



Annual Report and Accounts 2018/19

This annual report covers the period 1 April 2018 to 31 March 2019

**University Hospitals Birmingham NHS Foundation Trust
Annual Report and Accounts 2018/2019**

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Section 1

Annual Report 2018/19

This annual report covers the period 1 April 2018 to 31 March 2019

Performance report

1 Overview

The purpose of this section is to provide a short summary that provides sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

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

In recent years, the Trust has been increasingly acknowledged as one of the most successful NHS foundation trusts and has therefore been asked to provide management support to a number of other trusts. From October and November 2015 respectively, UHB's then Chief Executive and Chair held interim corresponding roles at Heart of England NHS Foundation Trust, along with other senior managers, to improve its clinical, financial and operational position. The acquisition of Heart of England NHS Foundation Trust (HEFT) by UHB was concluded successfully on 1 April 2018.

UHB now runs the Queen Elizabeth Hospital Birmingham, Birmingham Chest Clinic, Heartlands Hospital, Good Hope Hospital, Solihull Hospital and various community services across the region.

As a foundation trust, UHB has approximately 50,000 members and employs more than 20,000 members of staff. It is one of the largest trusts in England treating over 2.8 million patients each year and has more than 2,700 beds across its sites.

The Trust has regional centres for trauma, burns, plastics, neurosciences, dermatology and cancer. It also has centres of excellence for vascular, bariatric and pathology services, as well as the treatment of MRSA and other infectious diseases. It also has expertise in HIV/AIDS, premature baby care, bone marrow transplants and thoracic surgery.

The Trust delivers approximately 10,000 babies each year and provides around 20,000 days of neo-natal care.

UHB has the largest solid organ transplantation programme in Europe and runs Umbrella, the sexual health service for Birmingham and Solihull. It is also home to the West Midlands Adult Cystic Fibrosis Centre and a nationally-renowned weight management clinic and research centre.

The Queen Elizabeth Hospital Birmingham is a Major Trauma Centre treating the most severely injured casualties from across the region. The hospital's single site 100-bed critical care unit is the largest in Europe.

The Trust hosts the Institute of Translational Medicine (ITM) and led the West Midlands Genomics Medicine Centre as part of the national 100,000 Genomes Project.

UHB is proud to host the Royal Centre for Defence Medicine (RCDM). The RCDM provides dedicated training for defence personnel and is a focus for medical research.

UHB also holds the contract for providing medical services to military personnel evacuated from overseas via the aero medical service. QEHB is one of only a small number of hospitals that can provide the full range of medical specialties – trauma, burns, plastics, orthopaedics, neurosurgery and critical care – needed to treat the complex nature of conflict injuries, all under one roof.

The pioneering techniques in surgery and pain control that have been developed whilst treating military patients are now being used for civilian surgery in the UK and elsewhere and are being progressed through the Surgical Reconstruction and Microbiology Research Centre (SRMRC).

During 2018/19, the Trust has focused on its vision 'to build healthier lives'. This is underpinned by the Trust's values: collaborative, honest, accountable, innovative and respectful and its core purposes of excellent clinical quality, patient experience, workforce, and research and innovation.

1.1 Details of overseas operations

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

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

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

1.2 Royal Centre for Defence Medicine

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

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

RCDM is made up of approximately 380 uniformed personnel. Most fulfil a clinical role but around 50 personnel work in the Headquarters, with some working in academic positions throughout Birmingham.

The combined experience of the military and medical staff and the civilian doctors, nurses and allied health professionals working together means UHB strives to deliver the best clinical care in the country. The hospital is at the leading edge in the medical care of trauma injuries and the experience

gained by the staff working in this busy acute care environment provides the ideal training required for operations.

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

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

1.3 The Trust strategy

Following the merger with Heart of England NHS Foundation Trust, an updated strategy for the Trust was developed and agreed by the Board of Directors in 2018, supported by a revised planning process that will ensure its delivery.

As one Trust, with one vision, UHB is proud of its track record of providing high quality care to millions of patients. But, like the rest of the NHS, the Trust needs to adapt to meet growing challenges in the years ahead.

To do this UHB has set out three immediate key priorities:

- ▶ We will maintain high quality patient care across all our hospitals and services, even in the face of rising demand
- ▶ We will integrate the services we provide across our sites so that our patients can expect the same high standards and joined-up care wherever they are, and so we can ensure we are as efficient as possible
- ▶ And we will transform the model of healthcare by using new technology and treatments, with many more patients being seen in the community or virtually, and with hospitals concentrating on urgent, emergency and more complex, specialist care

With the challenges facing the Trust, our patients and citizens, we need to change the ways in which healthcare is provided.

We are facing growing healthcare costs, workforce shortages and financial constraints, so we cannot simply expand capacity to meet growing demand.

And we see unacceptable inequalities in health, in a region where over 400,000 people live in some of this country's most deprived areas.

A sign of these pressures is that emergency admissions to hospital are rising by at least 5% each year, and our hospitals are all working at full capacity.

Now providing care to over 2.8 million patients each year across the region – and patients from much further afield – we employ over 20,000 staff and have over 2,700 beds across four hospital sites and a range of satellite and community services.

We'll embrace and lead the change patients and employees need by looking inside and outside our hospital walls for the solutions, such as being at the forefront of the digital transformation in the NHS, supporting and promoting innovation and making use of technology to project the expertise of hospital specialists out to community professionals, or directly into patients' homes.

For staff, we want to be an inclusive and supportive employer of choice, benefiting their health and wellbeing whilst championing new ways of working, training and development.

We also need to work together with patients, communities and partner organisations, and we all have a role to play.

Our vision demonstrates our commitment to the health of our population, before, during and after patients need hospital care – from maternity to the end of our lives. We have a shared purpose of what we need to achieve and the ambition to make it happen.

1.4 Sustainability and Transformation Partnership

The Birmingham and Solihull Sustainability and Transformation Partnership (STP) is a collaboration of public NHS and council social care providers across Birmingham and Solihull, working together with partners in the community, voluntary and social enterprise sector to find the most effective ways to manage the health and care needs of our population within the available resources and to provide high quality, sustainable care for the future.

The STP aims to do everything within its considerable, collective power to address inequality and contribute to its people's health and happiness, from local residents to staff at its numerous sites across the city.

Birmingham and Solihull STP has developed a *Live Healthy, Live Happy* brand in order to communicate its core aims to local people.

Its vision is to help everyone in Birmingham and Solihull to live the healthiest and happiest lives possible.

Its mission is: Born well, grow well, live well, age well and die well. This ethos has been reflected in NHS England's (NHSE) Long Term Plan (LTP), which was launched in January 2019. The LTP is a new, 10-year plan for the NHS to "improve the quality of patient care and health outcomes".

The Birmingham and Solihull STP's three priorities are focused on people's lives; not sectors, organisations or diseases. They are:

1. Maternity, Childhood and Adolescence
2. Adulthood and Work
3. Ageing and Later Life

They will be supported by 'enablers' based on new approaches to clean air, urgent care, digital innovation and the best use of public estates.

Each STP priority has a Portfolio Board which will drive forward delivery of the projects detailed within the Transformation and Sustainability strategy.

2 Financial Review

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

2.1 2018/19 Changes in accounting policies

The financial statements have been prepared in accordance with International Financial Reporting Standards (IFRS) and International Finance Reporting Interpretation Committee (IFRIC) interpretations as endorsed by the European Union, applicable at 31 March 2019 and appropriate to NHS foundation trusts. This is the ninth set of full year results prepared in accordance with IFRS accounting policies.

There have been two changes of accounting standards during 2018/19 that are relevant to the Trust: IFRS 9 Financial Instruments (recognition and measurement) and IFRS 15 Revenue from Contracts with Customers. There are no material changes to the Financial Statements resulting from these changes.

2.2 Financial performance

The Trust's total annual revenue increased to £1,613.6 million (£851.9 million in 2017/18), this near doubling of turnover reflecting the acquisition of the Heart of England NHS Foundation Trust on 1 April 2018. The Trust is now the second largest foundation trust in the country in terms of revenue, behind Manchester University Hospitals NHS Foundation Trust. Like many NHS acute service providers, the Trust's 2018/19 financial position is a deficit, partly supported by the Provider Sustainability Funding allocated via NHS Improvement. The Trust delivered a deficit (before asset revaluation accounting impairments and the gain on absorption) of -£31.5 million, comparing favourably with the planned deficit of -£38.8 million. The bulk of the favourable variance is due to unplanned, non-recurring PSF revenue allocated to the Trust late in 2018/19 financial year. The Trust gained £12.2m in PSF bonus and incentive revenue, partially off-set by the loss of £6.1m PSF due to the failure to hit the national A&E 4 hour wait target between Quarter 2 and Quarter 4.

The Trust's overall 2018/19 retained surplus of £132.8m is due to the non-recurrent £165.0 million gain on the absorption of the assets and liabilities of the Heart of England NHS Foundation

Trust on 1 April 2018. This sum represents the book value of net assets of the former Trust at this date; it is not represented by an actual cashflow and is not considered part of the financial control total set by NHS Improvement for this Trust. Also excluded from the control total is the -£0.7 million impairment charge due to the accounting revaluation of the Trust's land and properties.

2.3 Income and expenditure

The table below compares the revised planned income and expenditure with the outturn position for 2018/19.

Summary income and expenditure – plan v. outturn

Consolidated summarised income and expenditure - Group			
	Plan Mar 19	Actual Mar 19	Variance Mar 19
	£m	£m	£m
Operating income	1,555.6	1,611.7	56.1
Operating expenditure	(1,530.2)	(1,584.4)	(54.2)
EBITDA	25.4	27.3	1.9
Depreciation	(37.6)	(36.4)	1.2
Interest receivable	0.1	0.7	0.6
Interest payable	(24.1)	(24.0)	0.1
PDC Dividends	(3.9)	(0.7)	3.2
Gains/(losses) on disposal	0.0	(0.2)	(0.2)
Corporation Tax	(0.1)	(0.1)	0.1
Donated / Granted income	1.4	1.9	0.5
Deficit before impairment	(38.8)	(31.5)	7.3
Impairment charged to I&E	0.0	(0.7)	(0.7)
Retained Deficit	(38.8)	(32.2)	6.6
Gain on Absorption	165.0	165.0	0.0
Retained Surplus after Gain on Absorption	126.2	132.8	6.6

The largest component of the Trust's income comes from the provision of NHS patient care services funded by NHS commissioners within England. This accounted for £1,384.7m (85.8%) of total income. Other patient care revenues contributed a further £24.9m (1.5%), which includes income for NHS patients treated from Scotland, Wales and Northern Ireland, private patients and costs recovered from insurers under the Injury Cost Recovery Scheme.

The Trust has a range of income streams which are not linked directly to patient care. These include education levies, which account for £52.0m (3.2% of the total income, such as the Service Increment for Teaching (SIFT), recognising the cost of training medical undergraduates from the University of Birmingham, the Medical and Dental Education Levy (MADEL), which supports the salary costs of post graduate doctors in training, and the Non-Medical Education and Training (NMET) levy.

Research and Development (R&D) activity funding totalled £34.7m (2.1% of total income). This includes grants from the National Institute of Healthcare Research (NIHR) to support the Wellcome Trust Clinical Research Facility.

As highlighted elsewhere in this report, Provider Sustainability Funding (PSF) income totalled £29.9m during 2018/19 and a further £19.2m was generated from services provided by the Trust to other organisations. The balance of the Trust's income is attributable to trading activities and other miscellaneous items.

Within Trust expenditure, the largest category is salaries and wages totalling £945.7m (including Directors and Non Executives) which is equivalent to 58.3% of total operating expenditure. Other significant components include £405.7m on drugs and clinical supplies (25.0%), estates and premises costs of £68.6m (4.2%) and depreciation and amortisation of £36.4m (2.2%).

2.4 Capital Expenditure Plan

During 2018/19, the Trust invested £40.4m of capital expenditure on medical equipment, ICT infrastructure and improvements to existing buildings:

SITE	TYPE	Actual £m
All	Medical Equipment replacement	12.7
All	Estates & Facilities Works	6.0
All	ICT Infrastructure	4.8
All	ICT GDE & Wi-Fi & Fast Follower	5.3
HGS	ACAD	2.0
QE	QEHB PFI Lifecycle	2.8
QE	Major Medical inc.	2.7
All	Winter Estates Schemes	1.7
All	Grants & Charitable	1.9
QE	Cancer Transformation	0.5
TOTAL		40.4

Planned capital investment in 2019/20 is currently estimated at £47.9 million and includes plans for the combined Trust (Queen Elizabeth, Heartlands, Good Hope and Solihull hospital sites):

- ▶ Proactive replacement of medical equipment
- ▶ Ongoing investment into IT infrastructure
- ▶ Statutory maintenance works within Trust buildings
- ▶ Major medical equipment
- ▶ Contracted lifecycle works within the QEHB
- ▶ ICT Global Digital Exemplar systems investments (externally funded)

2.5 Value for Money

During 2018/19, the Trust delivered £34.5m of efficiency savings across all services against a plan of £35.6m. A formal cost improvement programme (CIP) target was set across all divisions and corporate functions. A database of projects was developed to monitor CIP delivery (both expenditure reductions and income generation schemes) during the year.

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

2.6 UHB Charity

The charitable funds for the Trust are administered by UHB Charity, a separate legal entity from the Trust. In 2018/19, the Trust received grants of £1.5m and donated assets worth £1.4m from the UHB Charity.

2.7 External Auditor

The Trust's external auditor is Deloitte LLP; the audit cost for the year was £234,000 for the Trust's statutory audit and £20,000 for the subsidiary companies audit. Other work undertaken by Deloitte LLP in year totalled £118,000, including £90,000 for local counter fraud work and £28,000 of audit fees for the 2018/19 quality report audit.

The appointment of external audit services for 2018/19 was made by the Council of Governors. In addition, Deloitte also provide local counter fraud services to the Trust which is the non-audit work stated.

2.8 Basis for the Accounts

The Trust has four operational wholly-owned subsidiary companies;

- ▶ Pharmacy@QEHB Limited, which commenced trading in 2011, providing an Outpatients pharmacy service in the Queen Elizabeth Hospital Birmingham
- ▶ UHB Facilities Ltd, which commenced trading in 2014, providing estate management services

- ▶ Assure Dialysis Services Ltd, which commenced trading in 2014, providing renal dialysis services to the Trust
- ▶ Professional Activity Ltd, purchased in 2017/18, which is not yet trading but developing software for the job scheduling of clinicians

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

These group financial statements have been prepared in accordance with International Financial Reporting Standards (IFRS) and International Finance Reporting Interpretation Committee (IFRIC) interpretations as endorsed by the European Union, applicable at 31 March 2019 and appropriate to NHS foundation trusts.

2.9 Going Concern

Based on the financial performance detailed in these financial statements and the revised financial plan for 2019/20 submitted to NHS Improvement on 23 May 2019, the Trust is forecasting that its cash balances will remain sufficient to continue meeting its working capital requirements for the immediate future. Therefore, after making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, the Trust has continued to adopt the Going Concern basis in preparing these accounts.

