Early feedback suggests that the beds are providing enhanced comfort for those using them and staff are finding it easier to provide a bed when one is needed. The Friends of the Queen Elizabeth Medical Centre and Queen Elizabeth Hospital Birmingham Charity are thanked for their support in providing these beds.

Following patient feedback, the Trust has also implemented complimentary Wi-Fi access to the internet for patients and visitors (kindly provided by Queen Elizabeth Hospital Birmingham Charity). This has had such a positive impact, as it means that patients are able to keep up with life outside hospital, keeping in touch with family and friends, conduct any matters they need to via email (reducing stress and anxiety) and also keep themselves entertained, which increases their emotional wellbeing. It has been mentioned by numerous patients and visitors as a significant facility to be introduced.

1.11 Public and Patient Involvement

1.11.1 Patient and Carer Councils

The Trust has three Patient and Carer Councils: one for wards (inpatients), one for outpatients and a Young Persons' Council.

The purpose of the councils is for patients and the public to work in partnership with staff to further improve the services provided to patients. All council members are also Foundation Trust members. All of the councils have been active in seeking patients' views to influence the improvements in care. There are currently 54 patient and public representatives on the councils. All Patient and Carer Council members undergo the volunteer recruitment process and induction enabling them to safely undertake visits.

The wards and outpatients councils have continued to use the 'Adopt-a-Ward or Department' scheme to facilitate partnership working with staff to provide a patient perspective to improving the experience of patients and their relatives. During 2016/17, a total of 137 visits were undertaken by members of the wards and outpatients councils. Following their visits, feedback is given to the ward or department to enable action to be taken where necessary.

Council members continue to be given the opportunity to sit on Trust groups where public representation is required and to participate in annual Patient Led Assessment of the Care Environment (PLACE) assessments.

During the year, the Patient and Carer Councils have been successful in receiving grants from The Friends of the Queen Elizabeth Medical Centre to provide televisions for patients on Bournville Ward, remote controls for use on Edgbaston Ward and remote controls, headphones and two replacement televisions for West 2 in the Heritage Building (original Queen Elizabeth Hospital).

1.11.2 Young Persons' Council

The Young Persons' Council (YPC) looks at ways to further improve the experience for young people aged 16–24 years in, and those transitioning to, the hospital and is involved in visits to wards and departments to ask patients and staff for their views.

During 2016/17, the Young Persons' Council has seen an increase in the number and range of young people attending the council.

Following a team building orienteering day in October 2016, Young Persons' Council members participated in a planning session and developed a programme of events for 2017, including: mandatory training required to equip them to visit the wards and interact with people in hospital, regular speakers and a work plan for the year covering fundraising, young person web pages, developing Saturday Socials and surveys to gain feedback from 16–24 year olds using the Trust's services.

Saturday Socials is a scheme being developed by the Young Persons' Council members following a successful pilot of the scheme previously named the Buddy Scheme. The pilot tested peer visiting with young people and evaluated this via a survey. The scheme evaluated well and will now be developed into a regular programme with a change of name following feedback from patients.

1.11.3 Readership Panel

This group provides a forum for involving patients and the public in reviewing and influencing the way in which patient information is provided. This ensures that information within the Trust is produced in a way that is useful to patients, carers and the public.

This year the group has provided a patient perspective on 79 leaflets.

1.11.4 Healthwatch Birmingham

The Trust maintains links with Healthwatch Birmingham and has worked with them during the year to further develop their self-assessment tool: Quality Standard for Acute Hospital Providers 'Using Patient and Public Insight, Experience and Involvement to Reduce Health Inequality and to Drive Improvements in Health Outcomes'.

1.11.5 Patient and Carer Consultations

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

- myhealth@QEHB
- Constitution for Patient and Carer Councils
- Healthcare Evaluation Data (HED) – Your Right to Choose
- Trust performance against key national standards, for example cancer standards and four-hour emergency care standard
- Trust Annual Plan
- Trust Quality Priorities
- Volunteer Strategy
- The Nursing Associate role
- A Pets in Hospital scheme (task and finish group)
- University of Birmingham – understanding why medical students are reluctant to become General Practitioners
- Non-emergency patient transport new contract
- Visiting times
- Patient letters and maps
- Inpatient survey questions (Patient Experience Group)
- Internal buggy/wheelchairs scope (task and finish group)

1.11.6 Equality Delivery System

Members of the Patient and Carer Councils met to discuss the Trust's approach to equality at a meeting chaired by the Deputy Director of Partnerships. Members were asked for their feedback in regards to the 'RAG' (red/amber/green) rating in the EDS2 (equality delivery system) document and whether the Trust was excelling, achieving, developing, or was undeveloped in the outcomes below:

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

1.11.7 Volunteers from the local community

Currently, the Trust has around 500 highly-valued active volunteers who continue to provide an enhanced and quality experience for patients and terrific support to staff. People who are representative of the local community that the Trust provides a service to are encouraged to volunteer. A particular effort has been made to recruit volunteers from the under-25 age group to support the younger patients within the hospital.

The demographic profile of volunteers as at 31 March 2017 is:

	2016/17	2015/16	2014/15
GENDER			
Male	35.4%	37%	35%
Female	64.6%	63%	65%
AGE			
16 years old	1.2%	0.2%	—
18–30 years old	10.6%	12.9%	20%
31–50 years old	12.5%	14.5%	17%
51–65 years old	31.6%	42%	37%
66–74 years old	27.8%	23.7%	21%
75+ years old	15.3%	7.5%	6%
ETHNICITY			
White British	73%	74%	69%
Other white	1.6%	2.5%	—
Black/mixed	6.2%	9.5%	8%
Asian/mixed	15.8%	14.5%	18%
Other/undisclosed	2.2%	2.9%	4%
EMPLOYMENT *			
Employed	22.4%	20.4%	21%
Unemployed	9.0 %	9.8%	10%
Students	8.8%	10.4%	16%
Retired	52.2%	54%	46%
Other/undisclosed	9.2%	7.5%	7%

*Some volunteers are employed part time and are students or carers, hence total more than 100%

In March 2016, a volunteer strategy event was held, attended by around 40 volunteers. Views were sought around ways to further improve volunteering at the Trust, including supporting volunteers and any barriers experienced.

The Volunteers Group, chaired by a Trust Governor, continues to formally involve volunteers in the development of voluntary services within the Trust and participate in developing the Trust's volunteering strategy. The group continues to meet regularly to discuss volunteer recruitment, new volunteer roles and suggestions for celebrating volunteering.

In 2016/17, the group has also been involved in the development of a three year volunteer strategy. Working from the feedback gained at the aforementioned event held in March 2016, group members helped to identify

the Trust's volunteering strengths and weaknesses and provided suggestions and ideas for development of the service. From this, a three year action plan for the strategy has been developed.

The Voluntary Services risk register is now reported to the group quarterly, starting with Quarter 4 for 2016/17.

It has continued to be a busy year for reviewing and developing volunteering at the Trust and there are a number of new and ongoing projects in progress. The conclusion of the task and finish group set up to look at the feasibility of introducing an internal mobility scooter service to complement the service currently offered by the external car park buggy, was that this was not a practical option due to health and safety issues and limitations to the route. The plan for 2017/18 is to re-focus this group to assess the current wheelchair provision for patients and visitors and to identify how volunteers might enhance both the outpatient experience of patients and provide help for visitors who have mobility issues trying to visit on wards and departments. The Trust continues to receive feedback from patients regarding the distance patients and visitors have to walk once they are inside the hospital building, so it is striving for a suitable solution to make this easier for those visiting the site.

Following pilots of the Young Person's Buddy Scheme (now Saturday Socials) and Dining Companions, both of these projects are under development to be re-launched in 2017/18.

A pilot student volunteer programme is underway with Harborne Academy. Six health and social care students aged between 16 and 18 years of age are participating each Wednesday afternoon as part of the Trust's assessment of reducing its volunteering minimum age from 18 to 16.

In 2016, the Dignity Team asked if any volunteers could help knit 'Twiddlemuffs', a sensory aid for patients with dementia. A request was sent out via the newsletter for any knitters who could help, and by supplying a pattern, there is now a steady supply of Twiddlemuffs to be distributed to patients. The Friends of Queen Elizabeth Hospital have kindly donated monies to purchase some wool to ensure a sustained supply of Twiddlemuffs as they are single patient use. A request for beanie hats has now come in for patients who feel cold and sit under blankets, to aid their dignity and improve their experience.

The Voluntary Services Department has undertaken a project to recheck the Disclosure and Barring Status (DBS) of all volunteers at the Trust whose DBS was completed more than three years ago; and then to maintain this three-yearly check. The department continues to ensure all volunteers are also up to date with the Trust mandatory training requirements

The department has undertaken a review of processes to continually improve how volunteers are recruited, developed and managed. In 2016/17, there has been a significant reduction in the number of volunteers leaving, particularly after a short period of time. Voluntary Services introduced a welfare follow-up contact at six weeks post placement and again at 12 weeks if required. The follow up is undertaken by a Trust volunteer to enable volunteers to feed back, with any issues that need to be resolved discussed with Voluntary Services staff. The department has received very positive feedback regarding this initiative and this is supported by retention of volunteers.

This year has also seen the introduction of a formalised process relating to volunteers who have become too frail, ill or lack capacity to continue with their volunteering activities. Whilst an individual may no longer be able to continue with active volunteer duties, they are still invited to social events and can contribute in a non-physical way, for example, on the readership panel. There are now five volunteers who are classed as veterans and who are delighted to be invited to the social events and receive the volunteer newsletter.

Voluntary Services at the Trust continue to participate at a national level, including requests to provide speakers at events, being cited as a case study for the National Council for Voluntary Organisations young person volunteer's toolkit for the young persons' buddy scheme, and recommendations from the Department of Health as a Trust to contact for good practice. The National Conference held in Birmingham in September 2016 was again organised by the Voluntary Services Manager. As part of the Shelford Group network of acute hospitals for Voluntary Services, quarterly telephone conferences are undertaken to discuss various topics, issues and as an information exchange and knowledge share for best practice volunteering.

As a thank you to volunteers, the service runs regular afternoon tea events, where volunteers can come together socially and listen to an interesting speaker. An annual long-service awards event also helps show volunteers how much they are valued.

1.12 Complaints and Compliments

The Trust welcomes patients and families contacting it whenever they have any concerns about services, to help us continuously improve. The number of complaints received in 2016/17 was 779, which represents a 14% increase on the total number of complaints received in the previous year. This is in the context of an increase in patient activity during this time.

The complaints team liaise closely with key divisional colleagues to ensure that complaints are investigated and responded to in a timely manner to the satisfaction of the complainant. Senior divisional management 'triaging' of complaints is used effectively to secure an early resolution of complaints wherever appropriate, for example, issues around appointments can often be resolved quickly via a telephone call. Where a complaint requires a full investigation, the complaints team make early contact with the complainant, wherever possible, to agree the issues to be investigated, the preferred method of response and a realistic timescale for responding. Over the last year the Trust has improved the process of keeping in regular contact to ensure the complainant is kept updated with progress.

The Trust has consistently replied to complaints within 30 working days for around 80% of cases.

Weekly reports provided to the Executive Chief Nurse and senior divisional management teams have been developed further during the year to improve the intelligence provided to the senior nursing teams. Particular focus has been paid to cases which have taken slightly longer to resolve, so that robust management plans are developed to assist in the Trust's aim of keeping to an absolute minimum any complaints taking longer than three months to investigate and respond to.

Alongside these reports, a summary of Patient Advice and Liaison Service (PALS) activity for the previous week is also provided, together with the number and details of cases outstanding, so that, again, divisional management teams can provide support in expediting these responses.

A report has been produced following the most recent survey of complainants, which has helped to identify ways to further improve the service. An action plan is being developed to crystallise the necessary actions.

The Trust takes a number of steps to ensure that it learns from complaints. Agreed actions from individual complaints are shared with the complainant in the Trust's written response or at the local resolution meeting. Following its introduction last year, the Trust has continued to record and track actions from complaints via Datix (the complaints database). These actions are reported to divisional management teams at their regular clinical quality group meetings. Additionally, a 'Learning and Sharing' document is now shared quarterly via the Chief Executive's Team Brief, highlighting learning from feedback that can be replicated across the Trust.

Themes and trends from both complaints and Patient Advice and Liaison Service (PALS) concerns continue to be shared via reporting at both divisional and Trust-wide levels. Reports are provided to the Chief Executive's Advisory Group, the Executive Chief Nurse's Care Quality Group, Clinical Commissioning Group, Divisional Clinical Quality Groups to name but a few. The Head of Patient Relations also meets regularly with key senior staff around the Trust, including Matrons and Associate Directors of Nursing, to identify specific areas of concern, themes and trends, as well as highlighting positive feedback and good practice.

Whilst the Trust makes every effort to resolve complaints to the satisfaction of the complainant, for a variety of reasons this may not always be possible. Complainants are informed of the option of approaching the Parliamentary and Health Service Ombudsman to assess their complaint independently. Whilst, nationally, the Ombudsman investigates significantly more complaints than it did prior to the publication of the Francis Report, complaints about this Trust reviewed by the Ombudsman remain relatively low. In 2016/17, the Ombudsman upheld or partly upheld 13 complaints, the same as the previous year.

The Head of Patient Relations meets regularly with his counterparts from the Shelford Group of leading acute trusts, as well as those from the West Midlands' health economy, sharing good practice and ideas, as well as discussing mutual challenges and how they can be overcome.

The complaints team work very closely with their colleagues in the Patient Advice and Liaison Service (PALS), both teams collectively forming the Patient Relations Department. A single point of access number is available for Patient Relations, providing a seamless service to ensure that patients or their relatives can get the right help without needing to know whether they need to contact PALS or Complaints. This new 'hub' service has been working well during the year.

Positive feedback is also important in highlighting success and providing opportunities to replicate successful initiatives wherever possible. The Trust consistently receives considerably more compliments than it does complaints. In 2016/17, the Trust formally recorded receipt of 2,286 compliments, compared to the 779 complaints received.

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

During 2016/17, the Trust has worked closely with colleagues in Heart of England complaints and PALS teams to share good practice.

1.13 Research and Development

The Institute of Translational Medicine (ITM) opened to schedule in July 2015 and was officially opened in October 2016. The ITM delivers:

a. A single point of entry for commercial, pharmaceutical and technology sectors into the Trust and the University (through Birmingham Health Partners) for new ventures, from inception to a proof-of-concept testing pathway.
b. Consolidation of research support services including assistance with research grant applications and provision of guidance in technology commercialisation.
c. Increases in translational research with a view to direct improvements in patient outcomes; saving lives and improving quality of life. This will be quantifiable through increased patient activity, clinical trial activity and the associated income.
d. Increased income for commercial, private sector and research activity, along with new opportunities for clinical trials.
e. An enhanced profile for the Trust and University as a centre of excellence in life sciences and translational research.

Current ITM occupants key to this delivery include the Commercial Hub and Research and Development team. Device specialists include NIHR Health Care Technology. Research specialty groups resident in the ITM include audiology, skin and peripheral nerve, respiratory, cardiology, intensive care, liver, renal and cancer. Clinical academic research groups are forming faculties linked to the key ITM themes and hold many of their faculty and research meetings in the ITM. Delivery of the BHP Education programmes embedded within the ITM and linked to multi-disciplinary research include the Clinical Academic Internship Programme, PhD bridging programme, ITM Research Fellowship and the NHSE West Midlands Genomic Medicine Centre Education and Training programme.

The ITM's ground floor café and conference meeting rooms host various clinical/academic events including business engagement forums, collaborative, research set-up and seminar series, plus training days.

The Trust continues to engage with external bodies to leverage additional benefit associated with the ITM through collaborations and new funding for research and innovation infrastructure growth.

One such collaboration is with the Cobalt Health Charity, which has invested £2m in the ITM Imaging Centre, a new state-of-the-art Magnetic Resonance Imaging (MRI) research facility which opened to patients in December 2016. The centre will support a broad range of research for many specialties, including cardiac, liver, oncology and neurosurgery.

The Centre for Rare Diseases, co-located with the ITM, opened to patients in September 2015 and was officially opened on Rare Disease Day in February 2017. This centre is representative of UHB's intent to contribute to the delivery of the DH's strategy for rare disease and brings together multi-disciplinary and multi-specialty clinics to provide co-ordinated clinical care and increase access to research for patients with rare diseases.

The centre is benefiting hundreds of patients with the numbers attending growing year on year – from just over 2,000 in the first six months of the centre being open (Sept 15–Mar 16) to around 6,000 attendances this year (2016/17). There are now 69 rare disease specialties based within the Centre for Rare Diseases. In addition, there are three research clinics up and running, with plans for more imminently.

Since 2015, the Trust has led the largest Genomic Medicine Centre in the UK under the national 100,000 Genomes Project, bringing together 18 NHS trusts with linked data platforms and patient sample pathways. The West Midlands Regional Genomics Laboratory is the largest NHS service in the country, receiving more than 50,000 samples per year and training more clinical scientists, bio-informaticians and genetic technologists than any other NHS centre. The WM GMC co-leads for the cross-cutting national paediatrics Genomics England Clinical Interpretation Partnership for genomics in rare diseases and cancer. The Trust's experts have pioneered the portable surveillance systems for pathogen genomics internationally, tracking the Ebola and Zika epidemics, now being used in national hospital settings.

The Scar Free Foundation Centre for Burns Research, based at the QEHB, has established a fully integrated research infrastructure as evidenced by the success of the Scientific Investigation of the Biological Pathways Following Thermal Injury in Adults and Children (SIFTI) study, which completed in December 2016.

As well as improving understanding of how the body responds to burn injury in adults and children, the £6 million research centre also carries out translational clinical research to develop new treatments. The centre is supported by Vocational Training Charitable Trust (VTCT) and funded for five years with £1.5m investment from the Healing Foundation and funds from partner organisations of £4.5m.

During the past year, colleagues from the NIHR Surgical Reconstruction and Microbiology Research Centre (SRMRC) have undertaken a number of new trails and had research findings published. Highlights include:

- A Surgihoney trial which showed that specially engineered honey can combat bacterial biofilms found in chronically infected wounds and burns. The study found that, in laboratory conditions, Surgihoney prevented biofilm for 16 bacteria tested, both Gram-positive and Gram-negative, including several major antibiotic resistant strains such as MRSA, Ecoli and *Pseudomonas aeruginosa*.

- A study which showed that blue light could be an effective weapon to combat healthcare acquired infections (HAI). Laboratory tests on 34 different bugs which have been implicated in hospital infections showed that all could be killed or dramatically reduced by exposure to blue light for as little as 15-30 minutes.

- A £2.3 million world-first research project launched in August 2016 will look at whether contact lens wearers who contract a potentially blinding infection called microbial keratitis could have their sight saved with the development of a revolutionary new eye drop.

- A first full-scale trial in the world (MICROSHOCK) of a device that could save the lives of patients with serious injuries has begun in the Emergency Department at the QEHB. It is hoped that studying the circulation of blood in the smallest vessels (the microcirculation) may help guide the treatment of patients who are critically ill.

- A ground-breaking new study to investigate the effectiveness of giving patients blood products immediately after a major injury or trauma – before they reach hospital. Researchers hope to provide solid evidence one way or the other with the RePHILL (REsuscitation with Pre-HospItaL bLood products) multi-centre randomised controlled trial (RCT).

- The CONNECT (COnduit Nerve approximation versus Neurorrhaphy Evaluation of Clinical outcome Trial) study will evaluate the benefits of using "tensionless repair" to improve the quality of nerve regeneration in injured patients.

- Trauma research nurses at the QEHB are recruiting patients into a new trial which aims to improve the outcomes of those with respiratory failure. The pRotective vEntilation with veno-venouS lung assisT in respiratory failure (REST) trial is investigating whether removing carbon dioxide from blood outside of the body can reduce the burden of mechanical ventilation during treatment.

1.13.1 Funding

The Trust, in collaboration with the University of Birmingham, was awarded a £30.6m boost for a five-year research project into patient care. The funds comprise a £10 million investment from the National Institute for Health Research (NIHR), which will be complemented by £20.6m match-funding from local health and social services, to continue evaluating and developing healthcare until December 2018.

The funding is managed by the Collaboration for Leadership in Applied Health Research and Care for West Midlands (CLAHRC-WM), an innovative partnership hosted by UHB. CLARHC-WM has organised themes of research around:

- Child and Maternity Health.
- Youth Mental Health.
- Prevention and Detection of Disease.
- Chronic Diseases.
- Implementation and Organisational Studies.
- Research Methods.

In September 2016, UHB was designated as an NHS Global Digital Exemplar by NHSE, with the opportunity to receive up to £10m to invest in digital infrastructure and specialist training. Over the past 20 years, the Trust has developed one of the most sophisticated health informatics capabilities in the world, the only secondary care informatics system created and controlled by the NHS. This includes the pioneering and award-winning portal, myhealth@QEHB, which allows patients to access their own health records. The Trust created the informatics platforms for the national 100,000 Genomes Project, used not only across the region but across the UK by organisations such as Great Ormond Street, and has created innovative ways to link new data such as radiological images. This GDE route to funding will allow the Trust to further develop its informatics expertise for the wider benefit of the NHS.

In the past financial year the Trust, as part of BHP, has secured:

- £12 million to establish a new NIHR Biomedical Research Centre in Inflammatory Diseases.
- £12.8 million NIHR renewal of the Birmingham Clinical Research Facility (CRF).
- £5 million for a new Cancer Research UK Birmingham Centre.
- £2 million Experimental Cancer Medicine Centre (ECMC).

1.13.2 Public Engagement

The Trust's successful annual Research Showcase in May 2016 allowed members of the public, patients and staff to see how their involvement in research can make a real difference to the healthcare of future generations.

There were more than 25 presentation stands on the day. Patients and healthy members of the public were able to find out how they can get involved in research which offers cutting-edge treatments or expands understanding of how the human body works.

The NIHR Surgical Reconstruction and Microbiology Research Centre (SRMRC) Public and Patient Involvement (PPI) Group continues to meet on a quarterly basis when they are kept up to date about research and offer valuable suggestions and feedback. Group members support the Research Showcase and have also been interviewed about their experiences by Sinead Rushe, a London-based theatre producer, to help inform performers for her October 2016 production, Loaded, which focused on how the body deals with physical and emotional stresses and loads.

A number of SRMRC research projects have attracted high-profile media coverage, locally and nationally, including researchers investigating the effects of repetitive concussion in sport who are regularly interviewed about the subject, and most recently featured in a BBC Inside Out programme broadcast in March 2017.

1.13.3 Clinical Trials

The Trust's extensive and innovative Research and Development portfolio enables it to have access to new medicines earlier as part of clinical trials which can provide hope for patients for whom conventional treatments might have failed. During 2016/17, UHB has been able to deliver benefits to patients on clinical trials including reduced symptoms, improved survival times and improved quality of life. The total number of patients recruited into all studies open during 2016/17 was 8,493 (based on returns from annual reports). The number of new studies registered with the R&D Governance Office during 2016/17 was 258. Of these, processing was abandoned for 115 studies.

The table below shows the number of clinical research projects registered with the Trust's Research and Development (R&D) Team during 2016/17, 2015/16 and 2014/15. The number of studies which were abandoned is also shown for completeness. The main reason for studies being abandoned is that not enough patients were recruited due to the study criteria or patients choosing not to get involved.

Reporting Period	2014/15	2015/16	2016/17
Total number of projects registered with R&D	307	356	268
Out of the total number of projects registered, the number of studies which were abandoned	56	70	115
Trust total patient recruitment	**11,400**	**5,051**	**7,558***

*numbers only to January 2017 as it takes two to three months for UKCRN to upload UKCRN patient recruitment numbers

1.14 Enhanced quality governance reporting

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

Comprehensive use of electronic decision-support and monitoring tools enables the Trust to monitor compliance with essential clinical protocols and to identify potential risk areas at an early stage. Additional

investigations and audits can be undertaken following such triggers. The effectiveness of this monitoring system is backed up by regular unannounced governance inspections by board members and work is ongoing to ensure appropriate engagement with other relevant stakeholders.

The Board of Directors approved the Monitor Quarterly Governance Declaration until the introduction of the new Single Oversight Framework in October 2016, when NHS Improvement no longer required it to be submitted. Additional information regarding quality governance and quality is set out in the Quality Report in Section 3 and the Annual Governance Statement in Section 4.

2 Governance

2.1 NHS Foundation Trust Code of Governance

University Hospitals Birmingham NHS Foundation Trust (the Trust) has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance (the Code), most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issues in 2012 and was last updated in 2016.

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 2016/17. In its Annual Report, the Trust is required to report on how it applies the Code. Whilst foundation trusts must always adhere to the main and supporting principles of the Code, they are allowed to deviate from the Code provisions provided the reasons for any such departure are explained and the alternative arrangements reflect the main 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.
- The Corporate Governance Policy, incorporating the Schedule Of Reserved Matters and Role Of Officers.
- The Chief Executive's Scheme Of Delegation.
- The Annual Plan.
- Committee Structure.

2.1.1 Application of Principles of the Code

A. **The Board of Directors**

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

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

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

The Board of Directors remains accountable for all of its functions; even those delegated to the Chair, individual directors or officers, and therefore it expects to receive information about the exercise of delegated functions to enable it to maintain a monitoring role. As members of a unitary board, non-executive directors are in the same way responsible and accountable as the executive directors.

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

Details of the composition of the Board of Directors and the experience of individual Directors are set out in Board of Directors, page 34 of the Annual Report, together with information about the Committees of the Board, their membership and attendance by individual directors.

B. **The Council of Governors**

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

The Council of Governors appoints and determines the remuneration and terms of office of the Chair and Non-Executive Directors and the external auditors. The Council of Governors approves any appointment of a

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

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

Details of the composition of the Council of Governors are set out on page 32 of the Annual Report, together with information about the activities of the Council of Governors and its committees.

C. **Appointments and terms of office**

The balance, completeness and appropriateness of the membership of the Board of Directors was reviewed during the year by the Executive Appointments and Remuneration Committee.

Details of the composition of the Executive Appointments and Remuneration Committee and its activities are set out on page 41 of the Annual Report. Details of terms of office of the Directors are set out in Board of Directors, page 34, of the Annual Report and in the Remuneration Report in Section 2.

D. **Information, development and evaluation**

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

The Chair ensures all directors and governors receive a full and tailored induction on joining the Trust and their skills and knowledge are regularly updated and refreshed through seminars and individual development opportunities.

Both the Board of Directors and the Council of Governors regularly review their performance and that of their committees and, in the case of the Board of Directors, the individual members. Appraisals for all Executive and Non-Executive Directors (including the Chair) have been undertaken and the outcomes of these have been reported to the Council of Governors or the Executive Appointments and Remuneration Committee, as appropriate. The Board of Directors and the Audit Committee have each evaluated their own performance, using a bespoke 'Maturity Matrix'.

E. **Director Remuneration**

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

F. **Accountability and Audit**

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

The Audit Committee is responsible for the relationship with the Trust's auditors, and its duties include providing an independent and objective review of the Trust's systems of internal control, including financial systems, financial information, governance arrangements, approach to risk management and compliance with legislation and other regulatory requirements, monitoring the integrity of the financial statements of the Trust and reviewing the probity of all Trust communications relating to these systems. The Audit Committee receives instructions from the Board of Directors as to any areas where additional assurance is required and formally reports to the Board of Directors on how it has discharged its duty.

Deloitte LLP was appointed by the Council of Governors as the Trust's External Auditor with effect from 1 January 2014. In July 2016, the Council of Governors re-confirmed their appointment for the audit of the accounts for the financial year ending on 31 March 2017.

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

Additional information regarding audit is set out in the Audit Committee Report on page 39.

G. **Relations with Stakeholders**

The Board of Directors recognises the importance of effective communication with a wide range of stakeholders, including Birmingham City Council's Health, Wellbeing and the Environment Overview and Scrutiny Committee, whose members make occasional visits to the Trust.

2.1.2 Compliance with the Code

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

B6.2 Evaluation of the boards of NHS FTs should be externally facilitated at least every three years. The evaluation needs to be carried out against the board leadership and governance framework set out by Monitor. The external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.

The Trust has not carried out an externally facilitated evaluation of the board against the "Well-led framework for governance reviews" this year, for the following reasons:

1. The involvement of the Chair, Chief Executive and a number of other officers of the Trust in the intervention at HEFT and the demands this places upon the team; and
2. The Trust is working up a business case for a merger with/acquisition of HEFT – this will result in new board and governance structures and processes and it is considered that expenditure on an external review would be better spent following or in support of any such transaction.

B.7.1 Non-Executive Directors may in exceptional circumstances serve longer than six years (e.g. two three-year terms following authorisation of the NHS foundation trust), but subject to annual re-appointment.

Any re-appointment of a Non-Executive Director (NED) for a term exceeding 6 years is subject to a rigorous review of the balance and effectiveness of the board and the individual's competencies. In 2013, Professor Michael Sheppard was re-appointed for a further three years, subject to annual re-appointment, taking his tenure of service up to eight years. The need to re-fresh the Board was balanced against the need to provide a degree of continuity given that the then Chair and two other Non-Executive Directors were also retiring at that time. The Council of Governors considered that these exceptional circumstances warranted the further re-appointment of Professor Sheppard. Professor Sheppard resigned on 1 July 2016 as a result of being appointed as Non-Executive Director at Heart of England NHS Foundation Trust.

In June 2015, Ms Angela Maxwell's second three-year term of office expired. It was felt that her entrepreneurial and commercial experience had been a major factor in the development of the Investment Committee and the wider commercial agenda of the Trust. Her extensive range of contacts with external bodies, her clear understanding of the Trust's culture and background and general experience as a NED were also considered invaluable in the context of the Trust's buddying arrangements with other trusts and the Trust's future development. These factors and given the time it takes to recruit a new NED were considered sufficient to warrant her re-appointment for a further term of 3 years, subject to annual re-appointment.

D.2.3 The Council of Governors should consult external professional advisers to market-test the remuneration levels of the Chairman and other Non-Executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.

The Council of Governors have not appointed external professional advisors to market-test the remuneration levels of the Chair and other Non-Executive Directors. A material change to the remuneration of the Non-Executive Directors was last considered in 2009/10, when the proposed increases in remuneration were benchmarked against other similar trusts through a remuneration survey carried out by the Foundation Trust Network. For 2014/15 and 2015/16, the Non-Executive Directors did not receive any increase in remuneration, in line with the majority of NHS staff. In 2016/17, the Non-Executive Directors received a 1% inflationary increase, again in line with the majority of NHS staff.

3 Council of Governors

3.1 Overview

The Trust's Council of Governors continues to make a significant contribution to the success of the Trust and its commitment, support and energy is greatly valued. The Council was established in July 2004, with 37 representatives, and currently has 23 representatives.

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

Subsequently, the Council of Governors voted to amend the Constitution of the Trust so that the Council of Governors is now comprised as follows:

- 9 public Governors elected from the Parliamentary Constituencies in Birmingham.
- 1 public Governor elected from the Rest of England area.
- 3 patient Governors elected by Patient members.
- 5 staff Governors elected by the following staff groups:
  - Medical
  - Nursing (2)
  - Clinical Professions Allied to Healthcare
  - Corporate and Support Services
- 5 Stakeholder Governors appointed by five of its key stakeholders.

3.2 Governors

Elections for 5 Staff and 1 Public Governor were held in June 2016. Governors elected at these elections were appointed for a three-year term commencing on 1 July 2016. In addition, a by-election was held for 1 Public Governor for a one year term.

During this year, the Governors have been:

3.2.1 Patient

- Linda Stuart
- Paul Darby
- Aprella Fitch

3.2.2 Public (by Area and Parliamentary Constituency)

Birmingham Area

Northfield
- Mrs Edith Davies
- Mrs Sandra Haynes, MBE

Selly Oak
- Mr Alex Evans
- Dr John Delamere

Hall Green
- Mrs Bernadette Aucott
- Dr Elizabeth Hensel

Edgbaston
- Mr Paul Burgess
- Mrs Bridget Mitchell

Ladywood, Yardley, Perry Barr, Sutton Coldfield, Erdington & Hodge Hill
- Mrs Alka Handa (from 1 July 2016)

Rest of England Area
- Dr John Cadle (re-elected)

3.3 Staff

- Dr Tom Gallacher (Medical Class) (re-elected)
- Susan Price (Clinical Professions Allied to Healthcare) (up to 30 June 2016)
- Stephanie Owen (Clinical Professions Allied to Healthcare) (from 1 July 2016)
- Helen England (Nursing Class) (up to 30 June 2016)
- Yvonne Murphy (Nursing Class) (from 1 July 2016)
- Margaret Garbett (Nursing Class) (re-elected)
- Patrick Moore (Corporate and Support Services) (re-elected)

3.3.1 Stakeholders

- Rabbi Margaret Jacobi, appointed by the Birmingham Faith Leaders' Group
- Dr Iestyn Williams, appointed by the University of Birmingham
- Surgeon Vice Admiral Alasdair Walker, appointed by the Ministry of Defence
- Cllr Valerie Seabright, appointed by Birmingham City Council.

3.4 Lead Governor

Mrs Sandra Haynes MBE has been appointed by the Council of Governors as Governor Vice-Chair and Lead Governor.

3.5 Meetings

The Council of Governors met regularly throughout the year, holding six meetings in total. The Chair (the Rt Hon Jacqui Smith) attended all meetings.

Name of Governor	No. of meetings attended*
Mrs Bernadette Aucott	4 out of 5
Mr Paul Burgess	All
Dr John Cadle	2 out of 5
Mr Paul Darby	0 out of 5 *
Mrs Edith Davies	All
Dr John Delamere	4 out of 5
Mr Alex Evans	All
Mrs Aprella Fitch	All
Mrs Alka Handa	2 out of 4
Mrs Sandra Haynes MBE	All
Dr Elizabeth Hensel	3 out of 5
Mrs Bridget Mitchell	4 out of 5
Mrs Linda Stuart	All
Stakeholder Governors	
Cllr Valerie Seabright	1 out of 5
Dr Iestyn Williams	2 out of 5
Surg Vice Admiral Alasdair Walker	3 out of 5
Rabbi Margaret Jacobi	1 out of 5
Staff Governors	
Ms Helen England	0 out of 1
Ms Yvonne Murphy	3 out of 5
Dr Tom Gallacher	2 out of 5
Mrs Margaret Garbett	1 out of 5
Mr Patrick Moore	All
Ms Susan Price	0 out of 1
Mrs Stephanie Owen	2 out of 4

*Mr Paul Darby was on an approved leave of absence during the reporting period.

3.6 Steps the Board of Directors, in particular the Non-Executive Directors, have taken to understand the views of the Governors and members:

- Attending, and participating in, Governor meetings and monthly Governor seminars.
- Attending, and participating in, joint Council of Governor and Board of Director meetings to look forward and back on the achievements of the Trust.
- Attendance and participation at the Trust's Annual General Meeting.
- Governors and Non-Executive Directors are members of various working groups at the Trust e.g., Strategic Planning Group, Care Quality Group.
- During the Reporting Period, three meetings, on 19 September 2016, 15 March 2017 and 30 March. 2017, have been held between the Non-Executive Directors and Governors to facilitate the Governors in holding the Non-Executive Directors, individually and collectively, to account for the performance of the Board.

3.7 Governors' Register of Interests

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

4 Board of Directors

4.1 Overview

During the reporting period, the Board of Directors comprised the Chair, seven Executive and eight Non-Executive Directors.

Up and until his resignation on 1 July 2016, Professor Michael Sheppard held the appointment of Deputy Chair. This post was subsequently taken over by Harry Reilly. Catriona McMahon held the appointment of Senior Independent Director. The Senior Independent Director is available to meet stakeholders on request and to ensure that the Board is aware of member concerns not resolved through existing mechanisms for member communications.

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

- Chair: Rt Hon Jacqui Smith
- Chief Executive: Dame Julie Moore
- Chief Financial Officer: Mike Sexton
- Executive Medical Director: Dr David Rosser
- Executive Director of Delivery: Tim Jones
- Executive Chief Nurse: Philip Norman
- Executive Chief Operating Officer: Cherry West
- Executive Director of Strategic Operations: Kevin Bolger

Non-Executive Directors

- David Hamlett
- Angela Maxwell
- David Waller
- Professor Michael Sheppard (resigned on 1 July 2016)
- Jane Garvey
- Harry Reilly
- Catriona McMahon
- Jason Wouhra

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

Name	Date of appointment/ latest renewal	Term	Date of end of term
Rt Hon Jacqui Smith	1 December 2016	3 years	30 November 2019
Prof Michael Sheppard	5 December 2013	3 years	resigned on 1 July 2016
Angela Maxwell	30 June 2016	3 years	30 June 2017
David Hamlett	1 October 2014	3 years	30 September 2017
David Waller	1 October 2014	3 years	30 September 2017
Jane Garvey	1 December 2016	3 years	30 November 2019
Harry Reilly	1 December 2016	3 years	30 November 2019
Catriona McMahon	1 June 2014	3 years	31 May 2017
Jason Wouhra	1 December 2014	3 years	30 November 2017

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

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

4.2 Board meetings

The Board met regularly throughout the year, holding 6 meetings in total.

Directors	No. of meetings attended
Rt Hon Jacqui Smith	All
Dame Julie Moore	All
Mike Sexton	All
Tim Jones	5
Prof Michael Sheppard	2 out of 3
Dr David Rosser	All
Philip Norman	All
Angela Maxwell	5
Kevin Bolger	5
David Hamlett	All
David Waller	All
Jane Garvey	5
Harry Reilly	All
Cherry West	All
Catriona McMahon	4
Jason Wouhra	4

4.3 The Board of Directors composition

Rt Hon Jacqui Smith, Chair

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

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

She formally took up her new role as Chair of the Trust from December 2013. Since December 2015 she has held the post of interim Chair at Heart of England NHS Foundation Trust, in addition to her role at UHB.

Dame Julie Moore, Chief Executive

Julie is a graduate nurse who worked in clinical practice before moving into management. After a variety of clinical, management and director posts, she was appointed as Chief Executive of University Hospitals Birmingham (UHB) in 2006. In October 2015 she was appointed Interim Chief Executive of Heart of England NHS Foundation Trust (as well as remaining Chief Executive of UHB), to help lead it out of clinical and financial difficulties.

Julie is a member of the following bodies: The International Advisory Board of the University of Birmingham Business School, the Court of the University of Birmingham and is a Governor of Birmingham City University. She was an independent member of the Office for Strategic Co-ordination of Health Research (OSCHR) from 2009 to 2015 and was a member the Faculty Advisory Board of the University of Warwick Medical School until 2015. In September 2015 she was appointed as a Non-Executive Director of the national Precision Medicine Catapult. She was appointed a trustee of the Prince of Wales Charitable Foundation in 2016. She is a founder member and past Chair of the Shelford Group, the ten leading academic hospitals in England.

In April 2011 she was asked by the Government to be a member of the NHS Future Forum to lead on the proposals for Education and Training reform and in August 2011 was asked to lead the follow-up report. In September 2013, in recognition of the high quality of clinical care at UHB, Julie was asked by Secretary of State to lead a UHB team for the turnaround of two poorly performing trusts in special measures and since helped two further trusts. In 2014 she chaired the HSJ Commission on Hospital Care for Frail Older People and she was a member of the expert panel for the 2014 Dalton Review into New Models of Hospital Provision. In 2015 she was asked by Lord Victor Adebowale to join the NLGN Commission on Collaborative Health Economies.

Julie was made a Dame Commander of the British Empire in the New Year's Honours 2012. In 2013, she was awarded an Honorary Chair at Warwick University, was included in the first BBC Radio 4's Woman's Hour list of the 100 most powerful women in the UK and is included in the HSJ lists of the most influential clinical leaders, the top ten CEOs and a national LGBT role model in health. She has Honorary Doctorates from the University of Birmingham and Birmingham City University and in June 2016 received an Honorary Doctorate from Oxford Brookes University, specifically to commemorate the University's 125th anniversary of providing nurse education.

Executive Directors

Kevin Bolger, Executive Director of Strategic Operations and External Affairs

Kevin originally trained as a nurse and went on to work in many clinical areas over the next 18 years. His career then moved away from clinical responsibilities into management and operations in which he gained significant experience in all aspects of acute hospital services.

He moved to University Hospitals NHS Foundation Trust in 2000 as a Group Manager and then became Director of Operations 12 months later. In this role he successfully led a number of major change programmes and focussed on developing acute and emergency services. In 2006 he became Deputy Chief Operating Officer and Chief Operating Officer in September 2008.

He led, and was responsible for, the operational planning of the move to the new hospital in 2010 and redesigning the management structure pre- and post-move while maintaining existing operational performance throughout this time. In September 2012 he was appointed Executive Director of Strategic Operations and External Affairs leading regional service redesign, developing international opportunities and establishing a successful International Fellowship programme.

In 2013 he took the Executive lead role in supporting a number of Trusts put into special measures following the Keogh Review and was appointed improvement Director for George Eliot Hospital by the National Trust Development Agency. As well as maintaining his post at UHB in November 2015, Kevin was appointed as Interim Deputy Chief Executive (Improvement) at Heart of England NHS Foundation Trust following the appointment of UHB's Chair and Chief Executive there to lead the turnaround in its clinical performance and finances.

Tim Jones, Executive Director of Delivery

After graduating from University College Cardiff with a joint honours degree in History and Economics, Tim joined the District Management Training scheme at City and Hackney Health Authority based at St Bartholomew's Hospital in London.

Tim joined UHB in 1995 as an operational manager in General Medicine and Elderly Care. He continued to work in Operations until 2002, when he undertook the role of Head of Service Improvement and led the New Hospital Clinical Redesign Programme, before being appointed to the role of Chief Operating Officer in June 2006. In September 2008, he was appointed to the newly-created role of Executive Director of Delivery which incorporates board level responsibility for Strategy, Research, Education and Workforce. Tim also gained an MSc in Health Care Policy from the University of Birmingham.

Tim is also an executive Director of Birmingham Health Partners, Senior Responsible Owner for the West Midlands Genomic Medicine Centre, a board member of Birmingham Science City, Industry Governor and Deputy Chair for Harborne Academy and an Honorary Research Fellow at the University of Warwick.

