AGENDA ITEM No.

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 26 MAY 2011

Title:	**DRAFT TRUST ANNUAL REPORT 2010/11**
Responsible Director:	Fiona Alexander, Director of Communications
Contact:	Director of Communications, ext 14325

Purpose:	To provide the Board of Directors with the draft of the Trust's Annual Report 2010/11 that will be submitted to Monitor
Confidentiality Level & Reason	
Medium Term Plan ref:	N/A
Key Issues Summary:	• This is the Trust's draft Annual Report 2010/11 written in line with Monitor's Foundation Trust Financial Reporting Manual 2010/11 (FT FReM) • The guidance is very prescriptive, hence the detail included is not as 'user-friendly' as one would like. It is also repetitive in places, in line with Monitor's requirements • To remedy this, the Trust will publish an Annual Review which will be presented at the AGM in September. This will be a 'reader-friendly' summary of the performance of the Trust over the past 12 months and will be distributed to a much wider audience, in several formats. • The report and accounts document is still to be designed before being submitted to Parliament. • The first draft of the Annual Report 2010/11 was presented at the May Audit Committee.
Recommendations:	The Board of Directors is requested to **APPROVE** the draft of the Trust's Annual Report 2010/11 subject to consideration and approval of the Audit Committee on 2 June 2011.

Signed:		**Date:**	

University Hospitals Birmingham NHS Foundation Trust

Annual Report and Accounts

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

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

University Hospitals Birmingham NHS Foundation Trust

Annual Report and Accounts 2010/11

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Directors' Report

1. Overview

1.1. Names of persons who were Directors of the Trust

The Board is currently comprised as follows:

Chairman: Sir Albert Bore

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

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

1.2 Principal activities of the Trust

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

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

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

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

1.3 Royal Centre for Defence Medicine

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

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

1.4 Research and Development

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

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

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

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

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

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

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

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

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

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

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

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

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

The QEHB Charity has continued to support research projects and awarded £1 million in grants to the Trust and University of Birmingham during 2010-11. The latest awards, in March 2011, totalled more than £521,000.

A full summary of the Trust's R & D activities in the last 12 months is available on the website www.uhb.nhs.uk under Research.

2. Management Commentary

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

2.1.1 Strategic Planning

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

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

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

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

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

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

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

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

2.2 Principal Risks and Uncertainties Facing the Trust

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

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

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

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

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

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

Although there may be further changes in the details as it passes through Parliament it is clear that the Health and Social Care Bill will result in fundamental changes to the NHS in England. The following key areas of change relating to the new system are likely to have significant effects on the Trust's future position. These challenges were considered as part of the review of the five-year strategy following the publication of the White Paper and mitigating actions are being implemented to ensure that the risk to the Trust is minimised.

2.3.1 Information and Choice

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

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

2.3.2 Patient and Public Involvement

The Government intends to introduce HealthWatch England in the forthcoming Health Bill to be an independent consumer champion. This will replace the current Local Involvement Networks (LINks) and Overview and Scrutiny Committee and will form the local arm of the Care Quality Commission. The Trust has a long history of patient and public involvement, including supporting the work of LINks and it is important that the existing knowledge of the Trust and its services is not lost during the transition.

2.3.3 Improving Healthcare Outcomes and Payment for Performance

The Department of Health has developed an Outcomes Framework for the NHS which aims to measure the overall effectiveness of the NHS in improving outcomes. It is also linked to the development of Quality Standards by the National Institute for Health and Clinical Excellence (NICE)

which set out what a high quality service for a particular condition will look like.

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

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

2.3.4 Changes in Commissioning Arrangements

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

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

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

2.3.5 Regulation

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

2.3.6 Changes to Commissioning and Funding for Education

The Government has indicated in its consultation 'Developing the Healthcare Workforce' that it intends to replace the current system of commissioning, funding and quality assuring the education of current and future healthcare

professionals. Key changes that are proposed include the replacement of deaneries by Local Skills Networks, and the introduction of a tariff and levy for educational activities.