3 Performance Analysis

3.1 Overview

3.1.1 Purpose, Activities, Business Model, Structure, Objectives and Strategies

The Trust has entered a new strategic phase following the merger with Heart of England NHS Foundation Trust, becoming an even larger and more complex organisation. The Trust now has more patients under its care than any other NHS provider, with nearly 2.8 million patient attendances per year, over 20,000 employees, nearly 2,700 beds and an annual turnover of £1.6bn and is playing a leading role in local health system reform through Live Happy, Live Healthy, the Birmingham and Solihull Sustainability and Transformation Partnership.

Following the merger the Trust updated its vision to 'building healthier lives' which previously was the vision of Heart of England. This sets out the Trust's plan to create more equitable patient access to better quality and integrated healthcare across Birmingham, Solihull and South Staffordshire. It also demonstrates an important change in the Trust's outlook and a strategic pivot in how it operates within the health and care system. The Trust is no less committed to providing high quality care for the patients who come through its doors because that remains part of our core purpose, but it is increasingly concerned with the mental and physical health of our population before and after they come through our doors. All the Trust's activities are underpinned by its values: collaborative, honest, accountable, innovative and respectful.

There are three major priorities that have to be delivered to achieve our vision:

- ▶ Maintaining effective day-to-day operational and financial performance
- ▶ Integrating our clinical services and corporate functions
- ▶ Transforming our healthcare services to be more efficient and responsive using technology

Within these priorities there are nine major areas of focus for the Trust:

- ▶ Standardisation of high quality patient care
- ▶ Clinical service planning across sites
- ▶ Digital and technological transformation
- ▶ Making best use of all resources
- ▶ Developing and supporting our workforce
- ▶ Working with our partners
- ▶ Research and innovation
- ▶ Non-clinical support services
- ▶ Emergency preparedness

This was summed up in the Trust's new strategy (Our Strategy for Building Healthier Lives) that was approved by the Board of Directors and Council of Governors during 2018/19. This strategy will then be translated into an annual implementation plan that sets out the Trust's plans for practical action for the year ahead and that is monitored quarterly by the Board of Directors.

To ensure there is appropriate senior resource in key areas a new post of Director of Quality Development was appointed during 2018/19 and further changes in the Executive Team will take effect from 2019/20. This includes changes to portfolios to create a Chief Transformation Officer, a Chief Innovation Officer and a single Chief Operating Officer for the Trust. Divisional structures will also be revised from 1 June 2019 with the creation of six multi-site divisions that will allow them to best support the delivery of the Trust's strategy.

3.1.2 Performance against key health care targets

The Trust, and the NHS as a whole, has faced another very challenging year with continued increases in demand and funding challenges, despite increased investment. The table below shows the change for each of the main activity categories compared to previous years.

	2016/17	2017/18	2018/19	2017/18 change	2018/19 change
Inpatient FCEs	494,436	503,750	539,571	1.9%	7.1%
OPD attendances	1,788,473	1,782,585	1,871,680	-0.3%	5.0%
ED attendances	382,911	389,834	408,148	1.8%	4.7%
Total	2,665,820	2,676,169	2,819,399	0.4%	5.4%

The Trust has seen below target performance in 2018/19 in three national operational standard groupings:

A&E

The Trust has continued to see very significant growth in attendances, ambulance arrivals and emergency admissions through its Emergency Departments (EDs), particularly since Christmas 2018. The Trust now averages one day a week with more than 1,200 attendances and on its busiest day in 2018/19 1,395 patients attended our Emergency Departments. Performance has been affected by sub optimal flow resulting in high volumes of patients waiting for admission in the EDs, which has a consequential negative impact upon assessment capacity, time to be seen and access standard performance. Staffing challenges, particularly for middle grade doctors also continue to be a significant constraint. Other factors affecting performance include significant delays with inpatient mental health capacity resulting in extended lengths of stays in ED and high numbers of patients whose transfer to another care setting is delayed.

Referral to Treatment Time

The Trust continued its robust approach to capacity planning for 2018/19 however commissioners were unable to commission the required increase in activity required to allow ongoing delivery of the Referral to Treatment operational standard. Consequently performance over the year against this standard deteriorated over the year. Action plans are in place for each treatment function where the Trust is below the 92% target. The Trust has faced increasing challenges in staffing additional sessions as the current income tax and pension rules are reducing the incentives for additional sessions to be taken up.

Cancer

The Trust continued to perform below the 85% national standard for 62-day urgent GP referrals in 2018/19; in addition the 14-day standards were not met for a period during the year due to increasing demand and reduced capacity.

The Trust has continued to see large numbers of tertiary referrals late in the 62-day cancer pathway. Meetings to discuss the issue of late tertiary referrals have been arranged with the Chief Operating Officers of the referring trusts and a workshop is planned with NHS Improvement. Work is also being undertaken to improve particular tumour site pathways including Urology, Lung and Head and Neck.

Performance against the two 14-day referral to first appointment targets for suspected cancer and for breast symptoms was affected by a shortfall in capacity. This was caused both by an increase in referrals and a shortage in breast radiologists. The increase in referrals has been acknowledged as a regional trend whilst there is a national shortage in breast radiologists. Significant additional activity in breast clinics has been delivered, but this has being outstripped by the growth in referrals.

Fortnightly meetings continue with commissioners, the West Midlands Cancer Alliance and NHS Improvement in relation to the Trust’s performance against the cancer standards.

3.2 Performance Analysis

3.2.1 Key performance measures and monitoring

The Trust has a robust and effective framework in place to provide assurance around the quality of care it offers and to monitor organisational performance. The Board of Directors and Executive Director-level groups receive regular performance reports which present performance against national and local targets and priorities. These reports adopt a risk-based approach to reporting to ensure that the consequences of under-achievement are highlighted to the Executive Team and Board of Directors, as well as the actions that are in place to improve performance. The framework provides a good level of assurance and supports effective decision-making. Key Performance Indicators (KPIs) reported to the Board include those targets incorporated in NHS Improvement’s Single Oversight Framework, other national priorities, indicators underlying the Trust’s quality priorities, key workforce indicators (both resource and education), other clinical quality indicators, safety, patient experience, efficiency, research and financial performance including healthcare activity, expenditure variances and CIP delivery.

UHB also has a Clinical Quality Monitoring Group and a Care Quality Group in place led by the Executive Medical Director and the Executive Chief Nurse respectively. These groups report to the Board of Directors and provide additional

assurance and effective accountability around clinical quality and the patient experience. Please see the Trust’s Quality Account for further details.

Information on the Trust’s key performance indicators, broken down by specialty, ward or department, as appropriate, is included in the Trust’s programme of quarterly Performance Review which includes key issues for each clinical division. Key national targets are progress-monitored through the monthly Chief Operating Officer’s Group.

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

3.2.2 Key issues, risks and uncertainties that could affect the Foundation Trust in delivering its objectives

The Trust’s Executive Directors identify the key strategic risks to the achievement of the Trust’s aims. The assurances on the controls which mitigate these strategic risks form the Board Assurance Framework (BAF). All high-scoring risks from divisional, specialty and departmental risk registers and any risks arising from governance reviews are automatically escalated to the appropriate executive directors for review. Key risks to performance include:

Risk of failure to deliver operational performance targets due to capacity issues

Continued demand exceeding the Trust’s capacity affects its ability to deliver the national targets. The Trust continues to engage with commissioners to support them in managing demand and direct activity to the most appropriate service.

Unable to recruit, control and retain adequate staffing to meet needs of patients

This is made worse by national shortages and the effect of Brexit uncertainty of EU staff. Various workstreams are in place to resolve this, including the Strategic Workforce Group. Recruitment plans are in place for clinical professions including the use of medical associate professions as well as a focus on the retention of existing staff.

Increasing delays in the transfer of care from UHB sites in excess of agreed targets

The availability of additional social care funding via the iBCF and joint working between social care, health commissioners and providers has supported an improvement in social care.

Unable to maintain and improve the quality and quantity of physical environment to support required level of service

The Full Business Case for ACAD has been approved by the Board of Directors. A draft estates strategy for the enlarged Trust is in development. Estates will be a consideration of all standardisation and service planning work to ensure that services are provided from the most appropriate environment which will include community sites and innovative non-NHS locations.

Failure to realise the opportunities and benefits of merger

The integration project team is well-established and the first few specialties now aligned under a single Trust-wide management structure. A comprehensive assurance system is in place which reports to the Strategic Operations Steering Group chaired by the Executive Director of Strategic Operations with reporting to the Board of Directors.

3.3 Regulatory Action

The last full inspection by the Care Quality Commission took place in October and November 2018 with the report published in February 2019. This inspection assessed the Trust's full range of services against the five key questions the CQC uses:

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

The Trust was rated 'good' overall by the CQC – with an 'outstanding' rating for the 'well-led' aspect of the inspection.

The inspectors also gave a rating of 'good' for whether the Trust's services are responsive, effective, caring and safe.

They found that there were consistently high levels of constructive engagement with staff and people who used its services, including all equality groups. The inspectors found the Trust engaged and involved patients to shape services and culture; safe innovation was celebrated; and there was a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of care.

Between 8 October and 19 October 2018, the CQC inspected a total of five acute core services provided by the Trust across four locations. They inspected urgent and emergency care, medical care, surgery and outpatients at QEHB. They also inspected urgent and emergency care, medical

care, surgery and maternity at Heartlands, Good Hope and Solihull hospitals, plus community health services for end-of-life care and children, young people and families.

The CQC inspected the 'well-led' key question between 26 and 29 November 2018.

It was the first CQC inspection since the acquisition of Heart of England NHS Foundation Trust in April 2018.

To ensure the Trust continues to improve its services and that any future inspection achieves the same or better rating, the Trust refreshed its compliance framework in 2016/17. As part of this a number of additional measures were added to the framework, including many from the CQC's Key Lines of Enquiry. Nursing, clinical and operational leads complete an annual self-assessment against the measures within the framework for their speciality.

On a regular basis the Risk and Compliance team assess this against various performance and quality metrics available to provide the specialty with their overall score. Where there are areas that are reported as worse than 'good' this is reported back to the specialty and divisional management team to identify improvement(s) in the relevant area(s). The Risk and Compliance team identify any trends in areas that are less than 'good' across specialties to identify if a Trust-wide solution is required.

3.4 Policies in relation to disabled employees and equal opportunities

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

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

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

The Trust is 'committed' to the DWP Disability Confident scheme which recognises employers as having appropriate approaches to people with disabilities. This requires employers to meet the following standards:

- ▶ ensure our recruitment process is inclusive and accessible
- ▶ ensure against discrimination
- ▶ make job adverts accessible
- ▶ provide information in accessible formats (e.g. large print)
- ▶ accept applications in alternative formats (e.g. electronically)
- ▶ communicate and promote vacancies
- ▶ advertise vacancies through a range of communication channels
- ▶ get advice from Jobcentre Plus, Work Programme providers and local disabled people's user-led organisations
- ▶ review current recruitment processes
- ▶ offer interviews to disabled people
- ▶ encourage applications from disabled people by offering them an interview if they meet the minimum criteria for the job (this is the description of the job set by the employer)
- ▶ anticipate and provide reasonable adjustments as required
- ▶ make sure disabled people aren't disadvantaged when applying for and doing their jobs
- ▶ support any existing employee who acquires a disability or long-term health condition to stay in work
- ▶ retaining an employee who has become disabled means keeping their valuable skills and experience and saves on the cost of recruiting a replacement

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

Managers are required to promote the recruitment of all diverse groups.

All Trust policies and procedures are equality impact-assessed to ensure that they have no

adverse impact due to disability (or any of the other protected characteristics as per the Equality Act 2010).

In addition the Trust has seven Staff Network groups that look to support our staff and provide a conduit for views and opinion on future developments and planning:

- ▶ Disability and long-term conditions
- ▶ BAME
- ▶ LGBTQ+
- ▶ Women's
- ▶ Carers
- ▶ Young Persons
- ▶ Mental Health

Where possible Networks are run and chaired by their members.

3.5 Social and Community Issues

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

Once registered with the Learning Hub, clients will complete a 12-week programme of support which includes:

- ▶ Three weeks (three days per week) of classroom-based training including employability based skills as well as vocational sessions including Customer Service, First Aid at Work Awareness and Information Governance

Clients will then be referred to the 'Aftercare Team' for a further seven weeks of support which will include:

- ▶ Three weeks' work-shadowing placement (based on successful clearances of which costs are covered by the Learning Hub); attendance to workshops which support clients with the transition from unemployment to employment and ongoing 1-2-1 mentoring support.

The Learning Hub also delivers a customised training programme, 'Building Health', which is delivered in line with the Trust's recruitment of health care assistants. Following the assessment day clients will complete a five-day classroom based programme covering sessions that are pertinent to this role. Clients will also complete a three-week work shadowing placement within a clinical environment and on completion will apply for a vacancy.

The Learning Hub also works in partnership with the Prince's Trust in the delivery of a five week 'Get

into Hospitals Programme' which includes two weeks of classroom-based training followed by a three-week work based placement.

Within the last 12 months (April 18-March 19) The Learning Hub has supported 108 people into work with a majority being obtained through 'Youth Promise Plus', a Birmingham and Solihull Council initiative. Combined outputs to date demonstrate that the Learning Hub has supported in excess of 2,400 clients into employment from when the Trust began offering its employability programme.

3.5.1 Community cohesion

In 2019 UHB has for the first time moved into the Stonewall Top 100 Employers list, ranked 84 out of 445 organisations. Previously Heart of England ranked 136/434 in 2018 and University Hospitals Birmingham ranked 239/434 in 2018.

In addition UHB has established itself as a supporter of intersectionality following the hosting of two successful national conferences: the South Asian LGBT conference and Muslim LGBT Intersectionality National Conference. We are committed to using our hospitals as neutral 'safe' spaces for minority groups to meet and explore the issues affecting them.

3.6 Reducing Disadvantage

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

As detailed in the last report, UHB had signed a contract with Birmingham City Council until July 2018 to be a named delivery partner within a city-wide project funded by the European Social Funds and Youth Employment Initiative, called Youth Promise Plus (YPP). As of the 31 July 2018 UHB had engaged with 726 young people of which 431 participated in a work placement and 230 achieved a positive outcome, including job apprenticeships or entering further/ higher education. Due to the success of YPP, Birmingham City Council have been given an extension by the Department for Work and Pensions to continue delivery until July 2021, with UHB named as one of their delivery partners.

During the previous two years the focus for the Learning Hub had been on the delivery of training aimed at 18-29 year-olds. Based on the successful delivery of YPP the Learning Hub has been in discussions with Birmingham City Council to be a named delivery partner for their ESF 1.1 progression to pathways project 'World of Work' which is employability training focussed on the 30+

age group but with a priority group identified as 50+. Funding for this programme is until July 2020.

The focus for the next 12 months is to replicate the training delivered at the Learning Hub across our other hospital sites, in particular the Heartlands site which is in the heart of the West Midlands Combined Authority's priority ward areas. Discussions have already started with local community groups, in particular the Muath Trust where an Adult Education Budget tender has been submitted to deliver training for locally unemployed people, of which UHB hopes to be a sub-contractor. Notification of this tender round will be announced in May 2019 with contracts starting in August 2019.