Philip Norman, Executive Chief Nurse

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

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

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

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

Dr David Rosser, Executive Medical Director

David qualified from University College of Medicine, Cardiff in 1987, worked in general medicine and anaesthesia in South Wales, moving to London in 1993 as a research fellow in critical care and subsequently Lecturer in Clinical Pharmacology in UCLH. He was appointed to a Consultant post in Critical Care at University Hospitals Birmingham in 1996.

In 1998 he was appointed as Specialty Lead for Critical Care; as Group Director responsible for Critical Care, Theatres, CSSD and Anaesthesia in 1999; and as Divisional Director responsible for 10 clinical services in 2002.

David was seconded two days per week to the NPfIT in 2004 and appointed as Senior Responsible Owner for e-prescribing in November 2005-April 2007.

In December 2006, David was appointed as Executive Medical Director of UHB, with responsibilities including Executive Lead for Information Technology. He has led the in-house development and implementation of advanced decision support systems into clinical practice across the organisation.

He took up the role of Deputy Chief Executive with responsibility for clinical quality at Heart of England NHS Foundation Trust (HEFT) in November 2015, in addition to the Medical Director role at UHB, and was appointed as Executive Medical Director of HEFT in March 2016, retaining the responsibilities of the MD at UHB and the Deputy CEO at HEFT.

Mike Sexton, Executive Chief Financial Officer

Mike, who became FD in December 2006, spent five years in the private sector working for the accountancy firm KPMG and had a spell in commissioning at the Regional Specialities Agency (RSA) before joining the Trust in 1995. Over the past 19 years, he has held numerous positions including Director of Operational Finance and Performance and Interim Director of Finance. Mike is also the executive lead for international affairs, commercial development, healthcare contracts, procurement, arts and charities.

Cherry West, Executive Chief Operating Officer

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

She trained in medical physics and started her NHS career as a Clinical Physiologist in London. Cherry also spent some time in clinical research, and health services research and evaluation before moving into general management in the late 1990s, undertaking a range of operational roles. She completed a Master's Degree at University College London, an MBA at Henley Management College, and Diploma Health Planning and Management through Birkbeck College, University of London.

Cherry has had a successful record in managing complex health services and has spent the majority of her career in large acute Trusts leading operational delivery and numerous transformation and service redesign programmes. Prior to her appointment at UHB, Cherry held senior positions for 12 years, including Chief Operating Officer and Executive Board member at trusts on the south coast and in the east of England.

Non-Executive Directors

Professor Michael Sheppard, Deputy Chairman (resigned 1 July 2016)

Professor Sheppard was appointed a Non-Executive Director of the Trust in December 2007. He graduated from the University of Cape Town with MBChB (Hons), and was later awarded a PHD in Endocrinology.

His career at Birmingham began in 1982, when he was appointed as a Wellcome Trust Senior Lecturer in the Medical School at the University of Birmingham. He then subsequently held the roles of the William Withering Professor of Medicine, Head of the Division of Medical Sciences, Vice-Dean and Dean of the Medical School, and Vice Principal of the University of Birmingham. He is currently Chair of the Board of the West Midlands Academic Health Science Network and holds an Honorary Professor title at the University of Birmingham. Michael's main clinical and research interests are in thyroid diseases and pituitary disorders.

He holds honorary consultant status at the Trust and has published over 230 papers in peer reviewed journals and has lectured at national and international meetings, particularly the UK, Europe and the USA Endocrine Societies.

Jane Garvey

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

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

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

David Hamlett

David is a qualified solicitor who has worked at Linklaters & Paines (1978–1983) and then Wragge & Co LLP (1983–2016 (Partner 1988)). He has a strong track record as a Birmingham-based lawyer, with the added breadth of working with clients from around the world, and across the commercial and public sectors.

David works as a Consultant for Gowling WLG (UK) Ltd and Wragge & Co LLP. He has vast experience in health and care, life science, as well as public and corporate law. Whilst he was a partner at Wragge's, his health practice work took him around the world, including Abu Dhabi and Bahrain where he advised on joint partnerships. In addition to his health expertise, David has a strong track record working in defence, another highly regulated and complex sector.

Angela Maxwell OBE

Angela achieved prominence as one of the region's most dynamic entrepreneurs after she powered Fracino, the UK's only manufacturer of espresso and cappuccino machines from a £400,000 turnover in 2005 into a £3.6million world-class leading brand when she sold her interests in 2008.

A former European adviser to UK Trade & Investment, a finalist in Businesswoman of the Year 2005, Angela's latest enterprise is Acuwomen, the UK's first company to bring an all-women group of entrepreneurs under one roof. Angela is also an accredited business coach for the National Growth Accelerator programme and for UKTI.

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

Harry Reilly (Deputy Chair from 1 July 2016)

Harry, who trained as an accountant with Deloitte in the mid-1970s, joined British Leyland Plc in 1982. His career in the automotive sector took him via Leyland Trucks, DAF Holland, Rover Group and BMW.
During that time Harry has taken the opportunity to take on broader management positions and when he moved to the Rover Group and BMW he spent time in the Far East, Australia and South Africa, as well as some of the more developed markets in Europe and America.

In 1999 Harry was made Managing Director of Land Rover UK, immediately prior to its sale by BMW. He subsequently joined Brintons as Finance Director and later Managing Director, tasked with turning around and rebuilding the group. Since then Harry has taken on a variety of positions alongside his non-executive work. He supported a number of start-ups and since 2011 has been Chief Executive and now a NED of a Canadian group that includes a Chinese/Canadian joint venture. Harry continues to Chair the British American Business Council in the Midlands and is Chair of WMMBF Limited, Ashwell Corporation and the British American Business Council in the Midlands.

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

David Waller

David is Chairman of Pertemps Network Group Holdings Ltd, one of the UK's largest, recruitment, training and outsourcing companies. He holds a number of other company appointments including the Chairmanship of Birmingham Chamber of Commerce Group, Chairman of Delami Investments Ltd and Chairman of The Birmingham Conservatoire development Group Ltd. He is also a trustee of Millennium Point Trust Ltd.

Up until January 2009, David was Senior Partner of PricewaterhouseCoopers' Birmingham Office and PwC Regional Chairman with responsibility for 2,500 professional staff and over £250 million of revenues. He also headed PwC's regional Management Consultancy practice and represented PwC Middle Market interests globally. He was lead partner for several major clients in both the Private and Public Sectors. During his time with PwC he was actively involved with over 200 clients of all types and sizes.

Jason Wouhra

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

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

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

Dr Catriona McMahon

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

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

As well as her role as a Non-Executive and Senior Independent Director for UHB NHS Foundation Trust, she is owner of, and an Executive Coach within, her own Coaching business, specialising in supporting the development and delivery of senior leaders in the Healthcare and Life Science Sectors. She is also Lead Industry Member on the Scottish Medicines Consortium, working with both SMC and Industry on Health Technology Processes and Processes Improvement.

Catriona attended Edinburgh Medical School and, prior to joining the Pharmaceutical Industry, Catriona practised Anaesthetics and Critical Care Medicine in the North-East of England for nine years.

4.4 Directors' Register of 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, Mindelsohn Way, Edgbaston, Birmingham B15 2GW.

5 Audit Committee

5.1 Overview

The Audit Committee is a committee of the Board of Directors whose principal purpose is to assist the Board in ensuring that it receives proper assurance as to the effective discharge of its full range of responsibilities. Its duties include providing an independent and objective review of the Trust's systems of internal control, including financial systems, financial information, governance arrangements, approach to risk management and compliance with legislation and other regulatory requirements, monitoring the integrity of the financial statements of the Trust and reviewing the probity of all Trust communications relating to these systems.

The Committee meets regularly and is chaired by David Waller. The Committee currently comprises four Non-Executive Directors of the Trust, with the external and internal auditors and other Executive Directors attending by invitation.

5.2 Membership of the Committee

The members of the Committee during 2016/17 were as follows:

- Mr David Waller
- Ms Jane Garvey
- Mr Harry Reilly
- Dr Jason Wouhra

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

- **Mr David Waller**
  Director and part-owner, Pertemps Network Group Limited; Director, Delami Investments; Chairman – Birmingham Chamber of Commerce & Industry Ltd; Trustee – Millennium Point Trust Ltd; Patron – St Giles Hospice; Chairman – Birmingham Conservatoire of Music Development Group

- **Ms Jane Garvey**
  Nil declared

- **Mr Harry Reilly**
  Director – Galtons and Associates Limited; Chairman – British American Business Council Midlands; Director – Juyi TacFast UK Limited;Chairman – Ashwell Corporation Limited; Chairman – Economic Growth Solutions Limited; Chairman – WMMBF Limited.

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

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

5.3 Operation of the Committee

The Committee is required to meet at least four times a year. A total of six ordinary and extra-ordinary meetings took place during 2016/17 and were attended as follows:

Director	No. of meetings attended
David Waller	All
Jane Garvey	5
Harry Reilly	All
Jason Wouhra	3

The action plan following the annual self-assessment of 2015/16 was addressed and all recommendations were implemented during the reporting year. The annual self-assessment for 2016/17 is under way and its findings will be reported to the Council of Governors' meeting in July 2017.

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

The Audit Committee receives specific instructions from the Board of Directors as to the areas where additional assurance is required and has formally reported back to the Board of Directors on how it has discharged its duty. The Audit Committee has thus supported the Board of Directors in making its 'fair, balanced and understandable' statement. During 2016/17, the Audit Committee considered the following significant issues in relation to financial statements, operations and compliance:

Risks to the financial statements, including:

- Recognition of NHS revenue
- Capital programme and valuation
- Accruals and provisions
- Key Financial Controls, including:
  - Treasury management.
  - Income and receivables.
  - Expenditure & payables.
  - PPE.
  - General ledger.
  - Budgetary Control.
- The Trust's Board Assurance Framework (BAF) and risk management
- A review of 8 of the 45 IG Toolkit standards as published by the HSCIC
- A procurement review of the Trust's proposed

strategy and compliance analysis with existing policies, processes and operation of controls.
- UHB Payroll and Payroll Bureau
- Data Quality and Assurance
- A pre-live review of the Trust's Oceano PAS system which tracks a patient's journey through the Trust
- Cyber security

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

5.4 Auditors

During 2016/17, the Trust's External Auditor has been Deloitte LLP.

The current contract for the appointment of External Auditors is for a term of up to four years from 1 January 2014 subject to annual review by the Audit Committee and reappointment by the Council of Governors. The Audit Committee carries out a review of the effectiveness of the External Auditor following the completion of each annual audit, assessing the External Auditor's performance against an agreed framework and seeking the views of officers of the Trust, and reports the outcome of that review to the Council of Governors, together with a recommendation as to whether the External Auditor should be re-appointed for the following year.

The annual cost of the Trust's 2016/17 external audit was £103,000, in addition, Deloitte LLP provided the following services during 2016/17:

Counter Fraud Service: £55,000

Statutory and audit-related work: £50,000 (including audit of subsidiaries and the annual quality report.

5.5 Independence of External Auditors

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

a. Statutory and audit-related work – certain projects where work is clearly audit-related and the external auditors are best-placed to do the work (e.g. regulatory work, e.g. acting as agents to NHS Improvement, the Audit Commission, the Care Quality Commission, for specified assignments). Statutory and audit-related work assignments do not require further approval from the Audit Committee or the Council of Governors.
b. Audit-related and advisory services – projects and engagements where the auditors may be best-placed to perform the work, due to:

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

    Recognising that the level of non-audit fees may also be a threat to independence, a limit of £25,000 will be applied for each discrete piece of additional work, above which limit prior approval must be sought from the Council of Governors, following a recommendation by the Audit Committee. Neither approval of the Council of Governors nor a recommendation from the Audit Committee will be required for discrete pieces of work within this category with a value of less than £10,000, subject to a cumulative limit of £25,000 per annum.

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

5.6 Auditors' reporting responsibilities

Deloitte LLP, the Trust's independent auditors, report to the Council of Governors through the Audit Committee. Deloitte LLP's accompanying report on our financial statements is based on its examination conducted in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006, the Code of Audit Practice and the Financial Reporting Manual issued by the independent regulator Monitor. Their work, performed under International Standards on Auditing (UK and Ireland), includes a review of our internal control structure for the purposes of designing their audit procedures.

6 Nominations Committees

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

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

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

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

Council of Governors' Remuneration and Nominations Committee

- Rt Hon Jacqui Smith (Chair)
- Mrs Sandra Haynes MBE (Governor Vice-Chair)
- Dr John Delamere
- Mrs Linda Stuart
- Dr Tom Gallacher
- Rabbi Margaret Jacobi

The Remuneration & Nominations Committee met twice during the year.

Members	No. of meetings attended
Rt Hon Jacqui Smith	2
Dr Tom Gallacher	1
Dr John Delamere	2
Sandra Haynes	2
Rabbi Margaret Jacobi	0
Catriona McMahon*	2
Linda Stuart	1

*In attendance, as Senior Independent Director.

6.2 Nominations Sub-Committee

When there is a vacant post in the Trust's Executive team, the Executive Appointments and Remuneration Committee (EARC) appoints a Nominations Sub-Committee to deal with this appointment. During the reporting year, there was no such vacant position.

7 Membership

7.1 Overview

The Trust has three membership constituencies as follows:

- Public constituency (including the Rest of England constituency).
- Patient constituency.
- Staff constituency.

Public Constituency

The public constituencies correspond to the Parliamentary constituencies of Birmingham and a further constituency – the Rest of England constituency – which allows individuals who live outside the Public constituency, but are not Patient or Staff members, to become members of the Public constituency. Public members are drawn from those individuals who are aged 16 or over and:

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

Patient Constituency

Patient members are individuals who are:

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

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

Staff Constituency

The Staff Constituency is divided into four classes:

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

7.2 Membership Overview by Constituency

Constituency	Total at 31/03/17	%
Public	11,336	47
Patient	3,752	15
Staff	9,229	38
Total Membership	**24,317**	**100**

Membership size and movements

Public constituency	Last year (2016/17)	Next year (estimated) (2017/18)
At year start (April 1)	10,870	11,336
New members	738	800
Members leaving	272	250
At year end (March 31)	11,336	11,886
Staff constituency	**Last year (2016/17)**	**Next year (estimated) (2017/18)**
At year start (April 1)	9,071	9,229
New members	1,445	
Members leaving	1,287	
At year end (March 31)	9,229	
Patient constituency	**Last year (2016/17)**	**Next year (estimated) (2017/18)**
At year start (April 1)	3,906	3,752
New members	4	40
Members leaving	158	120
At year end (March 31)	3,752	3,672

Analysis of current membership

Public constituency	Number of members	Eligible membership
Age (years)		
0–16	0	270,545
17–21	24	89,426
22+	9,315	756,065
Ethnicity		
White	6,693	621,636
Mixed	111	47,605
Asian or Asian British	1,343	285,640
Black or Black British	379	96,360
Other	0	21,804
Gender analysis		
Male	5,027	552,124
Female	6,258	563,911

Patient constituency	Number of members	Eligible membership
Age (years)		
0–16	0	
17–21	3	
22+	3,217	

7.3 Membership Strategy

7.3.1 Membership Development 2016/17

During 2016/17, the overall membership remained consistent, with just a small increase from 23,847 to 24,317. The main increase was seen in the Public constituency, with a gain of 466 new members. The Trust's membership is largely representative of the populations it serves. The Trust has members from a broad range of backgrounds and the Trust publicises their contributions both internally and externally; for example through 'Member of the Year'.

Although under-16s appear to be under-represented, this is due to under-16s being ineligible for both membership and treatment at UHB.

Black and Asian patient members are under-represented by approximately 5%. However, around one quarter of patient members have chosen not to provide ethnicity information, therefore it is unclear as to whether those patients are of non-white backgrounds. This is replicated in the public constituency where Black and Asian public members are under-represented by around 3% and 12% respectively. Again, around 1 in 4 (25%) public members chose not to declare their ethnicity.

In order to increase BME membership, a plan to attract further members from BME communities which began in March 2016, has been executed throughout 2016/17. Activities included:

- Targeted membership social media content.
- Community-based recruitment via governors.
- Further promotion of BME member contributions.

7.3.2 Membership Objectives

The Membership Engagement and Recruitment Strategy, approved by the Board of Directors, is to replace the annual churn and maintain existing membership numbers to no less than 23,500. Emphasis is placed on the retention of existing members and further engagement, and achieved through:

- The quarterly publication of 'Trust in the Future'.
- Further development of the Ambassador Programme, ensuring that Ambassadors are involved in appropriate activities and contributing to the recruitment of new members.
- Further developing membership content published via social media and the Trust website.
- Community based activities such as drop-in sessions at GP surgeries, presentations to community groups and involvement in constituency events.
- The inclusion of members on appropriate patient groups.
- Raising the profile and role of Foundation Members, Ambassadors and Governors within the Trust.
- Working with QEHB Charity to increase membership opportunities amongst fundraisers.

In November 2016, UHB held its annual Membership Week campaign to attract new members. This year the campaign was supported by social media activity highlighting the work of members and raising awareness of their roles within the Trust.

7.3.3 Forward Plan/Objectives 2017/18

The successful strategy employed since 2014/15 – i.e, 'maintain numbers and replace churn' will be employed again in 2017/18.

There are no plans to launch a major recruitment campaign during the year. Such a campaign would cost between £12,000 and £15,000 to yield around 3,000 new members.

The number of Membership Week Campaigns will increase from one to four.

The objectives for 2017/18 are:

- to replace the annual churn and maintain existing membership numbers to no less than 23,500; and
- to ensure the membership is representative.

7.3.4 Governors' Development 2016/17

Meetings of the Governors' Development Group are held approximately 3-4 times a year. This group is made up of Governors from across all the constituencies and is overseen by the Director of Corporate Affairs. The content of seminars is agreed across the year. Last year's topics covered the following:

- Educational Talk on the Trust's Nursing Structure (Different Bands/Roles/Responsibilities).
- Educational Talk on the Trust's Organ Transplant Programme.
- An Overview of the RCDM and its presence at QEHB.
- An Insight into the Role and Physical Presence of Religious Groups.
- The Trust's Approach to Regulatory Compliance and Clinical Quality.

For 2017/18 topics are set to include:

- Community Engagement.
- Patient Engagement/Conducting Ward Visits/Difficult Situations.
- Health & Wellbeing.
- Sustainability & Transformation Plan.
- Good Governance.

Governors are able to attend update/training courses as part of the GovernWell programme run by the NHS Providers (formerly FTN). The themes covered each year are:

- Effective Questioning & Challenging.
- Core Skills.
- NHS Finance & Business Skills.
- The Governor role in Non Exec Appointments.

7.3.5 Member communication with governors and/or directors

There are several ways for members to communicate with governors and/or directors. The principal ones are as follows:

- Face-to-face interaction at monthly Members' Seminars. Governors attend these meetings and use them as a 'surgery' for members.

- Telephone, written or electronic communications co-ordinated through the Membership Office which then steers members to the appropriate Governor/Director.
- Governors' Drop-in Sessions. These sessions are held monthly at the Queen Elizabeth Hospital Birmingham. A mix of staff, patient and public governors 'set up camp' and talk to, advise, and take comments from staff, patients and visitors. These are then fed back to the Executive Directors for comment/action.
- The Annual General Meeting.
- Website. Each Governor has their profile and details of the constituency they serve, published on the Trust website including email address.
- 'Trust in the Future' magazine – highlights work of Governors and opportunities to be involved in projects/patient experience groups and promotes how members can contact the Membership Office or meet governors via regular drop-in sessions and health talks.
- Governors attend community presentations held in their constituency in relation to the hospital/patients issues.
- Health Talks. Governors attend health talks which are held on a monthly basis for members and wider community. Evening sessions are also held to provide greater access.
- news@QEHB – Trust newspaper distributed through the hospital sites.
- Social media tools – Twitter, Facebook, Flickr and YouTube.
- Membership Week – activities held over five days aimed at promoting membership.
- Monthly recruitment stand in the hospital atrium.

7.3.6 Contacting the Membership Office

The Membership Office triages queries from members to the most appropriate governor and or Director for action.

Email membership@uhb.nhs.uk
Tel 0121 371 4323
Post Membership Office, Third Floor, Nuffield House, University Hospitals Birmingham, Mindelsohn Way, Edgbaston, Birmingham, B15 2TH

8 Staff report

8.1 Breakdown of the number of male and female staff at the end of 2016/17

	Female	Male
All Staff	6553	2553
Executive Directors	2	5
Directors	1	2
Total Staff	**6556**	**2560**

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

8.2 Staffing Profile

The largest staff group at UHB is employed in Nursing, with the next highest groups of staff in Additional Clinical Services, Estates & Ancillary and Administrative and Clerical roles. The fewest number of staff are employed as Additional Professional Scientific & Technical and Healthcare Scientists. The highest numbers of permanent staff are in Nursing, Administration & Clerical, and Additional Clinical Services roles. Fixed-term working largely supports Medical & Dental and Administrative & Clerical roles, whilst bank working is underpinning workforce needs mostly in Medical & Dental, Nursing, and Additional Clinical Services.

Staff Group	Permanent	Fixed term temp	Bank*
Additional Professional Scientific and Technical	275	25	57
Additional Clinical Services	1,426	87	872
Administrative and Clerical	1,553	280	191
Allied Health Professionals	483	15	49
Estates and Ancillary	828	11	203
Healthcare Scientists	376	23	3
Medical and Dental	513	670	945
Nursing and Midwifery Registered	2,553	56	520
Total	**8,007**	**1,167**	**2,840**
	9,174		

*Please note that the Bank numbers include those individuals available to deliver work through UHB's Bank who have been active within the past two years. It does not include staff who hold both a substantive and a bank contract.

8.3 Exit packages

	Compulsory redundancies		Other agreed departures		Total termination	
	Number	Cost (£000)	Number	Cost (£000)	Number	Cost (£000)
Termination benefit by band – year ended 31 March 2017						
< £10,000	1	6	—	—	1	6
£10,000–£25,000	1	11	—	—	1	11
£25,000–£50,000	1	44	—	—	1	44
£50,000–£100,000	1	52	—	—	1	52
>£100,000						
	4	**113**	—	—	**4**	**113**
Termination benefit by band – year ended 31 March 2016						
< £10,000	1	6	—	—	1	6
£10,000–£25,000	4	58	—	—	4	58
£25,000–£50,000	5	159	—	—	5	159
£50,000–£100,000	2	139	—	—	2	139
	12	**362**	**—**	**—**	**12**	**362**

The termination benefits disclosed all relate to compulsory redundancies. Of the disclosed termination payments none (2015/16 – none) were non-contractual payments requiring HMT approval. There were no termination benefits paid or due in the reporting year to key management personnel, who are defined to be the Board of Directors of the Trust (2015/16 – £nil).

8.4 NHS Staff Survey

8.4.1 Commentary

UHB remains committed to engaging its workforce and recognises the contribution staff make to the care of its patients. It strives to find ways to work with staff to improve their working lives, and feedback is crucial to understanding their needs and views. The Trust works in partnership with its trade unions to engage with staff; the strength of this partnership is reflective of the value demonstrated by the Trust in its responsiveness to this feedback. The Trust works in partnership with the trade unions in responding to the staff survey results. There is a Trust Partnership Team which offers a platform for trade union interface with senior management including Executive Directors, and serves as a barometer for the climate of staff feelings in general terms and on specific subject areas.

The staff survey is an annual event, but there are also many other mechanisms in place throughout the year by which the Trust actively seeks the views and opinions of staff. These include hosting targeted focus groups, direct e-surveying on specific questions and Divisional Consultative meetings.

The Trust's engagement with staff is more than simply listening to their views. UHB is committed to keeping staff up-to-date with news and developments through an internal communications programme:

- Team Brief – staff receive the Chief Executive's core brief every two months;
- news@QEHB – the Trust's monthly staff magazine is available throughout the Trust;
- Intranet – the intranet is constantly updated and improved;
- In the Loop – staff receive weekly email updates on Trust news and developments;
- There is a programme of corporate and local induction and orientation for new starters to improve long-term retention of staff;
- There are monthly staff meetings with the Chief Executive and Executive Directors which are open to all staff, with encouragement to attend by management. These meetings allow staff to be updated on key projects and/or matters of interest around the Trust. Staff can ask any questions that they may have.

8.4.2 Summary of Performance

Each year UHB's results are compared against other similar acute NHS trusts. The results therefore show a comparison of the national average rate achieved across UK acute trusts with the results achieved by UHB, as well as a comparison of the 2016 response rate against the previous year's outcomes.

The 2016 results demonstrate significant strengths for the Trust, with our performance particularly strong benchmarked against other acute trusts and when compared with the Trust's own performance in previous years. It is especially heartening to see that staff satisfaction with the quality of work and patient care they are able to deliver and in feeling that their role makes a difference to patients/service users is amongst the best 20% of acute trusts.

Of the 32 areas surveyed in 2016, the Trust had 8 findings in the highest 20% of acute trusts, 14 above the national average, 7 average findings, 2 findings below the national average, and 1 finding in the bottom 20%. Our performance is also strongest against our nearest neighbouring trusts within the West Midlands.

8.4.3 NHS Staff Survey Response Rate

2015/16	2016/17		Trust improvement/ deterioration
UHB	UHB	Acute trust avg	
50%	**41%**	**43%**	**Decrease of 9%**

The staff survey results are presented in the form of key findings. This year there were 32 key findings.

Areas of improvement from 2015 survey

Performance remained strong across 22 key findings, with significant improvement on 2015 results in terms of the key finding below:

	2015	2016	Difference
KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	60%	52%	8% decrease

Areas of deterioration from 2015 survey

In terms of the key findings, there have been no areas of deterioration from the 2015 survey.

2016 Top 5 Ranking Scores

	2015	2016		Trust improvement/ deterioration
	UHB	UHB	Acute trust avg	
KF2. Staff satisfaction with the quality of work and patient care they are able to deliver (higher the score the better)	4.16	4.08 (on a 1–5 scale)	3.96 (on a 1–5 scale)	No statistically significant change
KF14. Staff satisfaction with resourcing and support (higher the score the better)	3.52	3.48 (on a 1–5 scale)	3.33 (on a 1–5 scale)	No statistically significant change
KF3. Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month (lower the score the better)	30%	26%	31%	No statistically significant change
KF15. Percentage of staff satisfied with the opportunities for flexible working patterns (the higher the score the better)	54%	54%	51%	No statistically significant change
KF1. Staff recommendation of the organisation as a place to work or receive treatment (higher the score the better)	4.02	3.97	3.76	No statistically significant change

2016 Bottom 5 Ranking Scores

	2015	2016		Trust improvement/ deterioration
	UHB	UHB	Acute trust avg	
KF24. Percentage of staff/colleagues reporting most recent experience of violence (higher the score the better)	69%	62%	67%	No statistically significant change
KF20. Percentage of staff experiencing discrimination at work in last 12 months (lower the score the better)	12%	13%	11%	No statistically significant change
KF26. Percentage of staff experiencing physical violence from staff in last 12 months (lower the score the better)	2%	2%	2%	No statistically significant change
KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion (higher the score the better)	88%	86%	87%	No statistically significant change
KF19. Organisation and management interest in and action on health and wellbeing	3.56	3.60 (on a 1–5 scale)	3.61 (on a 1–5 scale)	No statistically significant change

8.4.4 Areas of concern and action plans

The priorities are as follows:

- Target areas/staff groups where response rates have been lower.
- Divisional Action Plans to target their specific problem areas.
- Staff group action plans to be developed to target specific issues.

The action plan will be monitored every six months at Trust meetings of the Chief Operating Officer's Group.

8.4.5 Future priorities and targets

This year the Trust-wide action plan will focus on building on our strengths to maintain our strong performance, as well as targeting improvements in the following areas:

Development of a wellbeing strategy including a communications plan to raise awareness amongst staff and managers of the current and planned approach

- Reduction in staff experiencing discrimination.
- Increase in staff reporting incidents of violence.

8.5 Sickness Absence

In 2016/17, the Trust recorded an annual average sickness absence, across all clinical and corporate divisions, of approximately 4% (4.22%), a 0.2% (0.23%) decrease on the previous year. Trust management continues to work in partnership with Staffside to explore opportunities to reduce this to 3.6%. Long term sickness continues to be the main cause of absence from work, and continues to be consistent at an average of 2.68% each month.

Total days lost 94,286

For the year to date the top five reasons for both long term and short term absence are:

- S10 Anxiety/stress/depression/other psychiatric illnesses
- S13 Cold, Cough, Flu – Influenza
- S12 Other musculoskeletal problems
- S25 Gastrointestinal problems
- S28 Injury, fracture

Staff groups with absence consistently above average include Health Care Assistants, Porters, and Support Workers. Focus groups are currently taking place to understand and assist in addressing the causes. A deep dive of stress and anxiety data is being progressed in order to develop an action plan to target those groups/departments/personal characteristics most likely to suffer episodes.

New sickness cases being referred into the First Contact Team within Human Resources is averaging 85 a month over the current year. Dismissals on the grounds of ill-health are averaging four a month in the year to date.

Regular 'confirm and challenge' meetings are in place in Divisions A, C and D in which the top five long term cases (by number of days) and short term sickness cases (by number of episodes) are reviewed and progressed as appropriate. This has helped to resolve some complex long term cases.

An annual programme of sickness absence management training is provided by members of the operations team and this is currently under review in order to ensure that the training is more interactive and meaningful through the use of case studies.

In addition to the annual programme of training, bespoke sickness absence management training on request is also provided; recent groups receiving the training include facilities team leaders, and arrangements to deliver training to Division D ward managers and deputies are in hand. Bespoke training packages will continue to be provided for teams and departments where sickness absence is problematic.

UHB is proactive in promoting positive health and wellbeing amongst its staff. Staff can access over 20 topic areas for advice and guidance, including bereavement, exercise and weight loss, via the staff portal, *me@qehb*. It also importantly enables staff to refer themselves to the staff access physiotherapy service. Staff can access on-site mindfulness sessions and quiet rooms. A holistic plan for staff wellbeing is in progress, which includes the provision of a Green Gym within the green spaces around UHB, as well as designated walking routes around the site, yoga and Pilates classes, staff networks for potentially marginalised groups, and arts and culture events. The Trust also offers a health check for its staff where they undergo a complete health assessment, and then any necessary referrals can then be undertaken here at the Trust or passed back to the member of staff's GP. UHB offers trial passes to the onsite leisure centre (Morris Centre) where staff who want to get fit can enjoy introductory sessions at the gym and numerous classes. UHB is forging links with external organisations to maximise the opportunities for our staff.

8.6 Reporting high paid off-payroll arrangements

As part of the *Review of Tax Arrangements of Public Sector Appointees* published by the Chief Secretary to the Treasury on 23 May 2012, departments and their arm's length bodies, including Foundation Trusts, must publish information in relation to the number of off-payroll engagements that are for more than £220 a day and last longer than six months.

No. of existing engagements as of 31 March 2017	**5**
Of which...	
No. that have existed for less than one year at time of reporting.	—
No. that have existed for between one and two years at time of reporting.	**1**
No. that have existed for between two and three years at time of reporting.	**3**
No. that have existed for between three and four years at time of reporting.	—
No. that have existed for four or more years at time of reporting.	**1**

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

No. of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	—
No. of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations	—
No. for whom assurance has been requested	—
Of which...	
No. for whom assurance has been received	—
No. for whom assurance has not been received	—
No. that have been terminated as a result of assurance not being received.	—

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

8.7 Expenditure on consultancy

The expenditure on consultancy is £2,695,000 for the year. See note 5 in the accounts.

8.8 Analysis of staff costs

	Year ended 31 March 2017			Year ended 31 March 2016		
	Permanently		Other	Permanently		Other
	Total	Employed		Total	Employed	
	£000	£000	£000	£000	£000	£000
Short-term employee benefits – salaries and wages	321,951	311,171	10,780	313,516	301,646	11,870
Short-term employee benefits – social security costs	30,109	30,109	—	23,633	23,633	—
Post-employment benefits – employer contributions to NHS pension scheme	35,228	35,228	—	34,038	34,038	—
Pension cost – other contributions	27	27	—	12	12	—
Termination benefits	129	129	—	257	257	—
Temporary staff – external bank	583	—	583	—	—	—
Temporary staff – agency/contract staff	17,077	—	17,077	21,747	—	21,747
Revenue in respect of salaries and wages where netted off expenditure	—	—	—	(38)	(38)	—
	405,104	**376,664**	**28,440**	**393,165**	**359,548**	**33,617**

Employee costs include those of staff and directors, but exclude non executive director costs.

8.9 Health and Safety

Incidents reported last year (April 2016 – March 2017) include: 239 Inoculation injuries; 129 Slips, trips and falls and; 76 Musculoskeletal.

The Sharps Action Group has overseen the introduction of: safer sharps to replace hypodermic needles and blunt needles to draw-up medication where appropriate. Monitoring of inoculation incidents is performed by Directors of Operations, senior nursing staff and the Health and Safety Team who report to committee via quarterly divisional health and safety reports which include: details of inoculation incidents; action taken to prevent recurrence and; reports sent to the Health And Safety Executive (HSE).

A programme of unannounced inspections was undertaken in relation to inoculation incidents and 24 inspections of clinical areas were completed. The number of reported inoculation incidents during 2016/17 is the lowest annual number in the history of the Trust. A programme of unannounced inspections was also introduced in relation to slips and trips and 30 inspections were completed

Flu vaccination continues to be made available to all frontline staff as close to their place of work as possible to reduce any disruption to services. Due to the effectiveness of this year's campaign, the Trust hit its 75% flu vaccination uptake target in December, nine days ahead of its deadline.

8.10 Countering fraud and corruption

The Trust has a duty, under the Health and Safety at Work Act 1974 and the Human Rights Act 2000, to provide a safe and secure environment for staff, patients and visitors.

As part of this responsibility, regular reviews into security around the Trust are conducted along with pro-active crime reduction initiatives to reduce the opportunities for crime to occur. Examples are a virtually stolen scheme, where stickers are placed on items left lying around which could be stolen, also included within this programme is a virtual intruder operation when a person not known to staff wearing casual clothes will try to obtain access to secure areas, encouraging staff to be more challenging to visitors. There is also a targeted check of all cycles and their security locks to ensure that quality locks are in use. If any are found to be of poor quality the owners are offered quality locks at subsidised rates from the Trust. These are overseen by the NHS accredited Local Security Management Specialist, a post that is required under Secretary of State directions. The Trust encourages a pro-security culture amongst its staff. The Trust actively investigates all reported criminal incidents and has a close working relationship with local police officers. All security equipment i.e. CCTV

and Access Control are covered under comprehensive maintenance contracts to ensure any faulty equipment is repaired within a short timescale.

The Trust policy is to apply best practice regarding fraud and corruption and the Trust fully complies with the requirements made under the Secretary of State directions. The local counter-fraud service is provided by Deloitte LLP, who have undertaken a diverse range of counter-fraud work during the year. Key anti-fraud controls were monitored through continuous control testing and industry leading developments related to cyber security were addressed. A workforce that is alert to the risk of fraud continues to be our greatest defence against fraudsters and awareness of this risk has continued to gain pace through a combination of face to face presentations, site visits, newsletters and intranet updates designed to reach the maximum numbers and types of our staff.

In May 2016, the Chief Executive signed the Trust's Slavery and Human Trafficking Statement, pursuant to section 54(1) of the Modern Slavery Act 2015, for the financial year ending March 31 2016. The Trust supports and respects the protection of human rights for all its employees and workers within its supply chain. It believes in treating people with respect and dignity and does not condone the use of its products or services which infringe the basic human rights of others. The Trust expects its suppliers and business partners to adhere to the same high standards and to take reasonable steps to combat slavery and human trafficking.

9 NHS Improvement's Single Oversight Framework

9.1 Explanation of the foundation trust's risk ratings

NHS Improvement is the regulator and licensor of foundation trusts and has a duty to ensure that foundation trusts are effective, efficient and economic and maintain or improve the quality of their services. Since 1 April 2013 all foundation trusts were required to have a licence from Monitor to operate. Under Monitor's Risk Assessment Framework (RAF) it published two risk ratings for each NHS foundation trust: the Financial Sustainability Risk Rating (FSRR), and the Governance Risk Rating.

In October 2016 NHS Improvement introduced its Single Oversight Framework (SOF) that replaced Monitor's Risk Assessment Framework (RAF) as the system for overseeing NHS foundation trusts. Unlike the RAF, the new Framework is also applicable to NHS trusts that do not have foundation trust status.

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care.
- Finance and use of resources.
- Operational performance.
- Strategic change.
- Leadership and improvement capability (well-led).

Based on information from these themes, providers are segmented from 1 to 4, where 4 reflects providers receiving the most support, and 1 reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's Risk Assessment Framework (RAF) was in place. Information for the prior year and first two quarters relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Segmentation

For the whole period since the Single Oversight Framework was introduced on 1 October 2016, the Trust has been in Segment 2. Consequently no enforcement action has been taken against the Trust over that period. This segmentation information is the Trust's position as at 03/04/2017. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website at https://improvement.nhs.uk/resources/single-oversight-framework-segmentation/

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score.

Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above is not the same as the overall finance score here.

Area	Metric	Explanation	2016/17 Q3 score	2016/17 Q4 score
Financial sustainability	Capital Service Cover	Can the Trust's income cover its longer term financial obligations	3	3
	Liquidity	Cash held to cover operating costs	4	3
Financial efficiency	I&E Margin	I&E surplus or (Deficit) as a proportion of total Income	2	1
Financial controls	I&E Variance From Plan	Actual year to date surplus compared to plan	1	1
	Agency Spend	Distance of actual spend from the annual agency cap set by NHS Improvement	3	3
Overall scoring			**3**	**2**

NHS
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NHS Foundation Trust

Section 2

Remuneration Report 2016/17

This annual report covers the period 1 April 2016 to 31 March 2017

Remuneration report

1 Annual Statement on Remuneration

The year ended 31st March 2017 was yet another challenging year for the Trust. In addition to focussing on delivering high-quality healthcare to patients in the face of increasing demand, both in terms of numbers and complexity, as well as limited resources, the Trust has continued to support a regulatory intervention at the neighbouring Heart of England NHS Foundation Trust (HEFT). This intervention includes the Trust's Chief Executive, Dame Julie Moore, holding the position of Interim Chief Executive of HEFT and the Trust's Chair, the Rt Hon Jacqui Smith, as Interim Chair of HEFT. Other senior managers and staff of the Trust have been engaged to support the intervention. However, neither the Chief Executive nor any other senior managers have received any additional remuneration in connection with this intervention.[1]

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

Accordingly, the Committee recognises that, in order to ensure optimum performance, it is necessary to have a competitive pay and benefits structure. The objective of the Trust's policy for remuneration of senior managers[2] is to attract and retain suitably skilled and qualified individuals of high calibre, providing sufficient resources, strength and maintaining stability throughout the senior management team. Remuneration for such officers will be set and maintained at levels that remain competitive but affordable. The Committee considers that this is particularly so at present, when the demand for competent and effective senior leaders in the NHS is high, but the pool of suitable candidates is diminishing.

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

The Committee has reviewed the remuneration policy and the responsibilities and remuneration of the senior managers of the Trust (not including the Non-Executive Directors). The policy itself was considered appropriate. During the reporting period, the Committee approved a 1% pay increase for senior managers with effect from 1 April 2016. No other changes were made to the remuneration of senior managers.

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

Non-Executive Directors' fees are reviewed regularly with advice taken from independent consultants where appropriate. During the reporting period, the Governors' Remuneration and Nominations Committee for Non-Executive Directors recommended that the Chair and the Non-Executive Directors be awarded a 1% pay increase, in line with that awarded to Agenda for Change staff and doctors, following the recommendations of the NHS national review bodies. This was approved by the Council of Governors with effect from 1 April 2016.

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

May 18 2017
Rt Hon Jacqui Smith
Chair of the Executive Appointments & Remuneration Committee

1. The Chair is remunerated separately by HEFT for her work as Chair of that Trust.

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

2 Senior Managers' Remuneration Policy

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

The key goal of remuneration policy remains to recruit and retain competent and effective Senior Managers. This requires that the pay and benefits structure is competitive within the sector. The table below provides detail on each element of directors' remuneration packages for 2017/18:

<table>
<tr><th>Purpose and link to strategy</th><th>Operation (and changes if appropriate)</th><th>Maximum that could be paid in respect of that component</th></tr>
<tr><td colspan="3">Salary</td></tr>
<tr><td>Retains and motivates, takes account of complexity and scale of director's duties, and cognisance of market levels in the appropriate sector</td><td>Salary levels are set with reference to responsibilities and the need to retain and recruit. With regard to the latter, a comparison against similar roles in an appropriate comparator group is used (the comparator group comprises Shelford Group trusts and local trusts).</td><td>
<table>
<tr><th>Senior manager</th><th>£000</th></tr>
<tr><td>Julie Moore</td><td>253</td></tr>
<tr><td>Mike Sexton</td><td>167</td></tr>
<tr><td>Dave Rosser</td><td>218</td></tr>
<tr><td>Tim Jones</td><td>152</td></tr>
<tr><td>Kevin Bolger</td><td>152</td></tr>
<tr><td>Philip Norman</td><td>152</td></tr>
<tr><td>Cherry West</td><td>152</td></tr>
<tr><td>Andrew McKirgan</td><td>125</td></tr>
<tr><td>Fiona Alexander</td><td>125</td></tr>
<tr><td>David Burbridge</td><td>126</td></tr>
</table>
Salaries will be reviewed during the year ending 31 March 2018. Any increases will take into account salary increases awarded to the wider workforce.</td></tr>
<tr><td colspan="3">Pension</td></tr>
<tr><td>Provides post-retirement remuneration and ensures that the total package is competitive.</td><td>Senior managers are eligible to become members of the NHS Pension Scheme. The benefits provided to Senior Managers through the NHS Pension Schemes are the same as for all other Trust employees.

Where Senior Managers cease to accrue pensionable service in an NHS Pension Scheme due to reaching the lifetime allowance, they are entitled to a cash supplement equal to 10.5% of base salary.

