University Hospitals Birmingham NHS Foundation Trust

Annual Report and Accounts

This annual report covers the period 1 April 2009 to 31 March 2010

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

University Hospitals Birmingham NHS Foundation Trust

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Directors' Report

1. Overview

1.1.1 Names of persons who were Directors of the Trust

The Board is currently comprised as follows:

Chairman: Sir Albert Bore

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

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

Kevin Bolger was appointed as substantive Chief Operating Officer on 15 June 2009.

Tony Huq retired as a Non-Executive Director on 30 June 2009. Ms Angela Maxwell was appointed as a Non-Executive Director on 1 July 2009.

1.1.2 Principal activities of the Trust

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

The Trust runs two hospitals, Queen Elizabeth Hospital and Selly Oak Hospital, which provide adult services to nearly 700,000 patients every year, from a single outpatient appointment to a heart transplant. The Trust is a regional centre for cancer, trauma, burns and plastics, and has the largest solid organ transplantation programme in Europe.

The Trust employs around 6,900 staff and is about to start transferring services into Birmingham's first new acute hospital in 70 years. The hospital will open its doors to patients on June 16, 2010.

The Trust's services are distributed across the two hospital sites as follows:

Queen Elizabeth Site

- General Surgery
- Breast Surgery
- GI Surgery
- GI Medicine
- Cardiology
- Cardiothoracic Surgery
- Renal Medicine
- Renal Surgery
- Urology
- Liver Surgery and Transplantation
- Liver Medicine
- Ear, Nose, and Throat
- Maxillofacial Surgery
- Neurosciences
- Respiratory Medicine
- Oncology
- Haematology
- Endocrinology
- Critical Care

Selly Oak Site

- Accident and Emergency
- Medical Assessment Unit (MAU)
- General Medicine
- Elderly Care
- Stroke Services
- Trauma
- Vascular Surgery
- Burns and Plastics
- Hearing Assessment & Rehabilitation
- Rheumatology
- Diabetes
- Ophthalmology
- Dermatology
- Ambulatory Care
- Critical Care

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

1.1.3 Royal Centre for Defence Medicine

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

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

1.1.4 Research and Development

An on-going pilot to speed up the launch of cancer treatment trials is to be extended across all specialties within University Hospitals Birmingham NHS Foundation Trust.

The model involved the appointment of an oncology research team business manager and pharmacy manager who achieved a three-fold increase in the number of live trials – from 35 to more than 100 – by December 2009.

Income generated from pharmaceutical companies and through academic grants has funded an additional 14 posts. The commercial income for the first year of the pilot was £600k (March 2009-2010) and the projected income for the second year is £1.2 million (March 2010-2011). Previously there was no commercial income and no research staffing budget.

The Birmingham and Black Country CLAHRC, led by the Trust with the University of Birmingham as its main academic partner, staged a conference to mark its first year achievements at the Botanical Gardens in Edgbaston in November. Delegates heard from leaders of the nine applied health research or implementation projects within the collaboration, two of which are led by the Trust.

The Birmingham Clinical Research Academy, a joint venture between the Trust and the University of Birmingham marked its official launch with a seminar at the Post Graduate Medical Centre on February 22 2010.

Collaborative grant achievements so far include £3.75m for the National Institute for Health Research (NIHR) Biomedical Unit; £10m DoH plus £11m matched NHS funds for the NIHR CLAHRC (Collaborations for Leadership in Applied Health Research and Care); £2m from the Strategic Health Authority for the Quality Institute; £2m in the first instance for Health Innovation and Education Clusters; other grants from the NIHR, and assistance in selection of £1.5m grants from UHB Charities over the past year.

2. Management Commentary

2.1 Trust Development and Performance in 2009/10 and Position at Year End

2.1.1 Strategic Planning

The Trust has undertaken a significant amount of work in defining and developing its vision, values, and core purposes. This work has been further progressed with the development of a five-year strategy. The Trust Strategy has been developed with the objective of fulfilling its vision to deliver the best in care and the four core underpinning purposes (clinical quality, patient experience, education and training, and research and innovation). The Trust values (honesty, responsibility, respect, and innovation) have also played a significant role in the development of the strategy as they provide the governance framework within which it will be delivered. The Strategy considers the key challenges and drivers faced by the Trust:

- Ever higher expectations
- Demand driven by demographics
- Health in an age of information and connectivity
- The changing nature of disease
- Advances in treatment
- A changing health workplace
- The financial, political and local 'economy'

The Strategy was developed using a bottom-up approach and has benefited from comprehensive input ranging from clinical departments to the Board of Governors and Board of Directors. Consultation with the Trust's key strategic partners was also undertaken and feedback has been factored into the final strategy document.

The emerging Strategy has identified a number of overarching themes which provide the organisation with a foundation of common goals to meet and sustain:

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

An assessment of the Strategy's resilience has also been undertaken to ensure responsiveness and flexibility to changing drivers and challenges at a local and national level.

Following on from the challenges and overarching themes, the Trust Strategy has been distilled to four strategic aims categorised under each core purpose. To support this, a set of four strategic enablers and accompanying actions have been developed. These identify how the core purposes and strategic aims will be delivered. They also serve as a framework for the development of Trust annual plans.

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

Core Purpose 2:	Patient Experience
Strategic Aim:	To listen to what patients want and respond quickly and proactively

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

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

2.2 Principal Risks and Uncertainties Facing the Trust

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

One of the main factors determining the risks faced by the Trust is the impact of the economic climate. The Trust recognises that the state of the economy and decisions made by a range of external organisations will determine many of the individual factors that impact on the financial well-being of the Trust and the wider NHS. These risks primarily relate to income, cost, and activity.

The main uncertainties faced by the organisation relate to the external performance assessment framework determined by the Care Quality Commission, Monitor, and the standard NHS contract.

In terms of external regulatory requirements, performance against the cancer targets remains a risk along with the 18-week referral to treatment target. As UHB receives a high level of tertiary referrals due to the specialist services it provides, any referrals received late along the pathway make achievement of the targets more challenging. Infection control also remains a challenge even though significant reductions in MRSA and C.difficile rates were delivered in 2009/10.

The 2009/10 standard NHS contract carries a high level of risk due to the financial penalties that can be applied for a range of performance issues such as activity variance and under-achievement of targets.

The political climate and change of government presents uncertainty to the Trust. This could mark some significant changes in healthcare provision and configuration.

The recent reconfiguration of primary care trusts into clusters is likely to create instability across the local health economy driven by potential changes in personnel and revision of commissioning intentions.

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

As part of the development of the Trust's Five-Year Strategy, consideration was given to the main factors that will affect the organisation using the key challenges presented in 'High Quality Care For All' as a framework. These are described below.

2.3.1 Ever Higher Expectations

Wealth and technology have changed the nature of society's outlook and expectations. Patients expect more tailored treatment received at a time and place convenient to them. They will make greater demands and expect a more significant role in decision-making during their care. People are now more influenced by new technologies that provide unprecedented levels of control, personalisation, and connection. This puts the patient in a position to directly influence and shape healthcare.

The Trust has developed a core purpose to improve the patient experience which aligns with the national strategy to meet ever higher expectations. In 2009/10 UHB collected a wealth of information relating to how patients feel about the care they receive. This will be used as a platform to proactively listen to patients and respond to their needs.

2.3.2 Demand Driven by Demographics

The ever-growing life expectancy and ageing population poses a challenge to the sustainability of the NHS. By 2031, the number of over 75 year olds in the British population is predicted to increase from 4.7 million to 8.2 million. The NHS needs to be forward looking, proactively identifying, and mitigating health risks in order to cope with the increased demands of an ageing population.

The specialty clinical strategies have been developed specifically to meet the growing demand within this demographic area through a more proactive approach to care of the elderly and the delivery of synergistic services such as Stroke, Neurology, and Neurosciences through an aggregate service configuration.

2.3.3 Health in an Age of Information and Connectivity

The internet has transformed the relationship people have with information. This has profound implications for healthcare. It is now easier to access information on how to stay healthy than ever before. People are able to quickly and conveniently find information about their treatment and diseases in a way that was previously impossible. They want to do their own research, reflect on what their clinicians have told them, and discuss issues from an informed position. The challenge is ensuring that people are able to access reliable information.

UHB can pride itself on the advancements it has made with information and connectivity. Given the Government announcement to scale back the national IT programme, UHB is in a strong position to deliver local IT solutions and further reinforce its status as a leader in this arena with the development of items such as Prescribing Information and Communications System (PICS) and the clinical portal.

2.3.4 The Changing Nature of Disease

The NHS in the 21st Century increasingly faces a disease burden determined by the choices people make; to smoke, drink excessively, eat poorly, and not take enough exercise. Today, countless years of healthy life are lost as the result of these known behavioural or lifestyle factors. Unhealthy choices and missed prevention opportunities are, in part, the cause of the growth in the prevalence of conditions such as diabetes, depression, and chronic obstructive pulmonary disease. The NHS and all its partners must respond to this shifting disease burden and provide personalised care for long-term conditions.

The changing disease pattern is currently manifesting itself in a growth in a number of specialist tertiary services such as Diabetes, Renal Medicine and Surgery, Cardiology, Spinal Surgery, Trauma and Cancer Services.

2.3.5 Advances in Treatment

The past 60 years have seen big developments in capacity to understand the nature and impact of existing disease. Also, with the advances in genomic testing, it may be possible to predict future disease rather than simply understand present illness. This presents the NHS with an unprecedented opportunity to move from reactive diagnosis and treatment to be able to proactively predict and prevent ill health. The NHS continues to develop pioneering treatments for diseases. For the same illness, open surgery leaves patients in hospital for several weeks where keyhole surgery enables them to go home in just a few days. With advances in robotics, patients can look forward to scar-free surgery.

The recent improvements in clinical trials recruitment within cancer services and the relatively poor NHS record in delivering effective commercial trials activity provides a fertile market for the expansion of research and development activity within the Trust. The establishment of the Birmingham Clinical Research Academy in collaboration with the University of Birmingham (UoB) and the links with the Royal Centre for Defence Medicine (RCDM) added to the internal reconfiguration of Research & Development, PICS, and Informatics capability. It also adds to the optimal translational research environment available to UHB to proactively meet this challenge in the future.

2.3.6 A Changing Health Workplace

Healthcare has always been a knowledge-led sector, relying on expert learning and depth of experience. Expectations of work in healthcare are changing, with people today seeking quality work. Healthcare professionals expect the depth of their expertise to be recognised and rewarded, and their skills to be developed and enhanced. High quality work is also about meeting the productivity challenge; high quality workplaces make best use of the talents of their people, ensuring that their skills are up to date, and their efforts never wasted. Creating high quality workplaces requires great leadership and good management.

The Trust has a core purpose relating to education and training of the workforce. This component of the Strategy focuses on developing a fit-for-purpose workforce that provides and continues to improve on delivering quality work. It also ensures that UHB meets not only its own workforce requirements but facilitates other health economy partners in further developing workforce capability through vehicles such as the Health Innovation and Education Clusters developed in collaboration with UoB. The New Hospital will also act as a major incentive for potential new recruits to the Trust given its state of the art facilities.

2.3.7 Financial Climate

The medium term economic outlook is significantly worse than at any time in the last 25 years. As a consequence of the recession and the global financial crisis the UK's public finances are now under severe strain. It is recognised that this current economic downturn will have a significant impact on healthcare and there will be further downward pressure on the national tariff with inflation uplifts continuing to fall. Higher efficiency gains will be required and there are significant opportunities for the NHS under the new cross-Government Operational Efficiency Programme. Reduced spending growth will also put significant pressure on PCTs to manage demand.