In October 2015, the Trust launched three food collection points within the QEHB where members of staff, patients and visitors can donate food items to help those in real need, working in collaboration with Narthex (Sparkhill food and clothing bank). From May 2016 this was expanded to include clothing, which has enabled staff to 'draw down' clothes for patients who are assessed as being in need upon their discharge. This year, over 100 patients were provided with emergency clothing donations that have helped to support their discharge from hospital. In addition clothing has supported the Trust's 'Get up, Get dressed, Get moving' initiative. In total, in 2017/18, 2,969kg of clothes have been donated, a slight rise on the previous year's figure of 2,906kg.

In 2018/19 UHB donated 1414.9kg of food and issued 40 food parcels to patients in need.

UHB remains the major contributor of clothes to the clothes bank.

3.7 Modern Slavery and Human Trafficking

In May 2018, the Chief Executive signed the Trust's Slavery and Human Trafficking Statement, pursuant to section 54(1) of the Modern Slavery Act 2015. The Statement is renewed on an annual basis. The Trust supports and respects the protection of human rights for all its employees and workers within its supply chain. It believes in treating people with respect and dignity and does not condone the use of its products or services which infringe the basic human rights of others. The Trust expects its suppliers and business partners to adhere to the same high standards and to take reasonable steps to combat slavery and human trafficking. It is committed to prohibiting corruption in all its forms, including extortion and bribery.

3.8 Environmental Issues

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

The Trust recognises that the NHS is a major contributor to CO₂ emissions and is focusing on governance; energy; procurement practice; a Travel Plan; waste minimisation, segregation and recycling; together with an overarching communications strategy.

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

3.9 Energy

The performance of the Trust from April 2018 to March 2019 shows an estimated consumption saving on 2007/08, which is the baseline year for NHS carbon reduction targets, of 11.8%. Both QEHB and Heartlands were below their respective Department of Health energy efficiency target's upper limit; QEHB being 48.97 GJ/100m³, against a target range of 35-55GJ/100m³ and Heartlands being 60.81 GJ/100m³ against a target range of 55-65 GJ/100m³. Good Hope Hospital has also marginally improved its performance. The increases in clinical activity and the warmer weather in the summer will increase electrical consumptions for cooling. This will have a bigger effect at QEHB which has comfort cooling throughout.

Building on the success of energy reduction initiatives at Heartlands, Good Hope and Solihull hospitals, a review of the Heritage Building at the QEHB site will be undertaken and subsequent proposals submitted for 'spend to save' funding.

3.10 The Trust's Carbon Footprint

Treasury and NHS carbon reduction guidance relates to direct and indirect energy (Scopes 1 and 2) and official business travel (Scope 3). The emissions for Scope 1 and 2 (energy consumed) for 2018/19 are estimated to be 58,000 tonnes of CO₂ equivalent. The Trust has achieved the NHS target of 10% reduction in CO₂ emissions between 2007 and 2017 for Scopes 1 and 2, having achieved an estimated saving of 15%, primarily through site rationalisation and conversion of the boiler houses at QEHB, Heartlands and Good Hope to gas from coal. Combined Heat and Power has also been installed at the Heartlands, Good Hope and Solihull sites which will have a beneficial impact on carbon emissions. Ongoing decarbonisation of the national grid has also added to these savings. Solar PV has also been installed at all sites except QEHB, and

variable speed drives and building management system upgrades which have all contributed to energy savings and carbon reduction.

NHS National data and UHB's own estimates show the largest share of the total healthcare carbon footprint is procurement, especially pharmaceuticals, medical instruments and financial services. Procurement is currently outside of Scope 3 definitions because of measurement difficulties. However, preliminary independent estimates show that approximately 70% relates to procurement, 25% energy and 5% travel.

Note that all of the above data relates to the main hospital sites only and excludes all off-site and community premises.

In February 2019 UHB was recognised for excellent sustainability reporting as part of its annual report, receiving a certificate of excellence, awarded by the Sustainable Development Unit (SDU), NHS Improvement and the Healthcare Financial Management Association (HFMA).

The SDU, which works across the health and care sector on behalf of NHS England and Public Health England, conducted an analysis of all provider and Clinical Commissioning Group (CCG) annual reports to evaluate sustainability sections. 55 trusts and 42 CCGs (around 22%) were selected for recognition out of 432 organisations across England.

High quality reporting on sustainability is recognised as a fundamental way in which organisations can demonstrate their commitment to embedding environmental, social and financial sustainability.

3.11 Waste Recycling

The Trust currently has in place a comprehensive waste recycling programme across all UHB sites which has generated a total of 1,268 tonnes of re-useable and recyclable material. At QEHB and the Heritage Building the volume of recyclable waste has remained at 2017/18 levels despite an increase in the number of sites. It is hoped that this will increase with phases two and three of the recycling bin replacement programme and the ongoing promotion of waste recycling. At Heartlands, Good Hope and Solihull hospitals the amount of recyclable waste has increased by 140 tonnes (23%). These sites also introduced the Stericycle Bio System in July/August 2016 to reduce the cost of sharps containers and to reduce the carbon footprint of burning plastics. During 2018/19 the Trust saved the purchase and incinerating of 61,890 containers and made carbon footprint savings of 355 tonnes.

The Trust continues to recycle other material such as scrap metal, office/confidential paper, clothing, electrical and white goods, batteries and cardboard. Scheduled 'Dump the Junk' initiatives, continue to take place throughout the year to support the recycling programme.

The commercial waste tender is due for renewal in 2019/20, with an emphasis on engaging with a long-term provider who can take forward previous good work.

3.12 Sustainable Transport

The Trust employs some 20,000 staff and, last year, treated 2.8 million patients, with an estimated two million visitors. Consequently, our hospital sites are a major generator of traffic from across the city and beyond. Encouraging sustainable transport modes, specifically through a comprehensive Green Travel Plan, is a key part of the Trust's Sustainability Strategy and Action Plan.

Over the past year, the Trust has consolidated its Green Travel Plan, aimed at encouraging a further switch away from single occupancy car travel, by re-invigorating staff to travel sustainably and informing new staff of the travel package offers available to them. The strategy commits the Trust to developing and improving incentives for staff to minimise car use e.g. eligibility criteria, increase the use of sustainable transport modes and to continue to work with stakeholders to promote sustainable travel.

A 2018 staff Travel Survey has highlighted a 7.6% reduction in single occupancy car journeys (38%) compared to 2016, as well as a 4% increase in bus (15%) and 6% increase in train (20%) patronage.

The Trust continues to support the Green Travel District (GTD in conjunction with the City Council, the University of Birmingham, Birmingham Women's and Children's NHS Foundation Trust and Birmingham and Solihull Mental Health NHS Foundation Trust) as part of Birmingham's medium-term transportation strategy 'Birmingham Connected'.

3.13 Major Capital Development

3.13.1 Ambulatory Care and Diagnostic Centre (ACAD)

Strategic investment in the Heartlands site is gathering momentum under the unified Trust, as a number of the enabling works in readiness for the Ambulatory Care and Diagnostic centre (ACAD) construction phase are completed.

A 223 space surface car park at Yardley Green was completed in May 2018. The car park, which assisted in the satisfaction of one of the ACAD planning conditions, is to be brought into full use as ACAD development displaces cars from the main Heartlands site.

Demolition of the time expired redundant Estates building and the Oncology administration block took place over the summer and the sites were cleared by August 2018. This paves the way for the proposed new access road and on site car parking reconfiguration, to assist in minimising the disruption to patients and visitors during the construction of the main ACAD building; a detailed phasing plan for these works has been developed and will be implemented upon agreement of the ACAD price and funding.

Clearance of all pre-commencement planning conditions for the project was obtained in January 2019 and following approval by the Trust Board in the same month, the Full Business Case for the ACAD project has been submitted to NHSI.

In line with the Trust's sustainability agenda and general NHS guidance, the proposed building design and construction is targeting a Building Research Establishment Environmental Assessment Method (BREEAM) of 'Excellent'. All the indications to date are that the target will be met.

3.13.2 Negative Pressure Facilities at Heartlands

Work to provide two negative pressure suites on Ward 26 at Heartlands was completed in September 2018. This significantly improves the facilities to cater for highly infectious patients.

3.13.3 General refurbishments at Heartlands

A number of areas of the hospital have benefitted from refurbishments and building services upgrades, totalling circa £2m, throughout the year, including: Radiology; the Renal Unit; Ward 5 in the main ward tower block; and Ward 17 in the twin theatre block.

3.13.4 Good Hope

The old Cedarwood Ward at Good Hope has been converted to the 'Homeward Centre'; a step down facility for the care of older people that will also assist in relieving the pressure on the main hospital mainly over winter periods but which also allows for a decant ward to complete other essential works.

3.13.5 Solihull Haematology and Oncology Day Unit

The conversion of part of the old Bruce Burns mental health ward at Solihull to a new Oncology Day Unit has been completed, providing excellent facilities for cancer patients at Solihull. This modern unit has been designed to meet the needs of patients undergoing chemotherapy and supportive treatments.

3.13.6 QEHB Emergency Department capacity improvement

In order to reduce waiting times and thus improve patient care, the triage area in the Emergency Department has been reconfigured and expanded by the creation of an additional 12 assessment spaces and the creation of an emergency observation unit with eight trolley spaces, two assessment rooms and 19 recliners, which enables the area to be used flexibly. This has improved the capacity within ED but there are still challenges within the department.

3.13.7 Norman Power expansion

Working in conjunction with Birmingham City Council, the number of beds at this facility has been increased. Norman Power has two components: an inpatient enablement facility and the Early Intervention (EI) community team. This is one of five testing sites that will deliver health and social care in the home. This is intended to both prevent admissions into hospital and reduce the levels of packages of care required by service users. Early Intervention is one of the three strands of the Sustainability and Transformation Partnership, and is working across the five different Birmingham organisations: Birmingham City Council, Birmingham Community Healthcare NHS Foundation Trust, UHB, Birmingham and Solihull Mental Health NHS Foundation Trust and the Birmingham and Solihull CCG. Norman Power is providing a base for the new community team which combines nursing and therapy functions to deliver health and social care in the home.

3.13.8 Fire Compartmentation

In 2016, the Asset Management Department instructed a specialist contractor, KGC Ltd, to undertake a full survey of all of the fire separation at Heartlands, Good Hope and Solihull hospitals. Analysis of the survey results identified that the highest risk area on any of the Heartlands, Good Hope and Solihull sites was the main ward block and the main theatre block at Heartlands Hospital.

Therefore a programme of remedial works (known as Phase 1) commenced in February 2018, to

reinstate the fire compartments of all 12 wards in the main ward block, Theatres 1-5, and ITU. This programme, which involved a series of intricate ward moves and decants, was successfully completed, to schedule, in November 2018. Phase 2, planned to address the remedial work in all other areas at Heartlands, Good Hope and Solihull hospitals, commenced in December 2018. This phase is currently on schedule, and is due to be completed by the end of the 2019/20 financial year.

3.14 Procurement

With regards to the procurement of goods and services, the Trust complies with all relevant UK Government policies on sustainable development and sustainable procurement, and all relevant legislation and regulations, ensuring that sustainability principles are given due consideration at each stage of the procurement process, including:

- ▶ Developing an in-depth understanding of the sustainability issues relevant to each category;
- ▶ Building a detailed appreciation of customers' sustainability requirements, and ensuring that customers have access to sustainable products and services to assist them in meeting these requirements;
- ▶ Working with suppliers, including early market engagement, and working post-award to seek ongoing improvements to suppliers' sustainability performance and that of their supply chains; and
- ▶ Encouraging the appropriate uptake of sustainable products and services

3.15 Physical Environment

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

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

In recent years the Trust has developed in excess of 16,000m² of land on the site for food production or habitat enhancement and continues to make progress with its Community Orchards and Gardens project, with local community partner The Trust Conservation Volunteers (TCV).

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

Over the past year, the UHB TCV collaboration has further developed our partnership with QEHB Charity to help promote health and wellbeing through structured activities and events which are accessible. In addition to QEHB, we have undertaken general gardening and conservation tasks at the Norman Power Centre and created garden design plans for Solihull (Oncology) and Good Hope hospitals. We have shared our grow space produce with staff from the Medical School and Fisher House.

There are currently 45 active volunteers that participated in the 61 Green Gym sessions at QEHB. There are 118 active QEHB Charity volunteers that participated in 23 sessions across QEHB and the Norman Power Centre. The total amount of volunteers for this period is 356 (at QEHB).

Events and Activities

Green Gym; Big Garden Birdwatch; Orchard Pruning and Maintenance; Dawn Chorus Walk; Big Green Weekend; First Friday Walks

Groups

Headway; RCDM; University of Birmingham; Wesleyan; RBS (Nat West); Camelot; Wates; PwC; Mondelez Intl

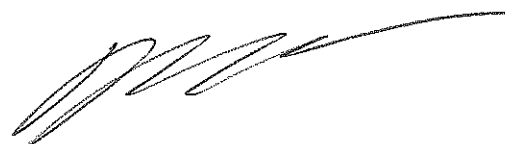
We are proud to be supporting the referral pathway for the new social prescribing programme at Queen Elizabeth Hospital Birmingham where we are working with patients with Hypertrophic Cardiomyopathy. We will help to provide a structured progression culminating with patients integrating into our weekly Green Gym sessions. QEHB Charity has kindly supplied a shed for patient use which will serve as a base and a hub for participants.

In addition, we have been approached by both Solihull Hospital and Good Hope Hospital to create garden designs based on feedback from staff and patients. We feel there is the opportunity to run some regular health and wellbeing activities within these spaces in the future, like the model at QEHB.

After the maintenance at the Norman Power Centre last year, we have produce growing in the raised beds and are developing the area to run weekly gardening and healthy eating sessions with residents and staff. Two other notable projects which continue to have a social and environmental benefit are:

Fruit and vegetable stall: As part of its sustainability and health and wellbeing strategies, the Trust wanted to make available to staff, patients, visitors and the wider community, fresh, competitively priced fruit and vegetables to give everyone healthier options both at work and at home. The Trust generates a small income from the stall which is re-invested into Trust-wide health and wellbeing programmes. The fruit and vegetable stall remains the most enquired about initiative at UHB with many other NHS organisations looking to emulate its success.

Farmers' Market: The Farmers' Market was started in November 2012 and trades twice a month. It has grown from eight stalls to more than 20. Key to the establishment of the market was the desire to provide staff, visitors, patients and local people with access to local produce as well as supporting local businesses. Many of the businesses are regulars at the region's farmers markets, but others are new to selling their produce.



Dr David Rosser, Chief Executive

24 May 2019

Accountability report

1 Directors' Report

1.1 Overview

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

1.2 Audit Information

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

1.3 Pensions

The accounting policy for pensions and other retirement benefits are set out in note 1.3 to the financial statements and details of senior employees' remuneration can be found in the Remuneration Report in point 10 of this report.

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

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

1.5 Other disclosures

Disclosures relating to NHS Improvement's well-led framework are included in the Annual Governance Statement.

Information on fees and charges are enclosed in the annual accounts.