This policy remains unchanged from 2013/14.</td><td>Dame Julie Moore withdrew from pensionable service on 31.03.2013 and Mike Sexton withdrew on 31.08.2014. No pensionable service in any NHS Pension Scheme has been accrued by these directors since these dates. They receive a cash supplement of 10.5% of base salary in lieu of pension accrual.</td></tr>
</table>

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

The table below provides detail on each element of non-executive directors' (including the Chair) remuneration for 2017/18:

Purpose and link to strategy	Operation (and changes if appropriate)	Maximum that could be paid in respect of that component	
Non-Executive Director fees			
Attracts, retains and motivates non-executive directors with the required knowledge, experience and ability	Non-executive directors are paid a fee each year. Some non-executive directors with additional responsibilities may receive an additional fee, although none do at present.	**Chair**	£53,045
		Non-Executive Director	£13,975
		Fees will be reviewed during the year ending 31 March 2018. Any increases will take into account salary increases awarded to the wider workforce.	

Notes

There are no benefits in kind, performance related pay, nor severance payments (2015/16 – £nil) paid to any executive or non-executive. There are no payments to any past senior managers that relate to the function of the Board of Directors (2015/16 – £nil).

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

No new components of the remuneration package have been introduced.

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

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

As shown in the table on page 59, a number of the Trust's Senior Managers are paid more than £142,500. The Trust has, through the Executive Appointments and Remuneration Committee, satisfied itself that this remuneration is reasonable for the reasons set out in the annual statement on remuneration above and taking into account that competition for suitably qualified and able individuals to serve as Senior Managers will come not only from within the NHS sector, but from other organisations, both public and private sector and in the UK and abroad.

2.3 Service contracts obligations

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

2.4 Policy on payment for loss of office

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

There were neither termination payments nor compensation for loss of office made to senior managers during 2016/17.

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

When determining Executive Directors' and senior managers' pay and conditions, the Committee has had regard to the pay and conditions of other staff on Agenda for Change and professional pay scales.

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

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

3 Pensions

All the Executive Directors are members of the NHS Pensions Scheme, with the exception of Dame Julie Moore and Mike Sexton. Under this scheme, members are entitled to a pension based on their service and final pensionable salary subject to HM Revenue and Customs' limits.

The scheme also provides life assurance cover of twice the annual salary. The normal pension age for directors is 60. None of the Non-Executive Directors are members of the schemes. Details of the benefits for Executive Directors are given in the tables provided on pages 60 and 61.

4 Annual Report on Remuneration

4.1 Service Contracts

With the exception of Rachel Cashman, Project Director, Senior Managers (other than Non-Executive Directors) are on substantive contracts with a notice period of six months. Rachel Cashman was on a fixed term contract.

Name of Senior Manager	Date of Service Contract	Unexpired term	Details of Notice Period
Dame Julie Moore	04/03/2002	N/A	Six months
Mike Sexton	26/10/2006	N/A	Six months
Dave Rosser	01/12/2006	N/A	Six months
Tim Jones	13/06/2007	N/A	Six months
Kevin Bolger	15/06/2009	N/A	Six months
Philip Norman	28/10/2013	N/A	Six months
Cherry West	01/09/2014	N/A	Six months
Fiona Alexander	01/02/2006	N/A	Six months
David Burbridge	07/05/2007	N/A	Six months
Andrew McKirgan	01/09/2014	N/A	Six months
Rachel Cashman*	05/01/2016	N/A	N/A

*Rachel Cashman resigned from the Trust 10 July 2016

4.2 Executive Appointments and Remuneration Committee

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

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

The Executive Appointments and Remuneration Committee comprises the Chair, all other Non-Executive Directors and, for appointments of Executive Directors other than the Chief Executive, the Chief Executive.

The Chair of the Committee is the Chair of the Trust.

The Executive Appointments and Remuneration Committee met on two occasions during the year. Attendance was as follows:

Directors	No. of meetings attended
Rt Hon Jacqui Smith	All
Dame Julie Moore	1
Prof Michael Sheppard	All
Angela Maxwell	All
David Hamlett	All
David Waller	1
Jane Garvey	1
Harry Reilly	All
Catriona McMahon	All
Jason Wouhra	None

The Committee approved a 1% pay increase for senior managers with effect from 1 April 2016, in line with that awarded to Agenda for Change staff and doctors, following the recommendations of the NHS national review bodies.

The Committee has not received advice or services from any person that materially assisted the Committee in their consideration of any matter relating to remuneration during the reporting period.

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

Non-Executive Directors' remuneration consists of fees which are set by the Council of Governors. The Council of Governors established a committee, the Council of Governors' Remuneration Committee for Non-Executive Directors, amalgamated on 22 December 2011 with the Council of Governors' Nominations Committee for Non-Executive Directors to form the Council of Governors' Remuneration and Nominations Committee for Non-Executive Directors. The role of the Committee is, among other things, to advise the Council of Governors as to the levels of remuneration for the Non-Executive Directors. (The Chair does not attend when the committee considers matters relating to her own remuneration.)

Details of membership and attendance of the Governors' Remuneration and Nominations Committee for Non-Executive Directors are set out on page 41.

During the reporting period, the Governors' Remuneration and Nominations Committee for Non-Executive Directors recommended that the Chair and the Non-Executive Directors be awarded a 1% pay increase, in line with that awarded to Agenda for Change staff and doctors, following the recommendations of the NHS national review bodies. This was approved by the Council of Governors with effect from 1 April 2016.

4.4 Disclosures required by Health and Social Care Act

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

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

Expenses

In addition, the Trust's governors and directors incur non-taxable expenses in association with activities that they undertake that support the objectives of the Trust, a summary of which is set out in the table below:

Year ended 31 March 2017			
	Number in office	Number receiving expenses	Total £00
Directors	19	4	233
Governors	22	1	Less than 100

Year ended 31 March 2016			
	Number in office	Number receiving expenses	Total £00
Directors	20	3	666
Governors	22	9	65

4.5 Salary and Pension Entitlements of Senior Managers

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

A. **Remuneration**

Salary entitlements of senior managers – 2016/17

Name and title	Year ended 31 March 2017					
	Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	Total
	(bands of £5000)	Total to nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2500)	(bands of £5000)
	£000	£00	£000	£000	£000	£000
Senior managers						
Julie Moore Chief Executive	250–255					250–255
Philip Norman Executive Chief Nurse	150–155				55–57.5	205–210
Dr David Rosser Executive Medical Director	215–220				67.5–70	285–290
Tim Jones Executive Director of Delivery	150–155				117.5–120	265–270
Mike Sexton Executive Chief Financial Officer	165–170					165–170
Kevin Bolger Executive Director of Strategic Operations	150–155				57.5–60	205–210
Cherry West Executive Chief Operating Officer	150–155				55–57.5	205–210
Fiona Alexander Director of Communications	120–125				90–92.5	215–220
David Burbidge Director of Corporate Affairs	125–130				42.5–45	165–170
Andrew McKirgan Director of Partnerships	120–125				107.5–110	230–235
Rachel Cashman Project Director (left office 10 July 2016)	35–40					35–40
Non-executive directors						
Jacqui Smith – Chair	50–55					50–55
David Hamlett	10–15					10–15
Angela Maxwell	10–15					10–15
David Waller	10–15					10–15
Prof Michael Sheppard	0–5					0–5
Jane Garvey	10–15					10–15
Harry Reilly	10–15					10–15
Jason Wouhra	10–15					10–15
Dr Catriona McMahon	10–15					10–15

Salary entitlements of senior managers – 2015/16

Name and title	Year ended 31 March 2016					
	Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	Total
	(bands of £5000)	Total to nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2500)	(bands of £5000)
	£000	£00	£000	£000	£000	£000
Senior managers						
Julie Moore Chief Executive	250–255					250–255
Philip Norman Executive Chief Nurse	145–150				135–137.5	285–290
Dr David Rosser Executive Medical Director	225–230				142.5–145	370–375
Tim Jones Executive Director of Delivery	145–150				67.5–70	215–220
Mike Sexton Executive Chief Financial Officer	165–170					165–170
Kevin Bolger Executive Director of Strategic Operations	145–150				57.5–60	205–210
Cherry West Executive Chief Operating Officer	145–150				125–127.5	275–280
Fiona Alexander Director of Communications	120–125				67.5–70	190–195
David Burbidge Director of Corporate Affairs	125–130				92.5–95	215–220
Andrew McKirgan Director of Partnerships	120–125					120–125
Rachel Cashman Project Director (Commenced office 5 Jan 2016)	25–30				37.5–40	65–70
Non-executive directors						
Jacqui Smith – Chair	50–55					50–55
David Hamlett	10–15					10–15
Angela Maxwell	10–15					10–15
David Waller	10–15					10–15
Prof Michael Sheppard	10–15					10–15
Jane Garvey	10–15					10–15
Harry Reilly	10–15					10–15
Jason Wouhra	10–15					10–15
Dr Catriona McMahon	10–15					10–15

The full cost of the directors' remuneration disclosed for 2016/17 is partially off-set by revenue from Heart of England NHS Foundation Trust, due to the management services provided by UHB as part of the interim support arrangements between the two trusts.

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

The Executive Medical Director – Dr David Rosser receives remuneration in both his capacities of board director and medical consultant, the combined total is disclosed in the tables above. The banding disclosure of the latter clinical role equates to 110–115 (2015/16: 120–125).

Rachel Cashman left office from the role of Projects Director on 10 July 2016.

The non-executive team is unchanged in year.

There are no benefits in kind, performance related pay, nor severance payments (2015/16 – £nil) paid to any executive or non-executive. There are no payments to any past senior managers that relate to the function of the Board of Directors (2015/16 – £nil).

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

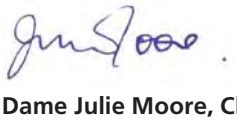
	Year Ended 31 March 2017	Year Ended 31 March 2016
Band of Highest Paid Director's Total Remuneration (£'000)	250–255	250–255
Median Total Remuneration	28,462	28,268
Ratio	**8.9**	**8.8**

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

B. **Pension Benefits**

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 2017	Total accrued pension related lump sum at age 60 at 31 March 2017	Cash Equivalent Transfer Value at 31 March 2016	Cash Equivalent Transfer Value at 31 March 2017	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder pension
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000	To nearest £100
Tim Jones, Executive Director of Delivery	2.5–5	0–2.5	50–55	135–140	823	884	62	N/A
Philip Norman, Executive Chief Nurse	0–2.5	5–7.5	55–60	175–180	968	1,040	73	N/A
Kevin Bolger, Executive Director Strategic Operations	2.5–5	7.5–10	65–70	195–200	1,378	1,474	96	N/A
Dr David Rosser, Executive Medical Director	2.5–5	7.5–10	70–75	220–225	1,287	1,379	92	N/A
David Burbridge, Director of Corporate Affairs	0–2.5	5–7.5	25–30	85–90	527	580	53	N/A
Fiona Alexander, Director of Communications	0–2.5	0–2.5	15–20	40–45	256	293	37	N/A
Cherry West, Chief Operating Officer	0–2.5	5–7.5	55–60	165–170	1,041	1,120	79	N/A
Andrew McKirgan, Director of Partnerships	2.5–5	0–2.5	40–45	110–115	613	676	63	N/A

As Non-Executive members do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive members. Details above are provided by the NHS Pensions Agency.



Dame Julie Moore, Chief Executive
Date: 18 May 2017

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Section 3

Quality Report 2016/17

This annual report covers the period 1 April 2016 to 31 March 2017

Contents

2016/17 Quality Report

1 Chief Executive's Statement

University Hospitals Birmingham NHS Foundation Trust (UHB) has continued to focus on delivering high quality care and treatment to patients during 2016/17. In line with national trends, UHB has again seen unprecedented demand for its services with large increases in Emergency Department attendances and admissions which has put significant pressure on our ability to deliver planned treatments. The Trust's Vision is "to deliver the best in care" to our patients. The Trust's Core Purposes – Clinical Quality, Patient Experience, Workforce and Research and Innovation – provide the framework for UHB's robust approach to managing quality.

UHB has made progress in relation to two of the five priorities for improvement set out in last year's Quality Report: 'reducing grade 2 pressure ulcers' and 'improving patient experience and satisfaction'. Performance for the remaining indicators – 'timely and complete observations', 'reducing medication errors' and 'infection prevention and control' – has been mixed with some progress and further work required to improve performance in 2017/18.

The Board of Directors has chosen to continue with four of the five priorities for improvement in 2017/18. They have chosen to remove priority 5 (infection prevention and control) and to replace it with two new priorities – 'reducing harm from falls' and 'timely treatment for sepsis in the Emergency Department'. Both of these can have a devastating impact on patients and relatives.

The selection of local patient survey questions included in priority 2 (improving patient experience and satisfaction) has been refreshed based on performance for 2016/17 by the Care Quality Group which has Governor representation.

The Trust continues to do all it can to improve performance for the 'All cancers – maximum 62-day wait for first treatment from urgent GP referral for suspected cancer' and 'A&E maximum waiting time of 4 hours from arrival to admission/transfer/discharge' indicators which are affected by late referrals from other trusts and ever increasing A&E attendances respectively.

It is very pleasing to see that inpatients and outpatients continue to recommend the Trust as a place to be treated in the 'Friends and Family' tests, and that responses to a number of the questions in the patient surveys have improved.

UHB's focused approach to quality, based on driving out errors and making incremental but significant improvements, is driven by innovative and bespoke information systems which allow us to capture and use real-time data in ways which few other UK trusts are able to do. A wide range of omissions in care have been reviewed in detail during 2016/17 at the regular Executive Care Omissions Root Cause Analysis (RCA) meetings chaired by the Chief Executive. Cases are selected for review from a range of sources including an increasing number put forward by senior medical and nursing staff: wards selected for review, missed or delayed medication, Serious Incidents (SIs), serious complaints, infection incidents, incomplete observations and cross-divisional issues.

Data quality and the timeliness of data are fundamental aspects of UHB's management of quality. Data is provided to clinical and managerial teams as close to real-time as possible through various means such as the Trust's digital Clinical Dashboard. Information is subject to regular review and challenge at specialty, divisional and Trust levels by the Clinical Quality Monitoring Group, Care Quality Group and Board of Directors, for example. An essential part of improving quality at UHB continues to be the scrutiny and challenge provided through proper engagement with staff and other stakeholders. These include the Trust's Council of Governors, General Practitioners (GPs) and local Clinical Commissioning Groups (CCGs).

A key part of UHB's commitment to quality is being open and honest with our staff, patients and the public, with published information not limited to good performance. The Quality web pages provide up-to-date information on UHB's performance in relation to quality: http://www.uhb.nhs.uk/quality.htm. The Trust has continued to publish monthly data during 2016/17 showing how each inpatient specialty is performing for a range of indicators on the dedicated *mystay@QEHB* website: infection rates, medication given, observations, clinical assessments and patient feedback.

The Trust's internal and external auditors provide an additional level of scrutiny over key parts of the Quality Report. The Trust's external auditor Deloitte has reviewed the content of UHB's 2016/17 Quality Report and undertaken testing for three areas in line with the NHS Improvement guidance on external assurance: *18-week maximum wait from point of referral to treatment (incomplete pathways), maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge* and one local indicator. The Trust's Council of Governors selected one of the new quality improvement priorities – priority 5 (reducing harm from falls) – as the local indicator to be audited.

The Trust has been given an unmodified opinion for the content of the Quality Report and the two nationally mandated indicators, with a number of recommendations for improvement which will be implemented during 2017/18. The auditors are not required to provide an opinion for the local indicator, for which there is one minor recommendation.

Following the Care Quality Commission's (CQC) focussed visit in December 2015 to review Cardiac Surgical Services, UHB was required to submit outcome and performance data on a weekly basis. In May 2016 the CQC wrote to UHB to remove the conditions from registration, and to inform the Trust that data and updates would only be required quarterly. The Cardiac Surgery Quality Improvement Programme, which was commenced prior to the CQC review, continues and the majority of the actions identified from the CQC and subsequent external visit have been completed. In November 2016, the Royal College of Surgeons conducted a review which recognised the progress made by the service.

In March 2017 the NHS published the *Next Steps on the Five Year Forward View*, outlining plans for the health service over the next few years that will deliver the ambitions set out in the Five Year Forward View, originally published in October 2014. This sets targets to "make the biggest national move towards integrated care of any major western country". The Trust is a partner in delivering the Birmingham and Solihull Sustainability and Transformation Plan (and I am its interim lead), which aims to co-ordinate and transform local health service delivery to meet changing patient needs within the available funding.

During 2016/17, UHB continued to support Heart of England NHS Foundation Trust (Heartlands Hospital, Good Hope Hospital, Solihull Hospital, Birmingham Chest Clinic and Solihull Community Services) in order to share learning and best practice. Plans are being developed to ensure the ongoing sustainability of those services through the formation of a single organisation.

UHB has also expanded Umbrella, a sexual health treatment and prevention programme, under which it is responsible for delivering sexual health services through clinics and partner GPs and pharmacies, across Birmingham and Solihull. This has pioneered the type of population-based system proposed by the *Next Steps on the Five Year Forward View* strategy to deliver better outcomes for users of its services alongside increased efficiency.

2017/18 will be another very challenging year for UHB as we focus on delivering the best in care and achieving outcome and access targets alongside ever increasing demand for our services coupled with tighter financial constraints. The Trust will continue working with regulators, commissioners, healthcare providers and other organisations to influence future models of care delivery and deliver further improvements to quality during 2017/18.

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

Dame Julie Moore, Chief Executive
18 May 2017

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

2.1 Priorities for Improvement

The Trust's 2015/16 Quality Report set out five priorities for improvement during 2016/17:

- **Priority 1:** Reduce grade 2 pressure ulcers
- **Priority 2:** Improve patient experience and satisfaction
- **Priority 3:** Timely and complete observations including pain assessment
- **Priority 4:** Reduce medication errors (missed doses)
- **Priority 5:** Infection prevention and control

The Trust has made progress in relation to two quality improvement priorities: Priority 1 – reducing grade 2 pressure ulcers and Priority 2 – improving patient experience and satisfaction. There has however been mixed performance for timely and complete observations, reducing medication errors and infection prevention and control during 2016/17.

Performance for the first indicator (observations) in Priority 3 achieved the end of year target, however the second indicator (timely analgesia) did not despite steady results throughout the year. Performance for Priority 4 (missed doses) has remained about the same, so did not achieve the proposed reduction in 2016/17. For Priority 5, the Trust missed the trajectory for zero Trust-apportioned MRSA bacteraemias but met the *C. difficile* infection trajectory during 2016/17.

The Board of Directors has chosen to continue with four of the five priorities for improvement in 2016/17. Priority 5, 'Infection prevention and control' has been removed and two new priorities have been added: 'Reducing harm from falls' and 'Timely treatment for sepsis in the emergency department'.

1	Reduce grade 2 pressure ulcers	New trajectory for 2017/18 agreed with CCG
2	Improve patient experience and satisfaction	New patient survey questions added, others removed due to achieving the 2016/17 target
3	Timely and complete observations including pain assessment	Targets for 2017/18 updated in line with 2016/17 performance
4	Reduce medication errors (missed doses)	Targets and methodology kept the same for 2017/18
5	Infection prevention and control	To be removed
	Reducing harm from falls	New priority for 2017/18
6	Timely treatment for sepsis in the emergency department	New priority for 2017/18

The improvement priorities for 2017/18 were confirmed by the Trust's Clinical Quality Monitoring Group chaired by the Executive Medical Director, following consideration of performance in relation to patient safety, patient experience and effectiveness of care. These were then discussed with various Trust groups including staff, patient and public representatives during Quarter 4 2016/17 as shown in the table below. The priorities for improvement in 2017/18 were also shared and discussed with interested parties outside the Trust including the Trust's lead Clinical Commissioning Group (CCG), Birmingham CrossCity CCG.

The focus of the patient experience priority was decided by the Care Quality Group and the priorities for improvement in 2017/18 were then finally approved by the Board of Directors in March 2017. The priorities for 2017/18 will be presented to the Trust Partnership Team and cascaded to all staff via Team Brief in May 2017.

Date	Group	Key members
February 2017	Council of Governors	Chairman, Chief Executive, Executive Directors, Directors and Staff, Patient and Public Governors
March 2017	Care Quality Group	Chairman, Chief Executive, Executive Directors, Directors and Staff, Patient and Public Governors
April 2017	Chief Operating Officer's Group	Executive Chief Operating Officer, Deputy Chief Operating Officer, Directors of Operations, Divisional Directors, Director of Operational Finance, Deputy Chief Nurse, Director of Patient Services, Director of Estates and Facilities, Director of IT Services plus other Managers
May 2017	Trust Partnership Team	Executive Directors, Directors, Human Resources Managers, Divisional Directors of Operations, Staff Side Representatives
May 2017	Chief Executive's Team Brief (cascaded to all Trust staff)	Chief Executive, Executive Directors, Directors, Clinical Service Leads, Heads of Department, Associate Directors of Nursing, Matrons, Managers

Although three of the 2017/18 priorities have been in place for a number of years, the focus and targets within each priority are regularly reviewed and updated in line with changes in performance and in response to priorities within the Trust.

The performance for 2016/17 and the rationale for any changes to the priorities are provided in detail below. It might be useful to read this report alongside the Trust's Quality Report for 2015/16.

Priority 1: Reduce grade 2 hospital-acquired pressure ulcers

Background

This quality improvement priority was first proposed by the Council of Governors and approved by the Board of Directors for 2015/16.

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

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

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

(National Pressure Ulcer Advisory Panel, 2014)

At UHB, pressure ulcers are split into two groups: those caused by medical devices and those that are not.

Due to very low numbers of hospital-acquired grade 3 and grade 4 ulcers at UHB, the Trust focus is on further reducing grade 2 ulcers. This in turn should help towards aiming for zero avoidable hospital acquired grade 3 and grade 4 ulcers, as grade 2 ulcers will be less likely to progress.

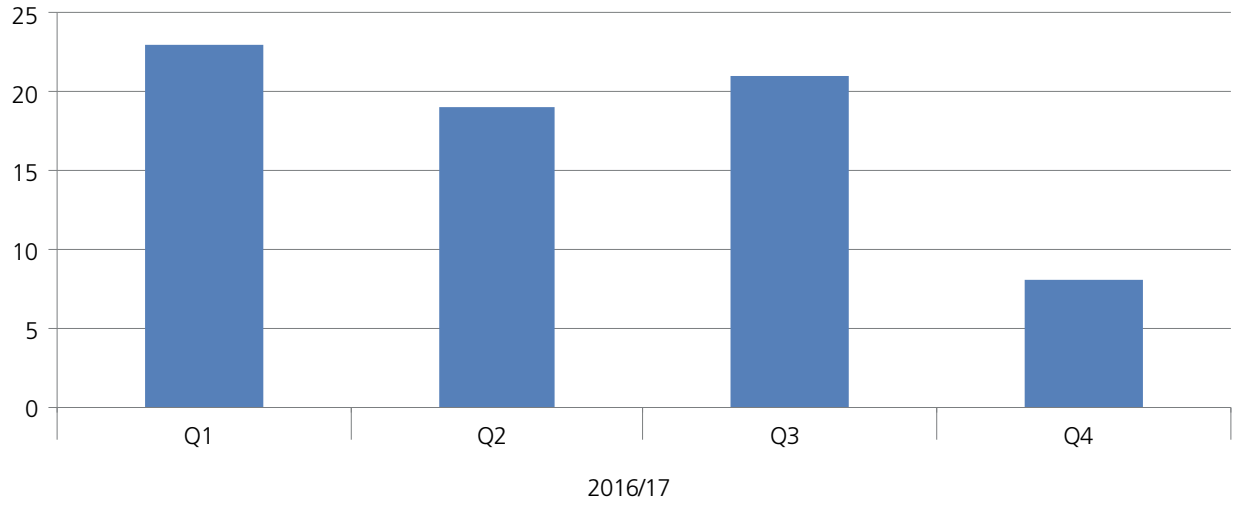
Performance

The 2016/17 reduction target agreed with Birmingham CrossCity Clinical Commissioning Group (CCG) was 125 patients with non device-related, hospital-acquired avoidable grade 2 pressure ulcers. This was chosen as a 5% decrease on the reduction target set for 2015/16.

UHB has seen a continued decrease in the number of hospital-acquired pressure ulcers during 2016/17.

For the period April 2016 to March 2017, UHB reported 71 patients with non device-related, hospital-acquired avoidable grade 2 pressure ulcers, against the agreed reduction target of 125. This compares to 79 reported in 2015/16, and 144 reported in 2014/15. For the latest Quarter (Quarter 4 2016/17), there were only 8 patients with such ulcers.

Number of patients with grade 2 hospital-acquired, non device-related avoidable pressure ulcers, by Quarter



Initiatives implemented in 2016/17

- Re-introduction of the React to RED (formerly Code RED) campaign
- Close working with therapists/Allied Health Professionals/Keep Moving Roadshow
- Device related task and finish groups regarding Anti Embolic Stockings
- Close Divisional working, with tissue viability nurses attending Divisional meetings and providing education
- The pressure ulcer action group became the Preventing Harms Group, which also receives information on patient falls and infection prevention and control
- Differentiation between moisture lesions and pressure ulcers
- Electronic records around repositioning
- Skin Champions study day for Health Care Assistants (HCAs)
- Networking with Shelford Group and regional Tissue Viability Nurses
- Targeted education campaigns
- Seating campaign and purchase of new equipment

Changes to improvement priority for 2017/18

The 2017/18 target agreed with Birmingham CrossCity Clinical Commissioning Group (CCG) is to maintain current performance.

Initiatives to be implemented during 2017/18

To continue to build on the improvements seen in 2016/17, to further identify any common causes or reasons behind hospital-acquired pressure ulcers and to target training and resources accordingly. Initiatives to aid improvements:

- To improve the classification and grading of pressure ulcers across the trust through a variety of education and training programmes.
- To improve repositioning documentation through educational campaigns and Tissue Viability Quality Audits, Back to the Floor visits by senior nursing staff and the introduction of electronic records.
- To empower tissue viability link nurses to be confident in verifying grade 2 pressure ulcers and to complete mini RCAs (root cause analysis), initially as a pilot on Critical Care.
- To reduce the number of Deep Tissue Injuries (DTIs) by utilising the 'prevent purple' campaign.
- Update Equipment Selection Flowchart to reflect equipment available in the Trust and to better guide staff on appropriate equipment choice through education and forums.
- Education for specific staff groups including medical staff.
- Monitoring competency figures and timely risk assessment.

How progress will be monitored, measured and reported

- All grade 2, 3 and 4 pressure ulcers are reported via the Trust's incident reporting system Datix, and then reviewed by a Tissue Viability Specialist Nurse.
- Monthly reports are submitted to the Trust's Preventing Harms meeting, which reports to the Chief Nurse's Care Quality Group.
- Data on pressure ulcers also forms part of the Clinical Risk report to the Clinical Quality Monitoring Group.
- Staff can monitor the number and severity of pressure ulcers on their ward via the Clinical Dashboard.

Priority 2: Improve patient experience and satisfaction

The Trust measures patient experience via feedback received in a variety of ways, including local and national patient surveys, the NHS Friends and Family Test, complaints and compliments and online sources (e.g. NHS Choices). This vital feedback is used to make improvements to our services. This quality priority focuses on improving scores in our local surveys, and also takes into account national survey results and correlations with what ranks as most important to patients in giving a high rating of care.

Patient experience data from local surveys
During 2016/17, 14,519 patient responses were received to our local inpatient survey, 941 to the Emergency Department survey, 2,122* to the outpatient survey and 2,029* responses to our discharge survey.

*postal surveys data up to February 2017

In addition, UHB usually publishes data taken from the National Inpatient Survey, run by the Picker Institute on behalf of the CQC, however publication of the 2016 survey report has been delayed and is not available at the time of writing. The results will be shown in Part 3 of this Quality Account once the report has been received by the Trust.

Methodology
The local inpatient survey is undertaken, predominantly, utilising our bedside TV system, allowing patients to participate in surveys at their leisure. Areas that do not have the bedside TVs use either paper or computer tablets for local surveys. The Emergency Department survey is a paper-based survey, and the outpatient and discharge surveys are postal – both sent to a sample of 500 patients per month. Results of the postal surveys are given up to February 2017 as that is the latest data available at the time of compiling this report.

Improvement target for 2017/18
For 2017/18 we reviewed 2016/17 performance for the questions set for this priority. Where these achieved or maintained their target during the year, some have been replaced with new questions – but continue on our local surveys for monitoring. Others remain as a priority but with a more challenging target because they are extremely important to patients in reporting high quality care.

This improvement priority was agreed at the Trust's Care Quality Group meeting in March 2017, which is a Chief Nurse-led sub-committee of the board, attended by clinical staff and also patient Governors to provide the patients' perspective. Rationale for keeping, removing or adding questions was included in the report to this committee. This was based on data available at that time (February for electronic surveys, January for postal surveys).

- **Questions carried forward** – targets have been carried forward from 2016/17 or new challenging targets set.
- **New questions with a 2016/17 baseline score from local surveys** – existing local targets will apply or be set by adding a 5% challenge to the 2016/17 score.
- **New questions without a 2016/17 baseline** – target to be set at Care Quality Group following collection of baseline data.

Historically our targets for this priority were capped at a score of 9, however it was agreed at Care Quality Group in January 2017 to exceed a score of 9 where appropriate for continued challenge and advancement of patient experience.

Results from local patient surveys

This table shows results for 2015/16 and 2016/17 along with the status for each question. Below this are the new questions added for 2017/18.

	2015/16 score	2016/17 target	2016/17 score	Status	2017/18 target	2016/17 No. responses
Inpatient survey						
1. Did you find someone on the hospital staff to talk about your worries or fears?	8.5	8.8	**8.8**	Achieved	Removed	6012
2. Do you think that the ward staff do all they can to help you rest and sleep at night?	8.9	9	**9**	Achieved	Removed	7175
3. Have you been bothered by noise at night from hospital staff?	8.3	8.5	**8.5**	Achieved	Removed	7079
4. Sometimes in hospital a member of staff says one thing and another says something quite different. Has this happened to you?	8.8	9	**8.8**	Carry forward	9.0	14348
5. During your time in hospital did you feel well looked after by hospital staff?	n/a	9	**9.5**	Carry forward	9.7	8785
Outpatient survey*						
6. How would you rate the courtesy of the reception staff during your time in the Outpatients Department?	8.9	9.0	**8.8**	Carry forward	9.0	2095
7. Did the staff treating and examining you introduce themselves?	8.8	8.9	**8.8**	Carry forward	8.9	2048
8. If you had important questions to ask the doctor, did you get answers that you could understand?	8.9	9.0	**8.9**	Carry forward	9.0	1892
Emergency Department survey						
9. During your time in the Emergency Department did you feel well looked after by hospital staff?	n/a	8.9	**8.6**	Carry forward	9.0	610
10. How would you rate the courtesy of the Emergency Department reception staff?	n/a	8.7	**8.5**	Carry forward	9.0	576
11. Were you kept informed of what was happening at all stages during your visit?	n/a	8.0	**7.9**	Carry forward	8.5	606
Discharge survey*						
12. Did a member of staff tell you about medication side effects to watch for when you went home?	5.7	6.1	**5.9**	Carry forward	6.1	1474
13. Did you feel you were involved in decisions about going home from hospital?	7.2	7.4	**7.2**	Carry forward	7.4	1846

*postal surveys – data up to February 2017

New questions to be added for 2017/18

	2016/17 score	Status	2017/18 target	2016/17 No. responses
Inpatient survey				
If you used the call bell, was it answered in a reasonable time?	9.1	**NEW for 2017/18**	9.5	5227
Did you get enough help to eat your meals?	n/a	**NEW for 2017/18**	To be set	n/a

How progress will be monitored, measured and reported

- This priority is measured using the local survey results as detailed in the methodology.
- The new 'help to eat meals' question will be added to the local inpatient survey and a baseline set once sufficient data has been collected.
- The target for the 'new' 'help to eat meals' question has been taken from the local catering survey, and will be added to the full inpatient local survey to maximise the number of responses.
- The new 'call bell' question is already on the local inpatient survey so has a reliable baseline measure.
- The operational Patient Experience Group (reporting to the Care Quality Group) monitors this priority.
- Monthly exception reports to Associate Directors of Nursing (ADNs) highlight individual wards not meeting the quality priority so that action can be taken. This report is presented to the Care Quality Group and includes a section from each ADN with actions for their division.
- This patient experience quality priority is also reported on the Clinical Dashboard so is always available for staff to view; updated monthly.
- Quarterly patient experience reports are provided to the Care Quality Group (summarised to the Board of Directors) and the local Clinical Commissioning Group – this includes a gap analysis on the patient experience quality priority.
- Feedback on patient experience is also provided by members of the Patient and Carer Councils as part of the Adopt a Ward/Department visits and via Governor drop-in sessions.

Update on Patient Experience initiatives in 2016/17

Initiative planned	Update
Using a more project-based approach to tackle challenging aspects of patient experience.	**Ongoing** From the 2015 National Inpatient Survey, three topics were chosen for projects rather than focusing on small changes to individual question scores. The topics chosen were: feeling well looked after, discharge medications and communication around operations and procedures. Early indications from preliminary data from the 2016 national survey are that this approach was successful.
Continued review and updating of the patient experience dashboard and reporting processes.	**Ongoing** The patient experience dashboard has been developed to include categorised free text comments aiding identification of themes and trends. New reporting has been developed for Inpatient Governor Drop Ins and Patient and Carer Council adopt-a-ward feedback.
Implement the use of patient stories as a feedback and training mechanism.	**Ongoing** Patient stories now used at all Patient Experience Group meetings and used in complaints and customer relations training. Developments in the use of patient stories to continue as a valuable and insightful tool.
Review of how patient experience data is monitored and used to drive improvements.	**Ongoing** A staff survey, initially looking at how data travels across the Trust, has been drawn up ready for implementation.
Finalisation of plans to implement an internal buggy system.	**Withdrawn** Based on the success of the car park buggy, a group was set up to look at the feasibility of implementing a buggy inside the hospital to help outpatients and visitors to get around. The group discovered that health and safety regulations, along with the limitations of the route that the buggy could take, meant that this was not a viable option. The group is now going to look at how internal movement could be better supported using wheelchairs.

Initiative planned	Update
Scope the potential implementation of therapeutic visits from trained and approved volunteers with pets.	**Ongoing** Planning for this scheme is well underway.
Increase the number of guest beds to allow carers to stay overnight.	**Complete** Wards were asked how many guest beds they currently had and how many they needed. With the kind help of QEHB Charity 60 new guest beds were purchased.
Pilot a new ward booklet to give patients and visitors improved information.	**Ongoing** Planning for this is underway, and draft text has been compiled with help from members of the Patient and Carer Council (Wards).
Additional wheelchairs for patient use.	**Complete** With the kind support of QEHB Charity 16 additional wheelchairs for outpatient use have been provided.
Implement updated survey system on bedside TVs to include free text comments.	**Complete** The bedside TV surveys now allow patients to leave free text answers.
Review of complaints process to streamline and improve response time.	**Ongoing** Response times have improved during the year with 80%+ of all complaints responded to within 30 working days. Work continues to try to increase this further.
Refresh the Friends and Family Test in outpatients to increase response rate.	**Complete** A number of initiatives have taken place during the year, contributing to an increase in response rate.
Implement new learning from complaints report to share learning Trust-wide.	**Complete** Sharing document developed, incorporating learning from complaints, feedback, incidents, safeguarding, observations in care and learning from excellence. Distributed with Chief Executive's Team Brief.

The Friends and Family Test
Response rates and positive recommendation percentages have been closely monitored throughout 2016/17 against internal targets set and tracked against national and regional averages to benchmark how we are doing against our peers.

The Friends and Family Test (FFT) asks patients the following question:

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

Patients can choose from six different responses as follows:
- Extremely likely
- Likely
- Neither likely or unlikely
- Unlikely
- Extremely Unlikely
- Don't know

Methodology
Patients admitted as day cases, or staying overnight on an inpatient ward, were asked to complete the FFT on discharge from hospital; either on the bedside TVs, on paper or tablet. Those attending the emergency department were asked either on leaving (using a paper survey), or afterwards via an SMS text message. Outpatients are given the opportunity to answer the question whenever suits them best, either before they leave the department (paper or check in kiosk), or they can access the question online via the Trust website.

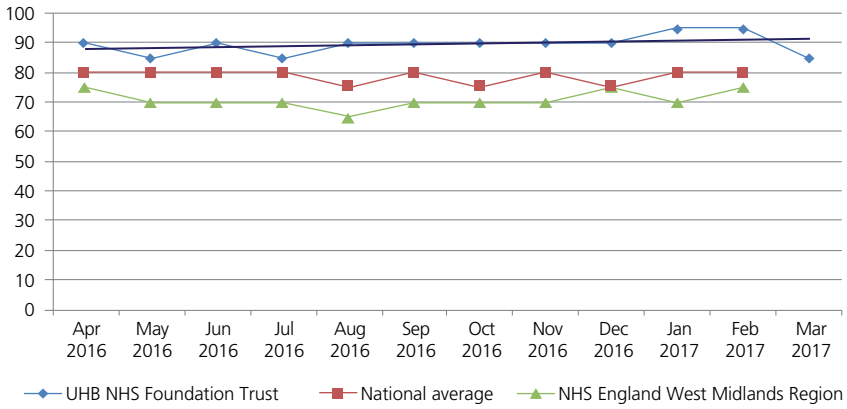
The Trust follows the national guidance for undertaking and scoring of the Friends and Family Test.

Performance
March data for the FFT is not currently available, and will be included the final report if it becomes available in time.

The charts below show benchmark comparisons for the positive recommendation percentages for the Friends and Family Test for Inpatients, A&E and Outpatients.

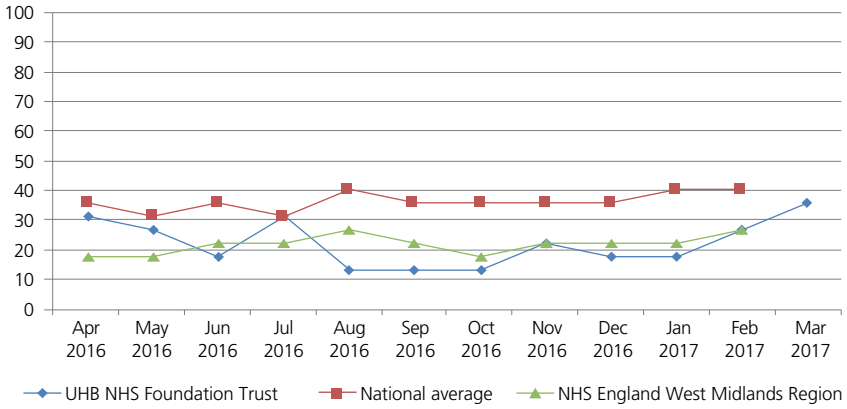
Inpatients

During 2016/17 the Trust has maintained a positive recommendation rate that was above the national and West Midlands average rates.



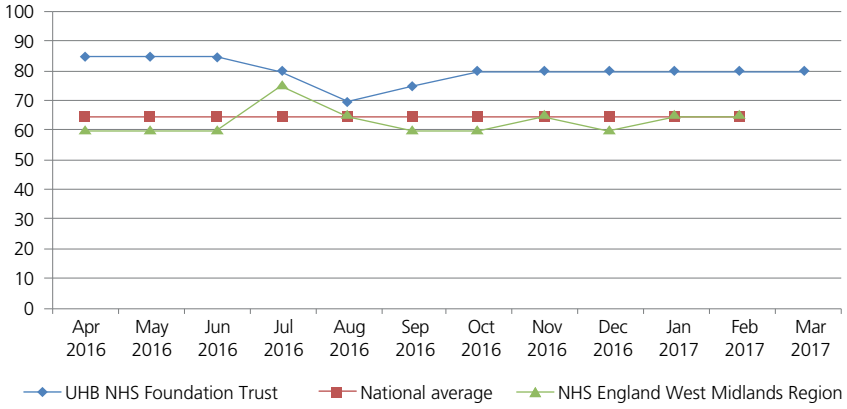
A&E

During 2016/17 the Trust's positive recommendation rate has fluctuated and has remained around the regional average but below the national average. Waiting times is often cited by patients as the reason for this reduction in score.



Outpatients

During 2016/17 the Trust has maintained a positive recommendation rate that is significantly higher than both the national average, and the West Midlands regional average



Complaints

The total number of all complaints (formal and informal) received in 2016/17 was 779, an increase of 15% on the 680 formal and informal complaints received in 2015/16. The largest increase was seen in Quarter 4 with an increase of 27% in the total number of complaints received compared to Quarter 3 2016/17.

The main subjects of all complaints received in 2016/17 related to clinical treatment (203), communication and information (129) and attitude of staff (110), matching the top three subjects from the previous year.

	2014/15	2015/16	2016/17
Total number of all complaints	792	680	779

The table below compares complaints received against activity data. The number of inpatient complaints received in 2016/17 reduced compared to the previous year, whilst activity increased, resulting in a lower complaints-to-activity ratio.

There was an increase in the level of complaints and activity in the outpatient and emergency department in 2016/17, resulting in slightly increased levels of complaints to activity ratios in both areas.

Rate of all complaints to activity		2014/15	2015/16	2016/17
Inpatients	FCEs*	127,204	129,574	135,216
	Complaints	429	345	327
	Rate per 1000 FCEs	**3.4**	**2.7**	**2.4**
Outpatients	Appointments**	752,965	788,996	817,407
	Complaints	271	245	331
	Rate per 1000 appointments	**0.4**	**0.3**	**0.4**
Emergency Department	Attendances	102,054	108,463	115,226
	Complaints	92	90	121
	Rate per 1000 attendances	**0.9**	**0.8**	**1.0**

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

Learning from complaints

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

Issue	Action taken
Concerns about how a patient's diabetes was managed when an inpatient	› Diabetes Nurse Consultant is reviewing education requirements on the ward where the patient was cared for. › Introduction onto wards of diabetes resource packs incorporating learning points from this case. › Increased provision of ketone meters into clinical areas, where required, to improve the monitoring and subsequent treatment of diabetic patients.
Poor experience of a patient with severe hearing loss when attending for cochlear implant surgery.	Group set up by deputy chief nurse to review arrangements for patients with hearing and visual impairments to try and improve all aspects of their experience.
Bereaved relatives did not receive a timely response from a consultant about their family member's death.	Improved process introduced to ensure that concerns are followed up via an email by the medical examiner to the appropriate consultant and the bereavement sister is also informed.
Concerns raised by diabetes user group around inadequate signage to diabetes clinic	Improved signage for diabetes clinic installed.
Poorly fitting anti-embolism stocking caused scarring.	Refresher training sessions arranged for all staff on the ward around the correct measuring and fitting of anti-embolism stockings.
Latex gloves used in theatre despite patient previously advising staff of an allergy.	New process implemented whereby the booking co-ordinator will screen all patients at the time of booking to check for any allergies prior to admission.
Delay with Chemotherapy medication being delivered to the unit.	Trial of Saturday working to produce Chemotherapy for patients attending the unit on Mondays and Tuesdays. Results of trial to be audited.
Delay in reporting of CT scan.	Report developed to identify urgent CT scans to help prevent delays.