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

2.4 Performance Governance Framework

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

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

2.5 National Targets/Standards and the Standard NHS Contract

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

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

The Trust saw nearly half a million outpatients, 67,000 inpatients, 32,000 daycases, and 83,000 A&E attendances. The Trust continues to ensure equitable access to services and over 95% of patients were treated, admitted, or discharged from A&E in less than four hours over the course of the year. The Trust continued to meet the national 18-week referral-to-

treatment target at Trust and specialty level and is already meeting the new 95th centile waiting times ahead of their introduction in April 2011. The Trust has also successfully delivered against all the national cancer waiting time targets in 2010/11.

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

2.6 Clinical Quality and Patient Experience

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

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

- Reducing errors (with a particular focus on medication errors)
- Time from prescription to administration of first antibiotic dose
- Venous thromboembolism (VTE) risk assessment on admission
- Improve patient experience and satisfaction
- Infection prevention and control

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

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

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

2.7 Trust Development and Performance during 2010/11

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

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

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

2.8 Performance against Key Patient Targets

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

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

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

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

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

2.9 Performance Monitoring and Improvement

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

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

management of national targets in particular. This approach aligns effectively with reporting target risks to Monitor.

2.10 Operational Efficiency

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

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

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

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

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

2.11 Social and community issues

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

The Trust's contribution to regeneration is to deliver the best in healthcare through world-class clinicians in a world-class environment aided by medical

technology and translational research. In turn this helps reduce social exclusion and increases prosperity in Birmingham and the broader West Midlands.

2.11.1 Reducing Disadvantage

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

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

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

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

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

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

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

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

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

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

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

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

2.11.2 Increasing Prosperity

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

The new hospital embodies latest technology and will be a catalyst for, and driver of, innovation in medical and healthcare technologies. Working with the best in Europe and beyond the Trust aims to further stimulate knowledge, technology transfer and best practice. Locally, the Trust has worked hard to ensure medical technology is integral to Advantage West Midlands' Regional Economic Strategy, the West Midlands Regional Competitiveness and Employment Programme, and the Birmingham Science City initiative and most recently the new Local Enterprise Partnership for Birmingham.

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

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

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

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

therapy and is awaiting a decision by the Department of Health on the number of centres that will be established nationally.

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

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

2.12 Patient Care

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

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

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

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

As a result of the feedback there has been a focus on areas that patients indicate they are most concerned with. For example, the Trust has changed its catering systems and supplier resulting in an improved patient experience and satisfaction rating. Care Rounds have been introduced by the Trust in response to patients who were feeling isolated as a result of being cared for in one of the 44% of single rooms available in the new hospital. Care Rounds provide a method in which patients are seen at least every hour and a full assessment of their needs is reviewed. The Trust has also introduced a red tray and beaker system for early identification of patients who have special eating and drinking requirements.

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

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

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

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

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

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

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

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

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

2.13 Public and Patient Involvement

2.13.1 Patient and Carer Councils

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

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

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

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

2.13.2 Young Person's Council

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

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

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

2.13.3 Mystery Patient

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

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

2.13.4 Information Group

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

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

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

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

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

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

2.13.6 Patient/Carer Consultations

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

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

2.13.7 Increase in volunteers from the local community

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

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

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

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

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

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2.14 Complaints

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

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

The main issues raised in complaints were:

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

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

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

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

2.15 Patient Advice and Liaison Service (PALS)

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

2.16 Stakeholders, Partnerships, alliances/contractual arrangements

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

Local Health organisations	
South Birmingham PCT/ Birmingham & Solihull Cluster	• Regular meetings between Chairs and CEOs and appropriate directors • Primary secondary interface group • Member of “system plan” group to develop QIPP plan for whole system • Negotiation and implementation of Local Delivery Plan • Quarterly finance and quality performance meetings
GPs/GP Consortia	• Within South Birmingham, participating and leading work on Rheumatology, Pain and ENT redesigned pathways working in partnership on Diabetes redesign and community hub • Early stages of discussion around provision of GI, TIA, Endoscopy and Community Infusions • Working closely with the GPs at Sutton Medical