1.6 Cost allocation

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

1.7 Better Payment Practice Code

	Number	£000
Total bills paid in the year	166,149	613,803
Total bills paid within target	160,460	606,065
Percentage of bills paid within target	96.6%	98.70%

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

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

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

1.9 Management costs/political donations

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

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

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

- ▶ Chair: Rt Hon Jacqui Smith
- ▶ Chief Executive: Dame Julie Moore (up to 31 August 2018)/ Dr David Rosser (from 1 September 2018)
- ▶ Chief Financial Officer: Mike Sexton
- ▶ Executive Medical Director: Dr David Rosser (up to 31 August 2018)/ Prof Simon Ball (from 1 January 2019)
- ▶ Executive Medical Director (Acting): Mr Mike Hallissey (from 1 September until 31 December 2018)
- ▶ Executive Director of Workforce and Innovation: Tim Jones
- ▶ Executive Chief Nurse: Lisa Stalley-Green (from 1 September 2018)
- ▶ Executive Chief Nurse (Acting): Michele Owen (up to 31 August 2018)

- ▶ Executive Director of Strategic Operations: Kevin Bolger
- ▶ Executive Chief Operating Officers: Cherry West and Jonathan Brotherton

Non-Executive Directors:

- ▶ Angela Maxwell (up to 30 June 2018)
- ▶ David Waller (up to 30 September 2018)
- ▶ Jane Garvey
- ▶ Harry Reilly
- ▶ Catriona McMahon
- ▶ Dr Jason Wouhra
- ▶ Professor Michael Sheppard (from 1 May 2018)
- ▶ Professor Jon Glasby (from 1 May 2018)
- ▶ Jackie Hendley (from 1 May 2018)
- ▶ Karen Kneller (from 1 May 2018)
- ▶ Mehrunnisa Lalani (from 1 May 2018)

1.11 Patient Care

1.11.1 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 and Patient Experience Groups, which are chaired by the Executive Chief Nurse and include Governors within their membership.

The Trust works closely with our Council of Governors to understand what matters most to patients, and welcomes Governors, members of the Trust, public and carers onto our site-based Patient, Carer and Community Councils where we welcome their involvement in consultations and service improvement projects. Governors also further contribute to improvements in patient care via our Governor Drop-ins.

During the year the Trust has continued to monitor feedback via a variety of different methods including patient advice and liaison contacts (PALS), complaints, compliments, friends and family test, and local and national surveys to drive service improvement. Feedback is proactively sought from patients, visitors and carers via surveys and visits to wards and departments. These mechanisms are well established at the point of care and enable the Trust to prioritise issues that are important to patients, as well as assisting the Trust in benchmarking the success of its patient improvement measures against the results of its peers.

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

More information on how we involve our members in the Trust can be found in the Membership section of this report.

1.11.2 Infection prevention and control

The Trust continues to have a robust Infection Prevention and Control programme in place. Innovative improvements have resulted in a plateau in the amount of *Clostridium difficile* Infection (CDI), where the Trust will end the financial year just above the agreed trajectory rate for CDI. In relation to *Meticillin Resistant Staphylococcus aureus* (MRSA) there were five Trust-apportioned bacteraemias reported for 2018/19; an MRSA reduction plan is in place across the Trust to maintain the low levels of MRSA. Improvements continue to be seen with other nosocomial alert organisms.

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

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

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

During 2018/19 the Trust has made significant progress in ensuring that carers are identified, recognised and supported throughout the acute hospital journey. This has included setting up of the Carer Coordinator service and developing an impressive number of resources to underpin the service.

Resources include:

- ▶ Carer Pack containing lots of useful information for carers
- ▶ Updated and relaunched 'Partners in Care' leaflet
- ▶ Carer Charter
- ▶ Carer Information leaflet
- ▶ List of Carer support services
- ▶ Carer Coordinator referral forms
- ▶ Carer pathway document outlining support / resources available at each stage of the carer pre and post-acute hospital journey
- ▶ Carer Awareness workshop based training for staff

This has resulted in increased staff awareness of carer needs, signposting for further support and an additional route for further referral on for a Carers Assessment via third sector partners.

Provision of guest beds across the Trust was reviewed and a number of additional beds were kindly provided by the hospitals' Charity, supplementing those supplied to the Queen Elizabeth Hospital site by the Friends of the Queen Elizabeth Medical Centre in the previous year. Guest beds have now been introduced onto the Heartlands, Good Hope and Solihull sites increasing the number of relatives and carers able to access them. Feedback relating to the availability and comfort of the beds continues to be very positive. With some areas now having more than one bed at their disposal it is easier to accommodate relatives or carers staying overnight on wards where more than one patient may need this support at any given time.

Charitable funds continue to be used to enhance the patient experience through provision of a variety of resources as well as colourful artwork in various wards and departments across the Trust.

Feedback has also been obtained from patients regarding current bedside entertainment provision and their views sought to inform future planned provision. This feedback was extremely useful as it gave insight we did not previously have in relation to what patients prefer to use in terms of entertainment. By also collecting demographic information at the same time we are able to plan future provision that will suit patients of different ages, backgrounds and those with a variety of communication, visual, hearing and other impairments or needs. A group has been set up to use this information to plan future services/ resources provided by the Trust. Any changes will be staged across the various sites as current contracts end.

A number of changes have been made to the Emergency Department at the QEHB to improve the patient flow, enhance the patient experience and respond to increased capacity pressures. Some of these changes relate to the configuration of the department whilst others relate to the patient pathway through the department depending on clinical need. Additional clinical areas have been introduced to ensure patients are able to access the assessment and treatment they need in a timely way. Information regarding this and other pertinent information is now displayed on an electronic screen in the main waiting area along with the current longest waiting time to be assessed or treated. Information also includes advice on self-care and other treatment pathways which may be more appropriate; for example

NHS walk-in centres, out of hours or emergency pharmacy and dental services.

Continuing the focus on patients feeling well looked after; a staff training video was made using a script based on real feedback obtained from staff and patients. The video demonstrated the thought processes of patients waiting for assistance once they have pressed their bedside call bell to either ask for pain relief or for assistance to get to the toilet. By also showing staff perspective of the same situation the video acknowledges the competing priorities faced by staff whilst further highlighting the detrimental impact on patient experience and wellbeing when assistance from staff is delayed. The impact of the video has been significant with positive feedback received when used in staff training sessions around patient experience and compassionate care. The video will continue to be used to engage staff in discussions around how to manage competing priorities whilst maintaining high standards of care.

To support the care of the newborn after birth and help prevent unnecessary separation of the mother and baby, a warm bundle of care was introduced, initially at Good Hope Hospital. For some babies hypothermia is associated with clinical morbidities which necessitate admission to the Neonatal Unit, prolonged stay and exposure to invasive clinical procedures. This can affect the mother's emotional and psychological wellbeing and impacts the neonatal service provision. Since introducing the initiative, in the first month there was an 80% reduction of babies becoming hypothermic and needing admission to the Neonatal Unit. Ongoing work continues and the next stage will see the introduction of the warm bundle to Heartlands Maternity Services.

Following insight from patients at QEHB regarding signage in outpatients, a survey took place in relation to signage and navigation to appointments; and while we knew that most patients found their outpatient clinic destination quite easily, there were a small number of patients finding it difficult. Although the numbers were small we felt it important to discover the reason for this so we could make informed changes to enhance the experience for those patients. Results proved insightful enabling actions to be planned which are being implemented early in 2019/20. Changes will be evaluated later in the year to assess the impact on the patient experience.

During the year a thematic review of complaints relating to end of life care was undertaken. This has been instrumental in developing the strategy for end of life care for the Trust with meaningful family insight.

1.12 Public and Patient Involvement

1.12.1 Patient, Carer and Community Councils

A new framework for Patient and Public Involvement at the Trust has been established following the merger. Patient, Carer and Community Councils (PCCCs) is the name given to this new framework of involvement which brings together previous lay forums from across the sites along with Governor Drop-in visits. There are four PCCC groups in total with one at Heartlands Hospital, Good Hope Hospital, Queen Elizabeth Hospital Birmingham and Solihull Hospital. The framework also includes a Young Persons' Council and Carers' Forum, both of which operate on a Trust-wide basis.

The site Patient, Carer and Community Councils work in collaboration with staff and act as a critical friend to the Trust to influence improvements in the patient experience. PCCCs have particular focus on care and the environment.

All council members are also Foundation Trust members. Throughout 2018/19, the councils have been active in seeking patients' views to influence improvements in care. There are currently 125 patient and public representatives on the councils. All members undergo the volunteer recruitment process and induction enabling them to safely undertake visits to wards and departments.

Patient, Carer and Community Council members visit wards and department areas to facilitate partnership working with staff to provide a patient perspective to improve the experience of patients and their relatives. During 2018/2019, a total of 162 visits were undertaken by members of the Councils. Following their visits, feedback is given to the ward or department to enable action to be taken where necessary. All feedback is further discussed at the Patient Experience Group and by exception to the Care Quality Group which reports to the Board.

Council members continue to be given the opportunity to sit on Trust committees where public representation is required and to participate in annual PLACE assessments. Council members have also taken part in visits to diagnostic areas as part of the QEHB's application for Improving Quality in Physiology Services (IQIPS) accreditation during the year. At the Heartlands, Good Hope and Solihull hospital sites, council members participated in catering audits at the retail units to examine the quality of food served and the customer service provided by the staff working in the areas. Customer Service training was carried out following the feedback received and a further

round of audits were carried out to identify if the customer service training had been of any benefit.

Some examples of other specific changes as a result of the feedback from ward/outpatient department visits undertaken by PCCC members are:

- ▶ Installation of a whiteboard to display clinic waiting times in the Diabetes Centre
- ▶ Introduction of a weekly cleaning programme of visitor chairs
- ▶ Extra wheelchairs purchased for Front of House reception
- ▶ Development of induction loop desk signage and staff education

1.12.2 Young Persons' Council

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

During 2018/19 the Young Persons' Council has seen an increase in the number and range of young people attending the council.

In 2018, YPC members participated in a planning session and developed a programme of events for 2019, including: mandatory training required to equip them to visit the wards and interact with people in hospital, regular speakers and a work plan for the year.

Saturday Social is a scheme developed by the Young Persons' Council members following a successful pilot of the scheme previously named the buddy scheme. The pilot tested peer visiting with young people and evaluated this via a survey. In 2018/19, a total of 34 of our younger patients have received a social visit and given their feedback about the hospital. As the name indicates these visits take place on a Saturday morning, currently once per month.

To support the Young Persons' Council Saturday Social visits, a number of mandala colouring books, pencil crayons and mindfulness puzzle books have been funded by the Friends of the QE. These are given out by the YPC volunteers when they visit on Saturday mornings. These gifts have been very well received as it is evident from patient experience feedback that this group of patients in particular can suffer from isolation and boredom in hospital.

1.12.3 Carers' Forum

The Carers' Forum brings together carers, service providers, staff, carer organisations and charities

to work together on how we engage and listen to carers in improving our hospital services for them. During the year the forum has been instrumental in supporting the work of the new carer coordinators – funded for a fixed term period via the Better Care Fund – and having input into their resources and training to ensure this is user-friendly.

A very successful Carers’ Conference was held in June 2018 – as well as some inspirational speakers the conference saw members of the Carers’ Forum, staff, carers and third sector representatives working together to co-produce the first draft of the Carer Pathway document.

1.12.4 Readership Panel

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

This year the group has provided a patient perspective on 28 leaflets.

1.12.5 Healthwatch Birmingham

The Trust maintains links with Healthwatch Birmingham and has worked with them during the year to further develop their self-assessment tool: Quality Standard for “Using Patient and Public Insight, Experience and Involvement to Reduce Health Inequality and to Drive Improvements in Health Outcomes” and has also used this as a benchmark itself. The Trust has also welcomed Healthwatch Birmingham to Heartlands Hospital, Good Hope Hospital and the Queen Elizabeth Hospital Birmingham as part of their study of emergency department and outpatient waiting rooms.

1.12.6 Patient and Carer Consultations

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

- ▶ Constitution for Patient and Carer Councils
- ▶ Patient and Public Involvement, a new framework for Patient, Carer and Community involvement
- ▶ Healthcare Evaluation Data (HED) – Your Right to Choose
- ▶ Trust Annual Plan
- ▶ Trust Quality Priorities
- ▶ Patient Experience Nursing Priorities (Patient Experience Group)
- ▶ Volunteer Strategy
- ▶ A Pets in Hospital scheme (task and finish group)
- ▶ Non-emergency patient transport
- ▶ Case for change merger with Heart of England

NHS Foundation Trust

- ▶ Inpatient survey questions (Patient Experience Group)
- ▶ Inclusion, Engagement and Wellbeing
- ▶ An event looking at Patients in the Big World of Data: What are you consenting to?
- ▶ A research focus group on Publication Bias
- ▶ An event looking at patient and public involvement in research
- ▶ An ‘end of treatment’ bell to signify the end of a patient’s treatment, or a ‘treatment tree’ for Chemotherapy patients
- ▶ Gender specific waiting areas in Whittall Street Sexual Health Clinics
- ▶ Criteria Led Discharge, a system designed to reduce the waiting times for patients prior to discharge from hospital
- ▶ Carers’ Charter, pack and carer journey strategy
- ▶ Privacy Notice for patients
- ▶ Food tasting (QE)
- ▶ Review of patient outpatient letters
- ▶ Catering provided in Café One (Heartlands Hospital)
- ▶ SupportUHome project (information given to patients regarding their discharge from hospital) (Solihull Hospital)

1.12.7 Volunteers from the local community

Following the merger the number of volunteers at the Trust now stands at 878 registered volunteers across all four hospitals who continue to provide an enhanced and quality experience for our patients and terrific support to our staff.

The demographic profile of our volunteers as at 31 March 2019 is:

2018/19	
GENDER	
Male	30%
Female	70%
AGE	
16-17 years old	0.6%
18–30 years old	6.0%
31–50 years old	9.5%
51–65 years old	21.8%
66–74 years old	36.9%
75+ years old	25.2%
ETHNICITY	
White British	75.3%
Other white	4.0%
Black/mixed	6.6%
Asian/mixed	10.7%
Other/undisclosed	3.4%

2018/19	
EMPLOYMENT	
Employed	8.5%
Unemployed	2.0%
Students	3.0%
Retired	33.8%
Other/undisclosed	45.6%

The Volunteer Service reports to the Patient Experience Group which will provide oversight to the activity and contribute to the future strategy of the service.

The quarterly social events for volunteers held at Queen Elizabeth Hospital Birmingham will continue and will also be held on the other sites as volunteers have expressed an interest in being able to meet with other volunteers and share experiences. Volunteers are also thanked for their help and support at annual site-based long service awards.

During the year the Trust launched its Pets in Hospital scheme which is currently being piloted at the Queen Elizabeth site. The scheme sees specially assessed dogs and their volunteer owners visiting patients in hospital to help to reduce anxiety and enhance patient communication and interaction. Early feedback is that these visits brighten the patients' day, especially for those who are missing their own dogs at home.

1.13 Complaints and Compliments

We welcome patients and families contacting us where they have any concerns about our services to help us to learn and continuously improve our services. The number of complaints received in 2018/19 was 1,950 which represents an 8.6% increase on the total number of complaints received in the previous year.

The Trust has robust procedures in place to ensure that complaints are investigated and responded to in a timely manner to the satisfaction of the complainant. Senior divisional management 'triaging' of complaints is used effectively to secure an early resolution of complaints wherever appropriate, for example issues around appointments can often be resolved quickly via a telephone call. Where a complaint requires a full investigation, the complaints team make early contact with the complainant, wherever possible, to agree the issues to be investigated, the preferred method of response and a realistic timescale for responding.