More information around how learning is shared across the Trust can be found in the patient experience annual report.

Accessible complaints process
The Trust makes every effort to ensure that our complaints process is accessible to all. Complaints can be made by telephone, by email, via our website, in writing or in person (at the PALS office). Feedback leaflets with contact details are located on every ward and department. We have an easy read complaints leaflet, which explains the process in simple terms. When we are contacted by someone who has difficulties with the process, we provide clear contact details for the local NHS complaints advocacy service, who can support the individual and make the complaint on their behalf. We have provided complaints responses in alternative formats to accommodate specific requests including large font and braille.

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

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

PHSO Involvement	2014/15	2015/16	2016/17
Cases referred to PHSO by complainant for investigation	23	28	28
Cases which then required no further investigation	2	0	0
Cases which were then referred back to the Trust for further local resolution	1	0	1
Cases which were not upheld following review by the PHSO	5	6	13
Cases which were partially upheld following review by the PHSO	9	11	12
Cases which were fully upheld following review by the PHSO	0	2	1

NB outcome numbers may not match the cases referred in any year as these may span different periods – e.g. cases received in one year may be finalised in another.

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

Thirteen cases were upheld or partially upheld by the Ombudsman in 2016/17, the same as for the previous year. A further thirteen cases were not upheld by the Ombudsman, compared to just six last year. In every case, appropriate apologies were provided, action plans were developed where requested and the learning from the cases shared with relevant staff.

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

UHB consistently receives considerably more compliments than it does complaints. The Trust recorded slightly fewer compliments in 2016/17 than in 2015/16. The Patient Experience team provide support and guidance to divisional staff around the collation and recording of compliments received directly to wards and departments.

Compliment subcategories	2014/15	2015/16	2016/17
Nursing care	242	579	211
Friendliness of staff	142	84	90
Treatment received	1,743	1,290	1,582
Medical care	56	83	88
Other	17	24	18
Efficiency of service	104	268	275
Information provided	12	15	20
Facilities	12	6	2
Total	**2,328**	**2,349**	**2,286**

Examples of compliments received during 2016/17

Month received	Compliment
Apr 2016	…You treated me with gentle care when I was feeling stressful, with your gentle words and quiet ways my treatment was successful. You explained each procedure, in explicit care and detail… Best wishes and thank you.
May 2016	Having been in many wards within the QE, the domestic team on ward 622 are the best. They have lovely personalities, are efficient and proficient.
Jun 2016	My whole experience to date has been excellent. The staff are caring, thoughtful and knowledgeable. The efficiency and organisation should be set as a standard for other NHS hospitals.
Jul 2016	I am an outpatient of the Liver Clinic, all the staff, admin, nurses, doctors are all amazing. Everyone is so friendly and informative, good listeners and put you at ease…
Aug 2016	…Doctors, nurse and sisters very good, were able to translate and this was good. Students were nice and helpful. Food was nice.
Sep 2016	…To the crash team who successfully resuscitated mum on the night of the 6th July, allowing us a few more days together. We didn't get to meet you all so I don't know who in particular I need to thank!
Oct 2016	Really impressed with all of the appointment staff, especially at the Cardiology department. The technology controlling the appointments works so well… and the volunteers there to support visitors are great.
Nov 2016	...Being portered up to the operating theatre was another pleasant experience and the talk before going into the theatre left me in no doubt I was in good hands...
Dec 2016	... What fantastic staff, nothing is too much trouble, ward is spotlessly clean, food is great... Thank you from the bottom of our hearts.
Jan 2017	Everybody is very warm and caring and extremely helpful, considering I am deaf, everybody has written the information down for me.
Feb 2017	...I was lucky enough to encounter rather a lot of amazing people over the subsequent 36 hours... A year on I remember that day and I am forever grateful to all the people who helped me... You are all amazing.
Mar 2017	The aftercare was so lovely by the nurses and sisters on duty that afternoon and also the bereavement care team, when we had to come down for the death certificates, were so helpful, caring and professional...

Feedback received through NHS Choices, Patient Opinion and Healthwatch websites

The Trust has a system in place to monitor feedback posted on three external websites; NHS Choices, Patient Opinion and Healthwatch. Feedback is sent to the relevant service/department manager for information and action. A response is posted to each comment received which acknowledges the comment and provides general information when appropriate. The response also promotes the Patient Advice and Liaison Service (PALS) as a mechanism for obtaining a more personalised response, or to ensure a thorough investigation into any concerns raised. Whilst there has been a further increase in the number of comments posted on each of these three websites the numbers continue to be extremely low in comparison to other methods of feedback received. The majority of feedback received via this method is extremely positive, negative comments tend to be reflective of feedback received via more direct methods for example concerns raised via PALS, complaints or locally received verbal feedback.

Initiatives to be implemented in 2017/18

- Implement more flexible visiting times, with an increase from 2.30pm–7.30pm to 11am–8pm
- Work with QEHB Charity to develop and implement a Pets in Hospital scheme
- Pilot a renewed volunteer dining companions programme
- Undertake a baseline assessment of existing and ideal numbers and roles of volunteers to identify the Trust's volunteering needs and build a vacancy list
- Work with Harborne Academy on a pilot permitting younger volunteers (aged 16-17) into the Trust (currently minimum age is 18 years old)
- Development of our patient experience collection, analysis and reporting system in conjunction with the Trust/University of Birmingham PROMs group
- Work with the Young Persons' Council to develop mechanisms to increase feedback from young patients aged 16–24
- Develop a campaign to increase the number of patients reporting that their call bell was answered in a time reasonable for their needs
- Evaluate the pilot of an accessible feedback card and put methods in place to ensure that the opportunity to provide feedback is easy and accessible to all

Priority 3: Timely and complete observations including pain assessment

Background

All inpatient wards have been recording patient observations (temperature, blood pressure, oxygen saturation score, respiratory rate, pulse rate and level of consciousness) electronically since 2011. The observations are recorded within the Prescribing Information and Communication System (PICS).

When nursing staff carry out patient observations, it is important that they complete the full set of observations. This is because the electronic tool automatically triggers an early warning score called the SEWS (Standardised Early Warning System) score if a patient's condition starts to deteriorate. This allows patients to receive appropriate clinical treatment as soon as possible.

For 2015/16 the Board of Directors chose to tighten the timeframe for completeness of observation sets to within 6 hours of admission or transfer to a ward and to include a pain assessment.

In addition, the Trust is monitoring the timeliness of analgesia (pain relief medication) following a high pain score. The pain scale now used at UHB runs from 0 (no pain at rest or movement) to 10 (worst pain possible). Whenever a patient scores 7 or above, they should be given analgesia within 30 minutes. The indicator also includes patients who are given analgesia within the 60 minutes prior to a high pain score to allow time for the medication to work.

Performance

These were new indicators for 2015/16 and the initial targets were nearly achieved, so for 2016/17 the Trust decided to again set challenging and ambitious improvement targets.

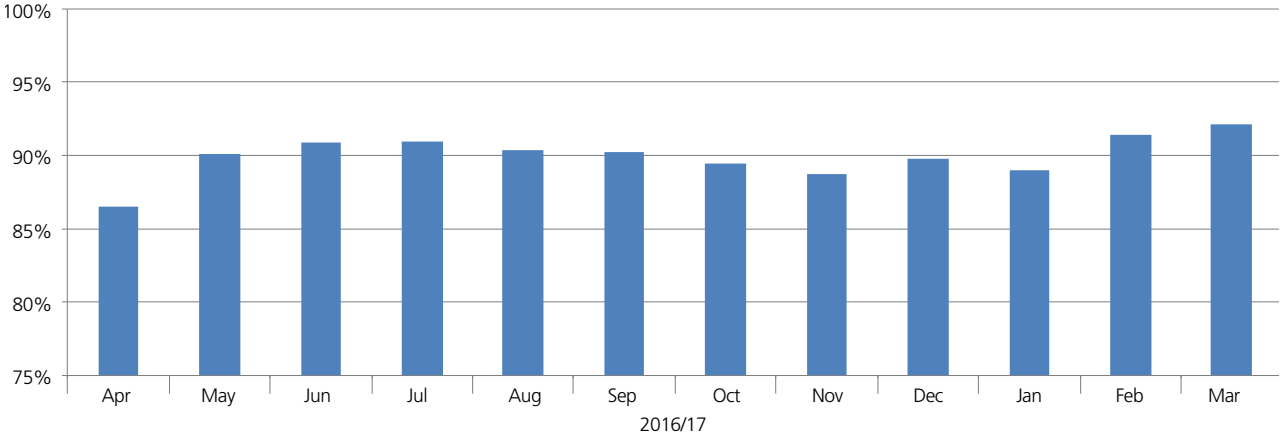
Indicator 1 achieved the target in Quarter 4, and also during the five months of May to September 2016. Performance during Quarters 1 and 3 was also high – above 89%.

Performance for Indicator 2 was steady throughout the year, between 74% and 76% each month, however the target of 85% was not achieved.

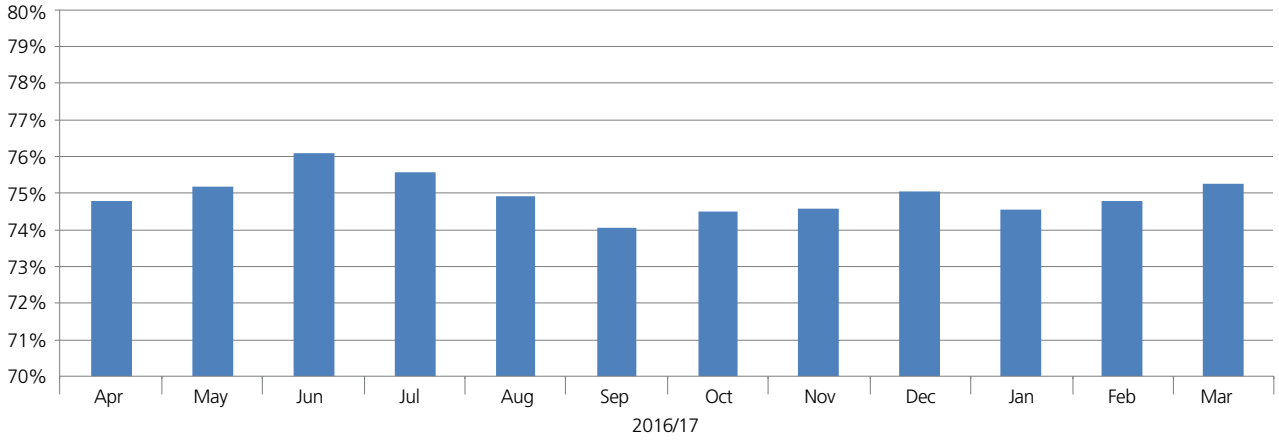
Performance by quarter

		Indicator 1	Indicator 2
		Full set of observations plus pain assessment recorded within 6 hours of admission or transfer to a ward	Analgesia administered within 30 minutes of a high pain score
Performance 2014/15		71%	64%
Performance 2015/16		79%	76%
2016/17	**Target**	**90%**	**85%**
	Q1	89.2%	75.3%
	Q2	90.5%	74.9%
	Q3	89.3%	74.7%
	Q4	90.8%	74.9%
	Year	**89.8%**	**75.0%**

Performance by month – Indicator 1: Complete observations and pain assessment within 6 hours



Performance by month – Indicator 2: Timely administration of analgesia



Initiatives implemented in 2016/17

- The bespoke electronic observations chart for the four Critical Care Units have been piloted and rolled out.
- Wards performance is monitored at a divisional and Trust level – lower performing wards developed action plans to make improvements, and can be called to an Executive Care Omissions Root Cause Analysis (RCA) meeting if required.

Changes to Improvement Priority for 2017/18

Indicator 1 – as the Trust achieved the target at the end of 2016/17, the Trust has chosen to increase the target for 2017/18:

1. Full set of observations plus pain assessment recorded within 6 hours of admission or transfer to a ward: 95% by the end of the year.

Indicator 2 – as performance was steady throughout the year, meaning the target was not achieved, the Trust has chosen to keep the same target for 2017/18:

2. Analgesia administered within 30 minutes of a high pain score: 85% by the end of the year.

Initiatives to be implemented in 2017/18

- A message is to be sent out via Team Brief, reminding wards of the importance of timely observations and assessments, and response to a high pain score.
- To consider bespoke indicators for the four Critical Care wards.
- Wards performing below target for the two indicators will continue to be reviewed at the Executive Care Omissions Root Cause Analysis (RCA) meetings to identify where improvements can be made. Observations and pain assessment compliance will be monitored as part of the unannounced monthly Board of Directors' Governance Visits to wards.

How progress will be monitored, measured and reported

- Progress will be monitored at ward, specialty and Trust levels through the Clinical Dashboard and other reporting tools. The Clinical Dashboard allows staff to compare their ward performance to the Trust as a whole, as well as seeing detailed data about which of the six observations or pain assessment were missed.
- Performance will continue to be measured using PICS data from the electronic observation charts.
- Progress will be reported monthly to the Clinical Quality Monitoring Group and the Board of Directors in the performance report. Performance will continue to be publicly reported through the quarterly Quality Report updates on the Trust's website.

Priority 4: Reduce medication errors (missed doses)

Background

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

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

The Trust has chosen to focus on maintaining performance for missed antibiotics and reducing non-antibiotic missed doses in the absence of a national consensus on what constitutes an expected level of drug omissions.

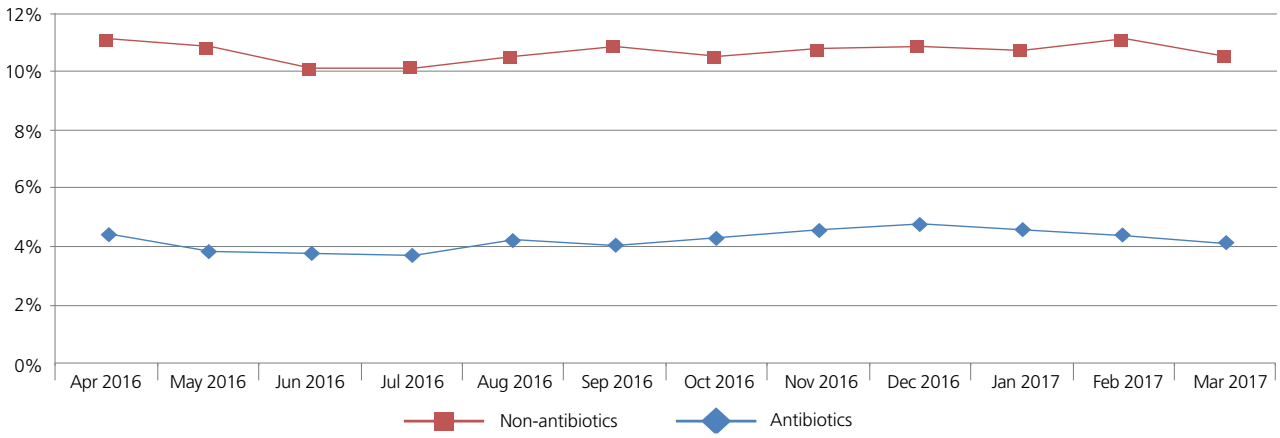
It is important to remember that some drug doses are appropriately missed due to the patient's condition at the time, and when a patient refuses a drug this is also recorded as a missed dose. The Trust has decided to record patient refusals as missed doses, as it is important for the staff looking after the patient to encourage them to take the medication, and to consider the reasons for refusal and whether a different medication would be more appropriate.

Performance

In the 2015/16 Quality Report, the Trust committed to maintaining performance for missed antibiotics at around 4.0% – performance during 2016/17 was around this mark (July 16 achieved 3.68%), however UHB has ended the year at 4.1%, slightly outside the target.

The Trust was aiming to reduce the percentage of missed non-antibiotics to 10% in 2016/17, however this has not been achieved. The best performance was in June 16 (10.1%), however overall performance for the year was 10.6% – very similar to the performance for the last two years of 10.5%.

Percentage of doses not give (missed doses)



Initiatives implemented during 2016/17 and learning from missed doses

- New 'Abloy' locks are being fitted to drug cupboards in wards across the Trust. These allow all members of nursing staff on a shift to unlock a drug cupboard, rather than having one set of keys for the whole ward. This reduces the time spent by staff looking for the keys and reduces delays in administration of medications.
- An observational audit was carried out during in late 2016 to review practice around missed doses, as part of this Pharmacy managers reviewed all missed doses that were due to the medication being out of stock.
- Nursing staff have been reminded that they have the ability to pause certain drugs until the prescription can be reviewed by a doctor.
- Various updates have been made to PICS, including
  - a new ordering system for wards to request medications from Pharmacy
  - nurses can now mark a dose as 'not administered' (missed) without it automatically generating a request to Pharmacy. This can be used when the nurse knows that the medication has already been ordered, reducing duplication of Pharmacy requests
  - improving what is recorded against due doses between the time that a prescription is suggested (e.g.) by a pharmacist, and the time when it is written by the doctor
  - a change to the prescription screen for certain medications to ensure prescriptions have the correct duration for each patient
- A report which displays missed doses due to medication being intermittently out of stock is used to identify cases for review at the Executive Care Omissions RCA meetings.
- Review of missed doses for the Executive Care Omissions RCA group has led to certain drugs, e.g. ones used to manage Parkinson's disease, being stocked in the emergency drug cupboards which ward staff can access when the medication is not available on their ward.
- Following one Executive Care Omissions RCA case,

the ward manager has reminded staff how to use the stock locator feature in PICS, and to escalate any missed doses to the Nurse in Charge. The ward have also started a daily review of all missed doses in PICS to ensure they have been addressed and escalated where appropriate.
- Following another Executive Care Omissions RCA case, staff were reminded to ensure that patients' medications were transferred with the patient when the patient moves to another ward.

Changes to Improvement Priority for 2017/18
The Trust has chosen to continue its focus on maintaining performance for missed doses of antibiotics and reducing missed doses of non-antibiotics in the absence of a national consensus on what constitutes an expected level of drug omissions.

As the targets were not achieved for 2016/17, the Trust has decided to keep the same targets for 2017/18:
- missed doses of antibiotics to be 4% or less by the end of 2017/18
- missed doses of non-antibiotic to be 10% or less by the end of 2017/18.

Initiatives to be implemented in 2017/18
- Publish a Practice Development Team "nil by mouth" mythbuster or practice update, to be circulated to all relevant staff
- Identify which medicines require exact timings for administration
- To consider new reports to identify types and patterns of missed doses across the Trust.
- Individual cases will continue to be selected for further review at the Executive Care Omissions RCA meetings.
- The Corporate Nursing team and Pharmacy will continue work together to identify where improvement actions should be directed to try to reduce missed doses.

How progress will be monitored, measured and reported
- Progress will continue to be measured at ward, specialty, divisional and Trust levels using information recorded in the Prescribing Information and Communication System (PICS).
- Data on missed drug doses is available to clinical staff via the Clinical Dashboard and includes a breakdown of the most commonly missed drugs and the most common reasons recorded for doses being missed. This is also monitored at divisional, specialty and ward levels.
- Performance will continue to be reported to the Chief Executive's Advisory Group, the Chief Operating Officer's Group and the Board of Directors each month to ensure appropriate actions are taken.
- Progress will be publicly reported in the quarterly Quality Report updates published on the Trust's quality web pages. Performance for missed doses by specialty will continue to be provided to patients and the public on the *mystay@QEHB* website.

Priority 5: Infection prevention and control (to be removed for 2017/18)

Performance

MRSA Bacteraemia

The national objective for all Trusts in England in 2016/17 was to have zero avoidable MRSA bacteraemia. During 2016/17, there were four MRSA bacteraemias apportioned to UHB.

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

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

Time Period	2013/14	2014/15	2015/16	2016/17				
				Q1	Q2	Q3	Q4	Total
Number of cases	5	6	8	1	2	0	1	**4**
Agreed trajectory	0	0	0			0		

Clostridium difficile Infection (CDI)

The Trust's annual agreed trajectory is a total of 63* cases during 2016/17, although NHS Improvement (NHSI) and the local Clinical Commissioning Group (CCG) measure the Trust against lapses in care. A lapse in care means that correct processes were not fully adhered to, and therefore the Trust had not done everything it could to try to prevent a *C. difficile* infection. The Trust uses a post infection review tool with the local Clinical Commissioning Group to identify whether there were any lapses in care which the Trust can learn from.

UHB reported 92 cases in total during 2016/17, of which 31** were deemed to have lapses in care.

The table below shows the total Trust-apportioned cases reported to Public Health England for the past three financial years, and how many of these were deemed to be avoidable.

Time Period	2013/14	2014/15	2015/16	2016/17				
				Q1	Q2	Q3	Q4	Total
Number of Trust-apportioned cases	80	66	66	24	23	24	21	**92**
Cases with lapses in care	16	17	24	13	9	6	3**	**31****
Agreed trajectory	56	67	63			63*		

* unless 17.6 per 100,000 bed days is higher – which equates to about 70 cases for 2016/17
** typing results awaited for 4 cases

Initiatives implemented in 2016/17

- Deep cleans of selected wards, in particular wards that have had a high number of CDI.
- Strict attention to hand hygiene and use of personal protective equipment (PPE).
- Increased compliance with MRSA screening before admission, on admission and for long stay patients.
- Ensuring appropriate antimicrobial use, to optimise patient outcomes and to reduce the risk of adverse events.
- Infection prevention and control nurses are available seven days per week to advise and support staff
- Ensure post infection review investigations are completed and lessons learnt are fed back throughout the Trust.

Changes to Improvement Priority for 2017/18

- The Governors and Board of Directors have agreed to remove this Priority for 2017/18, as data is presented elsewhere in the Quality Report (see part 3.1), and performance is widely monitored and reported both internally at the Trust and to other external bodies.

How progress will be monitored, measured and reported

This priority is to be removed from the Quality Account, however monitoring and reporting will continue as before:

- The number of cases of MRSA bacteraemia and CDI will be submitted monthly to Public Health England and measured against the agreed trajectories.
- Performance will be monitored via the Clinical Dashboard. Performance data will be discussed monthly at the Board of Directors, Chief Executive's Advisory Group and Infection Prevention and Control Group meetings.

- Any death where an MRSA bacteraemia or CDI is recorded on part one of the death certificate will continue to be reported as serious incidents (SIs) to Birmingham CrossCity Clinical Commissioning Group (CCG).
- Post infection review and root cause analysis will continue to be undertaken for all MRSA bacteraemia and CDI cases.
- Progress against the Trust Infection Prevention and Control delivery plan will be monitored by the Infection Prevention and Control Group and reported to the Board of Directors via the Patient Care Quality Reports and the Infection Prevention and Control Annual Report. Progress will also be shared with Commissioners.

Priority 5 – Reducing harm from falls (New for 2017/18)

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

Background

Inpatient falls are common and remain a great challenge for the NHS. Falls in hospital are the most common reported patient safety Incident, with more than 240,000 reported in acute hospitals and Mental Health trusts in England and Wales every year (Royal College of Physicians, National Audit of Inpatient Falls, 2015). About 30% of people 65 years of age or older have a fall each year, increasing to 50% in people 80 years of age or older (National Institute of Health and Clinical Excellence – NICE).

All falls can impact on quality of life, they can cause patients distress, pain, injury, prolonged hospitalisation and a greater risk of death due to underlying ill health. Falls can result in loss of confidence and independence which can result in patients going into long term care. Falling also affects the family members and carers of people who fall.

When a fall occurs at UHB, the staff looking after the patient submit an incident form via Datix, the Trust's incident reporting system. All falls incidents are reviewed by the Trust's Falls Team, a team of clinical nurse specialists. The lead for the area where the fall happened, usually the Senior Sister/Charge Nurse, investigates the fall and reports on the outcome of the fall, and whether there is any learning or if any changes in practice/policy need to be made.

Most falls do not result in any harm to the patient. Any falls that result in moderate or severe harm undergo an RCA (root cause analysis) process to identify any issues or contributory factors. Falls resulting in specific harm, e.g. a fractured neck of femur (broken hip), are also reported to the local Clinical Commissioning Group.

Falls prevention

All inpatients should undergo a Falls Assessment on admission/transfer to a ward or if their clinical condition changes. If a patient is found to be at risk at of falls, staff will identify the risk factors and the precautions that can be taken to reduce these risks. These may include a medication review by pharmacy staff, provision of good-fitting footwear, ensuring chairs are the correct height and width for the patient, or moving the patient to a height-adjustable bed.

The Falls Team also receive information on patients who have fallen more than once during their hospital stay. These patients are reviewed, taking account of mobility, medication, continence and altered cognition. The Falls Team will make suitable recommendations to the ward staff around intervention and prevention of further falls.

The Falls Team provide training on falls assessment, prevention and management to ward staff, junior doctors and students.

Performance

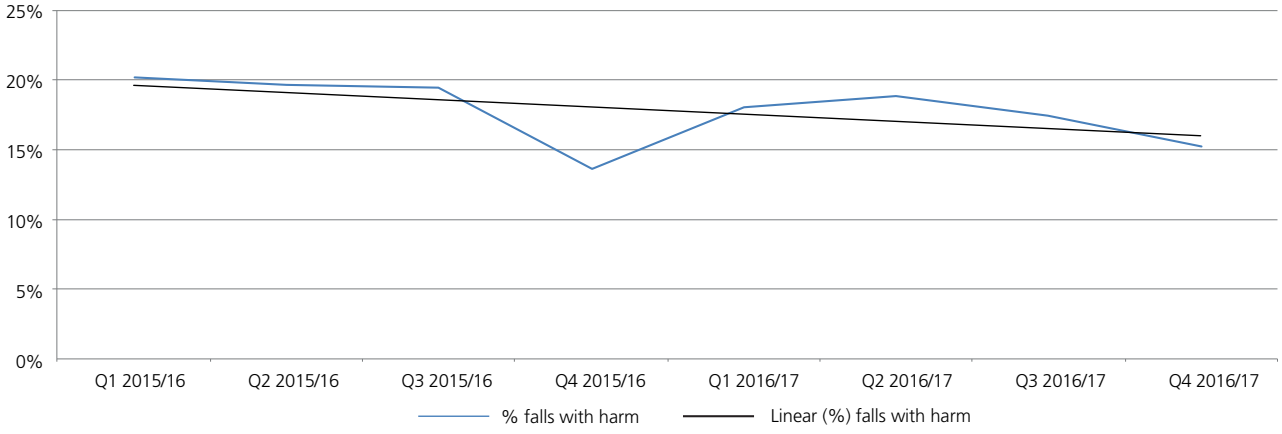
The Trust has chosen to measure 'percentage of falls resulting in harm'.

While staff take precautions to prevent falls from occurring, it is not possible to prevent all falls – therefore it is also important in minimise the harm that occurs due to falls.

Data for the last two years is presented below.

Year	Quarter	Percentage of falls with harm
2015/16	Q1	20.2%
	Q2	19.6%
	Q3	19.5%
	Q4	13.6%
	Year	**18.1%**
2016/17	Q1	18.1%
	Q2	18.9%
	Q3	17.4%
	Q4	15.3%
	Year	**17.4%**

Percentage of all falls that result in harm



Overall, the trend has been that the percentage of falls with harm has been decreasing since Quarter 1 2015/16 – this is shown by the trendline in the graph above.

The Trust has decided to set a target of 16.5% by the end of 2017/18 – this is a 5% reduction on the 2016/17 result.

Initiatives to be implemented during 2017/18

- Work with Divisions on their plans for 2017/18
- Continue providing Falls training to all Divisions on their mandatory training days and also FY1 (junior doctor) training induction days.
- Working with Lead Nurse for Standards to devise a new policy, procedure and guidelines.
- Participate in the Royal College of Physicians' National Audit of Inpatient Falls in May 2017, led by a Consultant in Geriatric Medicine

How progress will be monitored, measured and reported

- Data on falls is presented to the monthly Trust Preventing Harm group, which reports to the Chief Nurse's Care Quality Group. Data on falls is also provided to the Medical Director's monthly Clinical Quality Monitoring Group.
- Ward-level and trust-level data on falls is available to clinical staff via the Clinical Dashboard.
- Falls with specific outcomes, e.g. a fractured neck of femur (broken hip), are reported to the local Clinical Commissioning Group.
- Progress will be publicly reported in the quarterly Quality Report updates published on the Trust's quality web pages.

Priority 6 – Timely treatment for sepsis in the emergency department (New for 2017/18)

This quality improvement priority was proposed by the Clinical Quality Monitoring Group, agreed by the Council of Governors and approved by the Board of Directors.

Background
Sepsis is a potentially life-threatening condition which is the result of a bacterial infection in the blood. It affects an estimated 260,000 people per year in the UK and is a significant cause of preventable mortality. Approximately 44,000 people die each year as a result of sepsis – a quarter of which are avoidable.

Although there are certain groups in whom sepsis is more common – the very young and very old, people with multiple co-morbidities, people with impaired immunity and pregnant women – it can occur in anybody, regardless of their age or health status.

Though sepsis is common, it is poorly addressed. It is important to understand that if sepsis is recognised early and appropriately managed it is treatable. However, if recognition is delayed and appropriate treatment not instituted (usually oxygen, intravenous fluids and antibiotics), significant harm or even death can occur.

Sepsis has been on the national agenda as a high priority area for the Commissioning for Quality and Innovation (CQUIN) system. In 2016/17 certain trusts had a key target to implement systematic screening for sepsis of appropriate patients and where sepsis is identified, to provide timely and appropriate treatment and review. This CQUIN has been extended in the 2017–19 plan, which UHB is participating in.

The Trust intranet pages have a library of information on recognising the symptoms of sepsis, screening patients and treating sepsis – these pages are available for all staff to view and have been promoted by the trust Communications team.

The Trust's aim for 2017/18 is to improve the early recognition and management of patients with sepsis.

Performance
For this Quality Priority, UHB has chosen to base measurement on one of the indicators in the CQUIN process – "Timely treatment for sepsis in emergency departments". This will be measured by calculating the time between diagnosis of sepsis and first dose of IV (intravenous) antibiotic. To do this, the Emergency Department (ED) will need the PICS (Prescribing Information and Communication System) in place, in order to capture the exact times of diagnosis and drug administration.

There is a plan to implement PICS in the ED with initial testing to begin in May 2017. Once PICS is implemented in ED, data will be collected and then used to set a baseline and an improvement target.

Initiatives to be implemented during 2017/18
A new sepsis screening tool is to be rolled out across the trust, to help staff quickly identify patients who are at risk, or who have developed sepsis. It can be used for patients who have attended ED or have just been admitted to a ward, as well as patients who are already in hospital. As well as helping staff to identify patients who may have sepsis, it provides clear instruction on how to treat them and what further tests are required.

'THINK SEPSIS' is a national campaign aiming to raise awareness of sepsis. In April 2017, UHB held a Sepsis Awareness week, to raise awareness of the THINK SEPSIS campaign and to provide information and advice of how to recognise the symptoms, how to screen and how to treat red flag sepsis. On the first day there was a stall with information and a presentation from Dr Ron Daniels BEM, Chief Executive of the UK Sepsis Trust and Global Sepsis Alliance, and also Clinical Advisor (Sepsis) to NHS England. On the following days a multi-disciplinary Sepsis Team visited wards across the hospital site.

How progress will be monitored, measured and reported
- Once PICS is implemented in the Emergency Department, data will be collected and used to set a baseline and improvement target.
- Progress will be publicly reported in the quarterly Quality Account updates published on the Trust's quality web pages.
- Performance will be reported to the Clinical Quality Monitoring Group as part of the quarterly Quality Account update reports.

2.2 Statements of assurance from the Board of Directors

2.2.1 Information on the review of services

During 2016/17 the University Hospitals Birmingham NHS Foundation Trust* provided and/or sub-contracted 63 relevant health services.

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

The income generated by the relevant health services reviewed in 2016/17 represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2016/17.

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

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

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

2.2.2 Information on participation in clinical audits and national confidential enquiries

During 2016/17 44 national clinical audits and 6 national confidential enquiries covered relevant health services that UHB provides. During that period UHB participated in 92% (36 of 39) national clinical audits and 83% (5 of 6) 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 2016/17 are as follows: (see tables below).

The national clinical audits and national confidential enquiries that UHB participated in during 2016/17 are as follows: (see tables below).

The national clinical audits and national confidential enquiries that UHB participated in, and for which data collection was completed during 2016/17, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits

National Audit UHB eligible to participate in	UHB participation 2016/17	Percentage of required number of cases submitted
Acute Coronary Syndrome or Acute Myocardial Infarction	Yes	100%
Adult Asthma	Yes	100%
Adult Cardiac Surgery	Yes	100%
Asthma (paediatric and adult) care in emergency departments	Yes	100%
BAETS – Endocrine and Thyroid National Audit	Yes	100%
Cardiac Rhythm Management	Yes	<80%
Congenital Heart Disease	Yes	99.7%
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions	Yes	100%
Critical Care Case Mix Programme (ICNARC)	Yes	100%
Head and Neck Cancer Audit	Yes	100%
Inflammatory Bowel Disease programme	Yes	100%* Historical Data – upload only: new registry not commenced collection
Learning Disability Mortality Review Programme (LeDeR Programme)	No	Data collection not fully commenced at time of writing.
National Bowel Cancer Audit	Yes	66%
National Cardiac Arrest Audit (NCAA)	No	0%
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	Yes	Data collection not fully commenced at time of writing.
National Comparative Audit of Blood Transfusion – Audit of Patient Blood Management in Scheduled Surgery	Yes	100%
National Diabetes Audit	No	0%
National Emergency Laparotomy Audit	Yes	61%
National Heart Failure Audit	Yes	69%
National Hip Fracture Audit	Yes	86.9%
National Inpatient Audit (Diabetes)	Yes	100%
National Joint Registry (NJR)	Yes	100%
National Lung Cancer Audit	Yes	100%
National Neurosurgery Audit Programme	Yes	100%
National Ophthalmology Audit	Yes	100%
National Prostate Cancer Audit	Yes	>100%
National Vascular Registry	Yes	96%
Nephrectomy audit	Yes	100%
Oesophago-Gastric Cancer Audit	Yes	41–50%
Percutaneous Nephrolithotomy (PCNL)	Yes	100%
Radical Prostatectomy Audit	Yes	100%
Renal Replacement Therapy (Renal Registry)	Yes	100%
Rheumatoid and Early Inflammatory Arthritis	Yes	100%
Sentinel Stroke National Audit programme	Yes	100%
Severe Sepsis and Septic Shock – care in emergency departments	Yes	100%
Stress Urinary Incontinence Audit	Yes	100%
TARN – Major Trauma Audit	Yes	100%
Emergency Oxygen	Yes	100%
Use of blood in Haematology	Yes	100%

National Confidential Enquiries (NCEPOD)

National Confidential Enquiries (NCEPOD)	UHB participation 2016/17	Percentage of required number of cases submitted
Mental Health	Yes	100%
Acute Pancreatitis	Yes	100%
Acute Non Invasive Ventilation	Yes	100%
Chronic Neurodisability	Yes	100%
Young People's Mental Health	No	Insufficient cases and available information to participate
Cancer In Children, Teens and Young Adults	Yes	Active study – Ongoing

Percentages given are the latest available figures.

The reports of 14 national clinical audits were reviewed by the provider in 2016/17 and UHB intends to take the following actions to improve the quality of healthcare provided: (see separate clinical audit appendix published on the Quality web pages: http://www.uhb.nhs.uk/quality.htm).

The reports of 255 local clinical audits were reviewed by the provider in 2016/17 and UHB intends to take the following actions to improve the quality of healthcare provided (see separate clinical audit appendix published on the Quality web pages: http://www.uhb.nhs.uk/quality.htm).

At UHB a wide range of local clinical audits are undertaken. This includes Trust-wide audits and specialty-specific audits that reflect local interests and priorities. A total of 809 clinical audits were registered with UHB's clinical audit team during 2016/17. Of these audits, 255 were completed during the financial year (see separate clinical audit appendix published on the Quality web pages: http://www.uhb.nhs.uk/quality.htm)

2.2.3 Information on participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by UHB in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was:

NIHR portfolio studies	5,190
Non-NIHR portfolio studies	2,368
Total	**7,558***

*Data only available up to January 2017 (it takes 2–3 months for UKCRN to upload UKCRN patient recruitment numbers)

The total figure is based on all research studies that were approved during 2016/17 (NIHR: National Institute for Health Research).

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

Reporting period	2013/14	2014/15	2015/16	2016/17
Total number of projects registered with R&D	306	307	361	266
Out of the total number of projects registered, the number of studies which were abandoned	39	56	70	115
Trust total patient recruitment	**10,778**	**11,400**	**8,493****	**7,558***

*Data only available up to January 2017 (it takes 2-3 months for UKCRN to upload UKCRN patient recruitment numbers)
**This figure has been updated since the 2015/16 Quality Account, as the full year's data is now available.

The table below shows the number of projects registered in 2016/17, by specialty:

Specialty	No. of projects registered
Non-Specific	26
Anaesthetics	4
Burns & Plastics	5
Cardiac Medicine	1
Cardiac Surgery	1
Cardiology	15
Clinical Haematology	4
Clinical Immunology	2
Critical Care	10
Dermatology	3
Diabetes	4
Endocrinology	17
ENT	7
General Surgery	5
Genito-Urinary Medicine	6
Geriatric Medicine	1
GI Medicine	10
Haematology	10
Histopathology	1
HIV	1
Imaging	1
ITU	3
Liver Medicine	21
Liver Surgery	4
Lung Investigation Unit	3
Microbiology	5
Neurology	15
Neuroradiology	3
Neurosurgery	4
Oncology	36
Ophthalmology	6
Pain Services	2
Palliative Care	1
Renal Medicine	4
Renal Surgery	3
Respiratory Medicine	5
Rheumatology	6
Stroke Services	3
Therapy Services	1
Trauma	2
Urology	4
Vascular Surgery	1
Total	**266**

Examples of research at UHB having an impact on patient care

A joint study with the University of Birmingham is looking into treatment of head and neck cancer, specifically drugs that can be given alongside chemotherapy and radiotherapy, as well as trialling different regimens.

UHB is also involved in a study that has established a new cancer prevention network for colitis-associated dysplasia (CAD), which is looking at the impact that optimised surveillance has on organ preserving treatment. Current treatment of CAD requires radical panproctocolectomy – removal of the large bowel. An international consortium has been launched to support this organ preserving initiative with industry collaboration.

The sexual health research team is based within the Umbrella sexual health partnership at UHB which has regional coverage and operates eight walk-in satellite clinics across the West Midlands. Research activity has expanded to cover these clinics and has provided research opportunities and trial recruitment for the first time in Boots in Birmingham city centre and Solihull, and the Erdington Health & Wellbeing Walk-in Centre.

Working with industry means that UHB patients have been able to receive new treatments at an exceptionally early stage of trial and drug development, for example: PRELUDE – a rare neuroendocrine oncology trial cancer study; PIPEFLEX – a neuro-interventional study with flow diverter in intracranial brain aneurysms; WILSONS – a neuro-hepatology trial in this rare disease and GAMMACORE – an interventional migraine study for which UHB was also the top recruiting UK site.

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

A proportion of UHB income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between UHB and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2016/17 and for the following 12-month period are available electronically at www.uhb.nhs.uk/quality-reports.htm

The amount of UHB income in 2016/17 which was conditional upon achieving quality improvement and innovation goals was £12.3m.* Final payment for 2016/17 will not be known until June 2017.

* This represents the amount of income achievable based on the contract plans for NHS England and West Midlands CCGs. It isn't a precise figure for the following reasons;

- CQUIN would also be payable on any over-performance against these contracts
- CQUIN is also payable on out of area contracts
- A provision has been made in the accounts for non-delivery of some CQUINS
- CQUIN adjustments will also be applied for any adjustments made to the final outturn positions agreed with commissioners for 16/17.

UHB income in 2015/16 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because the Trust was paid by commissioners based on the Default Rollover Tariff in 2015/16 and therefore was not eligible for CQUIN funding.

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

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

The Care Quality Commission has not taken enforcement action against UHB during 2016/17.

UHB has not participated in special reviews or investigations by the CQC during 2016/17.

Following the Care Quality Commission (CQC)'s focussed visit in December 2015 to review Cardiac Surgical Services, the CQC placed two conditions on UHB's registration – to provide outcome and performance data on a weekly basis and to commission an external review. UHB submitted the data every week as requested, and a two-day external review was conducted in February/March 2016. In May 2016 the CQC then wrote to UHB to remove the conditions from registration, and to inform the Trust that data and updates would only be required on a quarterly basis. The Cardiac Surgery Quality Improvement Programme, which was commenced prior to the CQC visit, continues and the majority of the actions identified from the CQC report and subsequent external visit have been completed. In November 2016, the Royal College of Surgeons conducted a review which recognised the progress made by the service. Reports on progress against the project plan continue to be provided to the Cardiac Surgery Project Board, while performance data is reviewed at weekly meetings chaired by Executive Directors.

Information on visits conducted by Birmingham Cross City Commissioning Group is provided in the table below.