	Consulting Centre (Ashfurlong) to further develop the services provided in that locality, e.g. Ophthalmology Rapid Access Service, Neurology and Urology • Discussions are ongoing and opportunities are being explored with Solihull GP Consortium • Formed Clinical Interface Groups to progress service development/change programme, to reflect LDP settlement • Established Associate Medical Director post to be the lead clinician with GP Consortia • Developing data sharing protocols between 1° and 2° • Introduced regular meetings between Trust Executive Team and GP Consortia Boards
Specialised Commissioning Agency	• Chief Operating Officer continues to hold regular meetings with the head of the SCA • Exploring potential of improving rehabilitation facilities
West Midlands SHA	• Chair and CEO regularly meet their SHA counterparts • Attending professional fora • Trust developed an 18-week breach sharing protocol that has been adopted throughout the SHA • Assisting the Quality Observatory
Heart of England Foundation Trust	• Meeting of Executive teams has been held and agreement reached to co-operate on a number of issues including medical staff training and management development • Ongoing discussions with regard to operational issues
Sandwell and West Birmingham Trust	• Continued co-operation with SWBH on the Pan Birmingham Decontamination project • COO holds meetings with SWBH Director of Strategy
Birmingham Children's Foundation Trust	• The Trust is continuing to support BCH with its provision of tertiary paediatric care, where appropriate • Regular operational meetings with Medical Director and Chief Operating Officer to ensure appropriate SLAs in place to support delivery of services • Partner in Proton Therapy Centre project • FD sits on Shared Services Group
Birmingham Women's Hospital NHS Foundation Trust	• The Trust provides a number of services to the Women's eg. anaesthetics; critical care; finance; steam • Regular meetings of Chairs and Executive Directors

West Midlands Ambulance Trust	• Meeting of Chairs and Executive Directors has taken place • Working together to improve turnaround times for patients • Support the WMAS with patient transport • Process developed to record the clinical handover of the patients so that we will be able to robustly monitor performance
Birmingham Community Trust	• Agreed pathways for a number of different patient groups including fractured neck of femur and the elderly
National health bodies	
Monitor	• Chair and CEO have met Monitor Chair on a number of occasions • Quarterly finance and quality performance meetings to review quarter's performance against plan, national standards and declarations • Regular discussions take place with the Trust's Relationship Manager • The Trust Medical Director is a member of Monitor's working group developing Quality metrics
Care Quality Commission	• Trust hosted visit by Head of Operations • Pilot implemented re Learning Disabilities • Hosted visit for CEO and Regional Director to new hospital
Department of Health	• Ongoing discussions between key personnel at both organisations • The Trust has agreed two secondments to DH to influence policy and to continue to play an active role in developing Connecting for Health
National Institute of Health Research	• Partnership to deliver the UK's first and only Surgical Reconstruction and Microbiology Centre
Collaborative working	• Have working relationships with a number of trusts and the Department of Health to deliver a variety of services
Non NHS contractual Partners	
Consort/Balfour Beatty	• Relationships continue at all levels to ensure the delivery of the new hospital on time and on budget as well as health and safety issues
B-Braun	• Meetings every two weeks at operational level with UHB Contracts to measure quality standards • Quarterly Joint Management Board with the Pan Birmingham Collaborative and BBraun

University of Birmingham	• Quarterly liaison meetings • The Birmingham Clinical Research Academy has been developed • Working with Business School to Develop MBA Programme • Progress on ongoing discussions on various agendas are regularly reported to Board of Directors • UoB are partner in Proton Therapy project • Working in partnership to develop a proposal for medical devices testing
Ministry of Defence	• The Trust has established a close working relationship with the Ministry of Defence, including Joint Medical Command (JMC) and the Defence Medical Services Department (DMSD) Under this arrangement the Trust also sub-contracts work to: - Birmingham City University - The University of Birmingham - The Royal Orthopaedic NHSFT - Heart of England NHSFT - Birmingham City and Sandwell NHST (incorporating Birmingham Eye Centre)
FMC Renal Services Limited	• The Trust has worked closely with FMC in the planning of new satellite haemodialysis facilities. A 16-station purpose-built unit opened in Worcester in 2009 and a further unit in Woodgate Valley has just opened • Both of the new satellite units have been designed with the flexibility to house community outpatient clinics which will be used by Renal Medicine and associated specialties
Advantage West Midlands/Science City	• Government has announced the abolition of the Regional Development Agencies; Science City still aiming to provide strategic framework for innovation • UHB chairs Science City Innovative Healthcare Group • AWM grant (through European Regional Development Fund) for pan-European "Developing Centres of Excellence project focusing on translational research" varied to include e-prescribing • AWM support for accessing European commission Framework 7 programme for research and development (which has a strong medical technology element)
Birmingham City Council	• Member of citywide enablement forum • Continuing planning relationship

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

3. Financial Review

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

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

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

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

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

The financial statements have been prepared in accordance with International Financial Reporting Standards (IFRS) and International Finance Reporting Interpretation Committee (IFRIC) interpretations as endorsed by the European Union, applicable at 31 March 2011 and appropriate to NHS Foundation Trusts. This is the second set of full year results prepared in accordance with IFRS accounting policies. The previously reported 2009/10 financial statements have been restated where IFRS has required this; with the date of transition being 1 April 2009, which is the beginning of the comparative period for the year ended 31 March 2011.