Additional Key Performance Indicators (KPIs) have been introduced in 2018/19 to monitor performance at key stages of the complaint to identify where barriers may be delaying responses to complaints so that appropriate action can be taken. More information about our KPIs can be seen in the Quality Account section of this report.

Trust performance against our main KPI of responding to 85% of our complaints within 30 working days has been under pressure for much of the year. A trajectory to improve performance is being developed alongside further alignment and refinement of our processes to maximise efficiencies and ensure resources are targeted appropriately. Alongside this, a series of complaints training workshops have been delivered and more are planned in 2019/20. For medical staff, the complaints management session delivered by the Head of Patient Relations alongside an experienced consultant continues to be well received by new consultants as part their induction to the Trust.

The creation of a new Patient Experience Group in January 2019 provided an enhanced opportunity to provide a monthly report on complaints activity across all sites sharing data, performance, themes, actions and learning. This report has generated discussion of key issues and associated actions with key senior staff and Trust governors. Complaints are then reported onto Board via the Care Quality Group.

The Trust takes a number of steps to ensure that we learn from complaints. Agreed actions from individual complaints are shared with the complainant in the Trust's written response or at the local resolution meeting. This learning is further shared at divisional and departmental level. Reports on themes with individual learning examples are provided to the Chief Executive's Advisory Group, the Executive Chief Nurse's Care Quality Group, Patient Experience Group, Clinical Commissioning Group, Divisional Clinical Quality Groups, to name but a few.

Whilst the Trust makes every effort to resolve complaints to the satisfaction of the complainant, this may not always be possible for a variety of reasons. Complainants are made aware of the option of approaching the Parliamentary and Health Service Ombudsman to assess their complaint independently. The level of complaints about this Trust reviewed by the Ombudsman remained relatively low. In 2018/19, the Ombudsman upheld or partly upheld only three complaints, compared to eight in the previous year.

Positive feedback is also important in highlighting success and providing opportunities to replicate successful initiatives wherever possible. In 2018/19 the Trust formally recorded receipt of 1,971 compliments, compared to the 1,950 complaints received.

Below are a few examples of the compliments we receive:

Good Hope Hospital

I was extremely anxious about the procedure after the horrific pain earlier in the week. The reception ladies in X-ray, CT and MRI, along with the radiographers, were wonderful; they went out of their way to reassure me and to explain everything. I feel I was dealt with by people who actually cared about me and who were prepared to spend time with me.

Heartlands Hospital

*Ward 8 was the place they helped mend my bones and mind
The nurses and carers were all amazingly kind
I came on the ward in pieces that needed screwing back together
And a brain that was truly under the weather
But the staff stood no messing and soon made me smile
Making me wash, sit out of bed, eat, drink and hop for what seemed like a mile
But truly thankful I am to each and every one of you
Devotion to your profession shows to be true
You need to know just what an important part you all play
In making it tolerable a hospital stay.*

Solihull Hospital

I wish to inform you of the top class patient care we have recently experienced in Solihull Hospital. The medical professionals are very committed and treat patients with lots of respect and dignity. They are so helpful, polite and ready to answer any concerns that we as patients have which is honestly so much appreciated by all of us.

QEHB

I have just been discharged from a ten day stay in CDU, ward 408 and ward 727 and I just wanted to email to thank all of the staff who looked after me whilst I was in. Everyone I came across was friendly, helpful, and worked together to make the place as nice as can be for all of the patients. There were some fabulous porters particularly down in CDU who interacted with patients, fetched them extra sauces or salt at mealtimes (when they were obviously busy and had other things to do) but because they had been asked they did it cheerfully and helpfully.

1.14 Research and Development

1.14.1 Clinical trials activity

The Trust’s extensive and innovative Research and Development portfolio enables patients to have access to new medicines, devices or diagnostics early as part of clinical trials which can provide treatment options for patients for whom conventional treatments might have failed or where treatment options are limited. During 2018/19, UHB has been able to deliver benefits to patients on clinical trials including reduced symptoms, increased survival times and improved quality of life. The total number of patients recruited into all studies open during 2018/19 was 16,040 (QEHB and Heartlands, Good Hope and Solihull merged data).

The number of new studies registered with the R&D Governance Office during 2018/19 was 347 with a total of 808 studies open across all of the UHB hospital sites. Of these, processing was abandoned for 31 studies.

The table below shows the number of clinical research projects registered with the Trust’s Research and Development (R&D) team during the past two financial years. The number of studies which were abandoned is also shown for completeness. The number of studies being abandoned is reducing due to rigorous implementation of a new capacity and capability review system.

Reporting Period	2017/18 (HGS)	2017/18 (QEHB)	2018/19 (UHB total)
Total number of projects registered with R&D	167	270	347
Out of the total number of projects registered, the number of studies which were abandoned	35	72	31
Trust total patient recruitment	8,813	8,254	16,040

The number of patients receiving relevant health services provided or sub-contracted by UHB in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was:

NIHR portfolio studies (merged data)	15,068
Non-NIHR portfolio studies	972
Total	16,040

The number of UHB Consultants leading research studies as Principal Investigators and Chief Investigators has increased across UHB and is currently n=326 with 66 studies being sponsored by UHB. Four of the 66 studies sponsored by UHB are Clinical Trials involving Investigational Medicinal products (CTIMPs).

New research grant funding awarded in year across the merged sites was n=143. These include 21 NIHR funded, 98 research charity funded and 11 academic training fellowships.

385 patients have been recruited to rare disease studies in the time period April 2018 to February 2019.

1.14.2 Research Highlights

In July 2018 The Earl of Wessex visited The Centre for Clinical Haematology, which reopened in January 2018 following a £3.4m refurbishment. The Centre doubled its capacity, providing benefits for blood cancer patients and leading to an increased ability to provide ground-breaking clinical trials.

Heartlands Hospital was the leading recruiting site for a national trial aiming to reduce the use of unnecessary antibiotics during labour. The GBS2 trial is taking place across 16 trusts in the UK, with more than 50 new mums taking part at Heartlands. Results are expected to be published later this year.

Thomas Pinkney (Lead Researcher) and Linda Webber (Lead Research Nurse) were winners at the NIHR Clinical Research Network West Midlands (CRNWM) third annual awards in October. Thomas, based at QEHB, received the "Investigator of the Year" award for his work with the General Surgery team. Linda, based at Heartlands, was presented with the "Creative Recruitment" award, in part for introducing novel ways to encourage teams to meet recruitment targets.

UHB, in partnership with the University of Birmingham, has launched a new study to review and potentially enhance concussion diagnosis in football. The study is running throughout the 2018-19 football season. This expands research also being carried out by UoB and UHB, which began in 2017 and is currently ongoing, testing the urine and saliva of concussed Rugby Football Union players. The trial, led through the NIHR SRMRC, could lead to the development of a pitch-side diagnostic test for head injury, which would be the first objective test for concussion.

The Countess of Wessex officially opened the Scar Free Centre for Conflict Wound Research

in November 2018. The first military and civilian wound research centre of its kind in the world aims to minimise the psychological and physical impact of scarring among armed forces personnel and civilians wounded in terrorist attacks. The Centre for Conflict Wound Research was later visited by the Duke of Sussex in March, to find out more about the new treatments being tested, which could help reduce scarring.

A medallist at the 2018 Gold Coast Commonwealth Games was diagnosed and treated by staff at UHB. Melissa Courtney, who won a bronze medal in the 1500m, was diagnosed with an inherited metabolic disorder (IMD) at the Centre for Rare Diseases in March 2017.

A patient at QEHB was the first person in the world to take part in a pioneering gene therapy trial for his rare disease. Simon Smith was diagnosed with Ornithine Transcarbamylase (OTC) deficiency as a teenager. The trial, which involved a single intravenous injection that targeted the liver, has vastly improved Simon's quality of life. He now has no symptoms and has to take a much lower number of tablets.

Research Radiographer Hayley Carruthers represented England at the Toronto Marathon in October having previously finished as the first English athlete at the Great North Run and fourth in the London Marathon.

1.14.3 Building our Academic Capability

The Trust continues to work closely with academic colleagues at the University of Birmingham and other local academic institutions, as part of BHP.

In addition, a number of colleagues have recently been appointed to senior academic roles, which they will combine with their clinical commitments, bringing benefits to their patients, their colleagues, and the Trust.

Two Research Nurses, Liz Lees-Deutsch and Teresa Melody, have been awarded the 70@70 NIHR Senior Nurse and Midwife research leader programme. The programme supports senior clinical nurses and midwives to champion the promotion of an embedded research active culture, encourage and support innovation, and inform research priorities in their organisations.

Professor Fang Gao, Professor Antonio Belli, Professor Philip Newsome and Professor Hisham Mehanna have all been awarded NIHR Senior Investigator status. Senior Investigators are among the most prominent and prestigious researchers funded by the NIHR and the most outstanding

leaders of patient and people-based research within the NIHR research community. Senior Investigators are appointed from NIHR Investigators through annual competitions informed by the advice of an international panel of experts.

1.14.4 Patient and Public Engagement

The Trust's successful annual Research Showcase, held in May each year to coincide with International Clinical Trials Day, allows members of the public, patients and staff to see how their involvement in research can make a real difference to the healthcare of future generations.

In May 2018 there were more than 25 presentation stands. Patients and other members of the public were able to find out how they can get involved in research which offers cutting-edge treatments or expands understanding of how the human body works.

The Trust also celebrated Rare Disease Day on February 28, with stands providing information about the rare disease facilities across UHB, including the Cfrd and WMGMC.

Across UHB, there are a number of Patient and Public Involvement groups, whose contributions include helping researchers decide what matters to patients, supporting the development of grant applications, and reviewing patient information leaflets and questionnaires.

Groups include the Clinical Research Ambassador Group (CRAG) at Heartlands, the SRMRC's Accident, Burns and Critical Care (ABC) group, and the Trauma Advisor Group (TAG) which works across the SRMRC and Trauma MIC. The BRC has a number of PPI groups, including the Birmingham Rheumatology Research Patient Partnership (R2P2), Sarcopenia Public Involvement in Research Group (SPIRG), and Liver GI PPI Reference Group.

1.15 Enhanced quality governance reporting

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

Comprehensive use of electronic decision-support and monitoring tools, developed within UHB and now being rolled out across the enlarged organisation, enables the Trust to monitor compliance with essential clinical protocols and to identify potential risk areas at an early stage. Additional investigations and audits can be undertaken following such triggers. The effectiveness of this monitoring system is backed up by regular unannounced governance inspections by board members and work is ongoing to ensure appropriate engagement with other relevant stakeholders.

Additional information regarding quality governance, well-led assurances and quality is set out in the Annual Governance Statement page 71.

2 Governance

2.1 NHS Foundation Trust Code of Governance

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

The purpose of the Code is to assist NHS foundation trust boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance. The Code is issued as best practice advice, but imposes some disclosure requirements. These are met by the Trust's Annual Report for 2018/19. In its Annual Report, the Trust is required to report on how it applies the Code. Whilst foundation trusts must always adhere to the main and supporting principles of the Code, they are allowed to deviate from the Code provisions provided the reasons for any such departure are explained and the alternative arrangements reflect the main principles of the Code.

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

- ▶ The Constitution
- ▶ Standing Orders
- ▶ Standing Financial Instructions
- ▶ The Corporate Governance Policy, incorporating the Schedule Of Reserved Matters and Role Of Officers
- ▶ The Chief Executive's Scheme Of Delegation
- ▶ The Annual Plan
- ▶ Committee Structure

The Board of Directors has conducted a review of the effectiveness of the Trust's system on internal controls.

2.1.1 Application of Principles of the Code

A. The Board of Directors

The Board of Directors' role is to exercise the powers of the Trust, set the Trust's strategic aims and to be responsible for the operational management of the Trust's facilities, ensuring compliance by the Trust with its constitution, the

Provider Licence, other mandatory guidance issued by NHS Improvement, relevant statutory requirements and contractual obligations.

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

Annex 2 of the Trust's Constitution sets out a procedure for the resolution of any disagreements between the Board of Directors and the Council of Governors, through mediation.

The Board of Directors has reserved to itself matters concerning Constitution, Regulation and Governance; Values and Standards; Strategy, Business Plans and Budgets; Statutory Reporting Requirements; Policy Determination; Major Operational Decisions; Performance Management; Business Cases and Major Contracts; Finance and Activity; Risk Management Oversight; Audit Arrangements; External Relationships and any matter which may have a detrimental effect on the reputation of the Trust.

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

All powers which are neither reserved to the Board of Directors or the Council of Governors nor directly delegated to an Executive Director, a committee or sub-committee, are exercisable by the Chief Executive or as delegated by her/him 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 39, together with information about the Committees of the Board, their membership and attendance by individual directors.

B. The Council of Governors

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

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

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

Details of the composition of the Council of Governors are set out on page 36 of the Annual Report, together with information about the activities of the Council of Governors and its committees.

Governors have canvassed the opinion of the Trust’s members and the public, and for appointed governors the body they represent, on the Trust’s forward plan in a number of ways, including the following:

- ▶ Governors’ Drop-in Sessions, held monthly across all sites
- ▶ Governors attendance at community presentations held in their constituency in relation to the hospital/patients’ issues
- ▶ Health Talks. Governors attend health talks which are held on a monthly basis for members and wider community

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, resulting in the appointment of a Chief Operating Officer for Heartlands, Good Hope and Solihull, as

well as the Board attending Director of Finance and Director of Quality Development to ensure continued focus on financial performance as well as clinical quality.

Details of the composition of the Executive Appointments and Remuneration Committee and its activities are set out on page 49 of the Annual Report. Details of terms of office of the Directors are set out in Board of Directors, page 39, of the Annual Report and in the Remuneration Report, from page 60.

D. Information, development and evaluation

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

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

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

E. Director Remuneration

Details of the Trust’s processes for determining the levels of remuneration of its Directors and the levels and make-up of such remuneration are set out in the Remuneration Report, page 60.

F. Accountability and Audit

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

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

Deloitte LLP was appointed by the Council of Governors as the Trust's External Auditor with effect from 7 February 2014. In July 2018, the Council of Governors re-confirmed their appointment for the audit of the accounts for the financial year ending on 31 March 2019.

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

Additional information regarding audit is set out in the Audit Committee Report on page 47.

G. Relations with Stakeholders

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

H. Evaluation

The Trust has engaged the Good Governance Institute in the conduct of an externally facilitated evaluation of the Board against the "well-led framework for governance reviews" this year. The evaluation consisted of Board seminars, focus groups and workshops, meetings with external stakeholders, shadowing of Board and Board Committee meetings as well as interviews with each of the Board directors, including Non-Executive Directors. The outcome of this review will be reported to the Board during the summer of 2019.

2.1.2 Compliance with the Code

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

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

The Council of Governors has not appointed external professional advisers to market-test the remuneration levels of the Chair and other Non-Executive Directors. A material change to the remuneration of the Non-Executive Directors was last considered in 2009/10, when the proposed increases in remuneration were benchmarked against other similar trusts through a remuneration survey carried out by the Foundation Trust Network. For 2014/15 and 2015/16, the Non-Executive Directors did not receive any increase in remuneration, in line with the majority of NHS staff. In 2013/14 and 2016/17, the Non-Executive Directors received a 1% inflationary increase, again in line with the majority of NHS staff. There was no increase in remuneration in 2017/18 or 2018/19.