Inspections/visits undertaken by Birmingham Cross City Clinical Commissioning Group

Date	Type of inspection	Outcome	Actions taken
13 July 2016	An unannounced visit was conducted on ward 303.	Overall the verbal feedback was very positive. We are awaiting the final report.	N/A
21 July 2016	An unannounced visit was conducted on wards 727 and 728.	Overall the verbal feedback was very positive. We are awaiting the final report.	N/A
17 October 2016	An unannounced visit was conducted on ward 518 which focussed on Infection Control.	The initial feedback was that the ward was tidy and uncluttered. There were some areas identified during the visit which need attention such as a continued focus on equipment cleaning and infection prevention practices	All identified actions have now been rectified: equipment cleaning programme embedded, Trust wide Infection Prevention and Control action plans have been modified and displayed to fit individual ward profiles, clinical waste and domestic waste bins have been appropriately placed, daily monitoring of all bays and single rooms to ensure alcohol hand rub is available.
21 October 2016	An unannounced inspection was conducted on Edgbaston Ward and Ward West 2 by the safeguarding team.	There were no specific requirements or recommendations arising out of the visit other than three points for consideration: 1. "This is me" – could be utilised better, the content was rather light. 2. Potential for discussion of safeguarding/mental capacity issues to be built into handovers to embed learning and understanding. 3. Care plans specifically detailing DOLs for patients would be beneficial, with 'Dos and Don'ts' and spelling out what 'least restrictive practice' looks like.	Feedback was shared with the wards involved.
5 December 2016	An unannounced visit was conducted to the Emergency Department with an emphasis on quality, safety and patient experience.	There were no immediate concerns raised and no remedial actions to be taken. We are awaiting the final report.	N/A

Care Quality Commission: Inspection Ratings Grid

The CQC carried out a focused inspection of the Trust in January 2015. As a result of the inspection the Trust was overall rated as 'good' and full details of the Trusts ratings are below:

Domain	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Services	Requires Improvement	Requires Improvement	Good	Outstanding	Good	Good
Medical Care	Good	Good	Good	Good	Good	Good
Surgery	Good	Outstanding	Good	Requires Improvement	Good	Good
Critical Care	Good	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
End of Life Care	Good	Good	Good	Outstanding	Good	Good
Outpatient and diagnostic imaging	Good	N/A	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall Trust	Good	Good	Good	Good	Outstanding	Good

For the areas which were rated as 'requires improvement' the CQC provided recommendations the Trust must take to improve. An action plan was developed as a result of and is monitored by the Board of Directors on a quarterly basis.

2.2.6 Information on the quality of data

UHB submitted records during 2016/17 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS Number was*:
  - 99.46% for admitted patient care;
  - 99.65% for outpatient care; and
  - 97.61% for accident and emergency care.
- which included the patient's valid General Medical Practice Code was*:
  - 99.99% for admitted patient care;
  - 99.94% for outpatient care; and
  - 99.98% for accident and emergency care.

*Figures cover the latest available period: 1st April 2016 to 28th February 2017.

UHB Information Governance Assessment Report overall score for 2016/17 was 70% and was graded green (satisfactory).

UHB was not subject to the Payment by Results clinical coding audit during 2016/17 by the Audit Commission.

(Note: the Audit Commission has now closed and responsibility now lies with NHS Improvement).

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

- Continue to drive forward the strategy of the West Midlands Clinical Coding Academy and the UHB Coding Training programme to further improve training and clinical coding across the West Midlands.
- Implementation of a new integrated Trust-wide patient administration system which will reduce duplication of data entry.
- Continue to monitor data quality through the Ward Clerk quality monitoring and management programme.
- Ensure continued compliance with the Information Governance Toolkit minimum Level 2 for data quality standards.
- Review the Data Quality Policy and develop associated procedures.
- Continue to reinforce the embedded data quality culture by challenging data at the Data Quality Group and investigating any potential issues.
- Implementation of a quality assurance programme ensuring key elements of information reporting including data assurance, presentation and validation.
- Continue to improve the data quality in relation to 18 week referral to treatment time (RTT) through audit, validation and education of both clinical and non-clinical teams.

2.3 Performance against national core set of quality indicators

A national core set of quality indicators was jointly proposed by the Department of Health and Monitor for inclusion in trusts' Quality Reports from 2012/13. The data source for all the indicators is NHS Digital (formerly the Health and Social Care Information Centre, or HSCIC). The Trust's performance for the applicable quality indicators is shown in Appendix A for the latest time periods available. Further information about these indicators can be found on the NHS Digital website: http://content.digital.nhs.uk/

3 Other information

3.1 Overview of quality of care provided during 2016/17

The tables below show the Trust's latest performance for 2016/17 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 2015/16 Quality Report to enable patients and the public to understand performance over time.

The patient safety and clinical effectiveness indicators were originally selected by the Clinical Quality Monitoring Group because they represent a balanced picture of quality at UHB.

The patient experience indicators were selected in consultation with the Care Quality Group which has Governor representation to enable comparison with other NHS trusts.

The latest available data for 2016/17 is shown below and has been subject to the Trust's usual data quality checks by the Health Informatics team. Benchmarking data has also been included where possible.

Performance is monitored and challenged during the year by the Clinical Quality Monitoring Group and the Board of Directors.

Patient safety indicators

Indicator	Data source	2014/15	2015/16	2016/17	Peer Group Average (where available)
1(a) Patients with MRSA infection/100,000 bed days › (includes all bed days from all specialties) › *Lower rate indicates better performance*	› Trust MRSA data reported to PHE › HES data (bed days)	**1.52**	**2.06**	**1.00** April–Dec 2016	**0.44** April–Dec 2016 Acute trusts in West Midlands
1(b) Patients with MRSA infection/100,000 bed days › (aged >15, excluding Obstetrics, Gynaecology and elective Orthopaedics) › *Lower rate indicates better performance*	› Trust MRSA data reported to PHE › HES data (bed days)	**1.52**	**2.07**	**1.01** April–Dec 2016	**0.49** April–Dec 2016 Acute trusts in West Midlands
2(a) Patients with *C. difficile* infection/100,000 bed days › (includes all bed days from all specialties) › *Lower rate indicates better performance*	› Trust CDI data reported to PHE › HES data (bed days)	**16.73**	**16.76**	**23.88** April–Dec 2016	**15.69** April–Dec 2016 Acute trusts in West Midlands
2(b) Patients with *C. difficile* infection/100,000 bed days › (aged >15, excluding Obstetrics, Gynaecology and elective Orthopaedics) › *Lower rate indicates better performance*	› Trust CDI data reported to PHE › HES data (bed days)	**16.82**	**16.84**	**24.00** April–Dec 2016	**17.42** April–Dec 2016 Acute trusts in West Midlands
3(a) Patient safety incidents › (reporting rate per 1000 bed days) › *Higher rate indicates better reporting*	› Datix (incident data) › Trust admissions data	**47.2**	**63.3**	**63.6**	**58.7** April – Sep 2016 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
3(b) Never Events › The number of Never Events that occurred during the time period › *Lower number indicates better performance*	› Datix (incident data)	**3**	**5**	**1**	*Not available*
4(a) Percentage of patient safety incidents which are no harm incidents › *Higher % indicates better performance*	› Datix (incident data)	**81.0%**	**82.0%**	**83.1%**	**76%** April – Sep 2016 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)

Indicator	Data source	2014/15	2015/16	2016/17	Peer Group Average (where available)
4(b) Percentage of patient safety incidents reported to the National Reporting and Learning System (NRLS) resulting in severe harm or death › *Lower % indicates better performance*	› Datix (patient safety incidents reported to the NRLS)	**0.12%**	**0.14%**	**0.12%**	**0.30%** April – Sep 2016 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
4(c) Number of patient safety incidents reported to the National Reporting and Learning System (NRLS)	› Datix (patient safety incidents reported to the NRLS)	**16,222**	**20,516**	**22,532**	**11,155** (6 months) April – Sep 2016 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)

Clinical effectiveness indicators

Indicator	Data source	2014/15	2015/16	2016/17	Peer Group Average (where available)
5(a) Emergency readmissions within 28 days (%) › (Medical and surgical specialties – elective and emergency admissions aged >15) % › *Lower rate indicates better performance*	› HES data	**13.51%** **England: 13.87%**	**13.41%** **England: 14.15%**	**13.33%** Apr–Dec 2016	**13.55%** April–Dec 2016 University hospitals **England: 14.10%**
5(b) Emergency readmissions within 28 days (%) › (all specialties) › *Lower % indicates better performance*	› HES data	**13.48%** **England: 13.24%**	**13.39%** **England: 13.52%**	**13.45%** Apr–Dec 2016	**13.08%** Apr–Dec 2016 University hospitals **England: 13.47%**
5(c) Emergency readmissions within 28 days of discharge (%) › *Lower % indicates better performance*	› Lorenzo	**10.75%**	**10.68%**	**10.67%** Apr 2016–Feb 2017	*Not available*
6 Falls (incidents reported as % of patient episodes) › *Lower % indicates better performance*	› Datix (incident data), › Trust admissions data	**2.2%**	**2.1%**	**2.2%**	*Not available*
7 Stroke in-hospital mortality › *Lower % indicates better performance*	› SSNAP data	**9.5%**	**5.0%**	**1.8%**	*Not available*
8 Percentage of beta blockers given on the morning of the procedure for patients undergoing first time coronary artery bypass graft (CABG) › *Higher % indicates better performance*	› Trust PICS data	**94.7%**	**97.5%**	**97.4%**	*Not available*

Notes on patient safety and 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.

- **1a, 1b, 2a, 2b, 5a, 5b**
  Receipt of HES data from the national team always happens two to three months later, these indicators will be updated in the next quarterly report.

- **1a, 1b, 2a, 2b**
  For further information on action taken at UHB around MRSA and CDI, please refer to Priority 5 in Section 2 above.

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

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

  In January 2014, the Trust implemented an automatic incident reporting process whereby incidents are directly reported from the Trust's Prescribing Information and Communication System (PICS). These include missed observations and patients who need to be discharged off PICS. The Trust's incident reporting rate has therefore increased and this trend is likely to continue. The purpose of automated incident reporting is to ensure even small errors or omissions are identified and addressed as soon as possible. The plan is to include other automated incidents such as 'complete set of observations plus pain assessment within 6 hours of admission to a ward' during 2017/18.

- **3(b)**
  UHB had one Never Event in 2016/17: Patient underwent surgery; at the end of the procedure the swab count reported one swab missing. The consultant was at the point of skin closure; an x-ray was taken which failed to identify the swab. The consultant decided to transfer patient to Critical Care where they had another x-ray which could provide a clearer image and the missing swab was identified. The patient returned to theatre for removal of the swab, and duty of candour was completed.

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

- **5a, 5b**
  The methodology has been updated to reflect the latest guidance from the Health and Social Care Information Centre. The key change is that day cases and regular day case patients, all cancer patients or patients coded with cancer in the previous 365 days are now excluded from the denominator. This indicator includes patients readmitted as emergencies to the Trust or any other provider within 28 days of discharge. Further details can be found on the Health and Social Care Information Centre website. Any changes in data since the previous Quality Report are due to updates made to the national HES data.

- **5c**
  This indicator only includes patients readmitted as emergencies to the Trust within 28 days of discharge and excludes UHB cancer patients. The data source is the Trust's patient administration system (Lorenzo). The data for previous years has been updated to include readmissions from 0 to 27 days and exclude readmissions on day 28 in line with the national methodology. Any changes in previously reported data are due to long-stay patients being discharged after the previous years' data was analysed.

- **8**
  Beta blockers are given to reduce the likelihood of peri-operative myocardial infarction and early mortality. This indicator relates to patients already on beta blockers and whether they are given beta blockers on the day of their operation. All incidences of beta blockers not being given on the day of operation are investigated to understand the reasons why and to reduce the likelihood of future omissions. During 2014/15 there was a small adjustment to the methodology of this indicator, resulting in a very small change to the indicator results for this year.

Patient experience indicators

UHB usually publishes data taken from the National Inpatient Survey, run by the Picker Institute on behalf of the CQC, however publication of the 2016 survey report has been delayed and is not available at the time of writing. The text and table below refer to the 2015 survey results, which were reported in the 2015/16 Quality Account. Information on the 2016 results will be added to the published Quality Account once it is available. Alternative patient experience data and indicators are also available in Priority 2: Improving patient experience above, these are taken from the Trust's local patient surveys.

The results of the 2015 National Inpatient Survey reported that the Trust was 'better' than other Trusts in six questions (four in 2014): getting enough help from staff to eat meals, being given written or printed information about what to do/not do after leaving hospital, giving family/someone close all the information needed to care for the patient, telling patients who to contact if they are worried after leaving hospital, discussing with patient whether any further health or social care services were needed after leaving hospital, and asking patients during their stay about the quality of care they were receiving. The remaining questions scored 'about the same' as other trusts.

	2014/15		2015/16		2016/17	
Patient survey question	Score	Comparison with other NHS trusts in England	Score	Comparison with other NHS trusts in England	Score	Comparison with other NHS trusts in England
9. Overall were you treated with respect and dignity?	**9.2**	About the same	**9.2**	About the same	**TBC**	TBC
10. Involvement in decisions about care and treatment	**7.7**	About the same	**7.5**	About the same	**TBC**	TBC
11. Did staff do all they could to control pain?	**8.1**	About the same	**8.2**	About the same	**TBC**	TBC
12. Cleanliness of room or ward	**9.2**	About the same	**9.2**	About the same	**TBC**	TBC
13. Overall rating of care	**8.3**	About the same	**8.4**	About the same	**TBC**	TBC
Time period & data source	2014, Trust's Survey of Adult Inpatients 2014 Report, CQC		2015, Trust's Survey of Adult Inpatients 2015 Report, CQC		TBC – 2016, Trust's Survey of Adult Inpatients 2016 Report, CQC	

Note: Data is presented as a score out of 10; the higher the score for each question, the better the Trust is performing.

3.2 Performance against indicators included in the NHS Improvement Single Oversight Framework

In the 2015/16 Quality Account, trusts were required to report performance for the Monitor Risk Assessment Framework. This changed to the NHS Improvement Single Oversight Framework on 1st October 2016, and for the 2016/17 Quality Account trusts are required to report only on indicators common to both Frameworks. Therefore there are fewer indicators in the 2016/17 Quality Account than the previous 2015/16 report.

Indicator	Target	Performance		
		2014/15	2015/16	2016/17
A&E maximum waiting time of 4 hours from arrival to admission/transfer/discharge[1]	95%	94.8%	91.9%	81.8%
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway[1]	92%	93.6%	95.0%	92.5%
All cancers – maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	85%	73.8%	72.2%	75.4%
All cancers – maximum 62-day wait for first treatment from NHS cancer screening service referral	90%	89.3%	92.8%	96.2%
C. difficile – meeting the *C. difficile* objective	≤ 63 cases judged to be lapses in care	17 judged lapses in care (66 total)	24 judged lapses in care (66 total)	31 judged lapses (92 total)

1 – Indicators audited by the Trust's external auditor Deloitte as part of the external assurance arrangements for the 2016/17 Quality Report. Please see detailed notes below relating to the Maximum time of 18 weeks from point of referral to treatment (RTT) indicator.

Performance validation – maximum time of 18 weeks from point of referral to treatment (RTT) indicator

In line with practices across many NHS Trusts and Foundation Trusts, the Trust has a month end validation process in place prior to the submission of Referral-to-Treatment (RTT) performance data. The Trust undertakes a range of validation primarily because of the volume of patients recorded as being on a RTT pathway, the volume of referrals accepted from other organisations and also because of the complexity of the patient pathways as a specialist tertiary centre.

The Trust concentrates its month end reporting validation on the incomplete pathways with a waiting time in excess of 18 weeks. Previously validation only focused on the less well-performing specialties and ceased once overall performance reached between 92%-95%. This meant there was a possibility we may have previously overstated the number of breaches. As a result, performance against the 92% target was likely to have been historically under-reported. However, to improve data quality and accuracy of reporting, all incomplete pathways with a waiting time of 18 weeks or more are now validated, regardless of specialty or the level of performance reached.

There is also now a feedback loop to operational services which is aimed at sharing the most common errors found during the validation process. The validation team is able to identify individual users who make the most errors so that they can be targeted for training and support. As a result, fewer errors are made at the outset which reduces the month-end validation burden. As predicted, there was a reduction in the size of the unfinished waiting list during 2016 (against the national trend) which has been largely attributed to an improvement in data quality; i.e. fewer erroneous clock starts. A consequence of a smaller waiting list is that it also reduces the number of pathways allowed within the 8% tolerance for this standard, making it more challenging to achieve. The Trust has, however, maintained an above standard performance for the unfinished 18 week RTT target all year.

A weekly RTT Assurance meeting is chaired by the Head of Service Improvement and is attended by operational managers representing all specialties. Key themes that emerge from the month end validation process are discussed at the meeting, for example the validation process may have identified an increase in the number of missed clock stops for first treatment in outpatients. This discussion and subsequent rectification action planning ensures that key messages are disseminated and learning from validation is shared within the organisation.

Unknown clock starts

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

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

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

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

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

The Trust's approach in these cases, where information is not forthcoming after chasing the referring provider, is to treat a new treatment pathway as starting on the date that the Trust receives the referral for the first time. Rather than spend a significant amount of time chasing clock starts for tertiary referrals, the main focus is on recording receipt of the referral and ensuring timely appointments are made. This approach means that all patients are included in the calculation of the reported indicators, but may mean that the percentage waiting more than 18 weeks for treatment is understated as we cannot take account of time spent waiting with other providers which has not been reported by them. Due to how data is captured, it is not practicable to quantify the number of patients this represents for the year.

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

3.3 Mortality

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

The Trust has not included comparative information due to concerns about the validity of single measures used to compare trusts.

Summary Hospital-level Mortality Indicator (SHMI)

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

The Summary Hospital-level Mortality Indicator should be interpreted with caution as no single measure can be used to identify whether hospitals are providing good or poor quality care.[1] An average hospital will have a SHMI around 100; a SHMI greater than 100 implies more deaths occurred than predicted by the model but may still be within the control limits. A SHMI above the control limits should be used as a trigger for further investigation.

The Trust's latest SHMI is 104 for the period April – December 2016 this implies the mortality numbers are higher than expected but remain within tolerance control limits. The latest SHMI value for the Trust, which is available on the NHS Digital (formerly HSCIC) website, is 102 for the period April – September 2016. This is within tolerance.

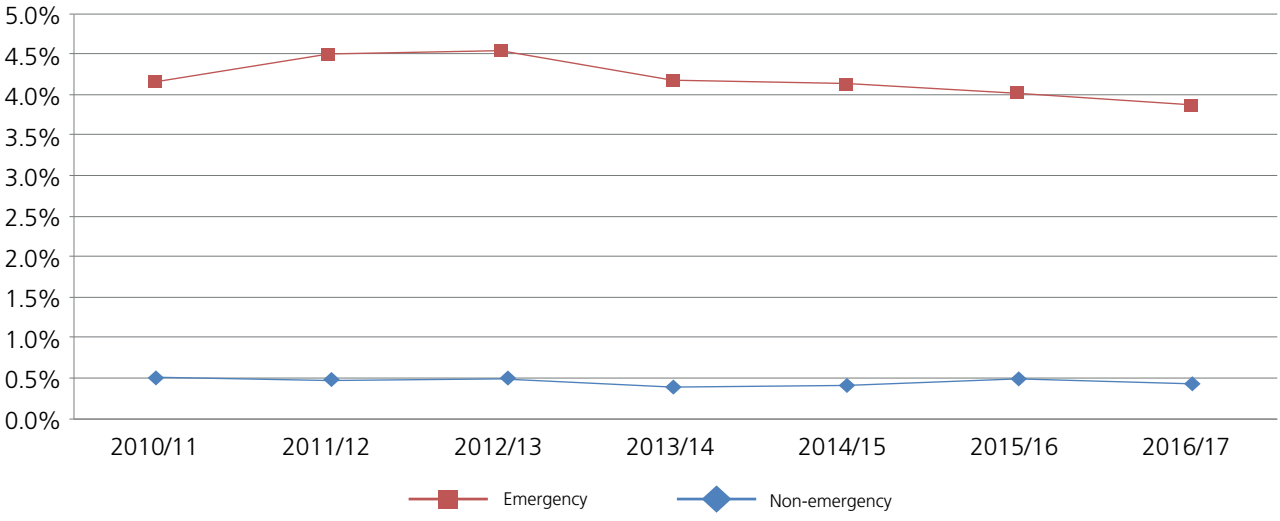
The Trust has concerns about the validity of the Hospital Standardised Mortality Ratio (HSMR) which was superseded by the SHMI but it is included here for completeness. UHB's HSMR value is 99.68 for the period April 2016 – January 2017 as calculated by the Trust's Health Informatics team. The validity and appropriateness of the HSMR methodology used to calculate the expected range has however been the subject of much national debate and is largely discredited.[2,3] The Trust is continuing to robustly monitor mortality in a variety of ways as detailed above.

Crude Mortality

The first graph shows the Trust's crude mortality rates for emergency and non-emergency (planned) patients. The second graph below shows the Trust's overall crude mortality rate against activity (patient discharges) by quarter for the past two calendar years. The crude mortality rate is calculated by dividing the total number of deaths by the total number of patients discharged from hospital in any given time period. The crude mortality rate does not take into account complexity, case mix (types of patients) or seasonal variation.

The Trust's overall crude mortality rate for 2016/17 is 2.96%, which is a small decrease compared to 2015/16 (3.04%) and 2014/15 (3.05%).

Emergency and non-emergency mortality graph

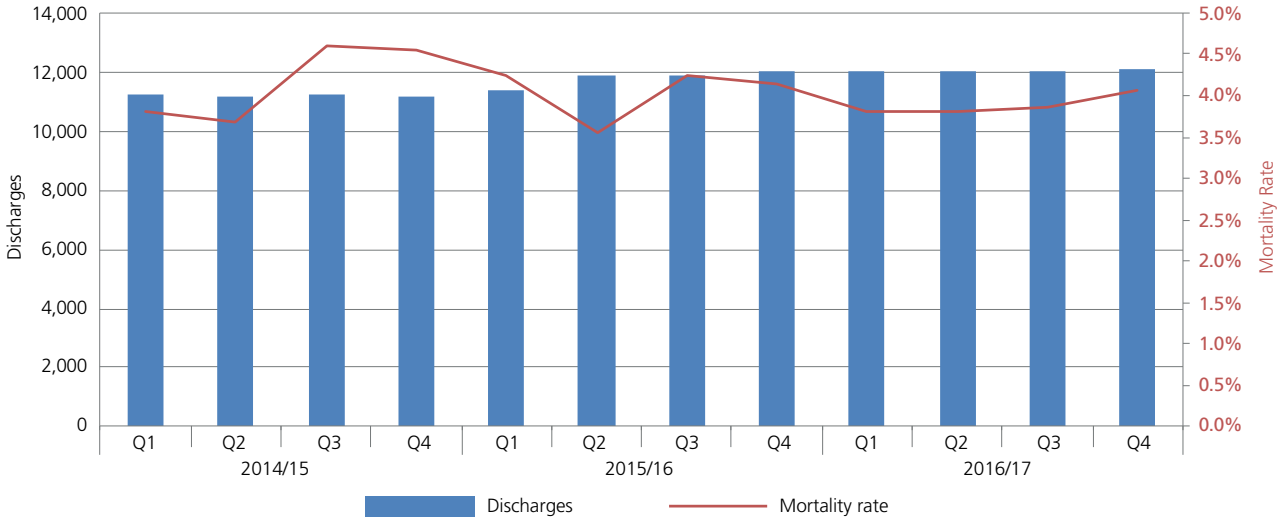


1 Freemantle N, Richardson M, Wood J, Ray D, Khosla S, Sun P, Pagano, D. Can we update the Summary Hospital Mortality Index (SHMI) to make a useful measure of the quality of hospital care? An observational study. BMJ Open. 31 January 2013.

2 Hogan H, Healey F, Neale G, Thomson R, Vincent C, Black, N. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review. BMJ Quality & Safety. Online First. 7 July 2012.

3 Lilford R, Mohammed M, Spiegelhalter D, Thomson R. Use and misuse of process and outcome data in managing performance of acute and medical care: Avoiding institutional stigma. The Lancet. 3 April 2004.

Overall crude mortality graph



3.4 Safeguarding

The Trust underwent a Care Quality Commission (CQC) inspection in January 2015 which included a review of safeguarding practice. The report, which was published in May 2015, was very positive in relation to safeguarding practice, training and leadership.

The Lead Nurse for Safeguarding receives details of relevant incidents on a daily basis and initiates follow up actions where necessary. The Lead Nurse for Safeguarding also receives any complaints or concerns raised via the Patient Advice and Liaison Service (PALS) relating to safeguarding and these are also followed up.

The Trust's framework for safeguarding adults and children is based on national guidance arising from the Care Act 2014 and the Working Together to Safeguard Children 2015 guide, which promotes development of inter-agency working to safeguard vulnerable adults and children. The Trust has also worked in partnership with Birmingham children services in developing new referral processes.

UHB has continued to ensure that safeguarding of adults and children remains a high priority.

Level 2 Adult and Children Safeguarding training is a combined session and has been mandatory for all patient-facing staff in 2016/17. A further two study days for Clinical Champions (one from each clinical area) have been held to improve knowledge across the Trust.

Factsheets on types of abuse are available to support staff, and patient information leaflets for adults and children are available in all clinical areas and have been well received. The Trust intranet pages on mental capacity, Deprivation of Liberty Safeguards (DoLS) and independent mental capacity advocates have also been updated.

The safeguarding team have developed a questionnaire for adult patients who pass through the safeguarding process to obtain their views on the process and the support they have received from the safeguarding team. The aim is to ensure that the safeguarding process is personal for every patient. The results have been extremely positive showing that patients feel they are involved in the safeguarding process, providing assurance that it is person-centred.

The Trust is committed to listening to the voice of the child and the safeguarding team visit all child admissions (16 and 17 year olds) to ensure they are being supported appropriately.

The Trust approaches safeguarding using an integrated 'think family' model. At all times staff are encouraged to think about the impact their patients' needs may have on children or vulnerable adults in their care.

The aim of safeguarding is to ensure that there is a robust policy with supporting procedural documents which allows a consistent approach to the delivery of safeguarding principles across the Trust. The policy provides a framework that can be consistently followed, reinforced by training and support, to enable all clinical staff to recognise and report adults and children who are at risk, ensuring that patients receive a positive experience, including support in relation to safeguarding where necessary. Further information can be found in the Trust's Annual Report for 2016/17: http://www.uhb.nhs.uk/reports.htm.

3.5 Staff Survey

The Trust's Staff Survey results for 2016 show that performance was average or better for 29 of the 32 key findings and below average for 3 key findings, when compared to other acute trusts.

The results are based on responses from 3553 staff which represents a decrease in response rate from 50% last year to 41% this year; this is below average for acute trusts in England. However the number of responses has increased from 418 last year as the survey was sent to all staff, whereas in previous years a sample of staff was chosen.

The results for the key findings of the Staff Survey which most closely relate to quality of care are shown in the table below.

UHB performed in the highest (best) 20% of trusts for

- Staff satisfaction with the quality of work and patient care they are able to deliver (see Question 1 below).
- Percentage of staff agreeing their role makes a difference to patients (see Question 2 below).
- Staff recommending the Trust as a place to work or receive treatment (see Question 3 below).

This is the same as 2015 survey.

To target lower performing areas identified by the survey, each Division has an action plan which looks at the key findings where they scored lowest. These also have actions based on staff groups, e.g. increase participation in the survey, or areas where a specific staff group have scored low. The action plans are monitored by the Chief Operating Officer.

Key Finding from Staff Survey	2014/15	2015/16	2016/17	Comparison with other acute NHS trusts 2016/17
1. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver *(KF2)*	82%	N/A	N/A	N/A
1. Staff satisfaction with the quality of work and patient care they are able to deliver *(KF2)*	N/A	4.16	4.08	Highest (best) 20%
2. Percentage of staff agreeing their role makes a difference to patients *(KF3)*	90%	93%	92%	Highest (best) 20%
3. Staff recommendation of the trust as a place to work or receive treatment *(KF1)*	3.96	4.02	3.97	Highest (best) 20%
4. Percentage of staff reporting errors, near misses or incidents witnessed in the last month *(KF29)*	83%	92%	91%	Average
5. Effective use of patient/service user feedback *(KF32)*	3.76	3.78	3.76	Above (better than) average
6. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months *(KF26)* (Lower score is better)	22%	27%	23%	Below (better than) average
7. Percentage of staff believing that the trust provides equal opportunities for career progression or promotion *(KF21)*	88%	88%	86%	Average
Data source	Trust's 2014 Staff Survey Report, NHS England	Trust's 2015 Staff Survey Report, NHS England	Trust's 2016 Staff Survey Report, NHS England	

Notes on staff survey
1: The scoring method changed in 2015/16 to a score (1-5) instead of a percentage – both have been displayed for completeness.
1 and 3: Possible scores range from 1 to 5, with a higher score indicating better performance.
5: In the 2015 report, the 2015 score was reported as 3.77, but the latest report has it as 3.78 – the latest value has been used in the table.

3.6 Specialty Quality Indicators

The Trust's Quality and Outcomes Research Unit (QuORU) was set up in September 2009. The unit has linked a wide range of information systems together to enable different aspects of patient care, experience and outcomes to be measured and monitored. The unit continues to provide support to clinical staff in the development of innovative quality indicators with a focus on research. In August 2012, the Trust implemented a framework based on a statistical model for handling potentially significant changes in performance and identifying any unusual patterns in the data. The framework has been used by the Quality and Informatics teams to provide a more rigorous approach to quality improvement and to direct attention to those indicators which may require improvement.

Performance for a wide selection of the quality indicators developed by clinicians, Health Informatics and the Quality and Outcomes Research Unit has been included the Trust's annual Quality Reports. The selection included for 2016/17 includes 69 indicators covering the majority of clinical specialties and performance for the past three financial years is included in a separate appendix on the Quality web pages: http://www.uhb.nhs.uk/quality.htm

This analysis is based on data for April 2016 to March 2017 for most indicators. Some run one to two months in arrears and this is indicated where relevant.

The Trust's clinical and management teams improved performance for 11% of the indicators during 2016/17. Performance for 75% stayed about the same (including four indicators which were already scoring the maximum and continued to do so). Performance for 14% of the indicators deteriorated during 2016/17. Two further indicators do not yet have any data for 2016/17 so cannot be compared to 2015/16 performance (this data is sourced nationally).

The majority of the 69 indicators have a goal; 62% of those with a goal met them in 2016/17, compared to 63% in 2015/16 and 54% in 2014/15.

Table 1 below shows performance for selected specialty indicators where the most notable improvements have been made during 2016/17. Table 2 below shows performance for selected indicators where performance has deteriorated during 2016/17.

Performance for the remaining indicators can be viewed on the Quality web pages: http://www.uhb.nhs.uk/quality.htm.

Table 1

Specialty	Indicator	Goal	Percentage Apr 14 – Mar 15	Percentage Apr 15 – Mar 16	Numerator Apr 16 – Mar 17	Denominator Apr 16 – Mar 17	Percentage Apr 16 – Mar 17	Data Sources
Stroke Medicine	In hospital mortality following stroke	< 15%	8.5%	5.0%	9	501	1.8%	SSNAP
Routine Surgery/ Care*	Unplanned return to theatre for all non-emergency surgical patients	<2.5%	1.2%	0.8%	83	24576	0.3%	Galaxy
Imaging	GP direct access patients who have report turnaround time of less than or equal to 7 days for Ultrasound	> 99%	94.4%	94.8%	8545	8585	99.5%	CRIS

*data up to February 2017 – indicator runs one month in arrears

Table 2

Specialty	Indicator	Goal	Percentage Apr 14 – Mar 15	Percentage Apr 15 – Mar 16	Numerator Apr 16 – Mar 17	Denominator Apr 16 – Mar 17	Percentage Apr 16 – Mar 17	Data Sources
Colorectal Surgery	Clexane medication after elective colorectal surgery (excluding day cases)	> 95%	94.2%	90.2%	190	224	84.8%	Lorenzo PICS
Maxillofacial Surgery	Percentage of emergency admissions with fractured mandible (lower jaw) who are operated on the same or next day	>90%	79.3%	76.1%	130	168	77.4%	Lorenzo
Surgery – Emergency	Perianal abscess operations should take place on the day of admission or the next day	> 90%	94.4%	83.3%	74	92	80.4%	Lorenzo

3.7 Sign Up to Safety

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

1. **Put safety first**
   Commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally.

   We will:
   - reduce medication errors due to missed drug doses.
   - improve monitoring of deteriorating patients through completeness of observation sets.
   - reduce hospital acquired grade 3 and 4 pressure ulcers.
   - reduce harm from falls.

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

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

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

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

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

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

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

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

UHB's Sign Up to Safety action plan can be found on the Trust intranet:
http://www.uhb.nhs.uk/sign-up-to-safety.htm

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

3.8 Duty of Candour

When a patient has been adversely affected by an incident, staff have a duty to inform the patient, relatives and/or carers as appropriate. This may fall under the Being Open process or Duty of Candour, depending upon the level of harm or potential for harm to the patient, and must include details of what happened and what is being done in response. Provision of reasonable support and an apology when things go wrong must also be addressed. This ensures that not only does the Trust meet its Duty of Candour statutory requirements, but that staff are open and transparent, honouring the Trust vision and values of providing the best in care and honesty to patients and service users.

When Duty of Candour is identified as being applicable, the risk team work with staff to support the process and provide expert advice as required. Conversations are recorded on a standard form which includes specific details of who is to be contacted for future feedback and who will undertake this feedback. These forms are logged against the Trust-wide Duty of Candour tracker, which is monitored by the Clinical Risk and Compliance department, and also contains information on actions taken. If an incident has led to further investigation then details of the investigation will also be recorded. The risk team work closely with the investigations team and complaints department to ensure that details are co-ordinated, providing patient focused feedback that is appropriate and timely, as well as meeting statutory deadlines.

The risk team support staff in understanding the process and how to complete Duty of Candour, as well as ensuring regulatory compliance. As part of the service review the risk team plan to embed Duty of Candour into the investigation process to ensure a holistic approach to patient feedback.

The Duty of Candour process at UHB was audited by Birmingham CrossCity CCG in January 2016 and the process was deemed compliant and the tracker content was deemed to be of a high standard.

The Trust plans to use the incident reporting system, Datix, to record Duty of Candour information by autumn 2017. Datix has been reviewed to ensure that it can record the information currently captured by the Duty of Candour forms, and supportive monitoring is also in place, to give information and assurance regarding deadlines. An education scheme is being planned to ensure all staff receive appropriate training before this is launched, and will be supported by ongoing education and training. The Duty of Candour/ Being Open Policy will also be reviewed to reflect the new processes.

3.9 Glossary of terms

Term	Definition
A&E	Accident & Emergency – also known as the Emergency Department
Acute Trust	An NHS hospital trust that provides secondary health services within the English National Health Service
Administration	When relating to medication, this is when the patient is given the tablet, infusion or injection. It can also mean when anti-embolism stockings are put on a patient.
Alert organism	Any organism which the Trust is required to report to Public Health England
Analgesia	A medication for pain relief
Bacteraemia	Presence of bacteria in the blood
Bed days	Unit used to calculate the availability and use of beds over time
Benchmark	A method for comparing (e.g.) different hospitals
Betablockers	A class of drug used to treat patients who have had a heart attack, also used to reduce the chance of heart attack during a cardiac procedure
Birmingham Health & Social Care Overview Scrutiny Committee	A committee of Birmingham City Council which oversees health issues and looks at the work of the NHS in Birmingham and across the West Midlands
CABG	Coronary artery bypass graft procedure
CCG	Clinical Commissioning Group
CDI	*C. difficile* infection
Clinical Audit	A process for assessing the quality of care against agreed standards
Clinical Coding	A system for collecting information on patients' diagnoses and procedures
Clinical Dashboard	An internal website used by staff to measure various aspects of clinical quality
Clinical Quality Committee	A committee led by the Trust's Chairman which reviews clinical quality in detail
Commissioners	See CCG
Congenital	Condition present at birth
Contraindication	A condition which makes a particular treatment or procedure potentially inadvisable
CQC	Care Quality Commission
CQG	Care Quality Group; a UHB group chaired by the Chief Nurse, which assesses the quality of care, mainly nursing
CQMG	Clinical Quality Monitoring Group; a UHB group chaired by the Executive Medical Director, which reviews the quality of care, mainly medical
CQUIN	Commissioning for Quality and Innovation payment framework
CRIS	Radiology database
Datix	Database used to record incident reporting data
Day case	Admission to hospital for a planned procedure where the patient does not stay overnight
DCQG	Divisional Clinical Quality Group - the divisional subgroups of the CQMG
Deloitte	UHB's external auditors
Division	Specialties at UHB are grouped into Divisions
Echo/echocardiogram	Ultrasound imaging of the heart
ED	Emergency Department (previously called Accident and Emergency Department)
Elective	A planned admission, usually for a procedure or drug treatment
Episode	The time period during which a patient is under a particular consultant and specialty. There can be several episodes in a spell
FCE	Finished/Full Consultant Episode - the time spent by a patient under the continuous care of a consultant
Foundation Trust	Not-for-profit, public benefit corporations which are part of the NHS and were created to devolve more decision-making from central government to local organisations and communities.
GI	Gastro-intestinal

Term	Definition
GP	General Practitioner
Healthwatch Birmingham	An independent group who represent the interests of patients and the public.
HES	Hospital Episode Statistics
HSCIC	Health and Social Care Information Centre – now known as NHS Digital
HSMR	Hospital Standardised Mortality Ratio
ICNARC	Intensive Care National Audit & Research Centre
Informatics	UHB's team of information analysts
IT	Information Technology
ITU	Intensive Treatment Unit (also known as Intensive Care Unit, or Critical Care Unit)
Lorenzo	Patient administration system
MINAP	Myocardial Ischaemia National Audit Project
Monitor	Independent regulator of NHS Foundation Trusts – now replaced by NHS Improvement
Mortality	A measure of the number of deaths compared to the number of admissions
MRI	Magnetic Resonance Imaging – a type of diagnostic scan
MRSA	Meticillin-resistant Staphylococcus aureus
Myocardial Infarction	Heart attack
mystay@QEHB	An online system that allows patients to view information/indicators on particular specialties
NaDIA	National Diabetes Inpatient Audit
NBOCAP	National Bowel Cancer Audit Programme
NCAA	National Cardiac Arrest Audit
NCEPOD	National Confidential Enquiry into Patient Outcome and Death - a national review of deaths usually concentrating on a particular condition or procedure
NHS	National Health Service
NHS Choices	A website providing information on healthcare to patients. Patients can also leave feedback and comments on the care they have received
NHS Digital	Formerly HSCIC - Health and Social Care Information Centre. A library of NHS data
NHS Improvement	The national body that provides the reporting requirements and guidance for the Quality Accounts
NIHR	National Institute for Health Research
NRLS	National Reporting and Learning System
Observations	Measurements used to monitor a patient's condition e.g. pulse rate, blood pressure, temperature
PALS	Patient Advice and Liaison Service
Patient Opinion	A website where patients can leave feedback on the services they have received. Care providers can respond and provide updates on action taken.
Peri-operative	Period of time prior to, during, and immediately after surgery
PHE	Public Health England
PICS	Prescribing Information and Communication System
Plain imaging	X-ray
PRISM	Cardiology System which records information on ECGs and Echoes
PROMs	Patient Reported Outcome Measures
Prophylactic/ prophylaxis	A treatment to prevent a given condition from occurring
QEHB	Queen Elizabeth Hospital Birmingham
QuORU	Quality and Outcomes Research Unit
R&D	Research and Development
RCA	Root cause analysis

Term	Definition
Readmissions	Patients who are readmitted after being discharged from hospital within a short period of time e.g., 28 days
Safeguarding	The process of protecting vulnerable adults or children from abuse, harm or neglect, preventing impairment of their health and development
Sepsis	A potentially life-threatening condition resulting from a bacterial infection of the blood
SEWS	Standardised Early Warning System
Shelford Group	A group of England's ten leading Academic Healthcare Organisations. UHB is a member, as are other hospital trusts such as University College Hospital in London.
SHMI	Summary Hospital Mortality Indicator
Spell	The time period from a patient's admission to hospital to their discharge. A spell can consist of more than one episode if the patient moves to a different consultant and/or specialty.
SSNAP	Sentinel Stroke National Audit Programme
TARN	Trauma Audit and Research Network
Trajectory	In infection control, the maximum number of cases expected in a given time period
Trust apportioned	A case (e.g. MRSA or CDI) that is deemed as 'belonging' to the Trust in question
Trust Partnership Team	Attendees include Staff Side (Trade Union representatives), Directors, Directors of Operations and Human Resources staff. The purpose of this group is to provide a forum for Staff Side to hear about and raise issues about the Trust's strategic and operational plans, policies and procedures.
TVS	Tissue Viability Service
UHB	University Hospitals Birmingham NHS Foundation Trust
VTE	Venous thromboembolism – a blood clot

Appendix A: Performance against core indicators

The Trust's performance against the national set of quality indicators jointly proposed by the Department of Health and Monitor (now NHS Improvement) is shown in the tables below. There are eight indicators which are applicable to acute trusts. The data source for all the indicators is the NHS Digital website (formerly the Health and Social Care Information Centre, or HSCIC).

Data for Indicators 2, 3 and 4 has not been updated on the NHS Digital website since the previous Quality Report. The latest available data has been provided for Indicators 1, 5, 6, 7 and 8. Data is displayed in the same format as found on the NHS Digital website. National comparative data is included where available.

1. **Mortality**

	Previous Period (Jul 2015–Jun 2016)	Current period (Oct 2015–Sep 2016)			
	UHB	UHB	National Performance		
			Overall	Best	Worst
(a) Summary Hospital-level Mortality Indicator (SHMI) value	1.03	**1.06**	1.00	0.69	1.16
(a) SHMI banding	2	**2**	—	3	1
(b) Percentage of patient deaths with palliative care coded at diagnosis or specialty level	28.08	**29.08**	29.57	0.39	56.27

Comment

The Trust considers that this data is as described for the following reasons as this is the latest available on the NHS Digital (HSCIC) website. The Trust intends to take the following actions to improve this indicator, and so the quality of its services, by continuing with the technical approach UHB takes to improving quality detailed in this report.

The Trust does not specifically try to reduce mortality as such but has robust processes in place, using more recent data, for monitoring mortality as detailed in Part 3 of this report. It is important to note that palliative care coding has no effect on the SHMI.