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

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

3.2 Financial Performance

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

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

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

3.3 Income and expenditure

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

Summary income and expenditure – plan v. outturn

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

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

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

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

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

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

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

3.4 Capital Expenditure Plan

In 2010/11 the Trust incurred £23.2 million of capital expenditure on equipment, new facilities and improvements to existing buildings. This is summarised below:

Category	**Capital Invested £ Million**
Brought Forward Programmes from 2009/10	0.7
IT Replacement, Modernisation, Infrastructure and additional capacity	1.3

Trust Buildings • Existing Estate • New Hospital	 1.4 4.2
	5.6
Trust Equipment • New Imaging Equipment • Replacement and other Equipment	 9.1 6.5
	15.6
TOTAL	**23.2**

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

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

3.5 Value for Money

The Trust's Financial Plan for 2010/11 included the delivery of cash-releasing efficiency savings of 3.5% against relevant budgets. In order to achieve this, a formal cost improvement programme (CIP) totalling £15.9m was agreed for all Divisions and Corporate areas. This programme involved a combination of both cost reduction and income generation schemes.

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

3.6 Private Patient Income (PPI)

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

3.7 QEHB Charity

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

3.8 Audit Information

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

3.9 External Auditors

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

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

3.10 Pensions

The accounting policy for pensions and other retirement benefits are set out in note 1.3.2 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 2 June 2011

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 Code was revised and re-issued by Monitor in March 2010.

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

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

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

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

1.1 Application of Principles of the Code

A. The Board of Directors

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

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

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

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

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

Details of the composition of the Board of Directors and the experience of individual Directors are set out in Board of Directors, page 42, 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 terms of appointment of the Chairman and three non-executive directors, David Ritchie, David Bailey and Michael Sheppard expired during the reporting year. All four having only served one term, were each re-appointed for further terms of three years by the Board of Governors, on a recommendation from the Board of Governors' Nomination Committee for Non-Executive Directors. Details of the composition of that Committee and its activities are set out on page 51 of the Annual Report. Details of terms of office of the Directors are set out in Board of Directors, page 42, of the Annual Report.

D. Information, development and evaluation

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

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

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

E. Director Remuneration

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

F. Accountability and Audit

KPMG LLP has been appointed by the Board of Governors as the Trust's External Auditor. The Trust has appointed RSM Tenon as internal auditors for the reporting year and has appointed Deloitte as internal auditors from 1 April 2011. The Board of Directors presents a balanced and understandable assessment of the Trust's position and prospects, maintains a sound system of internal control and ensures effective scrutiny through regular reporting directly to the Board of Directors and through the Audit Committee.

G. Relations with Stakeholders

The Board of Directors recognises the importance of effective communication with a wide range of stakeholders, including members of the Trust. Details of interactions with Stakeholders are set out from page 24 of the Annual Report and in Membership, page 52.

1.2 Compliance with the Code

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

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

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

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

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

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

Board of Governors

1. Overview

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

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

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

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

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

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

During this year, the Governors have been:

1.1 Patient

Shirley Turner
Colin McAllister
Valerie Jones
Jamie Gardiner

1.2 Public (by Parliamentary Constituency)

Northfield
Margaret Burdett
Edith Davies

Selly Oak
Rita Bayley
John Delamere

Hall Green
David Spilsbury
Tony Mullins MBE

Edgbaston
John Coleman
Rosanna Penn
Ian Trayer

Ladywood
Shazad Zaman

Yardley
Kadeer Arif

Perry Barr & Sutton Coldfield
Joan Walker

Erdington & Hodge Hill
Monica Quach

1.5 Staff

Up to 30 June 2010

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

From 1 July 2010 for terms of three years

Dr Tom Gallacher (Medical Class)
Susan Price (Clinical Scientist/Allied Health Professional)
Erica Perkins (Nursing Class)
Barbara Tassa (Nursing Class)
Patrick Moore (Ancillary, Administrative and Other Staff)