The state of the economy will impact directly on the Trust in many different ways, for example:

- NHS funding growth
- National tariff uplift
- Efficiency savings
- Inflation (RPI)
- Pay awards
- Interest rates

Whilst the individual variables are impossible to predict, it is clear that the Trust will face an extremely challenging financial landscape over the medium term. Maintaining financial stability during this period is likely to require additional efficiency gains in order to increase productivity and deliver additional work through the available capacity and a tight control on costs.

2.4 Performance Governance Framework

The Trust has a robust and effective governance framework in place to provide assurance and organisational performance. The Board of Directors and Executive Director level groups receive monthly performance reports which present performance against national and local targets/priorities. The reports adopt a risk-based approach so that performance underachievement and rectification plans are highlighted to the Executive Team and Board of Directors and Governors. Findings from Care Quality Commission assessments are also reported to the Board of Directors and Governors. This provides a good level of assurance and supports effective decision making. 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 forums provide additional assurance and effective

accountability around clinical quality and the patient experience. See Quality Report – Section 3.

2.5 National Targets/Standards and the Standard NHS Contract

The financial year of 2009/10 was another very successful year for UHB. The Trust has successfully met or exceeded some very challenging targets.

The Trust has made significant reductions in infection rates. A total of 13 MRSA cases were reported against a trajectory of 30 and 178 C.difficile cases were reported against a trajectory of 348. Although this level of reduction has been made, infection control remains a priority for the Trust.

UHB saw nearly half a million outpatients, 67,000 inpatients, 32,000 daycases, and 83,000 A&E attendances. The Trust continues to ensure equitable access to services and over 98% of patients were treated, admitted, or discharged from A&E is less than four hours over the course of the year. UHB has also met the national 18-week referral- to-treatment target at Trust and Specialty level. The Trust continues to sustain some of the lowest inpatient and outpatient waiting times in the NHS and has successfully delivered against the national cancer waiting time targets.

The Trust also reported full compliance against the 44 core standards set by the Care Quality Commission demonstrating that the organisation has effective governance processes in place as well as delivering high levels of quality care.

2009/10 was the second year of the standard NHS contract. Contract performance is monitored and discussed with South Birmingham Primary Care Trust and the West Midlands Specialised Commissioning Team on a monthly basis. The Trust has successfully complied with the terms of the contract.

2.6 Clinical Quality and Patient Experience

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

The priorities contained within the 2008/09 Quality Report have shown improvement:

- Reducing errors (with a particular focus on medication errors)
- Infection prevention and control
- Improve patient experience and satisfaction.

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

The milestones and outcomes contained within the CQUIN priorities have also been successfully delivered:

- Privacy and dignity
- Medication safety
- Pressure sore management
- Urgent care

2.7 Trust Development and Performance during 2009/10

The Trust broadly met its objectives for 2009/10 and has successfully met or exceeded some very challenging targets, treating more patients than ever before.

	2008/09	2008/09	% change
Inpatient Finished Consultant Episodes	67,515	67,058	-0.68
Day-cases (excluding renal dialysis regular day attenders)	30,165	31,825	5.22
Outpatient attendances	461,080	499,981	7.78
A&E Attendances	82,838	82,632	-0.25
Total treatments	641,201	681,496	5.85

Over 98% of patients were treated, admitted, or discharged from A&E in less than four hours over the course of the year. The Trust has also met the national target for thrombolysis and sustained some of the lowest inpatient and outpatient waiting times in the NHS.

It has also achieved further reductions in diagnostic waiting times.

2.8 Performance against Key Patient Targets

In October 2009, the Healthcare Commission published the performance ratings for 2008/09. The Trust achieved ratings of “excellent” and “excellent”, making it one of the most consistently highest performing healthcare organisations in the country. The organisation is also delivering the financial results needed to facilitate the move into the New Hospital building.

The Trust’s primary focus for the past year has been on improving quality outcomes for patients as well as infection control. And, thanks to the hard work and efforts of all, it has made improvements in quality (see Quality Report - Section 3) and significant reductions in healthcare acquired infections. However, there is still much to do in both areas and the focus will remain a priority for the coming year. The Trust will also continue to improve the patient experience and their satisfaction with the services it provides by listening carefully to its patients and acting upon that feedback.

The Trust received its Outpatient and Inpatient survey results which highlighted many areas of good practice as well as some priority areas that required improvement. The Trust has in place a formal committee, the Care

Quality Group, to enhance the patient experience and improve patient satisfaction.

The following table sets out performance against The Trust's main targets for 2009/10:

National Targets/Standards for 2009/10

Indicator	National Target	Data Period	YTD
Existing Commitments			
Data quality on ethnic group for patients	>=85%	Apr 09 – Feb 10	93.8%
Primary PCI - call to needle within 60 minutes	Thresholds not released by Care Quality Commission (CQC)	Apr 09 – Dec 09	68.4%
Delayed transfers of care	<=3.5%	Apr 09 – Mar 10	3.3%
A&E 4 hour waits	>=98%	Apr 09 – Mar 10	98.5%*
Inpatient waits longer than 26 weeks	<=0.03%	Apr 09 – Mar 10	0.0%
Outpatient waits longer than 13 weeks	<=0.03%	Apr 09 – Mar 10	0.0%
Revascularisation 13 week waits	<=0.1%	Apr 09 – Mar 10	0.0%
Rapid access chest pain clinic 2 week waits	>=98%	Apr 09 – Mar 10	100%
% Operations cancelled on day or after admission	<=0.8%	Apr 09 – Mar 10	0.64%
Cancelled operations not admitted within 28 days	<5%		0%
National Priorities			
Participation in heart disease audits	Participation in line with indicator construction	Apr 09 – Mar 10	Awaiting final figures
Engagement in clinical audits	Yes for 5 questions including question 1	Apr 09 – Mar 10	6 (including Q1)
Stroke care: patients spending >90% of time on stroke unit	Thresholds not released by Care Quality Commission (CQC)	Apr 09 – Mar 10	64.6%
Number of MRSA bacteraemias	<=30	Apr 09 – Mar 10	13
Number of C. difficile cases >48 hours after admission	<=348	Apr 09 – Mar 10	176
18 week referral to treatment - admitted patients	>=90%	Apr 09 – Mar 10	95.0%
18 week referral to treatment - non-admitted patients	>=95%		97.8%
Cancer – 31 days from decision to treat to treatment – first treatments	>=96%	Apr 09 – Mar 10	97.4%
Cancer – 31 days from decision to treat to treatment – subsequent treatments – surgery	>=94%		96.6%
Cancer – 31 days from decision to treat to treatment – subsequent treatments – drug therapy	>=98%		99.1%
Cancer – 62 days from urgent GP referral to treatment – first treatments	>=95%	Apr 09 – Mar 10	Awaiting final figures
Cancer – 62 days from urgent referral from screening service to treatment – first treatments	>=90%		85.7%
Cancer – 62 days from consultant upgrade to treatment – first treatments	Thresholds not released by CQC		92.6%
Cancer – 2 weeks from urgent GP referral to first outpatient appointment – suspected cancer	>=93%	Apr 09 – Mar 10	94.6%
Cancer – 2 weeks from urgent GP referral to first outpatient appointment – breast symptoms	>=93%		98.6%
Experience of patients	Target construction and thresholds not released by CQC	2009	Awaiting construction from CQC
NHS staff satisfaction	Target thresholds not released by CQC. UHB above national average.	2009	3.51

* Data includes patients who attended South Birmingham GP Walk In Centre (Katie Road) from July 2009.

2.9 Performance Monitoring and Improvement

The Trust has a robust performance monitoring system in place which contributes to driving improvements in the quality of care. On a monthly basis, the Board of Directors and Executive Director level groups receive a performance report detailing progress against national and local targets.

The reports act as an assurance mechanism that targets are being achieved and where there is underachievement, that action is being taken to improve performance.

The risk-based approach is taken to the performance management of national targets in particular. This approach aligns effectively with reporting target risks to Monitor. Findings from the Care Quality Commission assessments are also reported to Board level with detailed action plans incorporating any recommendations made.

2.10 Operational Efficiency

Operational efficiency remains a high priority for UHB and a number of initiatives were implemented in 2009/10 to drive improvements.

Length of stay is an important marker of the patient experience and efficiency of patient care. Work has therefore continued to ensure pathways are streamlined, non-value added steps removed, and the patient experience improved. Attention has also been focussed on improvement pre-operative assessment practices. At a high level, the actions required for the delivery of streamlined pathways include an increase in the proportion of patients pre-admitted which will in turn improve the Trust's day of surgery admission rates. Work has also been undertaken to further increase daycase and ambulatory care rates.

UHB is working closely with South Birmingham Primary Care Trust to ensure the patient pathway is further streamlined so that discharge planning takes place at an early stage. This work will help to improve the assessment of patients within the hospital setting, and ensure early discharge planning takes place.

UHB has also been testing the new models of care prior to the physical transfer to the new hospital. The Trust recognises that significant changes to the models of patient care need to be made to enable services to function at an optimal level from the first day in the New Hospital. An example of this is the approach to the use of acute medical inpatient beds via the multi-speciality medicine model. In September 2008, this planned assessment model was implemented on the Selly Oak site and brought together the relevant wards as they are configured in the New Hospital.

The Trust has applied LEAN processes within Theatres to improve utilisation and planning. An outcome of this work includes the way in which capacity is planned for major surgical cases. In the New Hospital, there is critical care capacity that can be flexed to contribute to the Trust's ability to plan for elective admissions post procedure. This ensures that sufficient critical care capacity is identified.

The Trust has made strides in delivering activity in the community working closely with commissioners. In partnership with South Birmingham Primary Care Trust, UHB is delivering a range of clinics such as Diabetes, Ophthalmology, Ear, Nose and Throat, Plastic Surgery, and Orthopaedic Assessment and Triage in a community setting.

There is also an already established Orthopaedic Assessment and Triage Service provision in the community borne out of a partnership with Heart of Birmingham PCT.

2.11 Social and community issues

UHB is key to Birmingham's regeneration. The health and social care sector as a whole accounts for over 10% of West Midlands gross domestic product. UHB itself has a similar budget to Coventry City Council – one of the biggest local authorities in England – and is Birmingham's third largest employer, employing some 6,900 staff. The new Queen Elizabeth Hospital Birmingham, opening in June 2010, is one of the region's largest capital projects and is adjacent to Birmingham University, creating one of Europe's largest academic/medical complexes. It is a catalyst for the wholesale regeneration of south Birmingham.

UHB's definition of regeneration would be to deliver the best in healthcare which reduces social exclusion and increases prosperity in Birmingham and the broader West Midlands. Essentially, this means projects that reduce worklessness and those that through medical technology, especially translational research, improve regional competitiveness.

2.11.1 Reducing Disadvantage

A key priority of the Trust has been to broaden access to the jobs and training it and Balfour Beatty - the builder of the New Hospital - has to offer to unemployed people, particularly those living in the most disadvantaged parts of the city. UHB has been doing this in temporary premises for five years but the culmination was the opening in August 2008 of the Learning Hub close to the New Hospital. Over the last five years the training projects now in the Hub have enabled almost 1,000 people to gain a job.

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

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

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

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

'Building Health' covers both healthcare and construction jobs arising from the New Hospital and is aimed at the whole of the health and social care sector including private sector care homes. The Sector Skills Council for Construction has designated Balfour Beatty (the builder of the New Hospital) working through the Learning Hub as its first Academy of Construction Excellence in the West Midlands. The aim is to improve training for existing employees of Balfour Beatty and its supply chain, complementing the focus of 'Building Health' on unemployed people.

Some 70% of its beneficiaries are from Black and Minority Ethnic communities.

Key stakeholders in the Learning Hub include JobCentre Plus, the Learning and Skills Council, Birmingham City Council, Further Education Colleges and Consort/Balfour Beatty, as well as UHB and NHS partners. The Learning Hub brings together in one place the skills and experience of all these organisations.