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

	Previous Period (Apr 2014–Mar 2015)	Current period (Apr–Sep 2015)			
	UHB	UHB	National Performance		
			Overall	Best	Worst
(i) Groin hernia surgery	0.069	**0.080**	0.087	0.135	0.008
(ii) Varicose vein surgery	—	**—**	0.103	0.129	0.037
(iii) Hip replacement surgery	Not applicable to UHB				
(iv) Knee replacement surgery	Not applicable to UHB				

Comment

The Trust considers that this data is as described for the following reasons as it is the latest available on the NHS Digital (HSCIC) website.

The Trust intends to take the following actions to improve this data, and so the quality of its services, by continuing to focus on improving participation rates for the pre-operative questionnaires which we have control over. Participation is shown in Part 2 as part of the audit section of this report. Figures for UHB for Varicose Vein Surgery are not available as insufficient responses were received.

3. **Readmissions to hospital within 28 days**

	Previous Period (Apr 2010–Mar 2011)*	Current period (Apr 2011–Mar 2012)*			
	UHB	UHB	National Performance		
			Overall	Best	Worst
(i) Patients aged 0–15 readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust (Standardised percentage)	—	—	10.01	5.86	12.50
(ii) Patients aged 16 or over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust (Standardised percentage)	11.60	**11.54**	11.45	10.64	13.55

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

Comment
The Trust considers that this data (standardised percentages) is as described for the following reasons as this is the latest available on the NHS Digital (HSCIC) website. UHB is however unable to comment on whether it is correct as it is not clear how the data has been calculated.

The Trust intends to take the following actions to improve this data (standardised percentages), and so the quality of its services, by continuing to review readmissions which are similar to the original admission on a quarterly basis. UHB monitors performance for readmissions using more recent Hospital Episode Statistics (HES) data as shown in Part 3 of this report.

3(i) is not applicable to UHB as the Trust does not provide a Paediatrics service.

4. **Responsiveness to the personal needs of patients**

	Previous Period (2013/14)	Current period (2014/15)*			
	UHB	UHB	National Performance		
			Overall	Best	Worst
Trust's responsiveness to the personal needs of its patients – average weighted score of 5 questions from the National Inpatient Survey (Score out of 100)	72.2	**72.0**	68.9	86.1	59.1

Comment
The Trust considers that this data is as described for the following reasons as it is the latest available on the NHS Digital (HSCIC) website.

The Trust intends to take the following actions to improve this data, and so the quality of its services, by continuing to collect real-time feedback from our patients as part of our local patient survey. The Board of Directors has again selected improving patient experience and satisfaction as a Trust-wide priority for improvement in 2017/18 (see Part 2 of this report for further details).

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

	Previous Period (2015)	Current period (2016)	
	UHB	UHB	National Performance
			Average (median) for acute trusts
Staff who would recommend the trust as a provider of care to their family and friends. Performance shown is based on staff who agreed or strongly agreed.	82%	**81%**	70%

Comment
The Trust considers that this data (scores) is as described for the following reasons as it is the latest available on the NHS Digital (HSCIC) website and performance for 2016 is consistent with 2015.

The Trust intends to take the following actions to improve this data, and so the quality of its services, by trying to maintain performance for this survey question.

6. **Venous thromboembolism (VTE) risk assessment**

	Previous Period (Q2 2016/17)	Current period (Q3 2016/17)			
	UHB	UHB	National Performance		
			Overall	Best	Worst
Percentage of admitted patients risk-assessed for VTE	99.5%	**99.4%**	98.2%	100%	65.9%

Comment
The Trust considers that this data (percentages) is as described for the following reasons as UHB has consistently performed above the national average for the past few years.

The Trust intends to take the following actions to improve this data, and so the quality of its services, by continuing to ensure our patients are risk assessed for venous thromboembolism (VTE) on admission.

7. ***C. difficile* infection**

	Previous Period (2014/15)	Current period (2015/16)			
	UHB	UHB	National Performance		
			Overall (England)	Best	Worst
C. difficile infection rate per 100,000 bed-days (patients aged 2 or over)	38.9	**38.0**	40.8	0	111.1

Comment
The Trust considers that this data is as described for the following reasons as it is the latest available on the NHS Digital (HSCIC) website.

The Trust intends to take the following actions to improve this rate, and so the quality of its services, by continuing to reduce *C. difficile* infection through the measures outlined in *Priority 5: Infection prevention and control in this report*.

8. Patient Safety Incidents

Since the 2014/15 report, the rate for this indicator has changed to 'per 1000 bed days' from 'per 100 admissions'.

	Previous Period (Oct 2014–Mar 2015)	Current period (Oct 2015–Mar 2016)			
	UHB	UHB	National Performance (Acute Teaching Providers)		
			Overall	Best	Worst
Incident reporting rate per 1,000 bed days	52.4	**60.7**	—	14	352
Number of patient safety incidents that resulted in severe harm or death	11	**15**	—	0	119
Rate of patient safety incidents that resulted in severe harm or death rate per 1,000 bed days	0.06	**0.08**	—	0.00	4.45

Note – although the table above refers to 'best' and 'worst', a high incident reporting rate can be reflective of a good, open reporting culture.

Comment

The Trust considers that this data is as described for the following reasons as the data is the latest available on the NHS Digital (HSCIC) website. UHB is however unable to comment on whether it is correct as it is not clear how the numerator (incidents) and denominator (admissions) data has been calculated.

The Trust intends to take the following actions to improve this data and so the quality of its services, by continuing to have a high incident reporting rate. The Trust routinely monitors incident reporting rates and the percentage of incidents which result in severe harm or death as shown in Part 3 of this report.

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

The Trust has shared its 2016/17 Quality Report with Birmingham CrossCity Clinical Commissioning Group, Healthwatch Birmingham and Birmingham Health & Social Care Overview and Scrutiny Committee.

Birmingham CrossCity Clinical Commissioning Group, Healthwatch Birmingham and Birmingham Health & Social Care Overview and Scrutiny Committee have reviewed the Trust's Quality Report for 2016/17 and provided the statements below.

Statement provided by Birmingham CrossCity Clinical Commissioning Group

University Hospitals Birmingham NHS Foundation Trust

Quality Account 2016/17

Statement of Assurance from Birmingham CrossCity CCG May 2017

1.1 Birmingham CrossCity Clinical Commissioning Group (BCC CCG), as coordinating commissioner for University Hospitals Birmingham NHS Foundation Trust (UHB), welcomes the opportunity to provide this statement for inclusion in the Trust's 2016/17 Quality Account.

1.2 A draft copy of the quality account was received by BCC CCG on the 21st April and the review has been undertaken in accordance with the Department of Health Guidance. This statement of assurance has been developed in consultation with neighbouring CCGs.

1.3 In the version of the quality account we viewed some full year data was not yet available and so we have not been able to validate those areas; we assume, however, that the Trust will be populating these gaps in the final published edition of this document.

1.4 In compiling this account the Trust has provided the reader with a well laid out and clear picture regarding performance against 2016/17 priorities, which describes the initiatives implemented, identifying any changes to the priority and further actions to be undertaken going forward.

1.5 Where existing priorities are being carried forward into 2017/18 the CCG supports the Trust's review of progress and setting of either revised or continuation of targets.

1.6 The Trust is to be congratulated for the achievement of priority 1: reducing grade 2 hospital acquired pressure ulcers. The final figure for this priority was 71 which is considerably below the target of 125.

1.7 The Trust has made a decision to remove the Infection prevention and control (IPC) priorities around MRSA Bacteraemia and *Clostridium difficile* infection (CDI) despite failure to achieve the targets set for 2016/17. The CCG would be keen to see the Trust maintaining MRSA and CDI as a priority, particularly given that the peer group scores are lower than UHB's.

1.8 The CCG supports the introduction of two new priorities – reducing harm from falls and timely treatment for sepsis in the emergency department. We look forward to hearing about the progress made in use of a new sepsis screening tool and the impact of falls training coupled with a new falls policy and guidelines.

1.9 It is pleasing to note that the Trust performance for 2016/17 for the Friends and Family Test (FFT) question on recommending the Trust is significantly higher than that of both the national average and West Midlands regional average (for both inpatients and outpatients). It is unclear from the account how the Trust intends to work on improving feedback for A&E.

1.10 It has been noted that there has been a 15% increase in complaints; the Trust has analysed the themes and determined that the 'top 3' remain the same as in previous years. It would be good to see information on how the Trust has learnt from complaints, including those 13 cases partially/fully upheld by the Ombudsman. Staff attitude has been identified as a regular theme for complaints, it is unclear what actions the Trust is taking to address this and indeed if this data has been triangulated with the reduction in the compliments received, particularly that of nursing care.

1.11 It was good to see that the Trust has included a section on how they have made the complaints process accessible and given examples of meeting individual needs such as provision of information in braille and large font.

1.12 The inclusion of information on Sign Up to Safety and the pledges made by the Trust was welcomed by the CCG demonstrating the Trust's continued commitment to improving safety and reducing avoidable harm.

1.13 The Trust's Staff Survey results show a pleasing performance for many areas, particularly the three areas where it is in the highest performing 20% of trusts. This element of the quality account would benefit from an overview of the actions being taken to address staff satisfaction, particularly where performance is below the average for acute trusts in England.

1.14 Under the 'speciality quality indicators' section data is provided where there have been the most notable improvements and deteriorations in performance. No information has been provided on what actions the Trust is taking to improve the deteriorating indicators.

1.15 We have made some specific comments to the Trust directly in relation to the quality account which we hope will be considered as part of the final document. These include: action being taken to improve the Information Governance score; the internal process for reviewing mortality (the role of the medical examiner

in enhancing the oversight of mortality and associated learning); revision to the Duty of Candour statement and comments on layout.

1.16 As commissioners we have worked closely with UHB over the course of 2016/17, meeting with the Trust regularly to review the organisation's progress in implementing its quality improvement initiatives. We are committed to engaging with the Trust in an inclusive and innovative manner and are pleased with the level of engagement from the Trust. We hope to continue to build on these relationships as we move forward into 2017/18.

Barbara King
Accountable Officer
Birmingham CrossCity Clinical Commissioning Group

Statement from Healthwatch Birmingham on University Hospitals Birmingham NHS Foundation Trust Quality Account 2016/17

Healthwatch Birmingham welcomes the opportunity to provide our statement on the Quality Account for University Hospitals Birmingham NHS Foundation Trust 2016/17. In line with our role, we have focused on the following:

- The use of patient and public insight, experience and involvement in decision-making.
- The quality of care patients, the public, service users and carers access and how this aligns with their needs.
- Variability in the provision of care and the impact it has on patient outcomes.

Patient experience and feedback
Healthwatch Birmingham recognises the Trust's approach to using different methods to measure patient feedback and make improvement to services. This includes: surveys for different departments, the Friends and Family Test, complaints, concerns, and compliments. We note that the focus of Quality Priority 2 (improve patient experience and satisfaction) is to improve scores and determine what ranks as most important to patients. What we would like to see in next year's report is:

- An introduction of qualitative questions to the survey that will complement the statistical data the Trust collects. This will help the Trust to understand why an issue is ranked highly by patients. Consequently, qualitative data will offer greater insight to barriers patients face to receiving good quality of care.

- A demonstration of how the Trust uses patient insight and experience to understand the barriers different groups face and the impact on health outcomes. Consequently, how this data is used to implement change or improvement that addresses the needs of these groups.

We therefore agree with the Trust's patient experience initiatives that will be carried over into the 2017/18 Quality Account. Namely:

- Implement the use of patient stories as a feedback and training mechanism. We note that these are now used at all patient experience group meetings, in complaints and customer relations training. Healthwatch Birmingham would like to see examples of these stories, learning that has occurred, and the impact on services.

- Review of how patient experience data is monitored and used to drive improvement – especially examining how data 'travels' across the Trust.

- Using a more project-based approach to tackle challenging aspects of patient care. Projects have been around discharge medications; communication and operations and procedures.

- Development of a patient experience collection, analysis and reporting system in conjunction with the University of Birmingham PROMs group.

In examining the various initiatives presented in the report around patient experience, Healthwatch Birmingham believes that the Trust has the foundation on which it can develop a strategy for involving, patients and the public in decision-making. Such a strategy will clearly outline how and why patients, the public and carers will be engaged in order to improve health outcomes and reduce health inequality. This will ensure that there is commitment across the Trust to using patient and public insight, experience and involvement. It will also make clear arrangements for collating feedback and experience. Therefore, we suggest that service user and carer's insight and experience should be collected to not only identify barriers to improved health outcomes but also to identify and understand health inequality. We believe that a project-based approach initiative, as part of a wider strategy, will be a novel way to understand barriers to improvements in health outcomes for different groups or characteristics.

Friends and Family Test (FFT)
Our review of the FFT scores for 2016/17 shows that the positive response rate for A&E has been inconsistent and has been below the national average. Conversely, the positive recommendation score for inpatients and outpatients has been above the national and regional average. Whilst we applaud the Trust for this performance for inpatients and outpatients, we believe that the difference between this and performance in A&E indicates variability in care. How people access services has an impact on their experience.

Patient Experience indicators
At the time of writing our response, the 2016 survey results were not available for us to comment on effectively. From the data provided, we note that many of the scores remained the same or slightly increased for 2015/16 in comparison to 2014/15. There was a slight decrease in the extent to which patients feel involved in decisions about their care and treatment; 7.7 in 2014/15 to 7.5 in 2015/16.[1] Similarly, the Trust's responsiveness to the personal needs of patients decreased slightly from 72.2% in 2013/14 to 72% in 2014/15 and this is below the best performing Trust (86.1%).

In order to make improvements, the Trust needs to ensure that service users are involved from the point of identifying the barrier to improvement in health outcomes including increasing independence and preventing worsening ill-health; and mapping out possible solutions to evaluating options and selecting the optimum solution. To do this effectively, the Trust needs to increase the number and diversity of people it's hearing from. Therefore, the Trust should consider including the number of responses to their surveys or for the Friends and Family Test to assess performance.

Complaints
The report shows that the total number of complaints has increased by 15% from 680 in 2015/16 to 779 (2016/17). The top three complaints were about clinical treatment (203); communication and information (129) and attitude of staff (110). In addition, complaints for inpatients reduced from 345 in 2015/16 to 327 in 2016/17 and there was an increase for outpatients (form 245 in 2015/16 to 331 in 2016/17) and the emergency department (from 90 in 2015/16 to 121 in 2016/17). We are concerned that the number of complaints and the FFT scores for emergency department seem to reflect a need for improvement. However, we welcome the Trust's actions taken to learn from complaints. In particular, the review of arrangements for patients with hearing and visual impairment, to try and improve all aspects of their experience. Consequently, the Trust is not only addressing the barriers but variability in care that might result in a health inequality.

The report states that the Trust aims to make the complaints process accessible to all. We would like to know what methods the Trust uses to get feedback on the complaints process and how this feedback is used to inform the necessary changes to the process?

Compliments
We note that the Trust's number of compliments received in 2016/17 (2286) decreased compared to 2015/16 (2349). What is concerning is that the number of compliments for nursing care decreased in 2016/17 (211) by more than half the number in 2015/16 (579). The Trust should consider making this topic a project so as to get an in-depth understanding of what the problem is and develop solutions to address it.

Variability in Healthcare
Healthwatch Birmingham is concerned that of the five priorities agreed in 2016/17, the Trust made progress in only two (reducing pressure ulcers and improving patient experience and satisfaction). Whilst there has been some improvement in priority 3 (timely and complete observations including pain assessment), this has been inconsistent. Priority 4 (reduce medication errors) has made no progress. We agree with the Trust that, based on performance, patient experience and effectiveness of care, four of these five priorities be carried over into the 2017/18 Quality Account.

Timely and complete observations including pain assessment
We commend the Trust for improving its performance in 2016/17 (89% from 79% in 2015/16) in the percentage of observations plus pain assessment recorded within three hours of admission or transfer to ward. However, the Trust has not met its target to increase the percentage of patients receiving pain medication (analgesia) within 30 minutes of a high pain score. There is a variability in care such that patients with the same diagnosis are receiving different treatments. Those patients receiving the pain medication within 30 minutes are accessing better quality of care and consequently better health outcomes than those not accessing this. We therefore welcome the Trust's improvement priority for 2017/18 to increase observations and pain assessment to 95% and 85% for those receiving analgesia within 30 minutes.

***Clostridium difficile* Infection (CDI)**
The Quality report states that the Trust had 92 apportioned cases of CDI in 2016/17, 31 of which were

1. No data is provided for 2015/16 and 2016/17.

deemed lapses in care. We are concerned that cases deemed lapses in care are increasing year on year. We note that this is not a priority for 2017/18 but hope to see an update on this in the 2017/18 Quality Account. In particular, how the Trust has learnt from cases deemed lapses in care and actions taken as a result.

To conclude – Healthwatch Birmingham would like to take this opportunity to congratulate the Trust for the impact of its research findings on patient care. Consequently, for being recognised for expertise in delivering commercial research studies and winning the 2016 West Midlands NIHR Clinical Research Network (CRN) Awards.

However, a theme that has been consistent through the various data provided on complaints, experience and performance is that patients' experience and outcome differs for inpatients, outpatients and A&E patients. We note the various initiatives the Trust will implement to address this and we hope to see an improvement in the 2017/18 Quality Account.

Andy Cave
CEO
Healthwatch Birmingham

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

The Birmingham Health & Social Care Overview and Scrutiny Committee has confirmed that it is not in a position to provide a statement on the 2016/17 Quality Report.

Annex 2: Statement of directors' responsibilities for the Quality Report

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

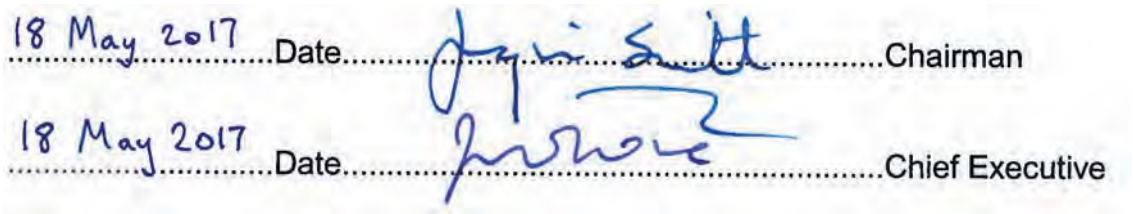
NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality 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 2016/17 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2016 to May 2017
  - papers relating to quality reported to the board over the period April 2016 to May 2017
  - feedback from the commissioners dated 11/05/2017
  - feedback from governors dated 14/02/2017
  - feedback from local Healthwatch organisations dated 17/05/2017
  - feedback from Overview and Scrutiny Committee dated 02/03/2017
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 18/05/2017
  - the 2015 national patient survey (published in June 2016; this is the latest available survey. The 2016 survey has been delayed and is unlikely to be published before June 2017)
  - the 2016 national staff survey March 2017
  - the Head of Internal Audit's annual opinion over the trust's control environment dated 18/05/2017
  - CQC inspection report dated 15/05/2015
- 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 NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board



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

Independent auditor's report to the Council of Governors of University Hospitals Birmingham NHS Foundation Trust on the quality report

We have been engaged by the Council of Governors of University Hospitals Birmingham NHS Foundation Trust to perform an independent assurance engagement in respect of University Hospitals Birmingham NHS Foundation Trust's quality report for the year ended 31 March 2017 (the 'Quality Report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of University Hospitals Birmingham NHS Foundation Trust as a body, to assist the Council of Governors in reporting University Hospitals Birmingham NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the Council of Governors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and University Hospitals Birmingham NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.

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

Respective responsibilities of the directors and auditors

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

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

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified below:
  - board minutes for the period April 2016 to March 2017;
  - papers relating to quality reported to the board over the period April 2016 to March 2017;
  - feedback from the Commissioners dated 11/05/2017;
  - feedback from the governors dated 14/02/2017;
  - feedback from local Healthwatch organisations, dated 17/05/2017;
  - feedback from the Overview and Scrutiny Committee, dated 02/03/2017;

  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 18/05/2017;
  - the 2015 national patient survey (published in June 2016);
  - the 2016 national staff survey (published in March 2017);
  - the Head of Internal Audit's annual opinion over the Trust's control environment dated 18/05/2017;
  - Care Quality Commission Inspection Report, dated 15/05/2017; and
  - any other information included in our review.
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance, and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with the documents listed above and specified in the detailed guidance for external assurance on Quality Reports (collectively the 'documents').

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

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

Assurance work performed

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

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Testing key management controls;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the 'NHS foundation trust annual reporting manual' and supporting guidance to the categories reported in the quality report; and
- Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient

appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance.

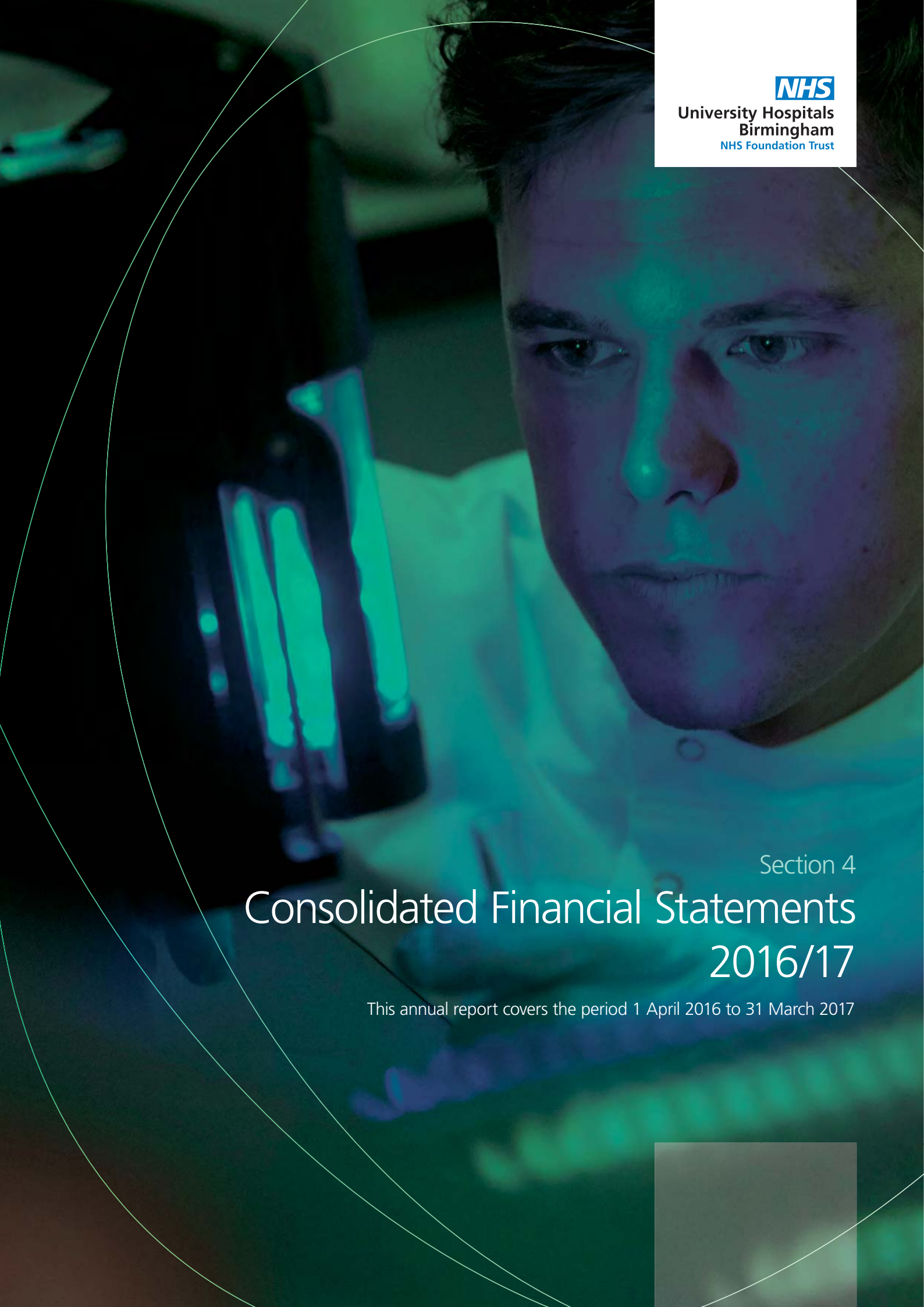
The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

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 2017:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in 2.1 of the NHS Improvement 2016/17 Detailed guidance for external assurance on quality reports for foundation trusts; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance.

Deloitte LLP
Chartered Accountants
Birmingham
United Kingdom
24th May 2017



NHS
University Hospitals Birmingham
NHS Foundation Trust

Section 4

Consolidated Financial Statements 2016/17

This annual report covers the period 1 April 2016 to 31 March 2017

University Hospitals Birmingham NHS Foundation Trust – Consolidated Financial Statements 2016/17

Foreword to the Financial Statements

University Hospitals Birmingham NHS Foundation Trust

These financial statements for the year ended 31 March 2017 have been prepared by the University Hospitals Birmingham NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Dame Julie Moore
Chief Executive
18 May 2017

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

The National Health Service Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require University Hospitals Birmingham NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. 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 Department of Health Group Accounting Manual and in particular to:

- Observe the Accounts Direction issued by NHS Improvement, 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 (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- prepare the financial statements on a going concern basis.

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

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

Dame Julie Moore
Chief Executive
18 May 2017

Independent auditor's report to the Council of Governors and Board of Directors of University Hospitals Birmingham NHS Foundation Trust

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

Opinion on financial statements of University Hospitals Birmingham NHS Foundation Trust

In our opinion the financial statements:

- **give a true and fair view of the state of the Group and Trust's affairs as at 31 March 2017 and of the Group's income and expenditure for the year then ended;**
- **have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and**
- **have been prepared in accordance with the requirements of the National Health Service Act 2006.**

The financial statements that we have audited comprise:

- the Consolidated Statement of Comprehensive Income;
- the Group and Trust Statements of Financial Position;
- the Group and Trust Statements of Changes in Taxpayer's Equity;
- the Group and Trust Statements of Cash Flows; and
- the related notes 1 to 34.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

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 Code of Audit Practice.

Summary of our audit approach

Key risks	The key risks that we identified in the current year were: • Recognition of NHS clinical revenue; and • Property valuations and capital developments. In 2015/16 we had an additional risk relating to financial sustainability. In the current year, this has not had a significant effect on our audit strategy, the allocation of resources in the audit and directing the efforts of the engagement team and therefore has been excluded from our report.
Materiality	The materiality that we used in the current year was £6.5m which was determined on the basis of 1% of revenue.
Scoping	The focus of our audit work was on the Trust, with work performed at the Trust's head offices in Birmingham directly by the audit engagement team, led by the audit partner. Our audit covered all of the entities within the Group, including the Trust's subsidiaries.
Significant changes in our approach	There has been no significant change in our approach.

Going concern

We have reviewed the Accounting Officer's statement contained within the Annual Report on page 16 that the Group is a going concern.

We confirm that:

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

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

Independence

We are required to comply with the Code of Audit Practice and Financial Reporting Council's Ethical Standards for Auditors, and confirm that we are independent of the group and we have fulfilled our other ethical responsibilities in accordance with those standards.

We confirm that we are independent of the Group and we have fulfilled our other ethical responsibilities in accordance with those standards. We also confirm we have not provided any of the prohibited non-audit services referred to in those standards.

Our assessment of risks of material misstatement

The assessed risks of material misstatement described below are those that had the greatest effect on our audit strategy, the allocation of resources in the audit and directing the efforts of the engagement team. In 2015/16 we had an additional risk relating to financial sustainability. In the current year, this has not had a significant effect on our audit strategy, the allocation of resources in the audit and directing the efforts of the engagement team and therefore has been excluded from our report.

Recognition of NHS clinical revenue

Risk description

As described in note 1.2 Accounting Policies and note 1.28 Critical Accounting Judgements and Key Sources of Estimation Uncertainty, there are significant judgements in recognition of revenue from care of NHS service users and in provisioning for disputes with commissioners due to:

- the complexity of the Payment by Results regime, in particular in determining the level of over-performance revenue to recognise; and
- the judgemental nature of provisions for disputes, including in respect of outstanding over-performance income for quarters 3 and 4.

Details of the Group's income, including £659.0m of Commissioner Requested Services are shown in note 3.2 to the financial statements. NHS debtors are shown in note 20 to the financial statements.

The Group earns revenue from a wide range of commissioners, increasing the complexity of agreeing a final year-end position.

How the scope of our audit responded to the risk	We evaluated the design and implementation of controls over recognition of Payment by Results income and assessment of provisions for disputes with commissioners. We performed detailed substantive testing on a sample basis of the recoverability of over-performance income and adequacy of provision for underperformance and disputes through the year, and evaluated the results of the agreement of balances exercise. We challenged key judgements around specific areas of dispute and actual or potential challenge from commissioners and the rationale for the accounting treatments adopted. In doing so, we considered the historical accuracy of provisions for disputes and reviewed correspondence with commissioners.
Key observations	Based on the audit evidence obtained, we conclude that NHS revenue is appropriately recognised.

Property valuations and capital developments

Risk description	The Group holds property assets within Property, Plant and Equipment at a modern equivalent use valuation of £478.1m as per note 14. The valuations are by nature significant estimates which are based on specialist and management assumptions (including the floor areas for a Modern Equivalent Asset, the basis for calculating build costs, the level of allowances for professional fees and contingency, and the remaining life of the assets) and which can be subject to material changes in value, as described in note 1.28 Critical Accounting Judgements and Key Sources of Estimation Uncertainty. The Trust commissioned a full revaluation as at 31 March 2016 and an interim revaluation exercise as at 31 March 2017. As a result of this a gain of £14.7m has been recognised in operating surplus, being the reversal of impairment in previous years. Capital additions for the year were £13.3m. Determining whether expenditure should be capitalised can involve significant judgement as to whether costs should be capitalised under International Financial Reporting Standards, and when to commence depreciation.
How the scope of our audit responded to the risk	We evaluated the design and implementation of controls over property valuations, and tested the accuracy and completeness of data provided by the Group to the valuer. We used Deloitte internal valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the Group's properties. We have reviewed the disclosures in notes 1.5 and 1.28 and evaluated whether these provide sufficient explanation of the basis of the valuation and the judgements made in preparing the valuation. We assessed whether the valuation and the accounting treatment of the impairment were compliant with the relevant accounting standards, and in particular whether impairments should be recognised in Operating Surplus or in Other Comprehensive Income. We evaluated the design and implementation of controls over capitalisation of expenditure and tested spend on both capital additions and revenue and maintenance on a focused sample basis to confirm that it complies with the relevant accounting requirements, and that the depreciation rates adopted are appropriate.

Key observations	Based on the audit evidence obtained, we conclude that the valuation of the Trust's estate is appropriate. We did not identify any issues with the capital additions recognised.

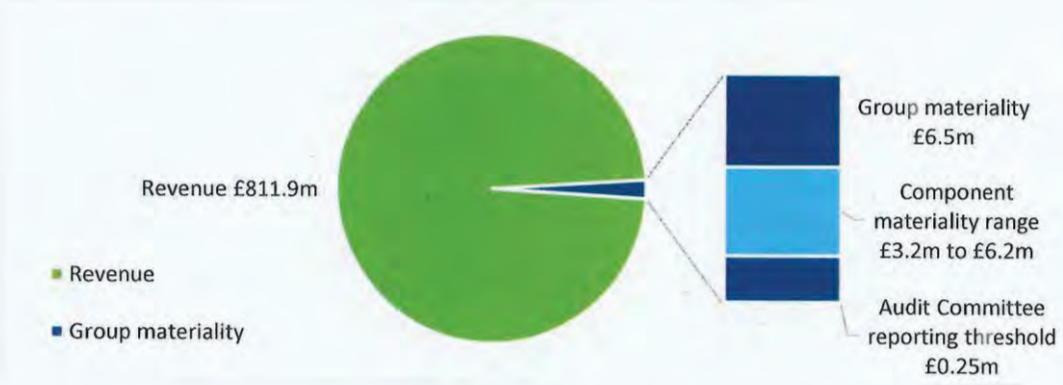
These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Our application of materiality

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

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Group materiality	£6.5m (2016: £6.1m)
Basis for determining materiality	1% of revenue (2016: 1% of revenue)
Rationale for the benchmark applied	Revenue was chosen as a benchmark as the Trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the financial statements.



We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £250,000 (2016: £121,000), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

Our group audit was scoped by obtaining an understanding of the Group and its environment, including group-wide controls, and assessing the risks of material misstatement at the Group level. Our audit covered all of the entities within the Group, including the Trust's subsidiaries Pharmacy@QEHB Limited, UHB Facilities Limited and Assure Dialysis Limited, which account for 100% of the Group's net assets, revenue and surplus (2015/16: 100%).

Our audit work was executed at levels of materiality applicable to each individual entity which were lower than group materiality. The range of materiality used was £3.2m to £6.2m.

At the Group level we also tested the consolidation process.

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

In our opinion:

- the parts of the Directors' Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

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

We have nothing to report in respect of these matters.

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

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

Our duty to read other information in the Annual Report

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

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

In particular, we are required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the annual report is fair, balanced and understandable and whether the annual report appropriately discloses those matters that we communicated to the audit committee which we consider should have been disclosed.

We confirm that we have not identified any such inconsistencies or misleading statements.

Respective responsibilities of Accounting Officer and auditor

As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Code of Audit Practice and International Standards on Auditing (UK and Ireland). We also comply with International Standard on Quality Control 1 (UK and Ireland). Our audit methodology and tools aim to ensure that our quality control procedures are effective, understood and applied. Our quality controls and systems include our dedicated professional standards review team.

This report is made solely to the Council of Governors and Board of Directors ("the Boards") of University Hospitals Birmingham NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Scope of the audit of the financial statements

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

Gus Miah (Senior statutory auditor)
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
Birmingham, United Kingdom
24 May 2017

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 2017 and up to the date of approval of the annual report and accounts.

3 Capacity to handle risk

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

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

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

Both the Board of Directors and the Clinical Quality Committee (CQC) receive reports that relate to clinical risks.

Nominated Managers (as defined in the Health & Safety Policy) attend the 'Managing Risks' course that covers the principles of risk assessment and the management of Risk Registers. The Trust's guidance document, available to all staff via the Trust's intranet ('Procedure for the Assessment of Risks and Management of Risk Registers'), sets out the processes for managing risk at all levels within the Trust. Risk Management is included, as appropriate, in Trust and Divisional Development programmes. It is incorporated into the Corporate, Consultant and Junior Doctor Induction programmes. Risk Management training is provided for nursing band 5 and 6 development programmes, Root Cause Analysis (RCA) training is provided to Senior Managers as identified in the Trust Training Needs Analysis. Ad-hoc training is also provided for divisional education development.

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

4 The risk and control framework

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

NHSLA

The NHSLA Risk Management standards were abolished in 2014/15. The Trust underwent its last successful assessment in September 2013 where a score of level 2 was achieved. The implementation of Trust policies continues to be monitored against similar standards set by the Trust. This ensures staff compliance with relevant legislation and other regulatory requirements and any areas of non-compliance are flagged up early.

CQC

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

Based on the discussions at the Clinical Quality Monitoring Group the Executive Medical Director provides a regular exception report to the Board of Directors. In April the Medical Director submits a draft

Quality Report/Account to the Board and a final Quality Report/Account is provided in May.

The Executive Chief Nurse provides a quarterly Patient Care Quality Report, which includes information regarding Infection Prevention and Control. He is also responsible for the bi-annual nurse staffing report, the annual report regarding the National Inpatient Survey and the annual Safeguarding Adults and Children report. The Executive Director of Strategic Operations (and External Affairs) provides a six-monthly Emergency Preparedness Update report to the Board.

The Board of Directors receives an Audit Committee Activity report from the chair of the Audit Committee following each Audit Committee meeting and a quarterly report on the Board Assurance Framework, from the Director of Corporate Affairs.

The Executive Director of Delivery provides a quarterly Performance Indicators report to the Board of Directors. The Clinical Quality Committee also receives a Performance Indicators report each time it meets which includes a more detailed analysis of a specific area of quality performance. The Board of Directors also approved the Monitor Quarterly Governance Declaration until the introduction of the new Single Oversight Framework in October 2016 when NHS Improvement no longer required it to be submitted. The Executive Director of Delivery provided an Annual Plan Progress Update to the Board of Directors in January and October 2016 and to the Council of Governors in February and November 2016.

Further details on the structure of board committees, their terms of references and board reporting, as well as information on compliance with the foundation trusts' Code of Governance (and reasons for any departure) are contained within the annual report.

4.1 Risk identification and evaluation

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

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

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

Other methods of identifying risks are:

- Complaints and Care Quality Commission reports and recommendations;
- Inquest findings and recommendations from HM Coroners;
- Health and Safety risk assessments;
- Medico-legal claims and litigation;
- Ad hoc risk issues brought to either the speciality meetings/departmental meetings, Divisional Clinical Quality Group meetings, Health, Safety and Environment Committee, Clinical Quality Monitoring Group, Care Quality Group or Safeguarding Group:
- Incident reports and trend analysis;
- Internally generated reports from the Health Informatics Team;
- Reviews by external regulators;
- Internal and external audit reports.

Identified risks are added to the local/departmental Risk Registers and reviewed on a quarterly basis to ensure that action plans are being carried out and that risks are being added or deleted, as appropriate. This process is audited on a quarterly basis and reported to the Board of Directors in the Compliance and Assurance Report. Any non compliance is addressed with the appropriate Divisional Management Team and where required, Executive Directors escalate high level risks identified by the Divisional and Corporate Management Teams to the Board of Directors through the Board Assurance Framework (BAF) process.

The Board of Directors undertakes a review of the Board Assurance Framework on a quarterly basis and the Audit Committee receives an annual report.

4.2 Risk control

High level risks (both clinical and corporate) are reported directly to the Board of Directors through the BAF. The process of reporting of risks is monitored and overseen by the Audit Committee. As one of the Trust's key controls, the BAF and its associated process is furthermore audited on an annual basis by the Trust's Internal Auditors.

Information governance

Risks to information are managed and controlled in accordance with the Trust's Information Governance Policy and the Incident Reporting Policy and reviewed during the Information Governance Group (IGG) meetings, chaired by the Director of Corporate Affairs, who has been appointed as the Senior Information Risk Officer. The Executive Medical Director, as Caldicott Guardian, is responsible for the protection of patient information. All information governance issues, including information security issues are integrated through the Information Governance Group. The Board of Directors receives a report regarding its systems of control for information governance. These include satisfactory completion of its annual self-assessment against the Information Governance Toolkit, mapping of data flows, monitoring of access to data and reviews of incidents.

The Trust completed the Information Governance Toolkit assessment for 2016/17 and achieved a score of 70%, achieving Level 2 or above for all the requirements, which is satisfactory.

No serious incident was reported to the Information Commissioner's Office (ICO) in 2016/17 via the Information Governance Incident Reporting Tool.

The Audit Committee received a joint presentation from the IG and IT department on cyber security.

Risk management
Risk management is well embedded throughout the organisation. Risks are usually reported locally through the local risk registers or speciality/departmental meetings. The 'Procedure for the Assessment of Risks and Management of Risk Registers' details how risks are escalated from a local/departmental level to Speciality/ Divisional/Executive and finally Board level. The Board of Directors establishes which risk tolerance is deemed to be acceptable to the Trust.

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

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

When an incident occurs and there is a remaining risk, all practical and reasonable steps are taken to prevent re-occurrence. The line manager is responsible for the provision of primary support for staff involved in the incident and this is made available immediately. Any incidents which are considered to be 'severe' (as defined by the National Patient Safety Agency (NPSA) definition) are escalated by the Clinical Risk and Compliance Unit to an appropriate Executive Director who decides whether the incident should be treated as a Serious Incident (SI).

All SIs must be investigated using the Root Cause Analysis (RCA) methodology. All SIs are reported and managed in accordance with the national framework. All new and revised policies undergo an equality impact assessment as part of the approval process.

There are elements of risk management where public stakeholders are closely involved. Members of the public are encouraged to participate through the regular 'Clean your hands' campaign led by Patient and Carer Councils supported by the Trust. There are patient representatives involved in the PLACE (Patient Led Assessment of the Care Environment) visits. Aspects of risk, including infection control, are discussed at all Patient and Carer Council meetings. The Council of Governors is represented on the Care Quality Group and receives regular reports on care quality, including infection control.

Strategic risks
The Board Assurance Framework (BAF) contains the organisation's major risks that may impact on the achievement of the Trust's overarching Strategic Priorities for 2016/17. These are linked to the Annual Plan and the Care Quality Commission's Fundamental Standards. This process ensures that the Board is informed about the most serious risks faced by the Trust.

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

- Significant deterioration in the Trust's underlying financial position being reported which is worse than planned. This could be further compounded by any financial pressures related to the UK's exit from the EU. Any material financial deterioration against the Trust's financial plan is likely to result in a worsening of the Trust's 'Use of Resources' score as part of the Single Oversight Framework.

- External factors impacting on the Trust's capacity and timely/effective transfer of care from UHB to other providers.

- Risk of failure to deliver operational performance targets including Sustainability and Transformation Fund (STF) trajectory due to capacity issues.

- Inability to recruit adequate numbers of sufficiently skilled, trained and competent staff including senior management (particularly academic consultants and doctors). This may be further compounded by the UK's exit from the EU affecting Trust EU grants.

- Adverse impact on recruitment and research funding (see above), as well as contracts for equipment/ consumables/services and finance generally as a result of the UK's exit from the EU.

- Potential breach of terms of NHSI's Provider Licence/ non-compliance with external regulatory requirements due to activity growth, capacity constraints and the receipt of late referrals.

The Trust maintains several compliance frameworks to ensure the collection of timely, accurate and relevant assurance data on any compliance risks. The corporate compliance framework provides oversight of the responsibilities of the Trust's various Committees/Groups and the effectiveness of the Trust's overall governance structure. The clinical compliance framework monitors compliance against the CQC fundamental standards and provides assurance on over 105 measures associated with clinical risks, including but not limited to infection control; service planning; admission, transfer and discharge. The information governance framework monitors compliance with the Data Protection and Freedom of Information Act.

Any anomalies, gaps in assurance or concerns about the quality of available assurance are reported on an exception basis to the relevant Executive Director, the DCA Governance Group or Information Governance Group meetings. The meetings are chaired by the Director of Corporate Affairs who decides whether further escalation to the Audit Committee or Board of Directors is required.