3 Council of Governors

3.1 Overview

The Trust's Council of Governors continues to make a significant contribution to the success of the Trust and its commitment, support and energy is greatly valued. The Council currently has 33 places filled by 31 representatives.

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

The Council of Governors is comprised as follows:

- ▶ 17 public Governors elected from the Parliamentary Constituencies in Birmingham, Solihull & Meriden and Lichfield & Tamworth (with one position being vacant)
- ▶ 3 public Governors elected from the Rest of England area
- ▶ 6 staff Governors elected by the following staff groups:
 - > Medical
 - > Nursing (2)
 - > Clinical Scientist and Professions Allied to Healthcare
 - > Corporate and Support Services (2)
- ▶ 7 Stakeholder Governors appointed by seven of its key stakeholders

3.2 Governors

Elections for 20 Public Governors were held in June and August 2018. Governors elected at these elections were appointed for a mixture of two to three-year terms commencing on 1 July 2018. In addition, a by-election was held for one Staff Governor for a one-year term.

During this year, the Governors have been:

3.2.1 Patient Governors (until 30 June 2018):

- ▶ Dr Prakash Naik
- ▶ Mrs Linda Stuart
- ▶ Vacant

3.2.2 Public (by area and Parliamentary Constituency)

Edgbaston

Dr Elspeth Insch OBE
Paul Burgess MBE

Selly Oak

Dr John Delamere
Alex Evans

Hall Green

Dr Elizabeth Hensel
Bernadette Aucott

Northfield

Sandra Haynes MBE
Edith Davies

Erdington, Hodge Hill, Ladywood, Yardley, Perry Barr & Sutton Coldfield

Dr Aisha Sharif

Rest of England

Dr John Cadle

After the elections in June, the new Constitution incorporated changes resulting in the following format:

Public Governors:

Rest of England & Wales

Mark Aspinall (resigned 31/03/19)
Kath Bell
Beverley Martin
Keisha Pinnock (from 01/04/19)

Birmingham South

Bernadette Aucott

Solihull & Meriden

Stan Baldwin
Dr Sue Balmer
Anne McGeever

Quinton, Halesowen & Southwest

Dr John Cadle

Sutton Coldfield North

Tony Cannon

Birmingham East

Keith Fielding

Birmingham North

Albert Fletcher

Birmingham South WestSandra Haynes MBE
Birmingham Southeast
Dr Elizabeth Hensel**Lichfield, Northwest & Northeast**

Phyl Higgins

Tamworth

Derek Hoey

Birmingham West

Dr Elspeth Inch OBE

Birmingham Central

Attiqa Khan

Birmingham Reservoirs

Adam Layland

Birmingham Heartlands

Gerry Moynihan

Sutton Coldfield South

Vacant

3.2.3 Staff**Medical and Dental**

Dr Tom Gallacher

Nursing and MidwiferyDr Kate Gee
Yvonne Murphy**Clinical Scientist & Allied Health Professional**

Sally Glover

Corporate & Support ServicesPatrick Moore
Lee Williams**3.2.4 Stakeholders****Birmingham City University**

Prof Carol Doyle

Birmingham City Council

Cllr Jayne Francis

Faith Leaders

Rabbi Yossi Jacobs

RCDM

Major General Martin Bricknell until December 2018

Acting Surgeon General AVM Alastair Reid from January 2019

University of Birmingham

Dr Iestyn Williams until 20/09/18

Prof Isabelle Szmigin from October 2018

Solihull Council

Cllr Kate Wild

Lichfield & Tamworth Council

Cllr Ashley Yeates from February 2019

3.3 Lead Governor

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

3.4 Meetings

The Council of Governors met regularly throughout the year, holding eight meetings in total, including one joint meeting with the Board of Directors. The Chair (the Rt Hon Jacqui Smith) attended all meetings.

Name of Governor	No. of meetings attended out of eight unless stated)
Public	
Mark Aspinall	2 out of 6
Bernadette Aucott	8 out of 8
Stan Baldwin	6 out of 8
Dr Sue Balmer	5 out of 7
Kath Bell	7 out of 8
Paul Burgess	1 out of 1
Dr John Cadle	3 out of 8
Tony Cannon	7 out of 8
Edith Davies	3 out of 3
Dr John Delamere	3 out of 3
Alex Evans	1 out of 1
Keith Fielding	6 out of 8
Albert Fletcher	3 out of 8
Sandra Haynes MBE	7 out of 8
Dr Elizabeth Hensel	4 out of 8
Phyl Higgins	3 out of 5
Derek Hoey	7 out of 8

Name of Governor Public	No. of meetings attended out of eight unless stated)
Elspeth Insch OBE	5 out of 8
Phillip Johnson	0 out of 1
Attiqua Khan	2 out of 5
Adam Layland	3 out of 6
Dr Prakash Naik	0 out of 1
Anne McGeever	5 out of 8
Beverley Martin	2 out of 5
Gerry Moynihan	5 out of 5
Linda Stuart	3 out of 3

Name of Governor Staff	No. of meetings attended (out of eight unless stated)
Dr Tom Gallacher	2 out of 8
Dr Kate Gee	4 out of 8
Sally Glover	2 out of 7
Patrick Moore	5 out of 8
Yvonne Murphy	3 out of 8
Lee Williams	5 out of 7

Name of Governor Stakeholder	No. of meetings attended (out of eight unless stated)
Surg.Gen. Martin Bricknell	1 out of 5
Rear Admiral Andrew Hughes	1 out of 1
Acting Surg Gen AVM Alastair Reid	0 out of 2
Cllr Carol Doyle	0 out of 8
Cllr Jayne Francis	1 out of 8
Rabbi Yossi Jacobs	0 out of 7
Prof Isabelle Szmigin	1 out of 4
Dr Iestyn Williams	1 out of 4
Cllr Kate Wild	3 out of 7
Cllr Ashley Yeates	1 out of 2

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

- ▶ Attending, and participating in, Governor meetings and monthly Governor seminars
- ▶ Attending, and participating in, joint Council of Governor and Board of Director meetings to look forward and back on the achievements of the Trust
- ▶ Attendance and participation at the Trust's Annual General Meeting
- ▶ Governors and Non-Executive Directors are members of various working groups at the Trust e.g., Strategic Planning Group, Care Quality Group
- ▶ During the Reporting Period, one meeting, on 28 February 2019, has been held between the Non-Executive Directors and Governors, specifically to facilitate the Governors in holding the Non-Executive Directors, individually and collectively, to account for the performance of the Board

3.6 Governors' Register of Interests

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

4 Board of Directors

4.1 Overview

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

Harry Reilly has held the appointment of Deputy Chair since 1 July 2016. Dr Catriona McMahon holds the appointment of Senior Independent Director. The Senior Independent Director is available to meet stakeholders on request and to ensure that the Board is aware of member concerns not resolved through existing mechanisms for member communications.

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

- ▶ Chair: Rt Hon Jacqui Smith
- ▶ Chief Executive: Dame Julie Moore (up to 31 August 2018)/ Dr David Rosser (from 1 September 2018)
- ▶ Chief Financial Officer: Mike Sexton
- ▶ Medical Director: Dr David Rosser (up to 31 August 2018)/ Prof Simon Ball (from 1 January 2019)
- ▶ Medical Director (Acting): Mr Mike Hallissey (from 1 September until 31 December 2018)
- ▶ Director of Workforce and Innovation: Tim Jones
- ▶ Chief Nurse: Lisa Stalley-Green (from 1 September 2018)
- ▶ Chief Nurse (Acting): Michele Owen (up to 31 August 2018)
- ▶ Director of Strategic Operations: Kevin Bolger
- ▶ Chief Operating Officers: Cherry West and Jonathan Brotherton

Non-Executive Directors:

- ▶ Angela Maxwell (term expired 30/6/2018)
- ▶ David Waller (term expired 30/9/2018)
- ▶ Jane Garvey
- ▶ Harry Reilly
- ▶ Dr Catriona McMahon
- ▶ Dr Jason Wouhra
- ▶ Prof Jon Glasby
- ▶ Jackie Hendley
- ▶ Karen Kneller
- ▶ Mehrunnisa Lalani
- ▶ Prof 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
Jane Garvey	1 December 2016	3 years	30 November 2019
Harry Reilly	1 December 2016	3 years	30 November 2019
Catriona McMahon	1 June 2017	3 years	31 May 2020
Jason Wouhra	1 December 2017	3 years	30 November 2020
Jon Glasby	1 May 2018	3 years	30 April 2021
Jackie Hendley	1 May 2018	3 years	30 April 2021
Karen Kneller	1 May 2018	3 years	30 April 2021
Mehrunnisa Lalani	1 May 2018	3 years	30 April 2021
Michael Sheppard	1 May 2018	3 years	30 April 2021

The Board of Directors considers Jane Garvey, Harry Reilly, Catriona McMahon, Dr Jason Wouhra, Prof Prof Jon Glasby, Jackie Hendley, Karen Kneller, Mehrunnisa Lalani and Prof Michael Sheppard to be independent. In coming to this determination, the Board of Directors has taken into account the following:

Dr Jason Wouhra is the Regional Chairman of Institute of Directors West Midlands.

4.2 Board meetings

The Board met regularly throughout the year, holding 11 meetings in total. Attendance was as follows:

Directors	No. of meetings attended (out of 11, unless stated)
Rt Hon Jacqui Smith	All
Dame Julie Moore	4 out of 4
Mike Sexton	All
Tim Jones	10 out of 11
Dr David Rosser	9 out of 11
Lisa Stalley-Green	6 out of 7
Michele Owen	4 out of 4
Angela Maxwell	1 out of 1
Kevin Bolger	10 out of 11
David Waller	1 out of 1
Jane Garvey	9 out of 11
Harry Reilly	9 out of 11
Cherry West	All
Dr Catriona McMahon	All
Dr Jason Wouhra	6 out of 11
Jonathan Brotherton	All
Mr Mike Hallissey	4 out of 4
Prof Michael Sheppard	10 out of 11
Prof Simon Ball	3 out of 3
Prof Jon Glasby	8 out of 11
Jackie Hendley	6 out of 11
Karen Kneller	8 out of 11
Mehrunnisa Lalani	7 out of 11

4.3 The Board of Directors composition

Rt Hon Jacqui Smith, Chair

Jacqui Smith has been Chair of University Hospitals Birmingham NHS Foundation Trust since December 2013. She now chairs the enlarged trust following the acquisition of Heart of England NHS Foundation Trust. Jacqui also chairs Birmingham Health Partners which coordinates the research partnership with the University of Birmingham.

Jacqui grew up in Worcestershire and, after reading Philosophy, Politics and Economics at Hertford College, Oxford University, she returned to the county and had a successful teaching career for 11 years in Worcestershire schools.

In 1997, Jacqui was elected as the MP for Redditch and served for 13 years. After a period on the Treasury Select Committee, she was appointed as a Minister in 1999 and became one of the longest serving Ministers in the Labour government. In 2007, Jacqui was appointed as the first female Home Secretary.

Jacqui is also Chair of the Sandwell Children's Trust, of the Precious Trust – a Birmingham based charity supporting girls at risk of gang violence – and of the Lunar Society. She is a Trustee of the Kings Fund and also works in Jordan and Egypt supporting parliamentary and political development.

Dame Julie Moore, Chief Executive (until 31 August 2018)

Julie is a graduate nurse who worked in clinical practice before moving into management. After a variety of clinical, management and director posts, she was appointed as Chief Executive of University Hospitals Birmingham (UHB) in 2006.

Julie was a Governor of Birmingham City University and a Trustee of the Prince of Wales's Charitable Foundation. She is a founder member and past Chair of the Shelford Group, the 10 leading academic hospitals in England. She was an independent member of the Office for Strategic Co-ordination of Health Research (OSCHR) from 2009 to 2015 and has been a member of the following bodies: The International Advisory Board of the University of Birmingham Business School, the Court of the University of Birmingham and the Faculty Advisory Board of the University of Warwick Medical School until 2015

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

In October 2015 she was appointed interim Chief Executive of Heart of England NHS Foundation Trust (as well as remaining Chief Executive of UHB), to help lead it out of clinical and financial difficulties. In March 2017 she was asked to take

over leadership of the Birmingham and Solihull Strategic Transformation Partnership - a partnership of health bodies and local authorities.

Julie was made a Dame Commander of the British Empire in the New Year's Honours 2012. In 2013, she was awarded an Honorary Chair at Warwick University, was included in the first BBC Radio 4's Woman's Hour list of the 100 most powerful women in the UK and is included in the HSJ lists of the most influential clinical leaders, the top CEOs and a national LGBT role model in health. She has Honorary Doctorates from the University of Birmingham, Birmingham City University and Oxford Brookes University. She retired from UHB in August 2018.

Dr David Rosser, Chief Executive (from 1 September 2018)

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

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

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

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

He took up the role of Deputy Chief Executive with responsibility for clinical quality at Heart of England NHS Foundation Trust (HEFT) in November 2015, in addition to the Medical Director role at UHB, and was appointed as Executive Medical Director of HEFT in March 2016. When the two trusts merged in April 2018, David continued in his role as Executive Medical Director and also became the Deputy Chief Executive for the combined Trust.

David was appointed as Chief Executive of UHB on 1 September 2018.

Executive Directors

Prof Simon Ball, Executive Medical Director

Simon was appointed as Medical Director in 2019. He trained in medicine at Oxford University and University College London, underwent postgraduate training in nephrology, dialysis and transplantation in North West London and was an MRC doctoral fellow in the Dept of Biology at Imperial College.

Appointed as a consultant nephrologist to UHB in 2001, he has been Clinical Service Lead in Nephrology, an Associate Medical Director and Director of Digital Healthcare. He was President of the British Renal Society between 2013 and 2016. His contributions to research and innovation include collaborations with academic and industry partners seeking to understand and quantify immune response in transplantation. More recently his interest has pivoted toward the curation and analysis of high value health data assets, such that in 2018 he became Health Data Research UK Research Director in the Midlands. This is based on his longstanding contributions to UHB's development and implementation of electronic health care records, to improve the quality and effectiveness of patient care. This convergence of technology and quality management will remain an important part of his role as Medical Director.

Kevin Bolger, Executive Director of Strategic Operations and External Affairs

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

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

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

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

After the merger of UHB and HEFT, Kevin became the Director of Strategic Operations for the combined Trust and from April became Chief Workforce and International Officer, a role which now includes responsibility for HR and workforce.

Jonathan Brotherton, Executive Chief Operating Officer (HGS)

Jonathan joined Heart of England NHS Foundation Trust in September 2014 as Director of Operations and was appointed to the Board of Directors in March 2015. He joined the NHS in 1992 as a trainee paramedic in Worcestershire and was one of the inaugural members of the National Emergency Care Intensive Support Team (ECIST) during which time he qualified as a performance coach and management consultant.

He graduated from the University of Worcester with a Masters' degree in management studies in 2007 and has worked in senior management roles at Burton Hospitals and most recently at University Hospitals Coventry & Warwickshire NHS Trust as Director of Performance.

When UHB and HEFT merged in April 2018, Jonathan became the Chief Operating Officer (COO) for Heartlands, Good Hope and Solihull hospitals. On 1 April 2019 he was appointed COO for the whole Trust.