UHB is currently planning to help train 40 apprentices and provide a further 60 placement opportunities for young people under the Government's Future Jobs Fund initiative.

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

UHB has signed both the Skills and Jobs Pledges and was one of the first NHS Trusts in Birmingham to sign a Local Employment Partnership (LEP) with JobCentre Plus, using the Learning Hub to help welfare claimants into training and work. The Learning Hub gained the 2009 West Midlands JobCentrePlus award for most innovative LEP and for the most outstanding contribution to LEPs. The Hub also gained a national Matrix excellence award for the quality of its information, advice and guidance.

2.11.2 Increasing Prosperity

Adjacent to Birmingham University the New Hospital will create one of the largest academic / medical complexes in Europe – at one of the key gateways to the region's Central Technology Belt.

The New Hospital will embody latest technology and be a catalyst for, and driver of, innovation in medical and healthcare technologies. Working with the best in Europe and beyond the Trust aims to further stimulate knowledge, technology transfer and best practice – very much in line with the direction of the Wanless Report, the Health Industries Task Force and, most recently, the Darzi Review. Locally, UHB has worked hard to ensure medical technology is integral to Advantage West Midlands' Regional Economic Strategy, the West Midlands Regional Competitiveness and Employment Programme and the Birmingham Science City initiative.

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

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

The Leukaemia Centre has undoubtedly helped develop a policy alignment around translational research in medicine including Advantage West Midlands, the regional development agency; Central Technology Belt and Birmingham Science City.

Most recently the Trust has been a leading partner in a successful Health Innovation Education Cluster bid to the Department of Health. UHB working with partners has also made a bid to be a national centre for proton therapy.

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

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

2.12 Patient Care

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

Following the development of a number of patient-focused initiatives last year, the Trust continues to improve patient care through the work of the Care Quality group chaired by the Executive Chief Nurse. Whilst the Trust has issues raised in patient advocacy and liaison contacts, complaints, and national and local surveys it also commenced its own electronic surveys last year enabling patients to give live feedback at the point of care.

These surveys have assisted the Trust in measuring the success of its patient improvement measures including a 20% increase in the number of patients who feel that they are always treated with dignity and respect.

It has also enabled the Trust to focus on the areas that patients indicate they are most concerned with. As a result of the feedback from patients, the Trust has changed its meal times, produced comfort packs to support better rest

and improve issues with noise at night. The Ward Dashboard on each area allows staff to see their own progress against a number of clinical areas and act on them. Use of the national Releasing Time to Care project (Productive Ward) is providing the Trust with an opportunity to standardise storage and systems of the wards in the New Hospital which assists staff with familiarisation and efficiency.

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

The Trust's Infection Prevention and Control programme has continued to demonstrate excellent progress in the last year. MRSA has reduced by 66% and Clostridium difficile has reduced by over 50% in year.

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

The Trust had its annual inspection against the Hygiene Code made by the Healthcare Commission in October 2009 and the report was positive with no breaches of the code identified.

The Trust took part in the Healthcare Commission's review of the arrangements for Safeguarding of Children and was passed as compliant against the standards reviewed.

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

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

In response to its patients and to the Department of Health's campaign to virtually eliminate mixed sex accommodation, the Trust has made a number of changes to ensure that where possible patients will not share sleeping areas, that all toilet areas are all clearly marked for male and female use and that privacy and dignity is maintained at all times. This will culminate in a major improvement as the Trust moves into its new hospital during 2010 when there will be single sex four-bedded rooms and 44% single rooms with en-suite toilets and showers.

2.14 Public and Patient Involvement

2.14.1 Patient and Carer Councils

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

The purpose of the Councils is for patients, Foundation Trust members and the public to work in partnership with staff to improve the services provided to patients. All council members are also Foundation Trust members. Both councils have been active in seeking patients' views to influence the improvements in care.

The Selly Oak Hospital Council has continued to use the 'Adopt-A-Ward' scheme to facilitate partnership working with ward staff to provide a patient perspective to improving the experience of patients and their relatives. During 2009, the Queen Elizabeth Hospital Council introduced the scheme.

The work programme this year has included nutrition and hydration of inpatients, infection prevention and control, privacy and dignity, patient experience data collection, and a review of the bedside entertainment system.

2.14.2 Clean Your Hands Campaign led by Patient and Carer Councils

For the fourth year running, the councils led and co-ordinated a campaign to raise awareness, amongst patients, visitors and staff, of the need to wash or clean their hands.

Staff and Patient and Carer Council members visited ward areas armed with ultraviolet light hand washing boxes, information leaflets and questionnaires. During these visits, patients, visitors and staff had the opportunity to use the light boxes to check their hand washing technique.

A report of the campaign, results and recommendations will be reported to the Infection Prevention and Control Committee in Spring 2010.

2.14.3 Models of Care

A group of Foundation Trust Members and Patient and Carer Council representatives have continued to meet with representatives of the Business Continuity and Clinical Redesign department in the Models of Care Group. The Models of Care were developed to help map out all of the different processes that patients will go through during their visit or stay in the New Hospital.

Group members have had the opportunity to comment on, or suggest, improvements that the Trust may need to undertake to ensure that the patient has the best possible experience during their visit or stay in the hospital.

This year the group has had the opportunity to contribute to discussions and decisions on the productive ward project, patient information in the new hospital, patient transport, and the introduction of a 3D wayfinding system.

2.14.4 Information Group

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

- Plasma Screens: the group has been involved in consultation on the messages and information to be displayed on the plasma screens.
- Audit of the hospital information channel/booklet which provides patients with various information about their hospital stay.
- Information for patients being discharged from hospital
- Information for patients about their medication

2.14.5 Local Involvement Networks (LINks): UHB Working Group

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

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

A representative from the group participated in the procurement process to award the contract to a provider of Non-Emergency Patient Transport.

A work programme has been developed for 2010/11 in collaboration with the Associate Director of Patient Affairs.

2.14.6 Patient/carer Consultations

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

- NHS Constitution - consultation on patients' rights
- Provider of cook-chill meals for inpatients
- 3D Wayfinding and Signage in the New Hospital - a consultation on the method of wayfinding for the New Hospital.

- Care Quality Commission – User Involvement and Quality Reports
- Intra-Bladder temperature measurement
- Ward comfort rounds for patients
- Direct Payments/Personal Health Budgets
- CLAHRC Research on Patient Experience

2.14.7 Increase in volunteers from the local community

The Trust had 880 people registered as volunteers at the end of February 2010. A continued effort has been made to recruit from groups that would not traditionally be linked with hospital volunteering. The profile of volunteers is now:

- 31% male
- 38% black and Asian
- 40% under 30 years old
- 19% over 66 years old
- 17% employed

Good working relationships have continued with the Birmingham Voluntary Services Council, and service level agreements made to attract people from seldom heard groups to become volunteers. Engagement with other voluntary organisations, Birmingham City Council, local universities, colleges and community groups has enhanced the development of the voluntary services at the Trust. This has helped to establish further the infrastructure, ensuring a sustainable future for the service.

National recognition of the standard of practice and achievements of the Voluntary Services has been demonstrated through inclusion in the recently launched Department of Health Strategic Vision, 'Volunteering: Involving people and communities in delivering and developing health and social care services'. Also, the Associate Director of Patient Affairs was elected to a key National role as the Chair for the National Association of Voluntary Services Managers, the organisation that leads volunteering in the NHS.

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2.15 Complaints

The Trust received 643 formal complaints in 2009/10, which was 5.6% higher than the number received in 2008/09. An increase in the number of complaints was anticipated as a result of improved access to the complaints process, following the implementation on 1 April 2009 of new legislation governing NHS and Social Care complaints. The Trust can now accept complaints by email and telephone, as well as in writing. Every effort is made to make contact with the complainant, on receipt of their complaint, to agree a way forward including the preferred method of resolving their concerns (letter, meeting or phone call) and an appropriate timescale.

Trends coming out of complaints are analysed, assessed and reported to the Audit Committee. The Trust responded fully to 91% of complaints within the timescale agreed with the complainant.

The main issues raised in complaints were:

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

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

- Revised policy, pro-forma and additional teaching session re: consultant input on back pain cases in A&E
- Recruitment of additional staff trained to administer specific chemotherapy treatment
- Improved handover and revised shift patterns to improve drug administration on wards
- Extra clinics, revised consultant rotas and nurse led clinics to reduce waiting times in Fracture Clinic

2.16 Patient Advice and Liaison Service (PALS)

The Trust runs a Patient Advice and Liaison Service (PALS). There were 2,688 PALS contacts in 2009/10 of which 1,300 (48%) were related to issues/concerns raised. This compares with 2,060 PALS contacts the year before of which 1,017 (49.5%) were related to issues/concerns raised. This equates to a 30% increase in PALS contacts overall but a 1.5% reduction in the percentage of issues/concerns in relation to the total number of PALS contacts. The main issues/concerns raised were similar to Complaints and were related to Communication and Information, perceptions around Clinical Treatment and Outpatient appointments being cancelled or delayed.

2.17 Stakeholders, Partnerships, alliances/contractual arrangements

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

Local Health organisations	
South Birmingham PCT	• Regular meetings between Chairs and CEOs and appropriate directors • Primary secondary interface group • Community services strategy being implemented and continually revised • Negotiation and implementation of Local Delivery Plan Quarterly finance and quality performance meetings
GPs	• Within South Birmingham, participating and leading work on Rheumatology, Pain and ENT redesigned pathways working in partnership on Diabetes redesign and community hub • Early stages of discussion around provision of GI, TIA, Endoscopy and Community Infusions. • Early stage discussions with Partners at Hall Green Health Centre to agree services that could be delivered within that locality • Working closely with the GPs at Sutton Medical Consulting Centre (Ashfurlong) to further develop the services provided in that locality, e.g. Ophthalmology Rapid Access Service, Neurology and Urology. • Within Sandwell discussions are ongoing with Regent Street Medical Centre and opportunities are being explored with Dudley, Redditch and Bromsgrove Practice Base Commissioning (PBC) Leads
Heart of Birmingham PCT	• Contract with HoB PCT for Orthopaedic Assessment & Treatment Services (OATS). Community based service for minor trauma and musclo-skeletal injuries and provides direct access x-ray & MRI service for GPs in HoB • More complex cases referred to UHB thus increasing our referral market share • Recently been awarded the tender for community cardiology services • Community based ENT, liver medicine and neurology services currently under development • Have lodged an expression of interest in managing Sexual Health Service currently based at Whittal Street Clinic
Birmingham East and North PCT and Specialised Commissioning Agency	• Chief Operating Officer continues to hold regular meetings with the head of the SCA • Exploring potential of improving rehabilitation facilities
West Midlands SHA	• Chair and CEO regularly meet their SHA

	counterparts • Regular performance meetings • Trust developed an 18-week breach sharing protocol that has been adopted throughout the SHA • Helping establish the Quality Observatory
Heart of England Foundation Trust	• Meeting of Executive teams has been held and agreement reached to co-operate on a number of issues including medical staff training and management development • Ongoing discussions with regard to operational issues
Sandwell and West Birmingham Trust	• Continued co-operation with SWBH on the Pan Birmingham Decontamination project • COO holds meetings with SWBH Director of Strategy
Birmingham Children's Foundation Trust	• The Trust is continuing to support BCH with its provision of tertiary paediatric care, where appropriate • Regular operational meetings with Medical Director and Chief Operating Officer to ensure appropriate SLAs in place to support delivery of services • Partner in Proton Therapy Centre project • FD sits on Shared Services Group
West Midlands Ambulance Trust	• Meeting of Chairs and Executive Directors has taken place • Working together to improve turnaround times for patients • Support the WMAT with patient transport • Process developed to record the clinical handover of the patients so that we will be able to robustly monitor performance
National health bodies	
Monitor	• Chair and CEO have met Monitor Chair on a number of occasions • Trust hosted visit by Monitor Chief Operating Officer • Quarterly finance and quality performance meetings to review quarter's performance against plan, national standards and declarations • Regular discussions take place with the Trust's Relationship Manager • The Trust Medical Director is a member of Monitor's working group developing Quality metrics
Healthcare Commission (Care Quality	• Trust hosted visit by Head of Operations • Pilot to be implemented re Learning Disabilities