Where the Trust is exposed to new compliance standards or recommendations, these are cross-

referenced to standards already logged on the various compliance frameworks and any gaps in assurance are highlighted.

The Trust is fully compliant with the registration requirements of the Care Quality Commission. As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that the deductions from salary, employer's contributions and payments into the Scheme are in accordance with Scheme rules, and that the member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations. Update on Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on the UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

5 Review of economy, efficiency and effective use of resources

The Trust's 2016/17 Financial Plan was approved by the Board of Directors in March 2016. The plan assumed an annual surplus (excluding revaluations) of £4.6m which included the need to deliver £18.2m of efficiency savings. This plan included an allocation of £16.7m from the Sustainability and Transformation Fund (STF) from NHS Improvement. The majority of NHS acute providers received some STF income to reset or improve the financial deficits reported in 2015/16.

Cost Improvement Plans (CIPs) were developed and the resulting savings applied to the relevant operational divisions and corporate department budgets. The Trust's financial performance (including delivery of cost improvements) is monitored throughout the year and reported to the Board of Directors on a monthly basis. The Trust's underlying financial performance (excluding revaluations) for 2016/17 was better than planned. This financial surplus has been delivered despite the operational pressures under which the Trust continues to work.

In addition to the agreed annual CIP, further efficiency savings are realised throughout the year with initiatives such as ongoing tendering and product rationalisation and review of all requests to recruit to both new and existing posts via the Workforce Approval Forms (WAF) group.

During 2016/17 the Board of Directors has continued to receive a quarterly report on Key Performance Indicators (KPIs). This ensures that the Board of Directors receives information on a number of measures of clinical quality, operational performance, efficiency and use of resources. Reporting is by exception and focusses on the key areas of risk, to achievement of targets, particularly in relation to NHS Improvement's Single Oversight Framework (SOF) which replaced Monitor's Risk Assessment Framework from October 2016. The SOF monitors the following five targets: A&E 4-hour wait; 18 week RTT; cancer 62-day wait for first treatment from urgent GP referral; cancer 62-day wait for first treatment from NHS cancer screening; and 6-week wait for diagnostic procedures.

In 2016/17 the Trust achieved all targets included in the SOF with the exception of cancer 62-day GP referral and A&E 4-hour wait. The 62-day GP referral and A&E 4-hour wait target also form part of the Sustainability and Transformation Fund (STF) improvement trajectories which were closely monitored by the Board during 2016/17. Underlying assumptions were agreed for each STF performance target. For Quarter 1 the payment was achieved for simply agreeing trajectories. In Quarter 2 and 3 the Trust achieved the 18-week RTT trajectory and the A&E 4-hour wait target following an appeal. For Quarter 4 the STF payment was made solely on the basis of financial performance against plan.

In addition to the above, the Board has received performance reports containing progress against CQUIN delivery, some of which contain efficiency measures. Efficiency is further measured via dashboards at a local level.

As part of the Trust's Quality Account for 2016/17 its data quality for two targets included in the SOF (18-week RTT and A&E 4-hour waits) has been audited by the Trust's external auditors who issued an unmodified opinion.

The objectives set out in the Trust's Internal Audit Plan include ensuring the economical, effective and efficient use of resources and this consideration is applied across all of the workstreams carried out. The findings of internal audit are reported to the Board through the Audit Committee.

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

Quality Accounts

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

The content of the Trust's Quality Report for 2016/17 builds on the 2015/16 report and was agreed by the Clinical Quality Monitoring Group, chaired by the Executive Medical Director, and by the Board of Directors. The Quality Improvement Priorities for 2017/18 were selected with input from the Council of Governors, Care Quality Group and the Clinical Quality Monitoring Group.

The Trust uses the same systems and processes to collect, validate, analyse and report on data for the annual Quality Reports as it does for other clinical

quality and performance information. Information is subject to regular review and challenge at specialty, divisional and Board level by the Clinical Quality Monitoring Group, Care Quality Group and Board of Directors, for example.

As in previous years, the Trust has produced quarterly update reports, showing performance for the quality improvement priorities and other key indicators during 2016/17. These are presented to the Clinical Quality Monitoring Group and the Board of Directors, and then made available to patients and the public on the Trust's external website.

The draft 2016/17 Quality Report was presented and approved at the Board of Directors meeting in April 2017. In line with the Trust's commitment to transparency, the data included in the Quality Report is not just limited to good performance.

6 Review of effectiveness

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

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

- the maintenance of a view of the overall position with regard to internal control by the Board of Directors through its routine reporting processes and its review of the Board Assurance Framework;
- the receipt of Internal and External Audit reports on the Trust's internal control processes by the Audit Committee; and
- personal input into the controls and risk management processes from all Executive Directors and Senior Managers and individual clinicians.

The Board's review of the Trust's risk and internal control framework is supported by the Annual Head of Internal Audit opinion. The opinion is based upon and limited to their work performed on the overall adequacy and effectiveness of the Trust's risk management, control and governance processes.

KPMG's Head of Internal Audit Opinion is derived from the reviews of the key financial controls (treasury management; income and debtors; expenditure and creditors, fixed assets and general ledger), IT control and the BAF. Its Opinion for 2016/17 states that "significant with minor improvements assurance can be given on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control".

In 2016/17, the Trust's external auditor reviewed the effectiveness of some of the processes through which data is extracted and reported in the Quality Report. Deloitte reviewed the content of the Trust's 2016/17 Quality Report and undertook testing for three areas: 18-week RTT times (unfinished pathways), A&E 4-hour waits and one local indicator of the Trust's choice (falls with harm).

The auditors issued an unmodified opinion for both the 18-week RTT indicator and the A&E 4-hour wait. Recommendations have been provided to help the Trust further strengthen data quality processes for these indicators.

No issues were identified with the content review and there is one minor recommendation for the local indicator.

7 Conclusion

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

Dame Julie Moore
Chief Executive
18 May 2017

Consolidated statement of comprehensive income

	Notes	Year Ended 31 March 2017 Total £000	Year Ended 31 March 2016 Total £000
Revenue from patient care activities	3	**675,740**	629,084
Other operating revenue – recurring	4	**136,137**	114,926
Other operating revenue – non recurring	4.1	**—**	13,800
Total revenue		**811,877**	757,810
Operating expenses – recurring	5	**(780,520)**	(741,029)
Operating expenses – non recurring	5	**14,666**	(15,075)
Total operating expenses		**(765,854)**	(756,104)
Operating surplus		**46,023**	1,706
Finance income	10	**312**	296
Finance expense	10	**(22,033)**	(22,260)
PDC Dividends payable	11	**—**	—
Net finance expense		**(21,721)**	(21,964)
Gains on disposal of non-current assets	11	**232**	609
Taxation	13	**134**	(76)
Retained surplus/(deficit) for the year		**24,668**	(19,725)
Other comprehensive income			
Will not be reclassified to income and expenditure			
Revaluation losses on property, plant and equipment		**(189)**	—
Revaluation gains on property, plant and equipment		**6,970**	14,040
Net other comprehensive income		**6,781**	14,040
Total comprehensive income/(loss) for the year		**31,449**	(5,685)

All income and expenditure is derived from continuing operations.

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

The non-recurring revenue and operating expenses are detailed in their respective notes and are due to movements in the revaluations of property (fair values) and disposal of surplus land.

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

Consolidated statement of financial position

		Group		Foundation Trust	
		31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	Notes	**£000**	£000	**£000**	£000
Assets					
Non-current assets					
Intangible assets	14	**2,158**	660	**2,158**	660
Property, plant and equipment	15	**517,262**	503,456	**514,470**	500,326
Trade and other receivables	20	**4,623**	11,050	**4,623**	11,050
Deferred tax asset	24	**146**	—	**—**	—
		524,189	515,166	**521,251**	512,036
Current assets					
Inventories	19	**14,965**	15,674	**13,212**	13,584
Trade and other receivables	20	**71,947**	61,532	**79,775**	71,739
Cash and cash equivalents	21	**70,829**	59,171	**70,228**	56,183
		157,741	136,377	**163,215**	141,506
Total assets		**681,930**	651,543	**684,466**	653,542
Liabilities					
Current liabilities					
Borrowings	25	**(12,275)**	(12,835)	**(12,275)**	(12,835)
Trade and other payables	22	**(127,458)**	(118,826)	**(131,134)**	(121,811)
Current tax liabilities		**(65)**	(25)	**—**	—
Provisions	28	**(740)**	(792)	**(740)**	(792)
Other liabilities	23	**(20,283)**	(18,703)	**(20,283)**	(18,613)
		(160,821)	(151,181)	**(164,432)**	(154,051)
Total assets less current liabilities		**521,109**	500,362	**520,034**	499,491
Non-current liabilities					
Borrowings	25	**(484,465)**	(496,740)	**(484,465)**	(496,740)
Provisions	28	**(3,065)**	(2,362)	**(2,807)**	(2,116)
Deferred tax liabilities	24	**(36)**	(82)	**—**	—
Other liabilities	23	**(5,093)**	(7,413)	**(5,093)**	(7,413)
		(492,659)	(506,597)	**(492,365)**	(506,269)
Total liabilities		**(653,480)**	(657,778)	**(656,797)**	(660,320)
Net assets/(liabilities)		**28,450**	(6,235)	**27,669**	(6,778)
Taxpayers' equity					
Public dividend capital		**186,210**	182,974	**186,210**	182,974
Revaluation reserve		**114,954**	108,173	**114,954**	108,173
Income and expenditure reserve		**(272,714)**	(297,382)	**(273,495)**	(297,925)
Total taxpayers' equity		**28,450**	(6,235)	**27,669**	(6,778)

The financial statements on pages XVIII to LXI were approved by the Board of Directors on 18 May 2017 and were signed on its behalf by:

Dame Julie Moore, Chief Executive, 18 May 2017

Consolidated statement of changes in taxpayers' equity

Group	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	**Total**
	£000	£000	£000	**£000**
Balance at 1 April 2015	180,663	95,112	(278,636)	**(2,861)**
Deficit for the year	—	—	(19,725)	**(19,725)**
Transfers in respect of assets disposed of	—	(979)	979	**—**
Public dividend capital received	2,311	—	—	**2,311**
Revaluation gains	—	14,040	—	**14,040**
Balance at 31 March 2016	182,974	108,173	(297,382)	**(6,235)**
Surplus for the year	—	—	24,668	**24,668**
Transfers in respect of assets disposed of	—	—	—	**—**
Public dividend capital received	3,236	—	—	**3,236**
Revaluation losses	—	(189)	—	**(189)**
Revaluation gains	—	6,970	—	**6,970**
Balance at 31 March 2017	186,210	114,954	(272,714)	**28,450**

Trust	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	**Total**
	£000	£000	£000	**£000**
Balance at 1 April 2015	180,663	95,112	(279,557)	**(3,782)**
Deficit for the year	—		(19,347)	**(19,347)**
Transfers in respect of assets disposed of	—	(979)	979	**—**
Public dividend capital received	2,311	—	—	**2,311**
Revaluation gains	—	14,040	—	**14,040**
Balance at 31 March 2016	182,974	108,173	(297,925)	**(6,778)**
Surplus for the year	—	—	24,430	**24,430**
Transfers in respect of assets disposed of	—	—	—	**—**
Public dividend capital received	3,236	—	—	**3,236**
Revaluation losses	—	(189)	—	**(189)**
Revaluation gains	—	6,970	—	**6,970**
Balance at 31 March 2017	186,210	114,954	(273,495)	**27,669**

Consolidated statement of cash flows

		Group		Foundation Trust	
		31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
		Total	Total	**Total**	Total
	Notes	**£000**	£000	**£000**	£000
Cash flows from operating activities					
Operating surplus for the year		**46,023**	1,706	**45,667**	1,796
Depreciation and amortisation		**21,174**	21,343	**20,833**	21,048
Net reversals of impairments		**(14,666)**	15,075	**(14,666)**	15,075
Non-cash donations/grants credited to income		**(555)**	(855)	**(555)**	(855)
Decrease/(increase) in inventories		**709**	(212)	**372**	227
(Increase)/decrease in trade and other receivables		**(15,414)**	20,963	**(13,067)**	16,730
Increase in trade and other payables		**9,781**	4,684	**10,418**	5,252
(Decrease) in other liabilities		**(740)**	(15,644)	**(650)**	(15,790)
Increase/(decrease) in provisions		**634**	(119)	**622**	(119)
Tax (paid)/received		**(18)**	(166)	**—**	—
Net cash generated from operating activities		**46,928**	46,775	**48,974**	43,364
Cash flows from investing activities					
Interest received		**229**	299	**513**	522
Payments to acquire property, plant and equipment		**(14,418)**	(15,626)	**(14,361)**	(13,654)
Receipts from sale of property, plant and equipment		**12,250**	9,000	**12,250**	9,000
Payments to acquire intangible assets		**(1,716)**	—	**(1,716)**	—
Net cash used in investing activities		**(3,655)**	(6,327)	**(3,314)**	(4,132)
Cash flows from financing activities					
Public dividend capital received		**3,236**	2,311	**3,236**	2,311
Capital element of finance lease obligations		**(43)**	(40)	**(43)**	(40)
Interest element of finance lease obligations		**(23)**	(27)	**(23)**	(27)
Capital element of PFI obligations		**(12,792)**	(12,589)	**(12,792)**	(12,589)
Interest element of PFI obligations		**(21,993)**	(22,200)	**(21,993)**	(22,200)
Net cash used in financing activities		**(31,615)**	(32,545)	**(31,615)**	(32,545)
Net increase/(decrease) in cash and cash equivalents		**11,658**	7,903	**14,045**	6,687
Cash and cash equivalents at 1 April		**59,171**	51,268	**56,183**	49,496
Cash and cash equivalents at 31 March	21	**70,829**	59,171	**70,228**	56,183

Notes to the Financial Statements

1 Accounting policies

Basis of preparation
NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2016/17 issued by the Department of Health. The accounting policies contained in that manual follow IFRS and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

Going concern
These accounts have been prepared on a going concern basis. After making enquiries, the directors have a reasonable expectation that the NHS foundation trust has adequate resources to continue in operational existence for the foreseeable future. The retained surplus for the reported year has resulted in an increase in cash held, Group cash balances have increased year on year. The Trust has for the subsequent financial year (2016/17) signed up to the NHS Sustainability and Transformation Fund and is committed to return a small operating surplus. For this reason, they continue to adopt the going concern basis in preparing the accounts.

1.1 Basis of consolidation
The Group financial statements consolidate the financial statements of the Trust and all of its subsidiary undertakings made up to 31 March 2017. Under IFRS 10, an entity controls an investee when it is exposed to, or has rights to, variable returns from its involvement with the investee and has the ability to affect those returns through its power over the investee. The income, expenses, assets, liabilities, equity and reserves of the subsidiaries have been consolidated into the Trust's financial statements and group financial statements have been prepared.

All intra-group transactions, balances, income and expenses are eliminated on consolidation. Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material, however there are no such differences at the reporting date. In accordance with the DH GAM 2016/17 a separate income statement for the parent (the Trust) has not been presented.

The DH GAM 2016/17 requires the consolidation of any NHS charity that meets the criteria of control under IFRS 10. The Queen Elizabeth Hospital Birmingham Charity is not considered to be a subsidiary of the Trust under IFRS 10 and consequently is not consolidated within these financial statements. The charity is a separate legal entity with an independent Board of Trustees and the benefits from its activities are shared between the Trust, University of Birmingham and Royal Centre of Defence Medicine.

Joint ventures are arrangements in which the trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method. The Trust has no joint operations nor any associate entities.

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.

Revenue relating to spells that are partially completed at year-end are apportioned across the financial years on a pro rata basis. This basis is based on the costs incurred over the length of the treatment and the expected or actual length of stay.

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 of the Trust are covered by the provisions of the two NHS Pensions Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. They are

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, each 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 commercial subsidiaries operate a defined contribution scheme with Standard Life and the Government's NEST scheme, employees of these companies do not have access to the NHS Pension Schemes.

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

a. **Accounting valuation**
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b. **Full actuarial (funding) valuation**
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

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

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

1.4 Expenditure on other goods and services

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

1.5 Property, plant and equipment

Recognition
Property, plant and equipment assets are capitalised where:

- They are held for use in delivering services or for administration purposes;
- It is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- They are expected to be used for more than one financial year;
- The cost of the item can be measured reliably;
- Individually they have a cost of at least £5,000; or
- They form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- They form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Buildings are depreciated over 10 to 50 years according to the estimated useful life of the asset;
- Dwellings are depreciated over 5 to 25 years;
- Land and properties under construction are not depreciated;
- Plant and machinery is depreciated over 5 to 15 years;
- Information technology is depreciated over 2 to 5 years;
- Furniture and fittings are depreciated over 5 to 10 years; and
- Intangible software and licences/trademarks are depreciated over 2 to 5 years.

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

In accordance with the DH GAM, 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 expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

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

1.8 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to revenue. The revenue is recognised in full in the reporting year the asset is received, unless the donor imposes a condition that the future economic benefits embodied in the donation are to be consumed in a manner specified by the donor. In which case the donation would be deferred within liabilities carried forward to future years to the extent that the condition has not yet been met. Donated assets continue to be valued, depreciated and impaired as described for purchased assets.

1.9 Government grants

The revenue is recognised when the foundation trust becomes entitled to the grant, unless the grantor imposes a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the grantor. In which case the grant would be deferred within liabilities carried forward to future years to the extent that the condition has not yet been met. Granted assets continue to be capitalised at their fair value upon receipt and are valued, depreciated and impaired as described for purchased assets.

1.10 Leases

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

The Trust as lessee

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

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

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

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

The Trust as lessor

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

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

1.11 Private Finance Initiatives (PFI) transactions

Recognition

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

- The grantor controls the use of the infrastructure and regulates the services to be provided to whom and at what price; 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 27.1 to the financial statements on page LIII. 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 estimation technique of the Modern Equivalent Asset (the 'Depreciated Replacement Value') includes the assumption that any replacement PFI hospital would be VAT recoverable. VAT is recoverable on PFI builds under HMRC guidelines whereas traditional NHS estate construction is not recoverable and therefore valued gross of VAT. It is recognised that a modern equivalent asset, would be another PFI on the same Edgbaston site, hence VAT would be recoverable on any cost. The DH GAM states the circumstances where it is appropriate to value assets exclusive of VAT, detailed in Chapter 6 Annex 3 – Valuation issues, paragraph 8: provision of a fully managed and serviced building under a PFI agreement, where the service potential would be replaced by the PFI provider.

The PFI lease obligations due at the reporting date are detailed in note 27.1 to the financial statements on page LIII.

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 XXXVIII.

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

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

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

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

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

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

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

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

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

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

1.15 Financial assets and financial liabilities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.17 Deferred income
Deferred income represents grant monies received where the expenditure is expected to take place in a future period. The deferred income is included in current liabilities unless the expenditure, in the opinion of management, will take place more than 12 months after the reporting date, which are classified in non-current liabilities.

1.18 Borrowings
The prudential borrowing code requirements in section 41 of the NHS Act 2006 have been repealed with effect from 1 April 2013 by the Health and Social Care Act 2012. The financial statements disclosures that were provided previously are no longer required. The Trust has not utilised any loan or working capital facility, borrowings as at the reporting date consist of obligations under finance leases and the 'Queen Elizabeth Hospital Birmingham' Private Finance Initiative contract.

1.19 Provisions
The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the reporting date on the basis of the best estimate of the expenditure required to settle the probable obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of -0.8% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of +0.24% 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 28 to the financial statements on page LV, 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 £1 million.

1.20 Contingencies
Contingent liabilities are not recognised but are disclosed in note 29 to the financial statements on page LVI, 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 29 to the financial statements on page LVI where an inflow of economic benefits is probable.

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

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

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

Research and development activity cannot always be separated from patient care activity and is considered to be a part of the core NHS healthcare operating segment within the Trust. It is therefore not separately disclosed.

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

1.24 Corporation Tax
The Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to disapply the exemption in relation to specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the future scope of income tax in respect of activities where income is received from a non public sector source.

The tax expense on the surplus or deficit for the year comprises current and deferred tax due to the Trust's trading commercial subsidiaries, see note 13 to the financial statements on page XXXIX. Current tax is the expected tax payable for the year, using tax rates enacted or substantively enacted at the balance sheet date, and any adjustment to tax payable in respect of previous years.

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

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

1.25 Foreign exchange
The functional and presentational currency of the Trust is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March 2017. 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 – key sources of estimation uncertainty

As detailed in accounting policy note 1.5 'Property, plant and equipment – valuation', the District Valuation Service provided the Trust with a valuation of the land and building assets (estimated fair value and remaining useful life). The significant estimation being the specialised building – depreciated replacement value, using modern equivalent asset methodology, of the new PFI hospital (the 'Queen Elizabeth Hospital Birmingham'). The result of this valuation, based on estimates provided by a suitably qualified professional in accordance with HM Treasury guidance, is disclosed in note 15.2 to the financial statements on page XLV. Future revaluations of the Trust's property may result in further material changes to the carrying values of non-current assets.

Provision for impairment of receivables – critical accounting judgement

Management will use their judgement to decide when to write-off revenue or to provide against the probability of not being able to collect debt. There are significant judgements in recognition of revenue from care of NHS patients and in provisioning for disputes with commissioners, this arises from the complexity of the Payments by Results regime and the judgemental nature of over performance activity levels and partially completed spells not yet agreed with commissioners.

Impairments and the estimated lives of assets – key sources of estimation uncertainty

As detailed in accounting policy note 1.7 'Depreciation, amortisation and impairments', the Trust is required to review property, plant and equipment for impairments and the accuracy of estimated useful lives. In between formal valuations by qualified surveyors, management make judgements about the condition of assets and review their estimated lives.

Provisions – critical accounting judgement

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

The carrying amounts of the Trust's provisions are detailed in note 28 to the financial statements on page LV.

1.29 Accounting standards, interpretations and amendments adopted in the year

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

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

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2016-17:

- IFRS 9 'Financial Instruments'recognition and measurement
- IFRS 13 'Fair Value Measurement'
- IFRS 15 'Revenue from Contracts with Customers'
- IFRS 16 'Leases'
- IFRIC 21 'Levies'
- IFRIC 22 'Foreign Currency Transactions and Advance Consideration'

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

2 Segmental analysis

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

Healthcare services

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

Revenue from activities (medical treatment of patients) is analysed by activity type in note 3 to the financial statements on page XXXII. Other operating revenue is analysed in note 4 to the financial statements on page XXXIV and materially consists of revenues from healthcare research and development, medical education and related support services to other organisations. Revenue is predominately from HM Government and related party transactions are analysed in note 31 to the financial statements on page LVI, where individual customers within the public sector are considered material. The proportion of total revenue receivable from whole HM Government is 96.6% (2015/16 – 94.2%).

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

Commercial subsidiaries

There are three trading companies that are all wholly owned subsidiaries of the Trust: (i) Pharmacy@QEHB Limited provides an Outpatient Dispensary service, (ii) UHB Facilities Ltd provides a fully managed healthcare facility and (iii) Assure Dialysis Services Ltd provides renal dialysis healthcare. As trading companies, subject to additional legal and regulatory regimes (over and above that of the Trust), these activities are considered to be a separate business segment whose individual operating results are reviewed by the Trust Board (the Chief Operating Decision Maker).

A significant proportion of these companies' revenues are inter group trading with the Trust which is eliminated upon the consolidation of these group financial statements. The monthly performance report to the Chief Operating Decision Maker reports financial summary information in the format of the table opposite.

Year ended 31 March 2017	Healthcare services	Commercial subsidiaries	Inter-Group Eliminations	Total
	£000	£000	£000	**£000**
Total segment revenue	812,740	44,034	(44,897)	811,877
Total segment revenue – non recurring	—	—	—	—
Total segment expenditure	(781,739)	(43,678)	44,897	(780,520)
Total segment expenditure – non recurring	14,666	—	—	14,666
Operating surplus	**45,667**	**356**	**—**	**46,023**
Net financing	(21,469)	(252)	—	(21,721)
Gains on disposal of assets	232	—	—	232
Taxation	—	134	—	134
Retained surplus	**24,430**	**238**	**—**	**24,668**
Reportable segment assets	684,466	10,347	—	694,813
Eliminations	—	—	(12,883)	(12,883)
Total assets	**684,466**	**10,347**	**(12,883)**	**681,930**
Reportable segment liabilities	(656,797)	(9,566)		(666,363)
Eliminations	—	—	12,883	12,883
Total liabilities	**(656,797)**	**(9,566)**	**12,883**	**(653,480)**
Net assets	**27,669**	**781**	**—**	**28,450**

Year ended 31 March 2016	Healthcare services	Commercial subsidiaries	Inter-Group Eliminations	Total
	£000	£000	£000	**£000**
Total segment revenue	744,757	38,981	(39,728)	744,010
Total segment revenue – non recurring	13,800	—	—	13,800
Total segment expenditure	(741,686)	(39,071)	39,728	(741,029)
Total segment expenditure – non recurring	(15,075)	—	—	(15,075)
Operating surplus	**1,796**	**(90)**	**—**	**1,706**
Net financing	(21,752)	(212)	—	(21,964)
Gains on disposal of assets	609	—	—	609
Taxation	—	(76)	—	(76)
Retained deficit	**(19,347)**	**(378)**	**—**	**(19,725)**
Reportable Segment assets	653,542	12,982	—	666,524
Eliminations	—	—	(14,981)	(14,981)
Total assets	**653,542**	**12,982**	**(14,981)**	**651,543**
Reportable Segment liabilities	(660,320)	(12,439)		(672,759)
Eliminations	—	—	14,981	14,981
Total (liabilities)	**(660,320)**	**(12,439)**	**14,981**	**(657,778)**
Net (liabilities)/assets	**(6,778)**	**543**	**—**	**(6,235)**

All activities are based in the UK.

3 Revenue from patient care activities

	Year Ended 31 March 2017	Year Ended 31 March 2016
	£000	£000
By commissioner		
Foundation Trusts	**169**	94
NHS Trusts	**1,032**	852
NHS England	**387,726**	357,259
Clinical Commissioning Groups	**252,677**	238,938
Department of Health	**—**	—
Local Authorities	**17,443**	15,568
NHS Scotland, Wales and Northern Ireland	**7,566**	8,332
Private Patients	**3,867**	3,526
Overseas Patients	**1,985**	362
NHS Injury Cost Recovery scheme	**3,275**	4,028
Ministry of Defence	**—**	125
	675,740	629,084

The responsibility for commissioning nationally funded NHS healthcare 'specialist healthcare activity' lies with NHS England which is the parent body of the CCGs. NHS England is the single largest commissioner of healthcare from the Trust under the new Social Care Act of 2012.

Healthcare activity income from the Ministry of Defence of £nil relates to the Trust contract with the Royal Centre for Defence Medicine (2015/16 – £125,000).

NHS Injury Cost Recovery scheme income, received from commercial insurance providers, is subject to a provision for impairment of receivables of 22.94% (2015/16 – 21.99%) to reflect expected rates of collection.

	Year Ended 31 March 2017	Year Ended 31 March 2016
	£000	£000
By activity		
Elective	**98,819**	100,817
Non elective	**117,017**	115,706
Outpatients	**96,990**	95,389
A&E	**13,247**	11,566
Other NHS clinical	**340,540**	297,565
Private and overseas patients	**5,852**	3,888
Other non-NHS clinical	**3,275**	4,153
	675,740	629,084

3.1 Overseas visitors (patients charged directly by the Trust)

	Year Ended 31 March 2017	Year Ended 31 March 2016
	£000	£000
Income recognised this year	**1,985**	362
Cash payments received in-year	**148**	392
Amounts added to provision for impairment of receivables	**(1,847)**	(381)
Amounts written off in-year	**(457)**	(204)

3.2 Commissioner requested services

	Year Ended 31 March 2017	Year Ended 31 March 2016
	£000	£000
Commissioner requested services		
Revenue derived from NHS clinical activity in England	**659,047**	612,711
Non-commissioner requested services		
NHS Scotland, Wales and Northern Ireland	**7,566**	8,332
Non-NHS derived clinical activity	**9,127**	8,041
	16,693	16,373
Revenue from patient care activities	**675,740**	629,084
Commissioner requested services as a percentage of revenue	**97.53%**	97.40%

With the exceptions of private and overseas patient, NHS injury cost recovery scheme and Ministry of Defence income, all of the revenue from clinical activities arises from NHS services within the United Kingdom.

Following changes to the Health and Social Care Act 2012 (the 'Act'), Monitor removed the requirement for foundation trusts to limit private patients revenue as a percentage of total revenue from activities. In its place, the Act requires that a foundation trust's principal activity is to deliver goods and services for the purposes of the National Health Service in England. These 'commissioner requested services' (as defined in the Trust's provider licence) are disclosed separately as a percentage of all revenue.

4 Other operating revenue – recurring

	Year Ended 31 March 2017	Year Ended 31 March 2016
	£000	£000
Research and development	**25,206**	22,943
Education and training	**30,620**	33,571
Sustainability and Transformation Fund income	**20,648**	—
Charitable and other contributions to expenditure	**1,353**	2,088
Non-patient care services to other bodies	**11,696**	11,431
Other revenue	**46,614**	44,893
	136,137	114,926

The Sustainability and Transformation Fund (STF) revenue is new in the reporting year. The Department of Health was given an additional £1.8billion by HM Treasury for the 2016/17 financial year and each NHS Trust was allocated a sum, conditional upon meeting certain financial and clinical targets. UHB was originally allocated a sum of £16,700,000 under the STF scheme. The Trust has exceeded its planned annual financial performance (see annual report for details) and as a consequence is due the original sum plus additional incentive and bonus amounts for this performance.

Other revenue includes PFI related income of £3,600,000 (2015/16 – £4,600,000); rental income of £2,366,000 (2015/16 – £2,141,000) due to the leasing of new hospital facilities by the University of Birmingham and Ministry of Defence; £3,235,000 from Clinical Excellence Awards (2015/16 – £3,346,000); recharges of £2,701,000 to the Ministry of Defence to fund the training expenditure of Nurses along with catering and car parking costs associated with the military contract (2015/16 – £2,481,000); £1,439,000 from the National Quality Assurance Service (2015/16 – £1,875,000); and funding of £1,818,000 (2015/16 – £1,939,000) for the organ retrieval service. The remainder of other income is largely made up of service level agreements with other West Midlands NHS trusts (not commissioners) for the supply of clinical and other supporting services.

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

4.1 Other operating revenue – non recurring

	Year Ended 31 March 2017	Year Ended 31 March 2016
	£000	£000
Charitable and other contributions to expenditure	**—**	13,800

Charitable and other contributions to expenditure includes a non-recurring £nil (2015/16 – £13,800,000). The prior year revenue was grant funding to build and refurbish the 'Institute of Translational Medicine', see note 15.2 to the financial statements on page XLV.

The comparative figure has been restated from the prior year due to two changes in accounting disclosures by the Department of Health Group Accounting Manual. Reversals of impairments are now disclosed alongside impairments in operating expenses, see note 5 to the financial statements on page XXXV and gains on disposals of non-current assets are disclosed in a separate note, see note 12 to the financial statements on page XXXIX. The prior year figures have not changed, this is merely a change of presentation.

5 Operating expenses

	Year Ended 31 March 2017	Year Ended 31 March 2016
	£000	£000
Recurring		
Services from Foundation Trusts	**7,213**	6,540
Services from other NHS Trusts	**944**	1,293
Services from CCGs and NHS England	**8**	29
Services from other NHS bodies	**685**	2,225
Purchase of healthcare from non NHS bodies	**15,781**	15,252
Directors' costs	**1,911**	1,873
Non executive directors' costs	**168**	176
Staff costs	**403,064**	391,035
Supplies and services – clinical	**228,104**	212,475
Supplies and services – general	**9,116**	9,491
Consultancy services	**2,695**	1,048
Establishment	**4,613**	4,775
Transport	**2,073**	2,414
Premises	**21,235**	21,077
Provision for Impairment of Receivables	**3,714**	(25)
Depreciation on property, plant and equipment	**20,956**	21,085
Amortisation on intangible assets	**218**	258
Audit services – statutory audit	**103**	103
Other auditor remuneration – taxation services	**—**	—
Other auditor remuneration – audit of subsidiaries	**20**	20
Other auditor remuneration – other services	**85**	177
Internal audit services	**113**	106
Clinical negligence	**10,823**	9,679
Other	**46,878**	39,923
	780,520	741,029
Non-recurring		
Net impairments of property, plant and equipment	**(14,666)**	15,075
	(14,666)	15,075
Total operating expenses	**765,854**	756,104

Other expenditure includes £25,771,000 (2015/16 – £26,657,000) in relation to payments to the Trust's PFI partner for services provided and Training, Courses and Conference fees of £4,684,000 (2015/16 – £5,025,000).

Internal audit services are provided by KPMG LLP.

The Trust's contract with its external auditors, Deloitte LLP, provides for a limitation of the auditors liability of one million pounds sterling. Other audit remuneration – other services includes £30,000 (2015/16 – £30,000) due to audit assurance of the Quality Report, £55,000 (2015/16 – £52,000) due to Local Counter Fraud Services and £nil (2015/16 – £95,000) for other services.

A material element of other operating expenses arises from the credit of £14,666,000 (2015/16 – £15,075,000 charge) due to net reversals of impairments. See note 15.2 to the financial statements on page XLV for details of the reporting year and prior year reversals of impairments and impairments respectively.

6 Operating leases

6.1 As lessee

Payments recognised as an expense	Year Ended 31 March 2017	Year Ended 31 March 2016
	£000	£000
Minimum lease payments	**1,092**	684

Total future minimum lease payments	Year Ended 31 March 2017	Year Ended 31 March 2016
	£000	£000
Payable		
Not later than one year	**1,037**	469
Between one and five years	**1,445**	1,123
After 5 years	**2,613**	2,325
Total	**5,095**	3,917

The Group holds various non-cancellable operating lease agreements, covering leasehold buildings (warehousing and renal dialysis) plus transport vehicles and general office equipment.

6.2 As lessor

Rental revenue	Year Ended 31 March 2017	Year Ended 31 March 2016
	£000	£000
Rents recognised as income in the period	**2,247**	2,219

Total future minimum lease payments	Year Ended 31 March 2017	Year Ended 31 March 2016
	£000	£000
Receivable		
Not later than one year	**2,247**	2,219
Between one and five years	**8,254**	8,151
After 5 years	**19,599**	20,059
Total	**30,100**	30,429

The lease rental revenue is due from the Ministry of Defence and University of Birmingham for their occupation of facilities within the new PFI hospital ('Queen Elizabeth Hospital Birmingham').

7 Employee costs and numbers

7.1 Employee costs

	Year Ended 31 March 2017			Year Ended 31 March 2016		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	£000	**£000**	**£000**	£000	£000	£000
Short term employee benefits – salaries and wages	**321,951**	**311,171**	**10,780**	313,516	301,646	11,870
Short term employee benefits – social security costs	**30,109**	**30,109**	**—**	23,633	23,633	—
Post employment benefits – employer contributions to NHS pension scheme	**35,228**	**35,228**	**—**	34,038	34,038	—
Pension cost – other contributions	**27**	**27**	**—**	12	12	—
Termination benefits	**129**	**129**	**—**	257	257	—
Temporary staff – external bank	**583**	**—**	**583**	—	—	—
Temporary staff – agency/contract staff	**17,077**	**—**	**17,077**	21,747	—	21,747
Revenue in respect of salaries and wages where netted off expenditure	**—**	**—**	**—**	(38)	(38)	—
	405,104	**376,664**	**28,440**	393,165	359,548	33,617

Employee costs include those of staff and directors, but exclude non executive director costs. The latter are disclosed separately in operating expenses, see note 5 to the financial statements on page XXXV. The termination benefits included above are disclosed within 'other' operating expenses in note 5 to the financial statements on page XXXV.

7.2 Key management compensation

	Directors		Non-executives	
	Year Ended 31 March 2017	Year Ended 31 March 2016	**Year Ended 31 March 2017**	Year Ended 31 March 2016
	£000	£000	**£000**	£000
Salaries and short term benefits	**1,549**	1,526	**156**	164
Social Security Costs	**202**	190	**12**	12
Employer contributions to NHS Pensions Agency	**160**	157	**—**	—
	1,911	1,873	**168**	176

Key management compensation consists entirely of the emoluments of the Board of Directors of the Trust. Full details of Directors' and non-executives' remuneration and interests are set out in the Remuneration Report which is a part of the annual report and financial statements.

8 Retirements due to ill-health

During the year to 31 March 2017 there were 10 early retirements from the Trust agreed on the grounds of ill-health (2015/16 – 13). The estimated additional pension liabilities of these ill-health retirements will be £453,000 (2015/16 – £735,000). 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 2017		Year Ended 31 March 2016	
	Number	**£000**	£000	£000
Trade				
Total trade bills paid in the year	**131,657**	**439,370**	137,423	432,851
Total trade bills paid within target	**130,050**	**435,656**	135,008	429,061
Percentage of trade bills paid within target	**98.78%**	**99.15%**	98.24%	99.12%
NHS				
Total NHS bills paid in the year	**8,541**	**201,133**	6,685	184,965
Total NHS bills paid within target	**7,606**	**196,510**	5,860	181,905
Percentage of NHS bills paid within target	**89.05%**	**97.70%**	87.66%	98.35%

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 (2015/16 – £nil) was charged to the Trust in the year for late payment of commercial debts.

10 Finance income and costs

	Year Ended 31 March 2017	Year Ended 31 March 2016
	£000	£000
Financing income		
Interest receivable	**312**	296
	312	296
Financing costs		
Interest on obligations under PFI contracts	**(21,993)**	(22,200)
Interest on obligations under finance leases	**(23)**	(27)
Other financing charges	**(17)**	(33)
	(22,033)	(22,260)
Net finance expense	**(21,721)**	(21,964)

11 Gains on disposal of non-current assets

	Year Ended 31 March 2017	Year Ended 31 March 2016
	£000	£000
Profit on disposal of non-current assets	**247**	653
Loss on disposal of non-current assets	**(15)**	(44)
	232	609

See note 15.3 to the financial statements on page XLVI for details of the gains and losses on disposal of non-current assets.

12 Public dividend capital dividends

Public dividend capital ('PDC') dividends paid and due to the Department of Health amounted to £nil (2015/16 – £nil). PDC dividends are calculated as a percentage (3.5%) of average net relevant assets. The Trust has negative taxpayers' equity as at the current and prior reporting dates hence there is no PDC dividend to pay.

13 Tax recognised in Statement of Comprehensive Income

Recognised in the income statement	**Year Ended 31 March 2017**	Year Ended 31 March 2016
	£000	£000
Current tax expense		
Current year	**65**	25
Adjustments in respect of prior years	**(7)**	(7)
	58	18
Deferred tax expense		
Origination and reversal of temporary differences	**(53)**	—
Adjustments in respect of prior years	**(145)**	58
Reduction in tax rate	**6**	—
	(192)	58
Total tax (credit)/expense recognised in income statement	**(134)**	76

Tax recognised in other comprehensive income is £nil (2015/16 – £nil).

Tax recognised directly in equity is £nil (2015/16 – £nil).

Reconciliation of effective tax rate	**Year Ended 31 March 2017**	Year Ended 31 March 2016
	£000	£000
Operating surplus before taxation – subsidiaries only *	**104**	(302)
Tax at the standard rate of corporation tax in the UK 20% (2015/16 – 20%)	**(3)**	82
Change in tax rate	**6**	—
Other	**32**	—
Adjustments in respect of prior years	**(169)**	(7)
Tax effect of expenditure not deductible	**—**	1
Total tax (credit)/expense	**(134)**	76

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

The impact of rate change arises from the reduction in the rate at which the temporary differences are expected to reverse from 20% to 19%. The standard rate of corporation tax in the UK changed from 20% to 19% with effect from 1 April 2016.