Tim Jones, Executive Director of Delivery

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

Tim joined UHB in 1995 as an operational manager in General Medicine and Elderly Care. He continued to work in Operations until 2002, when he undertook the role of Head of Service Improvement and led the New Hospital Clinical Redesign Programme, before being appointed to the role of Chief Operating Officer in June 2006. In September 2008, he was appointed to the

newly-created role of Executive Director of Delivery which incorporates board level responsibility for Research & Innovation, Education and Workforce. Tim also gained an MSc in Health Care Policy from the University of Birmingham. On 1 April 2019 he was appointed Chief Innovation Officer, retaining responsibility for Education and Research.

Tim is an Executive Director of Birmingham Health Partners, Senior Responsible Owner (SRO) for the NIHR Collaboration for Applied Health Research Centre, SRO for the West Midlands Academic Health Science Network, Industry Governor and Deputy Chair of Harborne Academy. Tim is also an Industrial Professor in the Warwick Manufacturing Group at the University of Warwick and Course Director for their Healthcare Operations Management Masters' Degree.

Michele Owen, Acting Executive Chief Nurse (until 31 August 2018)

Michele has over 35 years of nursing experience. She completed training at Dudley Road Hospital and worked mainly in medicine, before leaving her position as Associate Director of Nursing for Surgery/Emergency Department to join the National Clinical Governance team when clinical governance was being introduced in the NHS. This gave Michele the opportunity to travel the length of the country supporting clinical teams to undertake service improvement projects to develop patient care and pathways.

After two years, Michele joined the team at UHB as Associate Director of Nursing for Division One, covering theatres, critical care, ambulatory care and some surgical specialties. Michele then spent ten years as Deputy Chief Nurse, leading the corporate team, before taking up the Interim Chief Nurse position in September 2017.

Mike Sexton, Executive Chief Financial Officer

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

Lisa Stalley-Green, Executive Chief Nurse (from 1 September 2018)

Lisa graduated from Brunel University in 1990 with a BSc in Modern History & Politics. She spent nine years working in the Prison Service and private sector prisons in London, achieving a senior

management post by the age of 25 and gaining a Masters in Business Administration from Hull University in 1999.

Lisa changed career and completed her nurse education on rotation between St Bartholemew's, The Royal London and Homerton University Hospital (1999 – 2002). She became A Nurse Professional in 2002 having achieved a Diploma in Nursing, (Distinction) from City University/St Bartholemew's.

Lisa gained six months' experience in orthopaedics, and specialising in A&E nursing, as a Senior Nurse in Accident & Emergency at Homerton University Hospital between 2002 and 2005, with ALS (Advanced Life Support) and trauma courses completed. She was Senior Matron for Prison Health in the East Midlands for three years (2005 – 2008) before being appointed Service Manager Specialist Services at Nottinghamshire Community Health Services (2008 – 2010).

Lisa held the post of Chief Operating Officer for Newark & Sherwood CCG (2010 – 2012) before moving to Lincolnshire Community Health Services. Here, she was Deputy Chief Nurse and then Director of Nursing & Operations of a Trust which has been rated as Outstanding by the Care Quality Commission, prior to her taking up the role of Executive Chief Nurse at UHB.

Lisa is a Registered Nurse and member of the Royal College of Nursing, having completed her revalidation in 2017, and a Kings Fund Alumna.

Cherry West, Executive Chief Operating Officer (QEHB)

Cherry began her NHS career as a Healthcare Scientist - Clinical Physiologist - before moving into Operational Management 20 years ago. She joined University Hospitals Birmingham as Chief Operating Officer in August 2014, and has been the lead for delivery of patient services and operational performance through the Trust's Clinical Divisions at QEHB; Following a period of nine years as a Chief Operating Officer, in April 2019, Cherry was appointed to the role of Chief Transformation Officer across the whole of UHB, encompassing Healthcare Transformation, the digital agenda, long-term planning, Service Reconfiguration, Service Improvement & Quality Improvement Strategy, and Capital Developments.

Cherry's aim is to deliver and maintain effective, high quality services, providing timely, evidenced based pathways and best possible outcomes to the patients we serve. She believes that in complex health systems this requires distributed leadership supported by digitally enabled services designed to ensure that patients receive the right care, in

the right place, at the right time. Cherry is also the Executive Lead for the Cancer Pillar for Birmingham Health Partners, focusing on four key areas of work across primary and secondary care: How to achieve earlier cancer diagnosis; improving access to cancer diagnostics; use of AI to enable reporting opportunities; and translational research.

Cherry completed undergraduate studies at UMDS, London; an MSc at University College London; an MBA at Henley Management College; and a Diploma in Health Planning and Management through Birkbeck College, University of London.

Non-Executive Directors

Jane Garvey

Presenter of Radio 4's 'Woman's Hour', Jane was brought up in Liverpool, moving to Birmingham in the early 1980s as a student to study English Literature. Her early experience of the NHS came through her mother, who was a receptionist at the Royal Liverpool Hospital and, after leaving University, Jane's first job was as a Medical Records Clerk at the same hospital.

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

Jane, who has strong connections to the West Midlands, is keen to broaden her experience outside the 'BBC bubble'. She brings well-developed, high-level communications skills, developed over her very successful 30 year career in broadcasting. Jane's experience has given her valuable exposure to interacting with both high-profile figures and the public.

Jane joined the Board in December 2013.

Professor Jon Glasby

A qualified social worker by background, Professor Jon Glasby is Head of the School of Social Policy at the University of Birmingham. Prior to this, he was Director of the University's Health Services Management Centre for seven years, where he specialised in joint work between health and social care and was involved in regular policy analysis and advice.

He has previously served as a Non-Executive Director of Birmingham Children's Hospital and a trustee of the UK Social Care Institute for Excellence (SCIE). He is a Senior Fellow of the National Institute of Health Research (NIHR) School for Social Care Research, and a Fellow of the Academy of Social Sciences and the Royal Society of Arts.

Jon joined the Board at Heart of England NHS Foundation Trust in October 2015 and the UHB Board in May 2018. He is also a Non-Executive Director of the Birmingham Children's Trust.

Jackie Hendley

Jackie offers the Trust over 30 years of professional services experience, 11 as a KPMG partner for clients in plcs and private equity across a varied range of sectors both in the private and public sector. She has advised a wide range of Boards on tax, structuring, strategy, risk management and governance including operational restructuring and dispute mitigation.

Combining a commercial, accounting, auditing and tax background with Boardroom experience to offer constructive challenge and strategic advice, her experience includes challenging what business will look like in the future and how to maximise potential.

Jackie also advises clients and teams in many industries, including: retail, manufacturing, automotive, property, not-for-profit, public sector and transport. Jackie is passionate about supporting her local community and has been involved with a number of schools and charities in the area and is committed to bringing people together to build capacity and opportunity.

Jackie is currently Managing Partner of Smith Cooper in Birmingham and Head of Tax for the firm. She is also Regional Vice Chair of the Institute of Directors; a Council Member of Greater Birmingham Chambers of Commerce and an Executive Committee Member of Sutton Coldfield Chamber of Commerce.

Jackie joined the UHB Board in May 2018 and was previously a Non-Executive Director at Heart of England NHS Foundation Trust from June 2016.

Karen Kneller

Karen brings over 20 years' experience as a barrister; in addition to her legal skills she also brings experience of strong leadership, finance and audit developed in the public, not for profit / social business, and third sector.

Based in Birmingham where Karen is a CEO, she has both a strong executive and non-executive background. Karen is committed to diversity and inclusion and is Chair of brap, a national equalities charity based in Birmingham.

Karen joined the Board at Heart of England NHS Foundation Trust in October 2014 and joined the UHB Board in May 2018.

Mehrunnisa Lalani

Mehrunnisa has a diverse background having worked for a range of public sector organisations from local Government to HM Prison Service. She started her career working with older people and Black & Minority Ethnic (BME) communities experiencing mental health difficulties.

Mehrunnisa was Director of Inclusion for the Solicitors Regulation Authority (SRA) for 10 years leading on consumer affairs, corporate complaints and equality, diversity and inclusion. Mehrunnisa transformed complaint handling leading to an improvement in customer satisfaction and reduction in complaints. She led the establishment of 'Legal Choices', an online interactive platform where consumers of legal services can access information about legal services, standards and regulation and participate in key areas of regulatory policy development.

She has also held a number of Non- Executive positions in the health and voluntary sector, serving as a Non-Executive Director on the Leicestershire, Northampton and Rutland Strategic Health Authority, an East Midlands ACCEA and as an Independent Lay Member of the Leicester City Clinical Commissioning Group (CCG). More recently, Mehrunnisa has been a member of the Doctors and Dentists Pay Review Body (DDRB).

Mehrunnisa is currently a Lay Adjudicator/Fitness to Practice panel member for the British Association of Counselling and Psychotherapists (BACP) and an Independent Member on the Leicestershire, Leicester and Rutland Police and Crime Commissioners Panel. She is also an Authorised Representative for Leicestershire Health Watch. She works as a consultant providing advisory and training services to public, voluntary and private sector organisations.

Mehrunnisa has a Postgraduate Diploma in Health Studies, a JNC Qualification in Youth and Community Work and an MA in Health and Community Studies. She was appointed as Non-Executive Director at the Heart of England NHS Foundation Trust in February 2017 and joined the Board at UHB in May 2018.

Angela Maxwell OBE

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

A former European adviser to the Department for International Trade, a finalist in Businesswoman

of the Year 2005, Angela's latest enterprise is Acuwomen, the UK's first company to bring an all-women group of entrepreneurs under one roof. Angela is also an accredited business coach for the National Growth Accelerator programme and for DIT.

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

Angela resigned from the Board on 1 May 2018.

Dr Catriona McMahon

Catriona is a physician with over 16 years' experience in pharmaceutical medicine. Her NHS background is in anaesthetics and critical care medicine. She worked for AstraZeneca, a FTSE100 pharmaceutical company, as their Medical and Healthcare Affairs Director until December 2014. She has a wide experience of working as a national level board member in both the UK and Canada.

Catriona is passionate about the NHS, patient access to medicines and excellence in patient care. She is currently the Lead Industry Member of the Scottish Medicines Consortium and an Executive Coach with an interest in working with healthcare professionals. Prior to leaving the Industry, she was the Chair of the Medical Expert Network and member of the Innovation Strategy Board and Reputation Strategy Group of the Association of British Pharmaceutical Industries, and was the co-chair (with the Department of Health) of the MISG Clinical Research Working Group.

Catriona joined the Board in June 2014.

Harry Reilly

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

During that time Harry has taken the opportunity to take on broader management positions and when he moved to the Rover Group and BMW he spent time in the Far East, Australia and South Africa, as well as some of the more developed markets in Europe and America.

In 1999 Harry was made Managing Director of Land Rover UK, immediately prior to its sale by BMW. He subsequently joined Brintons as Finance Director and later Managing Director, tasked with turning around and rebuilding the group. Since

then Harry has taken on a variety of positions alongside his non-executive work. He supported a number of start-ups and since 2011 has been Chief Executive and now a NED of Quality Sterling Group based in Toronto. Harry continues as Honorary Chair of the British American Business Council in the Midlands and is Chair of Economic Growth Solutions Limited, Ashwell Corporation Limited and Biotronics Limited.

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

Harry joined the Board in December 2013.

Professor Michael Sheppard

After an early career as a clinical academic in South Africa, Michael received MBChB (Honours) and PhD degrees from the University of Cape Town. He was elected Founder Fellow of the Academy of Medical Sciences in 1998.

Michael took up a lectureship at the University of Birmingham where he remained until 2013

becoming Professor of Medicine and then headed up the Division of Medical Sciences whilst also building his academic endocrine practice. Michael served most recently as Dean of Medicine and Provost and Vice Principal at the University of Birmingham.

Michael has been a member of, and chaired, a number of UK and international committees and endocrine societies as well as roles at The Royal College of Physicians, Medical Research Council and WHO. Michael was previously a Non-executive Director (NED) at Birmingham Children's Hospital and he is also Chair of the West Midlands Academic Health Science Network Board.

Michael joined the Board at Heart of England NHS Foundation Trust in June 2016 followed by the UHB Board in May 2018.

David Waller

David is Chairman of Pertemps Network Group Holdings Ltd, one of the UK's largest, recruitment, training and outsourcing companies. He holds a number of company appointments including the Chairmanship of Birmingham Chamber of Commerce Group, Chairman of Delami Investments Ltd and Non-Executive Director of Pertemps Network Group Ltd. He is also a Director of Country People Ltd and Delami Ltd.

Up until January 2009, David was Senior Partner of PricewaterhouseCoopers' Birmingham Office and PwC Regional Chairman with responsibility for 2,500 professional staff.

David resigned from the Board in September 2018.

Jason Wouhra

Jason qualified with a BA (Hons) and LIM Master of Laws in 1999. This was followed by an Institute of Directors Chartered Director qualification for which he was the youngest person ever to qualify.

Jason is currently Director and Company Secretary of East End Foods Plc which is the UK'S foremost producer of ethnic food ingredients. Jason is currently responsible for the Company's wholesale division as well as for Group HR, Legal, Intellectual Property and Company Secretarial functions.

Jason is a highly experienced Company Director with entrepreneurial flair, strong work ethic and strong communication skills within a broad range of sectors including private, public and third sectors.

Jason's other previous and on-going roles include Chair of Institute of Directors West Midlands, Chair Child Poverty Commission, Chair Aston University Development Board (WM), Vice Chair Black Country Local Enterprise Partnership, Chair Library of Birmingham Advisory Board. Jason has also acted as a Business Advisor to Prime Minister David Cameron and has been recently appointed as UK Ambassador for the government of Punjab, India.

Jason was awarded an OBE in 2017 for services to Business and International Trade at the age of 39. He was also awarded an Honorary Doctorate by Aston University in 2014.

He has been involved in various charitable causes and has raised in excess of £250,000 for charity in the last three years.

Jason joined the Board in December 2014.

4.4 Directors' Register of Interests

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

5 Audit Committee

5.1 Overview

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

The Committee met regularly and was chaired by David Waller (up and until 30 September 2018) and Karen Kneller thereafter. The Committee currently comprises five Non-Executive Directors of the Trust, with the external and internal auditors and other Executive Directors attending by invitation.

5.2 Membership of the Committee

The members of the Committee during 2018/19 were as follows:

- ▶ David Waller (up to 30 September 2018)
- ▶ Karen Kneller
- ▶ Jane Garvey
- ▶ Harry Reilly
- ▶ Dr Jason Wouhra

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

- ▶ **David Waller** - Director and part-owner, Pertemps Network Group Limited; Director, Delami Investments; Chairman - Birmingham Chamber of Commerce & Industry Ltd; Trustee - Millennium Point Trust Ltd; Patron - St Giles Hospice; Chairman - Birmingham Conservatoire of Music Development Group
- ▶ **Jane Garvey** - nil declared
- ▶ **Harry Reilly** - Director - Galtons and Associates Limited; Chairman - British American Business Council Midlands; Director - Juyi TacFast UK Limited; Chairman - Ashwell Corporation Limited; Chairman - Economic Growth Solutions Limited; Chairman - WMMBF Limited
- ▶ **Dr Jason Wouhra** - Director & Company Secretary - East End Foods plc, Regional Chairman - Institute of Directors, Chair - Aston University Development Board, Board Member - Birmingham University Ethnicity and Diversity

Alliance; and Chair - Child Poverty Commission.