Commission)	
Department of Health	• Ongoing discussions between key personnel at both organisations • The Trust has agreed two secondments to DH to influence policy and to continue to play an active role in developing Connecting for Health
Collaborative working	• Have working relationships with a number of trusts and the Department of Health to deliver a variety of services
Non NHS contractual Partners	
Consort/Balfour Beatty	• Relationships continue at all levels to ensure the delivery of the New Hospital on time and on budget as well as health and safety issues
B-Braun	• Meetings every two weeks at operational level with UHB Contracts to measure quality standards • Quarterly Joint Management Board with the Pan Birmingham Collaborative and BBraun
University of Birmingham	• Quarterly liaison meetings • The Birmingham Clinical Research Academy has been developed. • Working with Business School to Develop MBA Programme • Progress on ongoing discussions on various agendas are regularly reported to Board of Directors • UoB are partner in Proton Therapy project
Ministry of Defence	• The Trust has established a close working relationship with the Ministry of Defence, including Joint Medical Command (JMC) and the Defence Medical Services Department (DMSD). Under this arrangement the Trust also sub-contracts work to: - Birmingham City University - The University of Birmingham - The Royal Orthopaedic NHSFT - Heart of England NHSFT - Birmingham City and Sandwell NHST (incorporating Birmingham Eye Centre)
FMC Renal Services Limited	• The Trust has worked closely with FMC in the planning of new satellite haemodialysis facilities. A 16-station purpose-built unit opened in Worcester in 2009 and a further unit in Wood gate Valley has just opened • Both of the new satellite units have been designed with the flexibility to house community outpatient

	clinics which will be used by Renal Medicine and associated specialties
Advantage West Midlands/Central Technology Belt	• UHB chairs AWM Innovative Healthcare Group • AWM grant (through European Regional Development Fund) for pan-European "Developing Centres of Excellence project focusing on translational research • AWM and Science City letters of support for HIEC status and Proton Therapy project and support for BCRA • AWM grant support for translational research at UoB through Science City • AWM part-funding of Selly Oak New Road
Birmingham City Council	• Continuing planning relationship • BCC involvement on strategic Transport Task and Finish Group • Improvement of public transport access to QE – working with BCC, Centro and West Midlands Travel • Community Transport link from Kings Norton 3 Estates to the QE and Selly Oak Hospitals – supported by BCC and funded by • Inward investment strategy – integrating medical technology, especially translational research and clinical trialling • Regular attendance at overview and scrutiny committee
Learning and Skills Council	• UHB representation on the Birmingham and Solihull Employer Board • Substantial benefit from work with the LSC through the Joint Investment Fund • Apprentice training funding • LSC awarded £2m Single Public Sector Hub contract for information, advice and guidance to unemployed people to a partnership where the Learning Hub leads on Healthcare for Birmingham and Solihull • Train to Gain support for existing staff
JobCentre Plus	• Continued effective working though Local Employment Partnership (LEP) with JCP • JCP seconds member of staff to the Learning Hub • JCP gives financial support for Learning Hub, particularly auxiliary nurse training programmes • UHB chairs pan-Birmingham Access to Employment Group focusing on LEP grant-aided schemes • Future Jobs Fund (44 FJF posts approved so far at UHB)

Government Office for the West Midlands (GOWM)	• Supported HIEC status and Proton Therapy project • Regional Health Strategy, especially the Employment chapter, which UHB is the co-lead for with the LSC • Regional Procurement Strategy which provides a "tool-kit" for maximising benefits to West Midlands firms from public sector procurement

3. Financial Review

The Trust runs two hospitals, the Queen Elizabeth and Selly Oak, which are situated 1.5 miles apart in South Birmingham.

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

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

3.1 Changes in accounting policies by The Trust in 2009/10

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 2010 and appropriate to NHS Foundation Trusts. This is the first set of full year results prepared in accordance with IFRS accounting policies. The previously reported 2008/09 financial statements have accordingly been restated to comply with IFRS, with the date of transition to IFRS being 1 April 2008, which is the beginning of the comparative period for the year ended 31 March 2010.

The principal effects of the adoption of IFRS are detailed in the reconciliation of taxpayers' equity (assets employed) and retained surplus under UK GAAP to IFRS stated in note 33 to the financial statements.

3.2 Financial Performance

In line with recent years the Trust has again reported strong financial results for 2009/10. Total income has increased by 6.8% to £496.2 million ensuring that the Trust remains amongst the largest foundation trusts in the country. Within this the Trust has achieved an income and expenditure surplus of £13.8 million which equates to 2.8% of turnover. This strong financial performance is expected to result in the Trust achieving an overall Financial Risk Rating of 4 (the second highest rating available) from Monitor.

Strengthening the underlying financial position has been a key objective for the Trust in advance of its move to a new PFI hospital from 2010/11 onwards. The achievement of significant surpluses ahead of the move has not been at the expense of healthcare provision to patients but has been part of the Trust's strategy to generate the cash required to fund a £25 million investment in new medical equipment in the New Hospital and will ensure the Trust is well-placed to manage the future increase in operating costs associated with the PFI.

3.3 Income and expenditure

The table below compares the original planned income and expenditure with the outturn position for 2009/10.

Summary income and expenditure – plan v. outturn

The Trust's Summarised Income and Expenditure (£M's)		
	Plan 2009/10	**Outturn Position 2009/10**
Income	483.3	496.2
Expenditure	-452.9	-468.5
EBITDA	**30.4**	**27.7**
Depreciation	-12.5	-10.9
Impairment	0.0	-1.2
Dividend	-3.3	-2.4
Loss on asset disposal	0.0	-0.0
Interest	0.5	0.6
Net Surplus / (Deficit)	**15.1**	**13.8**

The largest component of the Trust's income is the provision of NHS healthcare, accounting for £393.8 million (79.4%) of the total. Non NHS clinical income contributes a further £15.0 million (3.0%) and this includes private patients, provision of healthcare to the military and costs recovered from insurers under the Injury Cost Recovery scheme.

The Trust has a number of other income streams which are not linked directly to patient care. These include levy funding for education which accounts for £28.8 million (5.8%) of the Trust's income in 2009/10 and income associated with Research and Development (R&D) activities which totals £17.3 million (3.5%). Education funding comprises the Service Increment for Teaching (SIFT), recognising the cost of training medical undergraduates from the University of Birmingham, the Medical and Dental Education Levy (MADEL) which supports the salary costs of post graduate doctors in training and support for Non-Medical Education and Training (NMET). R&D income includes grants from the National Institute of Health Research, support for the Wellcome Trust Clinical Research Facility, and funding for the Birmingham and Black Country Comprehensive Local Research Network, which is hosted by the Trust.

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

The main variances against plan in 2009/10 include additional healthcare income primarily for high cost drugs and devices paid for on a cost-per-case basis and additional healthcare activity from the Ministry of Defence. Both these sources carry corresponding expenditure commitments and therefore do not impact significantly on the Trust's bottom line surplus.

The largest item of expenditure is salaries and wages, accounting for £275.5 million, equivalent to 58.8% of total expenditure. Other significant components include £50.0 million on drugs (10.7%) and £66.1 million on Clinical Supplies and Services (14.1%).

3.4 Capital Expenditure Plan

In 2009/10 the Trust incurred £18.3 million of capital expenditure on new facilities and improving old environments. This is summarised below:

Category	**Capital Invested £ Million**
Brought Forward Programmes from 2008/09	*1.6*
IT Replacement, Modernisation, Infrastructure and additional capacity	*1.4*
Retained Buildings • *Development of Wolfson building* • *Relocation of RRPPS service offsite* • *West End Development* • *Other Works*	 *1.2* *1.7* *1.0* *0.9*
Replacement of Equipment	*4.8*
Modernisation and Discretionary Spend: • *New Equipment* • *Other*	 *9.2* *1.3*
SUB TOTAL	***18.3***

In addition to the above, during 2009/10 the Trust incurred £13.8 million of expenditure on enabling works relating to the New Hospital.

The Trust's planned capital expenditure over the next three financial years (2010/11 to 2012/13) totals £61 million. This plan runs alongside the development of the New Hospital. It is not anticipated that there will be any requirement to borrow against the Prudential Borrowing Limit during these years.

Of the £61 million capital programme, £21 million will be spent on protected buildings which are being retained for continuing use by the Trust.

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

3.5 Value for Money

The Trust's Financial Plan for 2010/11 included the delivery of cash-releasing efficiency savings of 3.5% against relevant budgets. In order to achieve this, a formal cost improvement programme (CIP) totalling £12.0m was agreed for all Divisions and Corporate areas. This programme involved a combination of both cost reduction and income generation schemes.

In addition to the agreed annual cost CIP, further efficiency savings have been realised in the year through initiatives such as ongoing tendering and procurement rationalisation and a review of requests to recruit to both new and existing posts via the Workforce Approval Committee.

The Trust's use of resources is also assessed by the Healthcare Commission as part of the Annual Health Check based on the Financial Risk Ratings' assigned by Monitor. In the latest results published in October 2009 the Trust again achieved a rating of 'Excellent' for the use of resources (based on 2007/08 outturn data).

3.6 Private Patient Income (PPI)

PPI was £2.8 million which is within the authorised limit of 1.23%.

3.7 University Hospital Birmingham Charities

The charitable funds for the Trust are administered by UHB Charities, a separate legal entity from the Trust. In 2009/10 the Trust received grants of £1.1 million from UHB Charities.

3.8 Audit Information

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

3.9 External Auditors

The Trust's external auditors are KPMG LLP. The audit cost for the year is £168,000 of which £86,000 relates to statutory audit services, and £82,000 which relates to non-audit work.

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

3.10 Pensions

The accounting policy for pensions and other retirement benefits are set out in note 1.3.2 to the financial statements and details of senior employees' remuneration can be found in the Remuneration Report in Section 2.

3.11 Going Concern

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

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Julie Moore
Chief Executive

Date 3 June, 2010

Governance

1. NHS Foundation Trust Code of Governance

In September 2006 Monitor, the independent regulator of Foundation Trusts, published the NHS Foundation Trust Code of Governance as best practice advice. The 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 2009/10.

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

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

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

1.1 Application of Principles of the Code

A. The Board of Directors

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

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

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

The Board of Directors remains accountable for all of its functions; even those delegated to the Chairman, individual directors or officers, and

therefore it expects to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.
All powers which are neither reserved to the Board of Directors or the Board of Governors nor directly delegated to an Executive Director, a committee or sub-committee, are exercisable by the Chief Executive or as delegated by her under the Scheme of Delegation or otherwise.

Details of the composition of the Board of Directors and the experience of individual Directors are set out in Board of Directors, page 43, of the Annual Report, together with information about the Committees of the Board, their membership and attendance by individual directors.

B. The Board of Governors

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

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

Details of the composition of the Board of Governors are set out in Governors, page 38, of the Annual Report, together with information about the activities of the Board of Governors and its committees.

C. Appointments and terms of office

The balance, completeness and appropriateness of the membership of the Board of Directors were reviewed during the year by the Executive Appointments and Remuneration Committee. The term of appointment of Tony Huq expired on 30 June 2009 and it was decided to seek a replacement candidate with financial or commercial experience at a senior level within a commercial organisation. This appointment was made by the Board of Governors, on a recommendation from the Board of Governors' Nomination Committee for Non-Executive Directors. Details of the composition of that Committee and its activities are set out on page 53 of the Annual Report. Details of terms of office of the Directors are set out in Board of Directors, page 44, of the Annual Report.