14 Intangible assets

Group and Trust	Computer software – purchased	Licences and trademarks	Total
	£000	£000	£000
Cost			
At 1 April 2015	2,315	448	2,763
Additions	—	—	—
Reclassifications	16	185	201
Disposals	(241)	—	(241)
At 31 March 2016	**2,090**	**633**	**2,723**
Additions	1,105	611	1,716
Reclassifications	—	—	—
Disposals	(830)	(240)	(1,070)
At 31 March 2017	**2,365**	**1,004**	**3,369**
Amortisation			
At 1 April 2015	1,795	251	2,046
Charged for the year	170	88	258
Disposals	(241)	—	(241)
At 31 March 2016	**1,724**	**339**	**2,063**
Charged for the year	116	102	218
Disposals	(830)	(240)	(1,070)
At 31 March 2017	**1,010**	**201**	**1,211**
Net book value			
At 31 March 2017	**1,355**	**803**	**2,158**
At 31 March 2016	366	294	660
At 1 April 2015	520	197	717

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

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

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

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

15 Property, plant and equipment – 2016/17

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost									
At 31 March 2016	45,625	427,990	1,328	638	101,868	11	17,704	2,569	597,733
Transfers by absorption – modified	—	—	—	—	—	—	—	—	—
Additions purchased/leased	—	3,825	—	891	7,240	—	759	60	12,775
Additions donated	—	—	—	—	555	—	—	—	555
Reclassifications	—	671	—	(671)	—	—	—	—	—
Impairments charged to the revaluation reserve	—	(189)	—	—	—	—	—	—	(189)
Reversal of impairments credited to operating income	—	14,666	—	—	—	—	—	—	14,666
Impairments charged to operating income	—	—	—	—	—	—	—	—	—
Revaluations	—	(13,650)	(78)	—	—	—	—	—	(13,728)
Disposals/derecognition	—	—	—	—	(4,827)	—	(6,767)	(886)	(12,480)
At 31 March 2017	**45,625**	**433,313**	**1,250**	**858**	**104,836**	**11**	**11,696**	**1,743**	**599,332**
Depreciation									
At 31 March 2016	—	12,026	82	—	65,859	7	14,310	1,993	94,277
Provided during the year	—	10,591	88	—	8,850	1	1,168	258	20,956
Revaluations	—	(20,528)	(170)	—	—	—	—	—	(20,698)
Disposals/derecognition	—	—	—	—	(4,825)	—	(6,761)	(879)	(12,465)
At 31 March 2017	**—**	**2,089**	**—**	**—**	**69,884**	**8**	**8,717**	**1,372**	**82,070**
Net book value									
Owned	2,625	83,827	1,225	852	30,733	3	2,979	367	122,611
Donated	—	7,229	25	6	3,990	—	—	4	11,254
Government granted	—	14,854	—	—	—	—	—	—	14,854
Private Finance Initiative	—	325,314	—	—	—	—	—	—	325,314
Finance Lease	43,000	—	—	—	229	—	—	—	43,229
At 31 March 2017	**45,625**	**431,224**	**1,250**	**858**	**34,952**	**3**	**2,979**	**371**	**517,262**

15 Property, plant and equipment – 2016/17

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost									
At 31 March 2016	45,625	425,607	1,328	638	101,094	11	17,639	2,341	594,283
Transfers by absorption – modified	—	—	—	—	—	—	—	—	—
Additions purchased/leased	—	3,822	—	891	7,240	—	759	60	12,772
Additions donated	—	—	—	—	555	—	—	—	555
Reclassifications	—	671	—	(671)	—	—	—	—	—
Impairments charged to the revaluation reserve	—	(189)	—	—	—	—	—	—	(189)
Reversal of impairments credited to operating income	—	14,666	—	—	—	—	—	—	14,666
Impairments charged to operating income	—	—	—	—	—	—	—	—	—
Revaluations	—	(13,650)	(78)	—	—	—	—	—	(13,728)
Disposals/derecognition	—	—	—	—	(4,827)	—	(6,767)	(886)	(12,480)
At 31 March 2017	**45,625**	**430,927**	**1,250**	**858**	**104,062**	**11**	**11,631**	**1,515**	**595,879**
Depreciation									
At 31 March 2016	—	11,891	82	—	65,732	7	14,299	1,946	93,957
Provided during the year	—	10,429	88	—	8,741	1	1,155	201	20,615
Revaluations	—	(20,528)	(170)	—	—	—	—	—	(20,698)
Disposals/derecognition	—	—	—	—	(4,825)	—	(6,761)	(879)	(12,465)
At 31 March 2017	**—**	**1,792**	**—**	**—**	**69,648**	**8**	**8,693**	**1,268**	**81,409**
Net book value									
Owned	2,625	81,738	1,225	852	30,195	3	2,938	243	119,819
Donated	—	7,229	25	6	3,990	—	—	4	11,254
Government granted	—	14,854	—	—	—	—	—	—	14,854
Private Finance Initiative	—	325,314	—	—	—	—	—	—	325,314
Finance Lease	43,000	—	—	—	229	—	—	—	43,229
At 31 March 2017	**45,625**	**429,135**	**1,250**	**858**	**34,414**	**3**	**2,938**	**247**	**514,470**

15 Property, plant and equipment – 2015/16

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost									
At 31 March 2015	45,625	447,765	1,467	14,659	102,369	11	17,562	2,608	632,066
Transfers by absorption – modified	—	—	—	—	—	—	—	—	—
Additions purchased/leased	—	6,799	—	1,725	6,719	—	1,086	240	16,569
Additions donated	—	200	—	—	655	—	—	—	855
Reclassifications	—	(25,548)	(330)	(15,746)	149	—	(920)	18	(42,377)
Reversal of impairments credited to operating income	—	3,069	—	—	—	—	—	—	3,069
Impairments charged to operating income	—	(18,144)	—	—	—	—	—	—	(18,144)
Revaluations	—	13,849	191	—	—	—	—	—	14,040
Disposals/derecognition	—	—	—	—	(8,024)	—	(24)	(297)	(8,345)
At 31 March 2016	**45,625**	**427,990**	**1,328**	**638**	**101,868**	**11**	**17,704**	**2,569**	**597,733**
Depreciation									
At 31 March 2015	—	42,209	330	—	65,129	5	13,857	2,139	123,669
Provided during the year	—	10,472	82	—	8,947	2	1,431	151	21,085
Reclassifications	—	(40,655)	(330)	—	(237)	—	(954)	—	(42,176)
Disposals/derecognition	—	—	—	—	(7,980)	—	(24)	(297)	(8,301)
At 31 March 2016	**—**	**12,026**	**82**	**—**	**65,859**	**7**	**14,310**	**1,993**	**94,277**
Net book value									
Owned	2,625	79,526	1,221	632	31,457	4	3,394	550	119,409
Donated	—	7,251	25	6	4,277	—	—	26	11,585
Government granted	—	14,644	—	—	—	—	—	—	14,644
Private Finance Initiative	—	314,543	—	—	—	—	—	—	314,543
Finance Lease	43,000	—	—	—	275	—	—	—	43,275
At 31 March 2016	**45,625**	**415,964**	**1,246**	**638**	**36,009**	**4**	**3,394**	**576**	**503,456**

15 Property, plant and equipment – 2015/16

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost									
At 31 March 2015	45,625	447,765	1,467	13,513	102,063	11	17,539	2,608	630,591
Transfers by absorption – modified	—	—	—	—	—	—	—	—	—
Additions purchased/leased	—	6,745	—	542	6,251	—	1,044	12	14,594
Additions donated	—	200	—	—	655	—	—	—	855
Reclassifications	—	(27,877)	(330)	(13,417)	149	—	(920)	18	(42,377)
Reversal of impairments credited to operating income	—	3,069	—	—	—	—	—	—	3,069
Impairments charged to operating income	—	(18,144)	—	—	—	—	—	—	(18,144)
Revaluations	—	13,849	191	—	—	—	—	—	14,040
Disposals/derecognition	—	—	—	—	(8,024)	—	(24)	(297)	(8,345)
At 31 March 2016	**45,625**	**425,607**	**1,328**	**638**	**101,094**	**11**	**17,639**	**2,341**	**594,283**
Depreciation									
At 31 March 2015	—	42,209	330	—	65,104	5	13,857	2,139	123,644
Provided during the year	—	10,337	82	—	8,845	2	1,420	104	20,790
Reclassifications	—	(40,655)	(330)	—	(237)	—	(954)	—	(42,176)
Disposals/derecognition	—	—	—	—	(7,980)	—	(24)	(297)	(8,301)
At 31 March 2016	**—**	**11,891**	**82**	**—**	**65,732**	**7**	**14,299**	**1,946**	**93,957**
Net book value									
Owned	2,625	77,278	1,221	632	30,810	4	3,340	369	116,279
Donated	—	7,251	25	6	4,277	—	—	26	11,585
Government granted	—	14,644	—	—	—	—	—	—	14,644
Private Finance Initiative	—	314,543	—	—	—	—	—	—	314,543
Finance Lease	43,000	—	—	—	275	—	—	—	43,275
At 31 March 2016	**45,625**	**413,716**	**1,246**	**638**	**35,362**	**4**	**3,340**	**395**	**500,326**

15.1 Estimated useful economic lives

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

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

15.2 Valuation at the reporting date – Group and Trust

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 reversals of prior impairments being credited to operating expenses, inline with the Department of Health Group Accounting Manual, within the consolidated statement of comprehensive income.

Impairments of property, plant and equipment		**Year Ended 31 March 2017 £000**	Year Ended 31 March 2016 £000
Impairments			
Queen Elizabeth Hospital – PFI facility	1	—	(17,143)
Trust owned property	2	—	(1,001)
		—	(18,144)
Reversals of impairments			
Queen Elizabeth Hospital – PFI facility	1	**14,584**	—
External works		—	53
Trust owned property	3	**82**	3,016
		14,666	3,069
Net reversal of impairment/(impairment)		**14,666**	(15,075)

There are no movements on revaluation for assets owned by the subsidiaries, only the Trust's estate is revalued as there are no land or buildings owned by the subsidiaries.

All impairments and reversals of impairments are due to changes in market prices only.

1 – The valuation of the 'Queen Elizabeth Hospital Birmingham' PFI hospital gave rise to a reversal of a previous impairment resulting from the difference between the fair value in operational use (depreciated replacement cost), as measured at 31 March 2017 compared to 31 March 2016. The estimation technique of the Modern Equivalent Asset incorporates the rising cost of household and commercial property construction and is the main factor behind the increase in valuation. The impairment of the previous reporting year was due to the incorporation of an assumption that VAT is recoverable on construction costs for PFI builds within the NHS, this factor is consistent for both the reporting years disclosed. The reversal of impairment is disclosed within operating expenses – non recurring, note 5 to the financial statements on page XXXV.

2 – The valuation of the Regent Court and Yardley Court offices gave rise to a reversal of a previous impairment due to the difference between the fair values, at the reporting date compared to the prior year, again due to increasing property prices.

3 – The valuation of the refurbished 'Institute of Translational Medicine', opened in the previous reporting year, gave rise to a reversal of impairment as at 31 March 2016. This reversal of impairment was previously disclosed within other operating revenue – non recurring, note 4.1 to the financial statements on page XXXIV. In the current reporting year, the Department of Health Group Accounting Manual states that reversals of impairments are netted off with impairments in operating expenses, note 5 to the financial statements on page XXXV. Therefore, in the prior year comparative of the operating expenses note, the impairment of the PFI hospital is netted-off against the reversal of impairment of the Institute of Translational Medicine.

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

Revaluation gains/(losses) on property, plant and equipment Group	**Year Ended 31 March 2017**	Year Ended 31 March 2016
	£000	£000
Revaluation gains/(losses) recognised in other comprehensive income		
Land	**—**	—
Buildings – Heritage buildings (non-PFI)	**6,878**	13,849
Buildings – Radiology	**(189)**	—
Dwellings	**92**	191
	6,781	14,040

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

15.3 Profit on the disposal of property, plant and equipment

The sale of the surplus land at Selly Oak, Birmingham to Persimmon plc for residential housing (completed on 31 March 2015), gave rise to a profit on disposal of £247,000 (2015/16 – £653,000). The profit in the reporting year arises from the difference between the cash received of £12,250,000 and the unwinding of the discounted receivable owed by Persimmon as disclosed at the previous reporting date. The £7,300,000 still owed by Persimmon is disclosed within trade receivables, see note 20 to the financial statements on page XLVIII for details.

15.4 Assets held under finance leases and PFI arrangements – Group and Trust

	PFI assets	Assets held under finance leases	Total
	£000	£000	£000
Cost			
At 1 April 2015	366,182	43,699	409,881
Additions	3,515	—	3,515
Reclassifications	(30,822)	—	(30,822)
Impairments charged to operating income	(17,090)	—	(17,090)
At 31 March 2016	**321,785**	**43,699**	**365,484**
Additions	2,955	—	2,955
Reclassifications	(14,010)	—	(14,010)
Reversal of impairments credited to operating expenses	14,584	—	14,584
At 31 March 2017	**325,314**	**43,699**	**369,013**
Depreciation			
At 1 April 2015	30,822	378	31,200
Charged for the year	7,242	46	7,288
Reclassifications	(30,822)	—	(30,822)
At 31 March 2016	**7,242**	**424**	**7,666**
Charged for the year	6,768	46	6,814
Reclassifications	(14,010)	—	(14,010)
At 31 March 2017	**—**	**470**	**470**
Net book value			
At 31 March 2017	**325,314**	**43,229**	**368,543**
At 31 March 2016	314,543	43,275	357,818
At 1 April 2015	335,360	43,321	378,681

The Private Finance Initiative asset is the new Queen Elizabeth Hospital Birmingham as detailed in note 27.1 to the financial statements on page LIII. The impairment is detailed in note 15.2 to the financial statements on page XLV.

A separate schedule for the Trust's finance lease and PFI assets has not been produced as the subsidiaries have no assets classified as such. Within finance leased assets is land with a fair value of £43,000,000 (31 March 2016: £43,000,000), this is the Edgbaston site land leased from the Calthorpe Estate over a 999 year term.

16 Capital commitments

Commitments under capital expenditure contracts at the end of the period, not otherwise included in these financial statements, were £3,646,000 (31 March 2016: £1,095,000) for both Group and Trust. This amount relates entirely to property, plant and equipment, there are nil contracted capital commitments for intangible assets.

17 Subsidiaries and investments

The Trust's subsidiary undertakings and investments as included in the consolidation as at the reporting date are set out below. The reporting date of the financial statements for the subsidiaries is the same as for these group financial statements – 31 March 2017.

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

UHB Facilities Limited
The company is registered in the UK, company no. 08642236, with a share capital comprising one share of £1 owned by the Trust. The company commenced trading on the 10 October 2014 as a provider of a managed healthcare facility, see note 2 to the financial statements on page XXX.

Assure Dialysis Services Limited
The company is registered in the UK, company no. 08642238, with a share capital comprising one share of £1 owned by the Trust. The company commenced trading on the 1 January 2015 as a provider of renal dialysis healthcare, see note 2 to the financial statements on page XXX.

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

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

18 Joint Venture – Innovating Global Health China Limited

The Trust has established the following company as a joint venture between the Trust and Innovating Global Health SA (IGH): Innovating Global Health China Limited (IGHC). This was established for the identification, development and pursuit of healthcare opportunities in China. This is a private company limited by shares, with Trust and IGH each owning a 50% shareholdings. The partner company (IGH) is registered/organised under the laws of Switzerland.

19 Inventories

	Group		Trust	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
Consumables	**6,615**	8,818	**6,578**	8,771
Drugs	**8,347**	6,850	**6,631**	4,807
Other finished goods	**3**	6	**3**	6
	14,965	15,674	**13,212**	13,584

The Group expensed £129,260,000 of inventories during the year (2015/16 – £115,347,000). The Group charged £180,000 to operating expenses in the year due to write-downs of obsolete inventories (2015/16 – £557,000).

20 Trade and other receivables

Current

	Group		Trust	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
NHS receivables	**40,532**	24,937	**40,532**	24,937
Receivables with other related parties	**5,609**	6,582	**5,609**	6,582
Commercial trade receivables	**6,763**	5,778	**7,281**	9,755
Provision for impaired receivables	**(5,410)**	(2,607)	**(5,410)**	(2,607)
PFI prepayments – lifecycle (capital)	**8,487**	7,993	**8,487**	7,993
Prepayments	**5,463**	2,249	**5,396**	2,236
Accrued income	**442**	213	**506**	250
Other receivables – revenue	**2,761**	4,137	**10,074**	10,343
Other receivables – capital	**7,300**	12,250	**7,300**	12,250
	71,947	61,532	**79,775**	71,739

Non-current

	Group		Trust	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
Provision for impaired receivables	**(1,376)**	(1,127)	**(1,376)**	(1,127)
Other receivables – revenue	**5,999**	5,124	**5,999**	5,124
Other receivables – capital	**—**	7,053	**—**	7,053
	4,623	11,050	**4,623**	11,050

Other receivables – capital of both Group and Trust are the amounts owed by Persimmon plc which are due from the sale of the surplus land at Selly Oak, Birmingham detailed in note 15.3 to the financial statements on page XLVI. The timing of the future payments are contractual obligations and have been discounted (at 3.5%) to reflect the time value of the cash at the reporting date:

	Within one year	Between one and two years	Between two and three years
At 31 March 2017	£000	£000	£000
Commercial trade receivable – Persimmon	**7,300**	**—**	**—**

The land sale contract protects the Trust against the potential of credit risk associated with this material financial instrument by enacting a charge over the land, in proportion to the sale value not yet received in cash. Once the full sale value of £31,850,000 has been received, the security over the land will be discharged.

NHS receivables consist of balances owed by NHS bodies in England, receivables with other related parties consist of balances owed by other HM Government organisations. Related party transactions are detailed in note 31 to the financial statements on page LVI.

Included within trade and other receivables of both Group and Trust are balances with a carrying amount of £5,584,000 (31 March 2016: £11,478,000) which are past due at the reporting date but for which no specific provision has been made as they are considered to be recoverable based on previous trading history.

Aged analysis of past due but not impaired receivables	**Group**		**Trust**	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
By up to three months	**2,956**	6,246	**2,956**	6,246
By three to six months	**1,312**	1,402	**1,312**	1,402
By more than six months	**1,316**	3,830	**1,316**	3,830
	5,584	11,478	**5,584**	11,478

Provision for impaired receivables	**Group**		**Trust**	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
Balance at 1 April	**3,734**	4,135	**3,734**	4,135
Increase in provision	**5,939**	2,767	**5,939**	2,767
Amounts utilised	**(662)**	(376)	**(662)**	(376)
Unused amounts reversed	**(2,225)**	(2,792)	**(2,225)**	(2,792)
	6,786	3,734	**6,786**	3,734

Aged analysis of impaired receivables	**Group**		**Trust**	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
By up to three months	**332**	210	**332**	210
By three to six months	**934**	65	**934**	65
By more than six months	**3,156**	1,453	**3,156**	1,453
	4,422	1,728	**4,422**	1,728

21 Cash and cash equivalents

	Group		Trust	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
Cash and cash equivalents	**70,829**	59,171	**70,228**	56,183
Made up of				
Cash with Government Banking Service	**6,140**	4,214	**6,140**	4,214
Commercial banks and cash in hand	**64,689**	54,957	**64,088**	51,969
Cash and cash equivalents as in statement of financial position	**70,829**	59,171	**70,228**	56,183
Cash and cash equivalents as in statement of cash flows	**70,829**	59,171	**70,228**	56,183

22 Trade and other payables

Current	Group		Trust	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
NHS payables	**6,508**	8,268	**6,508**	8,268
Amounts due to other related parties	**5,432**	5,770	**5,430**	5,769
Commercial trade payables	**37,781**	34,462	**37,673**	35,972
Trade payables – capital	**2,167**	3,316	**2,166**	3,261
Taxes payable	**8,390**	7,307	**8,348**	7,265
Other payables	**1,304**	979	**4,812**	2,137
Accruals	**61,618**	52,425	**61,939**	52,840
Receipts in advance	**4,258**	6,299	**4,258**	6,299
	127,458	118,826	**131,134**	121,811

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 including pensions. Included within amounts due to other related parties are NHS pension contributions of £4,976,000 (31 March 2016: £4,653,000).

Non-current trade and other payables are nil (31 March 2016: £nil).

23 Other liabilities

Current	Group		Trust	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
Deferred income	**20,283**	18,703	**20,283**	18,613
Deferred government grant	**—**	—	**—**	—
	20,283	18,703	**20,283**	18,613

Non-current	Group		Trust	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
Deferred income	**5,093**	7,413	**5,093**	7,413
Deferred government grant	**—**	—	**—**	—
	5,093	7,413	**5,093**	7,413

24 Deferred tax

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

Group only*	Capital allowances	Tax losses	Total
	£000	£000	£000
At 1 April 2015	24	—	24
Charge to the income statement	58	—	58
At 31 March 2016	**82**	**—**	**82**
(Credit) to the income statement	—	(192)	(192)
At 31 March 2017	**82**	**(192)**	**(110)**

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

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

	Year Ended 31 March 2017	Year Ended 31 March 2016
	£000	£000
Deferred tax assets	**(146)**	**—**
Deferred tax liabilities	**36**	**82**
Net non current deferred tax (asset)/liability	**(110)**	**82**

There are no unrecognised deferred tax assets or liabilities in the current or prior year.

25 Borrowings

	Current		Non-Current	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
Obligations under finance leases	**47**	43	**222**	269
Obligations under Private Finance Initiative contracts	**12,228**	12,792	**484,243**	496,471
	12,275	12,835	**484,465**	496,740

The Private Finance Initiative obligation relates to the new Queen Elizabeth Hospital Birmingham as detailed in note 27.1 to the financial statements on page LIII.

The prudential borrowing code requirements in section 41 of the NHS Act 2006 have been repealed with effect from 1 April 2013 by the Health and Social Care Act 2012. The financial statements disclosures that were provided previously are no longer required.

The Trust has not utilised any loan or working capital facility in year and there is no such facility in place at the reporting date (31 March 2016: £nil).

26 Finance lease obligations (other than PFI)

Group and Trust	**Minimum lease payments**		**Present value of minimum lease payments**	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	£000	£000	**£000**	£000
Gross lease liabilities	**333**	399	**333**	399
Of which liabilities are due:				
Not later than one year	**67**	67	**67**	67
Later than one year, not later than five years	**256**	266	**256**	266
Later than five years	**10**	66	**10**	66
Net finance charges allocated to future periods	**(64)**	(87)	**(64)**	(87)
Net lease liabilities	**269**	**312**	**269**	**312**
Not later than one year	**47**	43	**47**	43
Later than one year, not later than five years	**213**	208	**213**	208
Later than five years	**9**	61	**9**	61

The finance lease obligations disclosed relate to medical equipment. The Edgbaston site land is a long term finance lease, detailed in note 15.4 to the financial statements on page XLVI, this has a nominal charge as the land is covenanted for the 'provision of healthcare and education' to the city of Birmingham.

27 Private finance initiative contracts

27.1 PFI schemes on-statement of financial position – Group and Trust

A contract for the development of the new hospital was signed by the Trust and its PFI partner on 14 June 2006. The purpose of the scheme was to deliver a modern, state of the art acute hospital facility on the QE site which is now fully operational as at the reporting date. This is part of a wider PFI deal between the Trust, Birmingham & Solihull Mental Health Trust and a consortium led by Consort Healthcare (Birmingham) Limited. The ownership of the consortium entity is as follows:

Balfour Beatty Infrastructure Investments Ltd (40%), InfraRed Infrastructure Yield Fund (30%) and Infrastructure Investments Holdings Limited, a subsidiary of HICL Infrastructure Company Limited (30%).

The contracted value of the new PFI hospital is £584,600,000 (of which £484,889,000 is capital and £99,711,000 are fees and finance costs incurred prior to 15 June 2010). The 'Queen Elizabeth Hospital Birmingham' was handed over in three phases:

- phase 1 on 15 June 2010 and phase 2 on 17 November 2010 were delivered on schedule and were complete as at 31 March 2011.
- phase 3 on 11 October 2011 was delivered on schedule and was complete as at 31 March 2012.

Total finance lease obligations for on-statement of financial position PFI contracts due: Group and Trust	**Year Ended 31 March 2017**	Year Ended 31 March 2016
	£000	£000
Gross PFI lease liabilities	**777,285**	806,293
Of which liabilities are due:		
Not later than one year	**28,038**	29,008
Later than one year, not later than five years	**110,390**	110,714
Later than five years	**638,857**	666,571
Net finance charges allocated to future periods	**(280,814)**	(297,030)
Net PFI lease liabilities	**496,471**	509,263
Not later than one year	**12,228**	12,792
Later than one year, not later than five years	**51,109**	49,827
Later than five years	**433,134**	446,644

The PFI obligation above is only that part of the unitary payment allocated to the finance lease rental, ie the annual finance expense and capital repayment of lease liability over the contract term. This apportionment of the unitary payment is described in accounting policy note 1.11 and the total unitary payment commitment, including annual service expense and lifecycle replacement is disclosed overleaf.

Total annual unitary payment for the reporting period by constituent element:	**Year Ended 31 March 2017**	Year Ended 31 March 2016
	£000	£000
Finance lease charge	**16,216**	16,621
Repayment of finance lease obligation	**12,792**	12,589
Service element	**15,271**	14,898
Addition to lifecycle prepayment	**494**	343
Capital lifecycle maintenance	**2,804**	2,646
Contingent finance charge (inflation)	**5,777**	5,579
	53,354	52,676

The service element and finance charges are expensed to the Statement of Comprehensive Income, see notes 5 and 10 to the financial statements on pages XXXV and XXXVIII respectively. The repayment of finance lease obligation is a reduction to the net PFI liability disclosed earlier in this note to the financial statements. The capital lifecycle payment is a sum allocated to maintain 'as new' the infrastructure of the QEHB hospital; this is initially prepaid, see note 20 on page XLVIII of the financial statements and subsequently capitalised to property, plant and equipment in the reporting period the work is actually carried out by the PFI provider.

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 unitary payment obligations for on-statement of financial position PFI contracts due: Group and Trust	**Year Ended 31 March 2017**	Year Ended 31 March 2016
	£000	£000
T**otal future unitary payments committed**	**1,601,829**	1,615,967
Of which liabilities are due:		
Not later than one year	**54,687**	53,354
Later than one year, not later than five years	**218,150**	212,830
Later than five years	**1,328,992**	1,349,783

The Trust will be committed to the full unitary payment till the contract expires on 14 August 2046, at which time the building will revert to the ownership of the Trust. The unitary payment is subject to change based on movements in the Retail Prices Index.

The Trust has the rights to use the Queen Elizabeth Hospital Birmingham for the length of the Project Agreement and has the rights to expect provision of the range of allied and clinical support services, including facilities management and lifecycle maintenance. In addition, the Trust has the rights to possible deductions from the unitary payment due to the non availability of the infrastructure or under performance regarding the services provided. At the end of the Project Agreement the assets will transfer back to the Trust's ownership.

27.2 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.

28 Provisions

Group	Current		Non current	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	£000	£000	**£000**	£000
Pensions relating to other staff	**42**	42	**482**	389
Legal claims	**426**	604	**2,583**	1,973
Other	**272**	146	**—**	—
	740	792	**3,065**	2,362

	Pensions relating to other staff	Legal claims	Other	**Total**
	£000	£000	£000	**£000**
At 1 April 2016	431	2,577	146	**3,154**
Change in the discount rate	40	294	—	**334**
Arising during the year	94	515	272	**881**
Used during the year	(42)	(170)	(123)	**(335)**
Reversed unused	—	(223)	(23)	**(246)**
Unwinding of discount	1	16	—	**17**
At 31 March 2017	**524**	**3,009**	**272**	**3,805**
Expected timing of cash flows:				
Within one year	42	426	272	**740**
Between one and five years	165	479	—	**644**
After five years	317	2,104	—	**2,421**

Trust	Current		Non current	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	£000	£000	**£000**	£000
Pensions relating to other staff	**42**	42	**482**	389
Legal claims	**426**	604	**2,325**	1,727
Other	**272**	146	**—**	—
	740	792	**2,807**	2,116

	Pensions relating to other staff	Legal claims	Other	**Total**
	£000	£000	£000	**£000**
At 1 April 2016	431	2,331	146	**2,908**
Change in the discount rate	40	294	—	**334**
Arising during the year	94	503	272	**869**
Used during the year	(42)	(170)	(123)	**(335)**
Reversed unused	—	(223)	(23)	**(246)**
Unwinding of discount	1	16	—	**17**
At 31 March 2017	**524**	**2,751**	**272**	**3,547**
Expected timing of cash flows:				
Within one year	42	426	272	**740**
Between one and five years	165	479	—	**644**
After five years	317	1,846	—	**2,163**

The provisions included under 'legal claims' are for personal injury pensions £2,446,000 (31 March 2016: £1,843,000), employers and public liability £286,000 (31 March 2016: £375,000) and other claims notified by the Trust's solicitors £20,000 (31 March 2016: £112,000). 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 £524,000 (31 March 2016: £431,000), disclosed as 'pensions relating to other staff' have been calculated on guidance received from the NHS Business Services Authority – Pensions Division.

The Group provision includes an amount of £258,000 (31 March 2016: £246,000) in respect of UHB Facilities Ltd and a tenant's dilapidations contractual commitment for the Rabone Lane site.

Provisions within the annual accounts of the NHS Litigation Authority at 31 March 2017 include £77,194,000 in respect of clinical negligence liabilities of the Trust (31 March 2016: £52,291,000).

29 Contingencies

There are £86,000 of contingent liabilities at the reporting date which relate to amounts notified by the NHSLA for potential employer and public liability claims over and above the amounts provided for in note 28 to the financial statements on page LV (31 March 2016: £30,000). There are no contingent assets at the reporting date (31 March 2016: £nil).

30 Events after the reporting period

As at the reporting date the Trust continues to provide senior management support to the Heart of England NHS foundation trust. A business case for the merger of the two trusts into a single entity is being explored with all the relevant parties.

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 has taken advantage of the partial exemption provided by IAS 24 'Related Party Disclosures', where the Government of the United Kingdom is considered to have ultimate control over the Trust and all other related party entities in the public sector.

The Trust considers other NHS Foundation Trusts to be related parties, as they and the Trust are under the common performance management of Monitor – part of the NHS in England. During the year the Trust contracted with certain other Foundation Trusts for the provision of clinical and non clinical support services.

The Department of Health is also regarded as a related party. During the year University Hospitals Birmingham NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities of the NHS in England to which the Department is regarded as the parent organisation.

The Trust has had a number of material transactions with other Government Departments and local Government bodies.

These related parties are summarised below by Government Department, with disclosure of the total balances owed and owing as at the reporting date and total transactions for the reporting year with the Trust:

Group and Trust	Receivables	Payables	Revenue	Expenditure
	£000	£000	£000	£000
NHS in England				
NHS Birmingham Crosscity CCG	3,623	837	90,713	6
NHS Birmingham South And Central CCG	4,909	—	81,609	—
NHS Dudley CCG	—	19	7,389	—
NHS Redditch And Bromsgrove CCG	1,919	—	11,527	—
NHS Sandwell And West Birmingham CCG	394	38	23,412	17
NHS Solihull CCG	—	66	7,492	—
NHS South Worcestershire CCG	—	101	3,599	—
NHS Walsall CCG	113	—	5,058	—
NHS England (specialised commissioning)	3,550	—	376,724	—
NHS England (Cancer Drugs Fund)	1,145	—	7,060	—
NHS England (West Midlands)	1,720	—	8,336	—
Health Education England	544	—	29,570	—
Heart of England NHS Foundation Trust	1,441	805	3,299	733
Birmingham and Solihull Mental Health NHS Foundation Trust	89	242	415	1,270
The Royal Orthopaedic Hospital NHS Foundation Trust	470	117	2,731	454
Birmingham Children's Hospital NHS Foundation Trust	2,608	601	4,508	2,004
Birmingham Community Healthcare NHS Foundation Trust	510	136	2,335	531
Sandwell and West Birmingham Hospitals NHS Trust	1,338	305	2,787	930
The Royal Wolverhampton NHS Trust	1,113	64	3,100	234
Department of Health	—	—	13,411	—
West Midlands Ambulance Service NHS Foundation Trust	7	467	60	5,249
NHS Litigation Authority	—	44	6	10,874
NHS England – Core (inc. sustainability & transformation fund)	9,079	—	24,044	—
Other	5,960	2,666	40,517	4,780
	40,532	**6,508**	**749,702**	**27,082**
Other related parties – Whole of Government Accounts				
Ministry of Defence	1,687	—	4,354	1,457
NHS Pension Scheme	—	4,976	—	35,228
Birmingham City Council	938	145	14,867	882
NHS Wales	155	—	7,537	44
NHS Blood and Transport	—	275	3,153	3,631
HMRC	1,870	8,491	—	29,975
Other	959	36	3,261	81
	5,609	**13,923**	**33,172**	**71,298**

The Trust has also received revenue and capital payments from the University Hospital Birmingham Charities totalling £1,352,000 (2015/16 – £2,079,000).

The financial statements of the parent (the Trust) are presented together with the consolidated financial statements and any transactions or balances between group entities have been eliminated on consolidation. The following directors of the Trust are also board members of the trading subsidiaries, roles as stated:

Trust director	Pharmacy@QEHB Ltd	UHB Facilities Ltd	Assure Dialysis Ltd
Mike Sexton	chair	non-executive	—
Kevin Bolger	non-executive	—	—
Philip Norman	—	—	clinical lead
Dr David Rosser	—	—	non-executive
David Burbridge	co. secretary	co. secretary	co. secretary

The three trading subsidiaries do not have any transactions with any NHS or other Government entity except those with its parent (the Trust) and HMRC (payroll and social security taxes). The Trust's receivables and payables includes the following:

The Trust's receivables include £4,151,000 (31 March 2016 – £3,842,000) owed by and payables include £3,996,000 (31 March 2016 – £2,247,000) owed to Pharmacy@QEHB Ltd. The Trust's revenue includes £879,000 (31 March 2016 – £718,000) received from and expenditure includes £41,237,000 (31 March 2016 – £37,369,000) paid to Pharmacy@QEHB Ltd.

The Trust's receivables include £3,750,000 (31 March 2016 – £86,000) owed by and payables includes £321,000 (31 March 2016 – £nil) owed to UHB Facilities Ltd. The Trust's revenue includes £252,000 (31 March 2016 – £67,000) received from and expenditure includes £1,947,000 (31 March 2016 – £1,217,000) paid to UHB Facilities Ltd.

The Trust's receivables include £594,000 (31 March 2016 – £48,000) owed by and payables includes £70,000 (31 March 2016 – £nil) owed to Assure Dialysis Services Ltd. The Trust's revenue includes £72,000 (31 March 2016 – £39,000) received from and expenditure includes £771,000 (31 March 2016 – £530,000) paid to Assure Dialysis Services Ltd.

32 Financial instruments and related disclosures

The fair value of a financial instrument is the price at which an asset could be exchanged, or a liability settled, between knowledgeable, willing parties in an arms-length transaction. All the financial instruments of the Trust are initially measured at fair value on recognition and subsequently at amortised cost. The following table is a categorisation of the carrying amounts and the fair values of the Trust's financial assets and financial liabilities:

Carrying values by category of financial instruments	Notes	Group		Trust	
		31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
		Total	Total	**Total**	Total
		£000	£000	**£000**	£000
Current financial assets					
Cash and cash equivalents	1	**70,829**	59,171	**70,228**	56,183
Loans and receivables:					
Trade and receivables	1	**56,273**	51,290	**64,168**	61,510
		127,102	110,461	**134,396**	117,693
Non-current financial assets					
Loans and receivables:					
Trade and receivables	1	**4,623**	11,050	**4,623**	11,050
		4,623	11,050	**4,623**	11,050
Total financial assets		**131,725**	121,511	**139,019**	128,743
Current financial liabilities					
Other financial liabilities:					
Finance leases	2	**47**	43	**47**	43
Private Finance Initiative contracts	2	**12,228**	12,792	**12,228**	12,792
Trade and other payables	1	**114,810**	105,220	**118,528**	108,247
Provisions under contract	1	**578**	634	**578**	634
		127,663	118,689	**131,381**	121,716
Non-current financial liabilities					
Other financial liabilities:					
Finance leases	2	**222**	269	**222**	269
Private Finance Initiative contracts	2	**484,243**	496,471	**484,243**	496,471
Provisions under contract	1	**258**	246	**—**	—
		484,723	496,986	**484,465**	496,740
Total financial liabilities		**612,386**	615,675	**615,846**	618,456
Net financial liabilities		**(480,661)**	(494,164)	**(476,827)**	(489,713)

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 26 and 27.1 to the financial statements on pages LII and LIII respectively.

The financial assets and financial liabilities of cash and cash equivalents, finance leases and private finance initiative contracts all equate to the amounts disclosed on the statement of financial position and supporting notes to the financial statements. Trade receivables, trade payables and provisions include non-financial assets and liabilities not disclosed in the table above. The reconciling amounts are as follows:

- Trade receivables includes prepayments which are not a financial instrument, see note 20 to the financial statements on page XLVIII.
- Trade payables includes receipts in advance and PDC payable which are not financial instruments, see note 22 to the financial statements on page L.
- Provisions includes liabilities incurred under legislation,

rather than by contract – early retirements due to ill health or injury. These are not considered by HM Treasury to fit the definition of a financial instrument, see note 28 to the financial statements on page LV.

Risk management policies

The Trust's activities expose it to a variety of financial risks, though due to their nature the degree of the exposure to financial risk is substantially reduced in comparison to that faced by business entities. The financial risks are mainly credit and inflation risk, with limited exposure to market risks (currency and interest rates) and to liquidity risk.

Financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Investment Committee. The main responsibilities of the Trust's treasury operation are to:

- ensure adequate liquidity for the Trust;
- invest surplus cash; and
- manage the clearing bank operations of the Trust.

(i) Credit risk

As a consequence of the continuing service provider relationship that the Trust has with NHS Commissioners and the way those organisations are financed, the Trust is exposed to a degree of customer credit risk, but substantially less than that faced by business entities. In the current financial environment where NHS Commissioners must manage increasing healthcare demand and affordability within fixed budgets, the Trust regularly reviews the level of actual and contracted activity with the NHS Commissioners to ensure that any income at risk is discussed and resolved at a high level at the earliest opportunity available.

As a majority of the Trust's income comes from contracts with other public sector bodies, see note 2 to the financial statements on page XXX, there is reduced exposure to credit risk from individuals and commercial entities. The maximum exposures to trade and other receivables as at the reporting date, are disclosed in note 20 to the financial statements on page XLVIII, including details of the amounts owing on the sale of surplus land. The Trust mitigates its exposure to credit risk through regular review of receivables due and by calculating a bad debt provision.

In accordance with the Trust's treasury policy, the Trust's cash is held in current accounts at UK banks only. There are no cash or cash equivalent investments held, the result being to minimise the counter party credit risk associated with holding cash at financial institutions.

(ii) Inflation risk

The Trust's has exposure to annual price increases of medical supplies and services (pharmaceuticals, medical equipment and agency staff) arising from its core healthcare activities. The Trust mitigates this risk through, for example, transferring the risk to suppliers by contract tendering and negotiating fixed purchase costs (including prices set by nationally agreed frameworks across the NHS) or reducing external agency staff costs via operation of the Trust's own employee 'staff bank'.

The unitary payment of the new 'Queen Elizabeth Hospital Birmingham' private finance initiative contract is subject to change based on movements in the Retail Prices Index (RPI), as disclosed in note 27.1 to the financial statements on page LIII. For the reporting year the relevant RPI index was 260.0 (annualised rate of 1.0%) fixed at February 2016. 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 2017**		Year Ended 31 March 2016	
	£000	**£000**	£000	£000
	+1.0%	**-1.0%**	+1.0%	-1.0%
Retained surplus/(deficit)	**(534)**	**534**	(534)	534
Taxpayers' equity	**(534)**	**534**	(534)	534

(iii) Market risk
The Trust has limited exposure to market risk for both interest rate and currency risk:

Currency risk – the Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations nor investments and all Trust cash is held in Sterling at UK banks: Barclays bank and the Government Banking Service 'GBS'. The Trust therefore has minimal exposure to currency rate fluctuations.

Interest rate risk – other than cash balances, the Trust's financial assets and all of its financial liabilities carry nil or fixed rates of interest. Cash balances at UK banks earn interest linked to the Bank of England base rate. The Trust therefore has minimal exposure to interest rate fluctuations.

(iv) Liquidity risk
The Trust's net operating costs are incurred under annual service agreements with Clinical Commissioning Groups and NHS England, which are financed from resources voted annually by Parliament. The Trust ensures that it has sufficient cash or committed loan facilities to meet all its commitments when they fall due. This is regulated by the Trust's compliance with the 'Continuity of Services Risk Rating' system created by Monitor, the Independent Regulator of NHS Foundation Trusts. 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 12 to the financial statements on page XXXIX. Therefore, the Trust does not manage its own capital. Liquidity risk and the funding of the Trust's activities are described above.

33 Third party assets

The Trust and Group held £2,963 of cash at the reporting date (31 March 2016: £2,963) which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

34 Losses and Special Payments

	Year Ended 31 March 2017		Year Ended 31 March 2016	
	Number	**£000**	Number	£000
Losses				
Cash losses	**28**	14	28	11
Bad debts and claims abandoned	**2,132**	679	1,776	223
Damage to property and stores losses	**3**	27	4	274
	2,163	720	1,808	508
Special payments				
Compensation payments	**—**	—	—	—
Ex gratia payments	**138**	17	139	16
	138	17	139	16
Total losses and special payments	**2,301**	737	1,947	524

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.

The Trust losses and special payments disclosed are the same as the Group, there have been no equivalent payments made by the subsidiaries.

These amounts are stated on an accruals basis but exclude any provisions for future losses.

National Health Service Act 2006

Direction by Monitor, in Respect Of Foundation Trusts' Annual Reports and the Preparation Of Annual Reports

Monitor, in exercise of powers conferred on it by paragraph 26 of schedule 7 to the National Health Service Act 2006, hereby directs that:

1. The annual report of each NHS foundation trust shall be in the form and provide such information as laid down in the annual reporting guidance for NHS foundation trusts within the *NHS Foundation Trust Annual Reporting Manual (FT ARM)* that is in force for the relevant financial year.

2. The annual report of each NHS foundation trust shall be submitted in accordance with the requirements specified in the FT ARM of equivalent document as to when such reports must be sent to Monitor.

3. The following sections contained in each annual report shall be signed and dated by the chief executive of the NHS foundation trust to which it relates:
   - The performance report
   - The accountability report
   - The remuneration report
   - The annual governance statement
   - The statement on quality from the chief executive (part 1 of the quality report)

4. The statement of directors' responsibilities in respect of the quality report contained in each annual report shall be signed and dated by the chair and chief executive of the NHS foundation trust to which it relates.

Signed by authority of Monitor

Signed:

Name: **Jim Mackey (Chief Executive)**

Dated: November 2015

National Health Service Act 2006

Direction by Monitor, in Respect Of Foundation Trusts' Annual Reports and the Preparation Of Annual Reports

Monitor, with the approval of the Secretary of State, in exercise of powers conferred on it by paragraphs 24(1A) and 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 Directions:
  a. references to "the accounts" and to the "the annual accounts" refer to:
    - for an NHS foundation trust in its first operating period since being authorised as an NHS foundation trust, the accounts of an NHS foundation trust for the period from point of licence until 31 March
    - for an NHS foundation trust in its second or subsequent operating period following initial authorisation, the accounts of an NHS foundation trust for the period from 1 April until 31 March
    - for an NHS foundation trust in its final period of operation and which ceased to exist as an entity during the year, the accounts of an NHS foundation trust for the period from 1 April until the end of the reporting period
  b. "the NHS foundation trust" means the NHS foundation trust in question.

2. **Form of accounts**

(1) The accounts submitted under paragraph 24(1) of Schedule 7 to the 2006 Act must comply with the requirements of the Department of Health Group Accounting Manual (DH GAM) in force for the relevant financial year.

3. **Annual accounts**

(1) The annual 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 annual accounts shall follow the requirements as to form and content set out in chapter 1 of this manual and meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual (FT ARM) in force for the relevant financial year.
(3) The annual accounts shall comply with the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) as in force for the relevant financial year.
(4) The Statement of Financial Position shall be signed and dated by the chief executive of the NHS foundation trust.

4. **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.

5. **Approval on behalf of HM Treasury**

(1) The foreword to the accounts shall be signed and dated by the chief executive of the NHS foundation trust.

Signed by the authority of Monitor

Signed:

Name: **Jim Mackey (Chief Executive)**

Dated: November 2015