1.6 Stakeholder

Rabbi Margaret Jacobi, appointed by the Birmingham Faith Leaders' Group
Professor David Cox, appointed by South Birmingham Primary Care Trust
Professor Edward Peck, appointed by the University of Birmingham
Vice Admiral Raffaelli, appointed by the Ministry of Defence
Cllr James Hutchings, appointed by Birmingham City Council
Ms Ruth Harker, appointed by the South West Area Network of the Secondary Education Sector in Birmingham

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

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

*While a member of the Board of Governors.

1.7 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, Mindelsohn Way, Edgbaston, B15 2PR.

Board of Directors

1. Overview

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

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

The Board is currently comprised as follows:

Chairman: Sir Albert Bore

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

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

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

NAME	Date of Appointment/Latest Renewal	Term	Date of end of term
Sir Albert Bore	1 December 2010	3 years	30 November 2013
Clare Robinson	25 September 2008	3 years	24 September 2011
Stewart Dobson	25 September 2008	3 years	24 September 2011
David Bailey	1 December 2010	3 years	30 November 2013
David Ritchie	1 December 2010	3 years	30 November 2013
Gurjeet	1 December 2008	3 years	30 November

Bains			2011
Michael Sheppard	5 December 2010	3 years	4 December 2013
Angela Maxwell	1 July 2009	3 years	30 June 2012

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

2. Board meetings

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

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

3. The Board of Directors composition

Sir Albert Bore, Chairman

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

Julie Moore, Chief Executive

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

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

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

Executive Directors

Kevin Bolger, Executive Chief Operating Officer

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

Kay Fawcett, Executive Chief Nurse

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

responsibility for Nursing, Facilities Management, Infection Prevention and Control and Business Continuity.

Tim Jones, Executive Director of Delivery

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

David Rosser, Executive Medical Director

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

Mike Sexton, Executive Director of Finance

Mike, who became FD in December 2006, spent five years in the private sector working for the accountancy firm KPMG and had a brief spell at the Regional Specialities Agency (RSA) before joining the Trust in 1995. Over the last 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 Council and one of fifty Ambassadors for the 2012 Olympics. She was appointed as a Governor for Birmingham Metropolitan College in 2010.

Angela Maxwell OBE

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

David Ritchie CB

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

Clare Robinson

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

Professor Michael Sheppard

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

4. Directors' Interests

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

Audit Committee

1. Overview

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

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

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

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

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 Committees

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 (Margaret Burdett). The other members of the committee for the year ended 31 March 2011 were Shirley Turner, Ian Trayer, Erica Perkins and Ruth Harker.

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

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

2. Nominations Sub-Committee

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

Membership

1. Overview

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

Public Constituency

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

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

Staff Constituency

The staff constituency is divided into four classes:

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

Patient Constituency

Patient members are individuals who are:

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

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

2. Membership Overview by Constituency

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

*Numbers correct up to 31 March 2011

3. Membership Strategy

3.1 Background

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

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

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

In March 2009 the Trust had 18,070 members. By March 2010 some 7,794 new patients, staff and members of the public had chosen to become a member of the Trust. Taking into consideration the 2,110 members who left the membership programme (due to death or moving away from the area) the net total number of members at the Trust as of March 31, 2010 was 23,754 – an increase of over 31%.

3.2 Membership development 2010/11

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

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

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

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

In Autumn 2010, Governors' Drop-in sessions were introduced to community settings within Governors' constituencies to broaden the range of interaction they have with their membership and raise the profile of membership.

Typical locations have been faith centres, libraries and health centres and these sessions have been well received by the public and Governors alike.