D. Information, development and evaluation

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

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

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

E. Director Remuneration

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

F. Accountability and Audit

KPMG LLP has been appointed by the Board of Governors as the Trust's External Auditor. The Board of Directors has appointed RSM Tenon as internal auditors. The Board of Directors presents a balanced and understandable assessment of the Trust's position and prospects, maintains a sound system of internal control and ensures effective scrutiny through regular reporting directly to the Board of Directors and through the Audit Committee.

G. Relations with Stakeholders

The Board of Directors recognises the importance of effective communication with a wide range of stakeholders, including members of the Trust. Details of interactions with Stakeholders are set out from page 24 of the Annual Report and in Membership, page 54.

1.2 Compliance with the Code

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

C.2.1 The Chief Executive and other Executive Directors should be subject to re-appointment at intervals of no more than five years.

Executive Directors are employed on substantive contracts and are not subject to re-appointment at intervals of no more than five years. The contracts may be terminated on six months' notice.

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

Prior to December 2008, the Board of Governors approved four-year terms of office for Non-Executive appointments. Since then, Non-Executive Directors have been appointed or re-appointed for terms of three years, in accordance with the Code.

Board of Governors

1. Overview

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

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

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

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

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

One by-election was held this year to fill a seat that was vacant. The Governor appointed to the public seat at this by-election was appointed for the remainder of a three year term commencing on 1 July 2009.

During this year, the Governors have been:

1.1 Patient (up to 30 June 2009)

Rita Bayley
Rosanna Penn
Valerie Jones

Paul Darby
Bridget Pearce
Alan Bailey

1.2 Patient (from 1 July 2009)

Shirley Turner
Colin McAllister
Valerie Jones
Jamie Gardiner

1.3 Public (by Parliamentary Constituency – up to 30 June 2009)

Northfield
Margaret Burdett
Vacant

Selly Oak
Brian Hanson
Gwyneth Harbun

Hall Green
David Spilsbury
Martin Straker-Welds

Edgbaston
Geoffrey Oates
Caroline Badley

Ladywood
Shazad Zaman

Perry Barr
Hazel Flinn

Yardley
Kadeer Arif

Hodge Hill
Vacant

Erdington
David Ward

Sutton Coldfield
Joan Walker

1.4 Public (by Parliamentary Constituency – from 1 July 2009)

Northfield
Margaret Burdett
Edith Davies

Selly Oak
Rita Bayley
John Delamere

Hall Green
Ann Durham (resigned 7 March 2010)
Tony Mullins MBE

Edgbaston
Rosanna Penn
Ian Trayer

Ladywood
Shazad Zaman

Yardley
Kadeer Arif

Perry Barr & Sutton Coldfield
Joan Walker

Erdington & Hodge Hill
Monica Quach (from August 2009)

1.5 Staff

(All elected for terms of three years from 1 July 2007)

Professor John Buckels (Medical Class)
Paul Brettle (Clinical Scientist/Allied Health Professional)
Erica Perkins (Nursing Class)
Barbara Tassa (Nursing Class)
Anne Waller (Ancillary, Administrative and Other Staff)

1.6 Stakeholder

Rabbi Margaret Jacobi, appointed by the Birmingham Faith Leaders' Group (succeeding The Most Revd Vincent Nichols, Archbishop of Birmingham) in July 2009)
Professor David Cox, appointed by South Birmingham Primary Care Trust
Professor Edward Peck, appointed by the University of Birmingham
Vice Admiral Raffaelli, appointed by the Ministry of Defence (succeeding General Lillywhite in December 2009)
Cllr James Hutchings, appointed by Birmingham City Council
Ms Ruth Harker, appointed by the South West Area Network of the Secondary Education Sector in Birmingham

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

Name of Governor	No. of meetings attended*
Alan Bailey	None (out of 1)
Rita Bayley	All
Paul Darby	None (out of 1)
Edith Davies	All
Valerie Jones	2 out of 4
Bridget Pearce	All
Rosanna Penn	All
Shirley Turner	All
Jamie Gardiner	All
Colin McAllister	1 out of 3
Gwyneth Harbun	None (out of 1)
Martin Straker-Welds	None (out of 1)
Brian Hanson	All
David Ward	None (out of 1)
Margaret Burdett	All
Hazel Flinn	None (out of 1)
David Spilsbury	All
Geoffrey Oates	All
Kadeer Arif	2 out of 4
Caroline Badley	None (out of 1)
Shazad Zaman	None (out of 4)
Joan Walker	2 out of 4
Anne Durham	1 out of 3
John Delamere	All
Monica Quach	1 out of 3
Tony Mullins	1 out of 3
Ian Trayer	All
Stakeholder Governors	
Cllr James Hutchings	3 out of 4
Prof. David Cox	2 out of 4
Lieutenant General Lillywhite	1 out of 2
Ruth Harker	All
The Most Revd Vincent Nichols	None (out of 1)
Rabbi Margaret Jacobi	2 out of 3
Vice Admiral Raffaelli	All
Prof. Edward Peck	1 out of 4
Staff Governors	
Barbara Tassa	All
Prof. John Buckels	3 out of 4
Paul Brettle	None (out of 4)
Anne Waller	2 out of 4
Erica Perkins	1 out of 4

*While a member of the Board of Governors.

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

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

1.8 Register of Interests

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

Board of Directors

1. Overview

Throughout the year, the Board of Directors comprised the Chairman, six executive and seven Non-Executive Directors. The Chairman has been appointed for a period of four years commencing 1 December 2006.

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

The Board is currently comprised as follows:

Chairman: Sir Albert Bore

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

Non-Executive Directors:
Professor David Bailey
Gurjeet Bains
Stewart Dobson
Angela Maxwell (from 1 July 2009)
David Ritchie
Clare Robinson
Professor Michael Sheppard

Kevin Bolger was appointed as substantive Chief Operating Officer in June 2009.

Tony Huq retired as a Non-Executive Director on 30 June 2009. Ms Angela Maxwell was appointed as a Non-Executive Director on 1 July 2009.

The Non-Executive Directors have all been appointed for terms of three years, with the exception of David Ritchie and David Bailey, who were both appointed for terms of four years, commencing 1 December 2006.

NAME	Date of Appointment/Latest Renewal	Term	Date of end of term
Sir Albert Bore	1 December 2006	4 years	30 November 2010
Tony Huq	1 July 2005	4 years	30 June 2009
Clare Robinson	25 September 2008	3 years	24 September 2011
Stewart Dobson	25 September 2008	3 years	24 September 2011
David Bailey	1 December 2006	4 years	30 November 2010
David Ritchie	1 December 2006	4 years	30 November 2010
Gurjeet Bains	1 December 2008	3 years	30 November 2011
Michael Sheppard	5 December 2007	3 years	4 December 2010
Angela Maxwell	1 July 2009	3 years	30 June 2012

The Board of Directors considers Tony Huq (retired 30 November 2008), Clare Robinson, Stewart Dobson, David Bailey, David Ritchie, Gurjeet Bains and Angela Maxwell to be independent.

2. Board meetings

The board met regularly throughout the year, holding 11 meetings in total.

Directors	No. of meetings attended*
Sir Albert Bore	All
Julie Moore	10 out of 11
Mike Sexton	All
Tim Jones	All
Stewart Dobson	All
Clare Robinson	All
David Ritchie	10 out of 11
Prof Michael Sheppard	7 out of 11
David Rosser	6 out of 11
Tony Huq	1 out of 4
Prof David Bailey**	5 out of 8
Kay Fawcett	10 out of 11
Gurjeet Bains	9 out of 11
Angela Maxwell	4 out of 7
Kevin Bolger	10 out of 11

*While a member of the Board of Directors
**David Bailey was granted a leave of absence from September 2008 to July 2009 with the approval of the Board of Governors

3. The Board of Directors composition

Sir Albert Bore, Chairman

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

Julie Moore, Chief Executive

Julie is a graduate nurse who spent ten years in clinical practice before entering nurse management. During her time as nurse manager and later director, she undertook an MA in Health Services Studies at Leeds University and was seconded to work at the Department of Health on developing nursing roles. After a year in general management, in 1998, Julie became a director in the newly-merged Leeds Teaching Hospitals Trust. She was appointed to the Executive Director of Operations post at University Hospital Birmingham in 2002, where she was responsible for the day-to-day running of two acute hospital sites. University Hospital Birmingham became a foundation trust in July 2004 and Julie's role was expanded and she became the Chief Operating Officer. In July 2006, Julie became acting Chief Executive prior to being appointed as substantive Chief Executive in November 2006. Julie was a Governor at Harborne Hill School from June 2005-December 2008, was appointed Visiting Lecturer at Keele University in March 2009. She was a member of the National Organ Donation Taskforce in 2007 and 2008.

Executive Directors

Kevin Bolger, Chief Operating Officer

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

Kay Fawcett, Executive Chief Nurse

Kay qualified as a Registered General Nurse in 1980 and held a series of clinical posts before moving on to be a Clinical Teacher and then Nurse Tutor, before returning to clinical work as a Lecturer Practitioner and Emergency Care manager in 1995. In 1998, Kay became an Operational Manager at the George Eliot Hospital NHS Trust before joining the Trust in 2000 as Head of Nursing. She became Deputy Chief Nurse in 2002, took a part-time secondment to work with the Director of Nursing at Birmingham and Black Country Strategic Health Authority and in July 2005 took up post as Executive Director of Nursing for Derby Hospitals NHS Foundation Trust. She had responsibility for Nursing and Allied Health Professionals, Infection Prevention and Control, Clinical Governance and Quality, Risk Management and Emergency Planning. In January 2008 Kay was appointed as Executive Chief Nurse at the Trust.

Tim Jones, Executive Director of Delivery

After graduating from University College, Cardiff, with a joint honours degree in History and Economics, Tim joined the District Management Training scheme at City and Hackney Health Authority based at St Bartholomew's Hospital in London. He joined The Royal Wolverhampton NHS Trust in 1992 as Business Manager for Medicine before taking up his first post at the Trust in 1995 as the Directorate Manager for Medicine. In 1999 he became the first Divisional General Manager (now Directors of Operations) for Division Three and was then appointed as the Deputy Chief Operating Officer before becoming Chief Operating Officer in June 2006 (initially in an acting capacity). In September 2008 Tim was appointed as Executive Director of Delivery. His key responsibilities are to lead the Clinical Redesign Programme in preparation for the transition to the New Hospital, developing the Trust's Organisational Development programme and has Board responsibility for Human Resources.

David Rosser, Executive Medical Director

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

Mike Sexton, Executive Director of Finance

Mike, who became FD in December 2006, spent five years in the private sector working for the accountancy firm KPMG and had a brief spell at the Regional Specialities Agency (RSA) before joining the Trust in 1995. Over the last 14 years he has held numerous positions including Finance Manager – Clinical Services, Acting General Manager – Neurosciences and Ophthalmology, Head of Operational Finance and Business Planning, Director of Operational Finance and Performance and Acting Director of Finance.

Non-Executive Directors

Stewart Dobson, Deputy Chairman

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

Professor David Bailey

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

Gurjeet Bains

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

Angela Maxwell

Angela achieved prominence as one of the region's most dynamic entrepreneurs after she powered Fracino, the UK's only manufacturer of espresso and cappuccino machines from a £400,000 turnover in 2005 into a £2.6million world-class leading brand when she sold her interests in 2008. A former European adviser to UK Trade & Investment, a finalist in Businesswoman of the Year 2005, Angela is a Board member of Advantage West Midlands. Acuwomen, her latest enterprise, is the UK's first company to bring an all-women group of entrepreneurs under one roof. Angela is also an accredited business advisor for Business Link and UKTI.

David Ritchie CB

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

Clare Robinson

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

Professor Michael Sheppard

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

4. Directors' Interests

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

Audit Committee

1. Overview

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

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

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

Directors	No. of meetings attended*
Clare Robinson	All
Gurjeet Bains	5 out of 6
David Bailey	3 out of 6
David Ritchie	5 out of 6
Stewart Dobson	All
Mark Santer	3 out of 4
Tony Huq	None (out of 2)
Michael Sheppard	4 out of 6
Angela Maxwell	2 out of 4

*While a member of the Audit Committee

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

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

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

2. Independence of External Auditors

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

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

b) Audit-related and advisory services - projects and engagements where the auditors may be best-placed to perform the work, due to:
   - Their network within and knowledge of the business (e.g. taxation advice, due diligence and accounting advice) or
   - Their previous experience or market leadership

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

Under the policy:

- Statutory and audit-related work assignments do not require further approval from the Audit Committee or the Board of Governors. However, recognising that the level of non-audit fees may also be a threat to independence, a limit of £25,000 will be applied for each discrete piece of additional work, above which limit prior approval must be sought from the Board of Governors, following a recommendation by the Audit Committee.

- For advisory services assignments, the Trust's Standing Financial Instructions (SFIs) Procurement of Services should be followed and the prior approval of the Board of Governors, following a recommendation by the Audit Committee, must be obtained prior to commencement of the work. Neither approval of the Board of Governors nor a recommendation from the Audit Committee will be required for discrete pieces of work within this category with a value of less than £10,000, subject to a cumulative limit of £25,000 per annum.

3. Auditors' reporting responsibilities

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

Nominations Committee

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

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

The Nomination Committee for Non-Executive Directors comprises the Chairman and four Governors of the Trust. The Chairman chairs the committee, save when the post of chairman is the subject of nominations, in which case the committee is chaired by the Governor Vice-Chair (Brian Hanson up to 30 June 2009 and Margaret Burdett from 1 July 2009). The other members of the committee for the year ended 31 March 2010 were Erica Perkins, Ruth Harker and Margaret Burdett (up to 30 June 2009), and Shirley Turner, Ian Trayer, Erica Perkins and Ruth Harker (from 1 July 2009).

The Committee met twice during the year. All Committee members in office at the relevant times attended all Committee meetings with the exception of Erica Perkins and Ruth Harker who each attended one of the two meetings.

During the year, the Committee oversaw the appointment of one new Non-Executive Director. The Committee approved the recommendation of the Executive Appointments and Remuneration Committee that an appointee should be sought with financial/commercial experience at a senior level in a commercial organisation. Following open advertisement of the post, the Committee met to discuss and shortlist the applications, interview short-listed candidates and determine whether a recommendation should be made to the Board of Governors. The Committee decided to recommend to the Board of Governors that Angela Maxwell be appointed as a Non-Executive Director of the Trust for an initial period of three years.

2. Nominations Sub-Committee

The Executive Appointments and Remuneration Committee appointed a Nominations Sub Committee to deal with the substantial appointment of a Chief Operating Officer. The Nominations Sub Committee consisted of the Chairman, the Chief Executive, Gurjeet Bains and Clare Robinson. The Nominations Sub Committee met once during the year and all members were in attendance.

Membership

1. Overview

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

Public Constituency

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

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

Staff Constituency

The staff constituency is divided into four classes:

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

Patient Constituency

Patient members are individuals who are:

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

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

2. Membership Overview by Constituency

Constituency	Total at 31/03/10	%	% change from previous year
Public	11,623	48.9	51.0
Patient	4,751	20.0	19.2
Staff	7,380	31.1	15.1
Total Membership	**23,754**	**100**	**31.5**

*Numbers correct up to 31 March 2010

3. Membership Strategy

3.1 Background

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

In July 2007 the Board of Directors and Board of Governors approved a new Membership Strategy. The key component of the strategy was to rationalise the membership to those who explicitly expressed a wish to be a member of the Trust.

Those people would then form the basis of a new membership that would be active, effective and value for money, one which the Trust could genuinely engage with, ensure was representative and then grow, over the coming months and years.

There was an acceptance that this was likely to result in a significant reduction in the number of members. This was articulated in the Trust's 2007/08 Annual Plan and Annual Report to Monitor.

3.2 The process

Three data capture mail-outs were issued to the 81,000-strong membership in May 2007, September 2007, and February 2008, asking members to fill in the required fields of information and indicate whether they wished to continue to be a member.

In April 2008, the Board of Directors and Board of Governors were informed that the above exercise had resulted in circa 8,000 people responding (excluding circa 6,900) staff. It was agreed by the Board of Directors and Board Governors that a fourth mail-out should be issued, asking one question only: 'Do you wish to be a member of Queen Elizabeth and Selly Oak hospitals?'

This exercise resulted in circa 11,500 people (excluding circa 6,900 staff) who actively wanted to remain a member of Queen Elizabeth and Selly Oak hospitals. This total of circa 18,000 (inclusive of staff) was significantly less than the 35,000 which was expected and articulated to Monitor in last year's Annual Plan and Annual Report.

In September 2008 the Trust went out to tender for a new database management company following persistent concerns with its existing provider. The key issues were: poor quality data, significant number of duplicate names, lack of robust cleansing of the database. Active were appointed in October 2008. A month later Active were taken over by Capita.

3.3 Membership recruitment campaign 2009/10

In November 2008 the Trust started to develop a membership recruitment campaign to increase membership to 35,000 in 12 months from March 2009.

The objectives of the campaign, launched in June 2009, was to provide a representative, quality, value-for-money membership that can help the Trust realise its vision of delivering the best in care.

The membership recruitment campaign adopted an 'inside-out' approach, first targeting those who already have an association/empathy with the hospitals (current members, visitors to the hospitals, stakeholder groups), in the belief this was most efficient and cost effective way of recruiting quality members.

Membership was split into four categories: thought donor, time donor, support donor, energy donor with each category having an indicative menu of the types of initiatives members could get involved with depending on which type of membership they opted for.

The membership recruitment strategy was linked with the recruitment of volunteers, charity fundraising strategy and the Trust's community visits programme to maximise all opportunities and ensure a 'joined-up' approach.

A number of recruitment channels were used with the most-effective being direct mail-outs to strategically targeted groups to ensure a representative membership and current patients, as well as recruitment 'days' within the hospital.

In March 2009 the Trust had 18,070 members. By March 2010 some 7,794 new patients, staff and members of the public had chosen to become a member of UHB. This represents a 43% increase on this time last year.

However 2,110 members had to be taken off the database, again mainly due to the fact that members had died or moved away.

Therefore the net total number of members at UHB as of March 31, 2010 was 23,754, an increase of over 31%.

3.4 Membership plans 2010/11

- To maintain the current number of quality members through the most effective and cost-efficient means
- To recruit an extra 5% of quality members
- To use the current membership to deliver tangible benefits for the members and for the Trust by strategically using the detailed membership database that has been established over the last 12 months.
- The membership database will drive the most effective communication and engagement strategy

3.5 Contact procedures for members who wish to communicate with governors and/or directors

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

- Face-to-face interaction at monthly Members' Seminars. Governors attend these meetings and use them as a 'surgery' for members
- Governors' Drop-in Sessions. New in 2008/09, these sessions are held on a monthly basis at either the Queen Elizabeth or Selly Oak hospitals. A mix of staff, patient and public governors 'set up camp' and talk to, advise, and take comments from staff, patients and visitors. These are then fed back to the Executive Directors for comment/action
- The Annual General Meeting
- Telephone, written or electronic communications co-ordinated through the Communications office which then steers members to the appropriate Governor/Director
- 'Trust in the Future' magazine – highlights a Governor each issue
- InsideOut magazine – runs an article In The Hot Seat, which is a questionnaire with a different governor. It also gives their contacts details
- Direct email and helpline number to the Members' Register management company who take any kind of membership query and then feed back into the Trust to action
- Chief Executive hotline – phone communication for queries, comments and ideas
- In 2010/11 Governors will start to attend community presentations in relation to the hospital/patients issues held their constituency

3.6 Healthcare talks for Foundation Members

Each month the Trust holds healthcare talks to which all members of the Foundation Trust are invited to attend. The seminars cover many different topics from healthcare issues such as healthy eating and exercise, infection prevention and control, diseases affecting the kidneys, to information about hospital services, such as the clinical decision unit, to new technology and developments in medical treatment.

The monthly events feature an hour-long presentation and a 30-minute question and answer session to enable members to air their views and ask the experts. The sessions are also a great opportunity for the governors to meet members.

Quarterly evening seminars were introduced in March 2009 to capture members who find it difficult to attend during the day due to work or child care commitments.

Sustainability/climate change

1. Overview

UHB aims to deliver the best in care and do this in a way which reduces disadvantage and increases prosperity and the sustainability agenda is part of this overall approach.

Sustainable development is an approach to business, whether public or private sector, that ensures minimal impact on the environment, maximum benefit for the health of employees and local communities, and does not compromise the opportunities for future generations.

In practical terms the Trust sees sustainable development as focusing on:

- ensuring buildings conform to best standards of sustainability and energy efficiency and waste is minimised
- reducing the harmful effects of transport
- procuring goods and services locally where possible and from organisations that encompass the principles of sustainability
- a workforce strategy which embeds sustainability through effective policies for a healthy workplace, valuing the workforce, diversity and inclusion, learning and development and broadening access for disadvantaged groups to the jobs healthcare can offer
- community engagement and participation
- considering sustainability during the formulation of the Trust's plans

There is a strong business case for enhanced action on sustainable development by UHB. This includes financial savings, improved staff morale, a healthier local population, reducing disadvantage and increasing local prosperity.

The Sustainable Development Commission has developed a Good Corporate Citizenship (GCC) Assessment Model especially for use within the NHS to help take a comprehensive approach to all aspects of sustainable development. The Trust scores highly as regards the buildings, facilities management and workforce elements of the GCC Index. The challenges of balancing energy savings against best value for procurement and reducing the carbon impact of business and visitor travel associated with a major hospital are recognised.

The new Queen Elizabeth Hospital Birmingham will meet the Department of Health energy efficiency target of 35-55GJ/100m3, at 54.9 GJ/100m3. Sustainability has been built in from the start. For example, wards have been built in an elliptical shape around inner courtyards to maximise natural light throughout. The ventilation system has been designed to minimise use of air conditioning and the lighting strategy designed to include installation of movement detectors in lower use areas. Demolition materials and excavated

materials have been re-used in earthworks and landscaping. The new hospital grounds will incorporate green spaces including one of the largest plazas in Birmingham. Whole-life costing methods have been used.

The Trust's Learning Hub building has been made of 80% sustainable materials and features innovative natural ventilation chimneys, a green roof and solar panels. The New Hospital project team use whole-life costing methods and the New Hospital grounds will incorporate green spaces including one of the largest plazas in Birmingham.

UHB has also focussed on addressing transport issues in order to reduce car usage and improve accessibility, especially from disadvantaged areas, by public transport. Agreement has been reached with CENTRO and National Express to improve bus services accessing the Queen Elizabeth site. The Trust has worked with Community Transport to run a successful scheme providing minibus access from the Kings Norton Three Estates to take residents to and from health appointments, jobs and training at the Trust. The Trust has a Green Travel Plan and is working with CENTRO to update this.

The environmental impact of waste is taken very seriously by UHB – especially reducing the amount of waste sent to landfill. This is a significant factor considered when awarding contracts for waste services. UHB is classified as an A rated Trust for carbon emissions/footprint associated with waste/water.

Carbon reduction crosses many components of sustainable development outlined above and is important in its own right because of the threats being posed by climate change.