3.3 Ambassador Programme

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

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

The role of an Ambassador is to:

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

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

3.4 Membership recruitment 2010/11

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

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

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

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

3.5 Recognition of the Trust's Membership Programme

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

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

3.6 Membership recruitment and engagement strategy 2011/12

Recruitment

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

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

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

Engagement

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

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

3.7 Engagement with members by Governors/directors

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

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

- Governors' Drop-in Sessions. These sessions are held monthly alternating between the new Queen Elizabeth and Selly Oak hospitals. A mix of staff, patient and public governors 'set up camp' and talk to, advise, and take comments from staff, patients and visitors. These are then fed back to the Executive Directors for comment/action

- The Annual General Meeting

- Telephone, written or electronic communications co-ordinated through the Membership Office which then steers members to the appropriate Governor/Director

- Website. Each Governor has their profile and details of the constituency they serve, published on the Trust website

- 'Trust in the Future' magazine – highlights work of Governors and opportunities to be involved in projects/patient experience groups

- Direct email and telephone number to the Membership Office who take any kind of membership query and then feed back into the Trust to action

- Chief Executive hotline – phone communication for queries, comments and ideas

- Governors attend community presentations held their constituency in relation to the hospital/patients issues

- Health Talks. Governors attend health talks which are held on a monthly basis for members and wider community.

- Insideout – Trust newspaper distributed through the hospital sites

Staff Survey

1. Commentary

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

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

The Trust is committed to keeping staff up-to-date with news and developments through an internal communications programme, as follows:

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

2. Summary of Performance – NHS Staff Survey

2.1 NHS Staff Survey Response Rate 2010 compared with 2009

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

2.2 Areas of improvement from 2009 survey

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

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

2.3 Area of deterioration from 2009 survey

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

2.4 2010 Top 4 Ranking Scores

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

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

2.5 2010 Bottom 4 Ranking Scores

	2009/2010		2010/2011		Trust Improvement Deterioration
Bottom 4 Ranking Scores	**The Trust**	**National Average**	**The Trust**	**National Average**	
% of staff working extra hours	72%	66%	69%	66%	3% decrease (improvement)
% of staff experiencing discrimination in the last 12 months	N/A*	N/A*	15%	13%	N/A*
% of staff saying hand washing materials always available	70%	71%	62%	67%	8% decrease (deterioration)
% of staff having equality & diversity training in last 12 months	33%	35%	37%	41%	4% increase (improvement)

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

3. Future Priorities and Targets

3.1 Summary of Actions taken in response to 2009 Results

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

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

- Improve response rates
- Increase work on reducing the number of staff experiencing discrimination at work
- Investigate why staff are working extra hours

- Increase the % of staff receiving equality and diversity training
- Ensure hand washing materials are always available
- Involving Directorates in producing specific actions for their areas and monitoring these through directorate meetings
- To develop and implement an action plan for all of the above with the aim of improving the Trust's performance by the next reporting period

Regulatory ratings

1. Explanation of ratings

1.1 Finance Risk Rating

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

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

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

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

1.2 Governance Risk Rating

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

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

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

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

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

1.4 Risk Ratings in 2009/10

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

1.5 Risks Declared in 2009/10

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

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

1.6 Risk Ratings in 2010/11

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

1.7 Risks Declared in 2010/11

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

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

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

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

1.9 Details and actions from any formal interventions

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

Public Interest Disclosures

1. Consultation

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

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

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

2. Policies in relation to disabled employees and equal opportunities

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

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

courses are also provided which focus on equality and diversity issues, and this includes equality and diversity workshops, disability awareness training, equality impact assessment training, cultural awareness workshops, recruitment and selection and deaf awareness programmes. All new staff receive information on equality and diversity issues during their induction. In addition a facility in partnership with Learn Direct is provided for staff who wish to improve upon their literacy and numeracy skills.

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

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

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

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

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

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

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

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

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

3. Public and patient involvement activities

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

4. Sickness absence

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

5. Cost allocation

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

6. Serious untoward incidents – Information Governance

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

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

SUMMARY OF OTHER PERSONAL DATA RELATED INCIDENTS IN 2010/11		
Category	**Nature of incident**	**Total**
I	Loss/theft of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0
II	Loss/theft of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	0
V	Other	9

7. Health and Safety

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

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

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

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

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

8. Countering fraud and corruption

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

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

9. Better Payment Practice Code

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

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

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

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

11. Management costs

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

SECTION 2

Remuneration Report 2010/2011

1. Executive Appointments and Remuneration Committee

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

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

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

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

2. Executive Remuneration Policy

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

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

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

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

3. Pensions

All the executive directors are members of the NHS Pensions Scheme. Under this scheme, members are entitled to a pension based on their service and final pensionable salary subject to HM Revenue and Customs' limits. The scheme also provides life assurance cover of twice the annual salary. The normal pension age for directors is 60. None of the Non-Executive Directors are members of the schemes. Details of the benefits for executive directors are given in the tables provided on pages 72 and 73.