The NHS provides enormous opportunities for action in sustainable development and reduction of greenhouse gas emissions. Nationally, the NHS has a carbon footprint of 21 million tonnes a year CO2 equivalent gasses. This is larger than some medium-sized countries. Work by the NHS Sustainable Development Unit indicates that these emissions are split as follows: 24% building energy, 17% transport and 59% procurement. Government has set challenging national targets for NHS England to reduce its emissions:

- a 10% reduction by 2015 from 21 million tonnes of CO2 equivalent (21mtCO2e) to 19 million tonnes
- an 80% reduction in CO2 equivalent gasses by 2050 which would reduce NHS England emissions to around 4m tonnes a year

April 2010 sees the introduction of the national Carbon Reduction Commitment (CRC) scheme - a new mandatory emissions trading scheme for the UK. UHB has been involved in carbon trading for some time and is fully aware of the importance of the CRC in terms of reducing energy and efficiency savings.

The Trust is working with the Carbon Trust. An initial scoping study has already begun. This will provide the background information for UHB – working with the Carbon Trust – to develop a full Carbon Management Programme. The Carbon Management Programme will be completed by the end of the 2010/11 financial year and will provide detailed measurement of UHB's carbon footprint together with a strategic approach to reducing this carbon footprint and a detailed action programme with specific targets.

The Trust is also working in partnership with the Carbon Trust and has a Sustainability Group in place to implement Saving Carbon, Improving Health.

The current Sustainability Group is chaired by the New Hospitals Project Director. Its members are the Executive Director of Delivery, Executive Director of Finance, Head of Estates, Learning and Development Manager and Head of Regeneration.

2. Energy Usage and Expenditure 2008/09 to 2009/10

University Hospitals Birmingham						
		2008/09	**2009/10 Estimate**		**2008/09**	**2009/10 Estimate**
Waste minimisation and management	Total amount of waste produced (tonnes)	2,626	2,650	Expenditure on waste disposal	£ 620,700	£ 677,500

					£	£
Finite Resources Purchased	Water (cu m)	287,072	256,000	Water	490,290	671,000
	Electricity (GJ)	69,828	113,175	Electricity	2,017,268	2,600,000
	Gas (GJ)	244,963	187,872	Gas	1,904,127	1,500,000
	Oil (GJ)	4,500	464	Oil	30,877	4,000
	Coal (GJ)	110,204	95,576	Coal	427,428	132,000
				Total Cost	4,379,699	4,907,000

NB Waste and Energy data for 2009/2010 is not scheduled to be returned to the Department of Health until 30 June 2010 and most data is still being collated and validated. Hence all data for 2009/2010 is estimated.

The table above compares waste and energy use between 2008/09 and 2009/10. Waste produced is estimated to have increased by some 9% - largely associated with the move to the New Hospital. The best estimate for energy is for a 62% increase in electricity purchased and a 77% fall in gas purchased. This is explained by changed energy supply arrangements. Prior to September 2008 the Trust operated coal-fired steam boilers and a gas-fired combined heat and power plant (CHP) to generate steam and electricity. This reduced the amount of electricity purchased and increased the amount of gas (gas includes fuel used to generate electricity). In September 2008 the CHP and coal-fired boilers were decommissioned and now new gas fired boilers generate steam for the hospital and all electricity is purchased from the national grid.

Equality and Diversity

1. Overview

University Hospitals Birmingham NHS Foundation Trust is committed to delivering equality of opportunity for all staff and service users and is the responsibility of the Executive Director of Delivery. Equality of opportunity underpins three of our strategic aims and objectives which are:

- to improve access and facilities via capacity expansion and public/private joint ventures
- to reduce inequalities in Birmingham, which will enable us to better understand and remove barriers to access for patients from all demographical backgrounds
- to improve the working lives of our staff

Equality and Diversity are a component part of the Trust's Values which are Honesty, Respect, Innovation and Responsibility. Through our Annual Action Plan, and a particular focus on Inclusion, the Trust looks to build on the work conducted prevously and ensure that patients staff, and public are treated both fair and equitably.

The Trust publishes on its website the following information (which can be accessed from a prominent link on the homepage www.uhb.nhs.uk):

- Single Equality Scheme (SES)
- Race Equality Scheme – which the SES incorporates
- Gender Equality Scheme – which the SES incorporates
- Statements regarding Disability and Age schemes which have been incorporated into the SES
- Annual Equality Report which reviews previous action plans laid down by the Trust and sets out the annual action plan
- Workforce demographics that are included in the Annual Report
- Contact details for enquiries around Equality and Diversity matters
- Equal Opportunities of Employment statement and the Disability Two Ticks commitment
- Equality Impact Assessments results
- Recruitment analysis by Race
- Staff disciplinary and grievance monitoring report
- A review of arrangements in the Trust around safeguarding children
- Useful links page around Foreign Languages

This meets the requirements for the Trust's publication duties.

2. Summary of performance

The table below lists the Trust's workforce and membership statistics by age, ethnicity; gender and disability (staff recorded disability). This information and more below was included in the Annual Equality Report 2009/10 which was publicly released in March 2010.

	Staff 2008/09	%	Staff 2009/10	%	Membership (patient and public) 2008/09	%	Membership (patient and public) 2009/10	%
Age								
16 - 17	4	0.1	1	0.01	0	0.00	8	0.05
17-21	149	2.1	125	1.74	43	0.37	170	1.08
22+	6,802	97.8	7,076	98.25	11,480	99.63	15,493	98.86
Not known	0	0	0	0	115		703	
Ethnicity								
White	5,049	76.05	5,258	74.88	7,135	93.22	10,618	67.76
Mixed	96	1.45	105	1.50	13	0.17	111	0.71
Asian or Asian British	756	11.39	845	12.03	381	4.98	1,189	7.59
Black or Black British	504	7.59	539	7.68	67	0.88	397	2.53
Other	234	3.52	275	3.92	58	0.76	128	0.82
Not known					3,984		3,931	
Gender								
Male	1,981	28.5	2,070	28.74	5,390	46.32	7,616	46.49
Female	4,974	71.5	5,132	71.26	6,247	53.68	8,714	55.61
Not specified	0	0	0	0	1		46	
Recorded Disability	45	0.65	136	1.89				

* Percentages exclude numbers "not known" or "not specified" in some categories. These figures do not include Bank Staff.

3. Future priorities and targets

The Trust's key priorities for 2010/11 have a particular focus on Inclusion, both within our current workforce and future potential job applicants. We will be publishing our revised Single Equality and Human Right Scheme, including a three-year plan, later in the year, and will be working on a variety of service improvement projects including improving the effectiveness of the Equality Impact Assessment process and building the awareness of Human Rights and Learning Disability within the organisation.

4. Performance monitoring of Equality and Diversity

Performance is monitored in a variety of different methods including:

- Bi-monthly review of the Annual Equality Report Action Plan by the Trust Diversity Group
- Workforce statistics are reviewed on a monthly basis by the Executive Director as part of the HR KPI report
- Recruitment statistics are reviewed every 6 months
- The Annual Equality Report Actions are reviewed by the Chief Executive Advisory Group
- Pertinent issues around Equality and Diversity are monitored by the Strategic Delivery Group on a monthly basis

Staff Survey

1. Overview

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

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

The results of the Care Quality Commission 2009 National Staff Survey read very positively for the Trust with 28 out of 40 indicators in the highest 20% or above average. The Trust also improved in 14 areas.

The survey was completed by 446 staff which represented a response rate of 54.7%; average national response rate for acute trusts was 55%.

The Trust also performed well compared to other acute trusts in staff feeling that senior management communicate well with staff, appraisals and personal development planning, feeling that they get good support from their managers and the quality of job design.

Although the numbers are small, the Trust is concerned that staff are experiencing discrimination, bullying and harassment and is working with its trade unions to address these alongside issues relating to physical violence from patients and staff working extra hours.

Top 4 ranked scores	**2009 Score**	**2008 Score**	**+/-**	**National Average**
% feeling satisfied with the quality of work and patient care they are able to deliver	83%	75%	⇧	74%
% agreeing that their role makes a difference to patients	93%	91%	⇔	90%
% receiving health & safety training in last 12 months	74%	68%	⇧	76%
% that would recommend the Trust as a place to work or receive treatment	3.79	N/A	N/A	3.50

Bottom 4 ranked scores	2009 Score	2008 Score	+/-	National Average
% experiencing physical violence from patients/relatives in the last 12 months	11%	12%	⟺	11%
% experiencing harassment , bullying or abuse from staff in the last 12 months	20%	20%	⟺	18%
Working extra hours	72%	67%	⟺	65%
% experiencing discrimination at work in the last 12 months	10%	8%	⟺	7%

2. Future priorities and targets

The Trust recognises that staff feedback is an important starting point to improving the staff experience and an action plan for 2010/11 has been developed, agreed by the Chief Executive at her advisory group and is being implemented.

The action plan concentrates on five key areas and each concern has action points, a lead, timescales and measurements set against it.

The five key areas are as follows:

- % of staff working extra hours
- % of staff experiencing discrimination at work
- % of staff experiencing discrimination at work continued
- % of staff experiencing physical violence from patients
- % of staff experiencing bullying and Harassment

Regulatory ratings

1. Explanation of ratings

1.1 Finance Risk Rating

When assessing financial risk for the period 2009/10 Monitor assigned a risk rating using a scorecard which compared key financial metrics. The risk rating was intended to reflect the likelihood of a financial breach of the Authorisation.

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

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

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

1.2 Governance Risk Rating

Monitor's assessment of governance risk in 2009/10 was based predominantly on the NHS foundation trust's plans for ensuring compliance with its Authorisation, but also reflects historic performance where this may be indicative of future risk. Monitor considers seven elements when assessing the governance risk:

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

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

1.3 Mandatory Services Risk Rating

When assessing mandatory services in 2009/10, Monitor considered two key elements:

1. Changes to mandatory service provision will trigger a requirement for a variation of the Authorisation. Monitor may evaluate a specific risk where the proposed service change has a material impact on the NHS foundation trust's business plan.

2. Disposals of protected assets (or removal of protected status) will trigger the asset protection process. This is to ensure that asset disposals affecting mandatory services undergo a formal structured approval process.

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

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

The tables below shows the risk ratings for UHB under the categories of Finance, Governance, and Mandatory Services identified in the Annual Plan and the quarterly self-certifications in 2008/09 and 2009/10. Additional detail is provided where risks are declared and have a contribution to the risk rating against the three categories.

1.5 Risks Declared in 2008/09

	Annual Plan 2008/09	Q1 2008/09	Q2 2008/09	Q3 2008/09	Q4 2008/09
Financial Risk Rating	5	5	5	5	5
Governance Risk Rating	Amber	Amber	Amber	Green	Green
Mandatory Services	Green	Green	Green	Green	Green

1.6 Governance Risks Declared in 2008/09

	Annual Plan 2008/09	Q1 2008/09	Q2 2008/09	Q3 2008/09	Q4 2008/09
Governance Risk Rating	MRSA C.difficile Thrombolysis	MRSA C.difficile Thrombolysis	C.difficile Thrombolysis	Thrombolysis 4 hour A&E	Cancer 31 day Cancer 62 day

In 2008/09, UHB declared and achieved low risk ratings for finance and mandatory services. With regard to the governance risk rating, this was declared as Amber in the Annual Plan due to risks associated with achievement of the national targets for MRSA, C.difficile, and Thrombolysis for people suffering a heart attack. A risk was also declared for the 4 hour A&E target as part of the quarter 3 self-certification. Due to effective contingency planning and performance improvement all of these targets were met for the year. The Trust declared the 31 day decision to treat to start of treatment cancer target, and the 62 day referral to treatment cancer target in quarter 4, however, Monitor did not include these in the assessment process to derive the Trust's governance rating.

1.7 Risks Declared in 2009/10

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

1.8 Governance Risks Declared in 2009/10

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

In 2009/10, UHB declared low risk ratings for finance and mandatory services. A risk was declared regarding achievement of the national 4 hour A&E target, resulting in a green Governance rating. As part of the quarterly self-certifications, risks were declared against the 2 week, 31 day, and 62 day cancer targets. Again due to effective planning, the A&E and cancer targets were met for the full year.

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

Achievement of the 4-hour A&E target was declared as a risk in the 2009/10 Annual Plan due to the unpredictability of emergency pressures that can cause significant spikes in activity and impact on achievement of the target. The Trust undertook a process of contingency planning to address the activity pressures and this supported the achievement of the target for the full year.

The cancer targets were declared as risks in 2009/10 via the quarterly self-certifications due to the change in methodology introduced that removed a number of existing waiting time adjustments that were valid under the previous methodology and the fact that operational thresholds had not been set at that point. Also, as a tertiary centre, the Trust receives a high number of patients being referred from neighbouring trusts late along the pathway which has an impact on target. UHB undertook contingency planning to mitigate the impact of these issues and the cancer targets were met for the full year.

1.10 Details and actions from any formal interventions

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

Public Interest Disclosures

1. Consultation

The Trust believes that communication and consultation with staff and its representatives are an essential part of delivering the best in care. This is supported by its vision and values.

The Trust conducts an annual staff survey, publishes the results to staff and implements an action plan each year. In the 2009 survey 93% of staff indicated that the work they do makes a positive difference to patient care and were recognised as being in the best 20% of acute Trusts nationally for this indicator.

The Trust has a monthly newspaper, 'Inside Out' which is widely circulated and a weekly e-newsletter, 'In the Loop', that contain a wide range of information for staff much of which encourages staff engagement in a wide range of service developments and activities. This includes training and promotional opportunities and services for staff.

Each month the Chief Executive holds a Team Briefing for senior managers who are required to cascade the information given to their teams. This is supported by a written briefing which is circulated around the Trust.

The Trust has a formal structure for engaging with the recognised Trade Unions. This includes a Trust-wide group - The Trust Partnership Team - which comprises Directors, senior managers and representatives from the Trade Unions. Each Division has a Consultative Committee. These meet monthly. The Trust also has a Joint Local Negotiating Committee which deals with matters relating to medical staff. This meets quarterly.

The Trust is making significant progress in ensuring that the workforce is ready for the move to the New Hospital. Workforce plans have been developed to ensure it has the right staffing levels and skills for when it moves into the New Hospital. These are focused on a range of developments including new services and new modes of care. There is significant engagement with staff and staff representatives in this work.

2. Policies in relation to disabled employees and equal opportunities

The Trust's Single Equality Scheme was approved by the Board of Directors in July 2008 and is being re-launched in the Summer of 2010. The scheme covers its responsibilities to employees with disabilities and all other diverse groups.

Disabled employees have regular access to the Trust's Occupational Health Services including ergonomic assessment of the workplace to ensure that access and working environment is appropriate to their needs. Staff who become disabled whilst in employment have access to these services and

are also supported in moving posts with appropriate adjustments, should it become inappropriate for them to continue in their original post.

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

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

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

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

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

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

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

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

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

The Learning Hub provides employment placement programmes for a six-week period for members of the local community who are looking for work. During this period trainees will be able to experience first hand job roles available within the hospital. They will also receive advice and guidance on life coaching skills, career guidance and job preparation, practical support and mentoring. The Trust's Single Equality Scheme and associated information is available on our website www.uhb.nhs.uk

3. Public and patient involvement activities

Please see Public and Patient Involvement activities under Patient Care on page 21

4. Sickness absence

The Trust recorded an annual average sickness absence of 4.39% across all clinical and corporate divisions.

5. Cost allocation

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

6. Serious untoward incidents – Information Governance

The Trust has had no Information Governance Serious Untoward Incidents involving personal data as reported to the Information Commissioner's Office in 2009/10.

The table below sets out a summary of other personal data related incidents in 2009-10

SUMMARY OF OTHER PERSONAL DATA RELATED INCIDENTS IN 2009-10		
Category	**Nature of incident**	**Total**
I	Loss/theft of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	
II	Loss/theft of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	
IV	Unauthorised disclosure	
V	Other	1

7. Health and Safety

The staff incident rate for 2009/10 was 15.02 incidents per 100 staff. No Improvement Notices were issued by the Health and Safety Executive (HSE).

The most common injuries sustained by staff remain unchanged and relate to inoculation and musculo-skeletal injuries. Trials of safety cannulae and needles are being undertaken in some clinical areas to reduce inoculation injuries and the products will be evaluated by the Trust Medical Equipment Group. The New Hospital is designed to reduce the risk of injury from moving and handling activities by the inclusion of ceiling track hoists and height adjustable baths and training for clinical staff in the use of this equipment is scheduled to commence prior to the move.

An internal systems audit to measure compliance with health and safety legislation is established and any ward or department found to be less than 75% compliant is issued with an action plan to improve their compliance within a three month time scale when they are then re-audited.

Swine Flu vaccination was made available to all frontline staff as close to their place of work as possible to reduce any disruption to services and this resulted in 41.4% of staff being vaccinated.

8. Countering fraud and corruption

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

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

9. Better Payment Practice Code

	Number	**£000**
Total bills paid in the year	95,539	201,652
Total bills paid within target	94,269	199,643
Percentage of bills paid within target	98.67	99.00

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

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

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

11. Management costs

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

SECTION 2

Remuneration Report 2009/2010

1. Executive Appointments and Remuneration Committee

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

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

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

The Executive Appointments and Remuneration Committee met regularly throughout the year, holding five meetings in total.

Directors	No. of meetings attended*
Albert Bore	All
Julie Moore	All
Clare Robinson	All
Tony Huq	None (out of 2)
Stewart Dobson	3 out of 5
David Bailey**	3 out of 5
David Ritchie	1 out of 3
Michael Sheppard	2 out of 5
Gurjeet Bains	All
Angela Maxwell	All

*While a member of the Executive Appointments and Remuneration Committee

**David Bailey was granted a leave of absence from September 2008 until July 2009 with the approval of the Board of Governors

2. Executive Remuneration Policy

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

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

Executive Directors are on substantive contracts with a notice period of six months. Each Director has annual objectives which are agreed by the Chief

Executive. Reviews on performance are quarterly. The Chairman agrees the objectives of the CEO and associated performance measures.

There were no termination payments to Senior Managers and the Contracts do not stipulate that there is any entitlement to them. No significant awards and no compensation for loss of office were made to Senior Managers during 2009/10.

3. Pensions

All the executive directors are members of the NHS Pensions Scheme. Under this scheme, members are entitled to a pension based on their service and final pensionable salary subject to HM Revenue and Customs' limits. The scheme also provides life assurance cover of twice the annual salary. The normal pension age for directors is 60. None of the Non-Executive Directors are members of the schemes. Details of the benefits for executive directors are given in the tables provided on page 80 and 81.

5. Salary and Pension Entitlements of Senior Managers

A. Remuneration

Name and Title	Year Ended 31 March 2010			Year Ended 31 March 2009		
	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100
SENIOR MANAGERS						
Julie Moore, Chief Executive	210-215	0	0	205-210	0	0
Mike Sexton, Executive Director of Finance	135-140	0	0	135-140	0	0
Tim Jones, Executive Director of Delivery (commencing 01/09/2008)	135-140	0	0	75-80	0	0
Tim Jones, Chief Operating Officer (up to 31/08/2008)	0	0	0	55-60	0	0
Kay Fawcett, Chief Nursing officer	120-125	0	0	120-125	0	0
Kevin Bolger, Chief Operating Officer (commenced office 01/09/2008 in acting capacity, appointed 15/06/2009 on permanent basis)	130-135	0	0	75-80	0	0
Dr David Rosser, Executive Medical Director	85-90	95-100	0	85-90	95-100	0
David Burbridge, Director of Corporate Affairs	90-95	0	0	90-95	0	0
Fiona Alexander, Director of Communications	95-100	0	0	95-100	0	0
Morag Jackson, New Hospitals Project Director	115-120	0	0	115-120	0	0
Sam Chittenden, Director of Strategic Developments (commenced office 24/3/2008, left office 1/11/2009) **	65-70	0	100	115-120	0	100
Caroline Wigley, Director of Organisation Development (Left office 31/08/2008)	0	0	0	50-55	0	0
Mike Sharon, Director of Policy, Planning and Performance Management (Left office 01/02/2009)	0	0	0	85-90	0	0
NON EXECUTIVE DIRECTORS						
Sir Albert Bore, Chairman	50-55	0	0	45-50	0	0
David Bailey *	10-15	0	0	5-10	0	0
Stewart Dobson	15-20	0	0	10-15	0	0
Gurjeet Bains (commenced office 1/12/2008)	10-15	0	0	0-5	0	0
Professor Michael Sheppard	10-15	0	0	10-15	0	0
Angela Maxwell (Commenced office 01/07/2009)	10-15	0	0	0	0	0
David Ritchie	10-15	0	0	10-15	0	0
Clare Robinson	15-20	0	0	10-15	0	0
Rev Mark Santer (Left office 30/11/2008)	0	0	0	5-10	0	0
Tony Huq (Left office 30/06/2009)**	0-5	0	0	10-15	0	100

B. Pension Benefits

Name and title	Real increase in pension at age 60 (bands of £2500) £000	Real increase in pension related lump sum at age 60 (bands of £2500) £000	Total accrued pension at age 60 at 31 March 2010 (bands of £5000) £000	Total accrued pension related lump sum at age 60 at 31 March 2010 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2009 £000	Cash Equivalent Transfer Value at 31 March 2010 £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension To nearest £100
Julie Moore, Chief Executive	0-2.5	5-7.5	75-80	230-235	1,407	1,554	79	N/A
Mike Sexton, Executive Director of Finance	2.5-5	7.5-10	45-50	135-140	819	944	74	N/A
Tim Jones, Director of Delivery	0-2.5	5-7.5	25-30	85-90	411	485	45	N/A
Kay Fawcett, Chief Nursing officer	0-2.5	2.5-5	45-50	145-150	900	994	50	N/A
Kevin Bolger, Chief Operating Officer	5-7.5	17.5-20	45-50	135-140	745	939	123	N/A
Dr David Rosser, Medical Director	0-2.5	2.5-5	45-50	140-145	722	803	44	N/A
David Burbridge, Director of Corporate Affairs	0-2.5	2.5-5	10-15	40-45	206	241	20	N/A
Fiona Alexander, Director of Communications	0-2.5	2.5-5	0-5	15-20	56	79	15	N/A
Morag Jackson, New Hospitals Project Director	0-2.5	2.5-5	30-35	95-100	535	600	36	N/A
Sam Chittenden, Director of Strategic Developments (left office 01/11/09)	0-2.5	0-2.5	20-25	60-65	333	384	20	N/A

Details above are provided by the NHS Pensions Agency.

6. Non-Executive Directors' remuneration

Non-Executive Directors' remuneration consists of fees which are set by the Board of Governors. The Board of Governors has established a committee, the Board of Governors Remuneration Committee for Non-Executive Directors, to advise the Board of Governors as to the levels of remuneration for the Non-Executive Directors. NED fees are reviewed each year with advice taken from independent consultants where appropriate. In addition to the Chairman (who does not attend when the committee considers matters relating to his own remuneration), the Committee comprised Brian Hanson, Barbara Tassa, David Spilsbury and James Hutchings, up until 30 June 2009, and Margaret Burdett, Jamie Gardiner, Ian Trayer, John Buckels and James Hutchings, from 1 July 2009. It met once during the year and all members attended that meeting.

…….. ……

Julie Moore, Chief Executive June 3, 2010