5. Salary and Pension Entitlements of Senior Managers

A. Remuneration

Salary entitlements of senior managers

Name and Title	Year Ended 31 March 2011			Year Ended 31 March 2010		
	Salary	Other Re - munerat -ion	Benefits in Kind	Salary	Other Re – munerat- ion	Benefits in Kind
	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100
SENIOR MANAGERS						
Julie Moore Chief Executive	210-215	0	0	210-215	0	0
Kay Fawcett Executive Chief Nurse	125-130	0	0	120-125	0	0
Dr David Rosser Executive Medical Director	85-90	95-100	0	85-90	95-100	0
Tim Jones Executive Director of Delivery	135-140	0	0	135-140	0	0
Mike Sexton Executive Director of Finance	135-140	0	0	135-140	0	0
Kevin Bolger Executive Chief Operating Officer	130-135	0	0	130-135	0	0
Fiona Alexander Director of Communications	100-105	0	0	95-100	0	0
Morag Jackson New Hospitals Project Director	115-120	0	0	115-120	0	0
David Burbridge Director of Corporate Affairs	95-100	0	0	90-95	0	0
Viv Tsesmelis Director of Partnerships (commenced office 01/04/2010)	95-100	0	0	0	0	0
Sam Chittenden Director of Strategic Developments (left office 1/11/2009) **	0	0	0	65-70	0	100
NON EXECUTIVE DIRECTORS						
Sir Albert Bore Chairman	50-55	0	0	50-55	0	0

Stewart Dobson	15-20	0	0	15-20	0	0
Angela Maxwell (commenced office 01/07/2009)	10-15	0	0	10-15	0	0
David Ritchie	10-15	0	0	10-15	0	0
Clare Robinson	15-20	0	0	15-20	0	0
Gurjeet Bains	10-15	0	0	10-15	0	0
Professor Michael Sheppard	10-15	0	0	10-15	0	0
Professor David Bailey *	10-15	0	0	10-15	0	0
Tony Huq (left office 30/06/2009)	0	0	0	0-5	0	0

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

B. Pension Benefits

Name and title	Real increase in pension at age 60	Real increase in pension related lump sum at age 60	Total accrued pension at age 60 at 31 March 2011	Total accrued pension related lump sum at age 60 at 31 March 2011	Cash Equiva-lent Transfer Value at 31 March 2010	Cash Equiva-lent Transfer Value at 31 March 2011	Real Increase in Cash Equivalent Transfer Value	Employers Contribu-tion to Stakehold-er Pension
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000	To nearest £100
Julie Moore, Chief Executive	2.5-5	7.5-10	80-85	240-245	1,554	1,446	0	N/A
Mike Sexton, Executive Director of Finance	2.5-5	12.5-15	50-55	150-155	944	928	0	N/A
Tim Jones, Director of Delivery	0-2.5	5-7.5	30-35	90-95	241	440	0	N/A
Kay Fawcett, Chief Nursing officer	0-2.5	2.5-5	50-55	150-155	994	923	0	N/A
Kevin Bolge, Chief Operating Officer (Acting)	0-2.5	2.5-5	45-50	140-145	485	871	0	N/A
Dr David Rosser, Medical Director	0-2.5	5-7.5	50-55	150-155	939	720	0	N/A
David Burbridge, Director of Corporate Affairs	0-2.5	2.5-5	15-20	45-50	803	236	0	N/A
Fiona Alexander, Director of Communications	0-2.5	2.5-5	5-10	15-20	79	83	4	N/A
Morag Jackson, New Hospitals Project Director	0-2.5	2.5-5	30-35	100-105	600	556	0	N/A

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

Details above are provided by the NHS Pensions Agency.

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 Margaret Burdett, Jamie Gardiner, Ian Trayer, John Buckels and James Hutchings, up until 30 June 2010, when Dr Tom Gallacher replaced John Buckels. The Committee met once during the year and all members, with the exception of Tom Gallacher, were in attendance.

……..	…….
Julie Moore, Chief Executive	2 June 2011