- ▶ **Jackie Hendley** - Director - SC Advisory Services Ltd, Director - Smith Cooper Ltd, Partner/Member - SHH 101 LLP, Member - Executive Committee, Sutton Coldfield Chamber of Industry & Commerce
- ▶ **Karen Kneller** - CEO, Criminal Case Review Commission, Tribunal Judge Social Entitlement Chamber, Fitness to Practice Member for General Dental Council, Vice Chair of BRAP (equalities think tank).

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

5.3 Operation of the Committee

The Committee is required to meet at least four times a year. A total of six ordinary and extraordinary meetings took place during 2018/19 and were attended as follows:

Directors	No. of meetings attended (out of six, unless stated)
David Waller	1 out of 1
Jane Garvey	4
Harry Reilly	5
Dr Jason Wouhra	3
Jackie Hendley	4 out of 5
Karen Kneller	4 out of 5

The action plan following the annual self-assessment of 2017/18 was addressed and all recommendations were implemented during the reporting year. The annual self-assessment for 2018/19 is under way and its findings will be reported to the Council of Governors' meeting in July 2019. The self-assessment, based on the Good Governance Institute maturity matrix for Audit Committees, has been used in previous years, which allows the Trust to track any progress made.

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

The Audit Committee receives specific instructions from the Board of Directors as to the areas where additional assurance is required and has formally reported back to the Board of Directors on how it has discharged its duty. The Audit Committee has thus supported the Board of Directors in making its 'fair, balanced and understandable' statement. During 2018/19, the Audit Committee considered the following significant issues in relation to financial statements, operations and compliance:

Risks to the financial statements, including:

- ▶ Recognition of NHS revenue
- ▶ Capital programme and valuation
- ▶ Accruals and provisions
- ▶ Cost Improvement Plans (CIPs)
- ▶ Key Financial Controls, including:
 - > Treasury management
 - > Income and receivables
 - > Expenditure & payables
 - > PPE
 - > General ledger
 - > Budgetary Control
- ▶ UHB Payroll and Payroll Bureau

The Audit Committee further supported the Board by providing assurance on risk management and compliance with regulatory requirements by considering external and internal reports on the Trust's Board Assurance Framework (BAF) and risk management processes, compliance with the General Data Protection Regulation (EC 679/2016) and the new Data Security and Protection Toolkit, compliance with the CQC essential standards, procurement processes and controls as well as cyber security. It received several presentations throughout the year on the Well Led and Use of Resources Framework, Consultant Job Planning and Patient Level Costing (PLICs).

Throughout the year, the Audit Committee was supported by the Internal Auditors, External Auditors and Local Counter Fraud Specialists who provided external assurance on general governance matters, financial reporting, as well as processes for fraud detection, investigation and prevention.

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

5.4 Auditors

During 2018/19, the Trust's External Auditor has been Deloitte LLP.

The previous contract for the appointment of External Auditors was for a term of up to four years from 7 February 2014 subject to annual review by the Audit Committee and reappointment by the Council of Governors. The current contract runs from 7 February 2018 until 31 March 2019. The Audit Committee carries out a review of the effectiveness of the External Auditor following the completion of each annual audit, assessing the External Auditor's performance against an agreed framework and seeking the views of officers of the Trust, and reports the outcome of that review to the Council of Governors, together with a recommendation as to whether the External Auditor should be re-appointed for the following year.

The annual cost of the Trust's 2018/19 external audit was £234,000; in addition, Deloitte LLP provided the following services during 2018/19:

Counter Fraud Service: £90,000

Statutory and audit-related work: £48,000 (including audit of subsidiaries and the annual quality report.

5.5 Independence of External Auditors

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

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

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

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

5.6 Auditors' reporting responsibilities

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

6 Nominations Committees

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

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

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

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

- ▶ Rt Hon Jacqui Smith (Chair)
- ▶ Mrs Sandra Haynes MBE (Governor Vice-Chair)
- ▶ Mr Stan Baldwin
- ▶ Ms Carol Doyle
- ▶ Dr Tom Gallacher

The Remuneration & Nominations Committee met twice during the year.

Members	No. of meetings attended
Dr Tom Gallacher	1
Dr John Delamere	1
Mrs Sandra Haynes MBE	1
Mrs Linda Stuart	1

6.2 Nominations Sub-Committee

When there is a vacant post in the Trust's Executive team, the Executive Appointments and Remuneration Committee (EARC) appoints a Nominations Sub-Committee to deal with this appointment. During the reporting period, three Nominations Sub-Committees were appointed as follows:

- ▶ To oversee the recruitment of a Chief Nurse, consisting of the Chair, the Chief Executive, Harry Reilly, Non-Executive Director, and Jane Garvey, Non-Executive Director, with two external advisors
- ▶ To oversee the recruitment of a Chief Executive, consisting of the Chair, Karen Kneller, Non-Executive Director, Jason Wouhra, Non-Executive Director, and Michael Sheppard, Non-Executive Director, with two external advisors
- ▶ To oversee the recruitment of a Medical Director, consisting of the Chair, the Chief Executive, Michael Sheppard, Non-Executive Director, Harry Reilly, Non-Executive Director, and Catriona McMahon, Non-Executive Director, with two external advisors

7 Membership

7.1 Overview

The Trust has two membership constituencies as follows:

- ▶ Public constituency (including the Rest of England constituency)
- ▶ Staff constituency

Public Constituency

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

- ▶ Who live in one of the Trust's public constituencies; or
- ▶ Who live in the Rest of England constituency; and
- ▶ Who are not eligible to become members of the staff constituency

Staff Constituency

The Staff constituency is divided into four classes:

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

7.2 Membership size and movements

Public constituency	Last year (2018/19)	Next year (estimated) (2019/20)
At year start (April 1)	30,545	30,545
New members	1,097	1,097
Members leaving	2,184	2,184
At year end (March 31)	29,458	29,458
Staff constituency	Last year (2018/19)	Next year (estimated) (2019/20)
At year start (April 1)	20,631	N/A
New members	3,727	N/A
Members leaving	3,469	N/A
At year end (March 31)	20,889	N/A

Analysis of current membership		
Public constituency	Number of members	Eligible membership
Age (years):		
0-16	12	423,985
17-21	129	130,926
22+	26,546	1,316,002
Ethnicity:		
White	17,251	1,241,308
Mixed	197	62,253
Asian or Asian British	3,088	347,248
Black or Black British	775	112,836
Other	77	27,736
Socio-economic groupings*:		
AB	7,894	104,350
C1	8,325	157,328
C2	6,147	103,241
DE	7,049	159,729
Gender analysis		
Male	12,867	922,602
Female	15,842	948,304

The analysis section of this report excludes:

- ▶ 2779 public members with no stated dates of birth, 1575 members with no stated ethnicity and 749 members with no stated gender

General exclusions

* Socio-economic data was completed using profiling techniques (eg: postcode) or other recognised methods.

7.3 Membership Strategy

7.3.1 Membership Development 2018/19

During 2018/19, the overall membership remained relatively consistent, with a decrease from 51,176 to 50,347. The main decrease was seen in the Public constituency, with a loss of 1,087 members.

The Trust's membership is largely representative of the populations it serves. The Trust has members from a broad range of backgrounds and the Trust publicises their contributions both internally and externally.

Although under-16s appear to be under-represented, this is due to them not being eligible for membership at UHB.

7.3.2 Membership Objectives

The Membership Engagement and Recruitment Strategy, approved by the Board of Directors, is to replace the annual churn and maintain existing membership numbers to no less than 48,500. Emphasis is placed on the retention of existing members and further engagement achieved through:

- ▶ Membership monthly e-bulletins
- ▶ Community-based activities such as drop-in sessions at GP surgeries, presentations to community groups and involvement in constituency events
- ▶ The inclusion of members on appropriate patient groups
- ▶ Raising the profile and role of Foundation Members and Governors within the Trust via social media and the Trust website
- ▶ Working with UHB Charity to increase membership opportunities amongst fundraisers

In December 2018, UHB held its annual Membership Week campaign to attract new members. This has been taken forward into quarterly membership recruitment weeks held across all sites of the Trust.

7.3.3 Forward Plan/Objectives 2019/20

Following the merger of University Hospitals Birmingham and Heart of England NHS foundation trusts on 1 April 2018, the membership strategy was reviewed and aligned to promoting a representative membership for the new combined organisation.

7.3.4 Governors' Development 2018/19

Meetings of the Membership, Engagement & Governors' Development Committee are held approximately 2-3 times a year. This committee is made up of Governors from across all the constituencies and is overseen by the Director of Corporate Affairs. The content of seminars is agreed across the year. Last year's topics covered the following:

- ▶ Proposed 2018/19 Annual Plan
- ▶ Building the Best Council of Governors in the Country
- ▶ Research including work of the Institute of Translational Medicine (ITM) and Institute of Biomedical Research (IBR)
- ▶ Communications and Governors

For 2019/20 topics are set to include:

- ▶ An update on the recent CQC Inspection
- ▶ Patient Experience – the well-looked after patient
- ▶ Service Integration
- ▶ The use of Artificial Intelligence in treatment including On-Line Consultations

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

- ▶ Effective Questioning & Challenging (in holding the NEDs to account)
- ▶ Core Skills
- ▶ NHS Finance & Business Skills
- ▶ The Governor role in Non Exec Appointments

7.3.5 Member communication with governors and/or directors

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

- ▶ Telephone, written or electronic communications co-ordinated through the Membership Office which then steers members to the appropriate Governor/Director
- ▶ Governors' Drop-in Sessions. These sessions are held monthly across all sites. A mix of staff and public governors talk to and take comments from staff, patients and visitors in both the Inpatient and Outpatient areas overseen by members of the Patient Experience Team. The findings are then fed back to the Patient Experience Group for comment/action before being forwarded to the Care Quality Group
- ▶ The Annual General Meeting

- ▶ Website. Each Governor has their profile and details of the constituency they serve, published on the Trust website including email address which is co-ordinated through the Corporate Affairs office
- ▶ Governors attend community presentations held in their constituency in relation to the hospital/patients issues
- ▶ Health Talks. Governors attend health talks which are held on a monthly basis for members and wider community. Evening sessions are also held to provide greater access
- ▶ news@UHB – Trust newspaper distributed through the hospital sites
- ▶ Social media tools – Twitter, Facebook, Instagram and YouTube
- ▶ Quarterly Membership Weeks – activities held over 3 days aimed at promoting membership; Recruitment stands in hospital atriums

7.3.6 Contacting the Membership Office

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

Contact:

members@uhb.nhs.uk

0121 371 4323

Membership Office, Third Floor, Nuffield House,
University Hospitals Birmingham, Mindelsohn Way,
Edgbaston, B15 2TH

8 Staff Report

8.1 Breakdown of the number of male and female staff at 31 March 2019

	Female	Male
All Staff	17,792	5,451
Executive Directors*	2	6
Directors**	1	4
Total Staff	17,795	5,461

*Definition of Executive: Statutory Directors

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

8.2 Staffing Profile

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

Staff Group	Permanent	Fixed Term Temp	Bank*
Add Prof Scientific and Technic	723	28	111
Additional Clinical Services	3,366	115	1,554
Administrative and Clerical	3,521	380	314
Allied Health Professionals	1,106	26	22
Estates and Ancillary	1,671	22	308
Healthcare Scientists	661	34	18
Medical and Dental	1,028	1,138	82
Nursing and Midwifery Registered	5,526	114	799
Total	17,602	1,857	3,208
		19,459	

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

8.3 Staff Exit Packages

Termination benefit by band - Year Ended 31 March 2019	Compulsory redundancies		Other agreed departures		Total termination	
	Number	Cost	Number	Cost	Number	Cost
<£10,000	2	9,659	0	0	2	9,659
£10,000 - £25,000	0	0	2	28,516	2	28,516
£25,000 - £50,000	0	0	1	25,228	1	25,228
£50,000 - £100,000	1	80,000	0	0	1	80,000
>£100,000	1	160,000	0	0	1	160,000
Totals	4	249,659	3	53,744	7	303,403

8.4 NHS Staff Survey

8.4.1 Commentary

UHB is committed to engaging its workforce and recognises that the quality of the services we deliver to patients is defined by our people. We strive to find ways to work with staff to improve their working lives, and feedback is crucial to understanding their needs and views. The Trust works in partnership with its trade unions to engage with staff; the strength of this partnership is reflective of the value demonstrated by the Trust in its responsiveness to this feedback.

There is a Trust Partnership Team which offers a platform for trade union interface with senior management including Executive Directors, and serves as a barometer for the climate of staff feelings in general terms and on specific subject areas.

The Trust runs a quarterly Staff Friends and Family Test to seek the views of staff on their experiences at work, and reasons for recommending it as a place to work and recommending it for care and treatment. In addition, all staff are invited to take part in the annual staff survey which provides detailed feedback on staff experience across a range of key themes.

The Trust uses other mechanisms throughout the year to actively seek the views and opinions of staff. These include hosting targeted focus groups, direct e-surveying on specific topics and engagement briefing sessions.

UHB is committed to keeping staff up-to-date with news and developments through an internal communications programme:

- ▶ Team Brief – staff receive the Chief Executive’s core brief every month
- ▶ news@UHB – the Trust’s monthly staff magazine is available throughout the Trust
- ▶ The staff intranet is constantly updated with current news and important information
- ▶ In the Loop – staff receive weekly email updates on Trust news and developments
- ▶ Social Media – the Trust has active Twitter and Facebook accounts, sharing information and stories

There are regular staff meetings with the Chief Executive and Executive Directors, with encouragement to attend by management. These meetings allow staff to be updated on key projects and/or matters of interest around the Trust. Staff can ask any questions that they may have.

The Trust’s intranet is also a central source for policies, guidance and online tools. Staff are able to directly access information which affects them individually, e.g. payslips, training records, absence records.

8.4.2 Summary of Performance

The NHS Staff Survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in 10 indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

The response rate to the 2018 survey among Trust staff was 36% (2017: Queen Elizabeth 44%, Heartlands, Good Hope & Solihull 41%). Scores for each indicator together with that of the survey benchmarking group (acute trusts) are presented below.

	2018/19	
	Trust	Benchmarking Group
Equality, Diversity & Inclusion	8.9	9.1
Health & Wellbeing	5.7	5.9
Immediate Managers	6.7	6.7
Morale	6.0	6.1
Quality of appraisals	5.3	5.4
Quality of care	7.5	7.4
Safe environment – bullying and harassment	8.0	7.9
Safe environment – violence	9.4	9.4
Safety culture	6.6	6.6
Staff engagement	7.0	7.0

This is the first set of scores for the merged Trust and in the new theme format shown above. Comparing 2018 scores on individual questions with the 2017 scores, of the 82 questions, 8 were significantly better, 7 were significantly worse and 67 had no significant change. Overall, the results show our scores are around average for each theme, which is a good baseline the first year of the merged Trust. There are no comparative scores for the last two years as UHB and Heart of England NHS Foundation Trust merged in 2018.

8.4.3 Future priorities and targets

Based on our headline results and key themes from the additional comments, there are three priority areas of focus on in the year ahead:

- ▶ **Culture of High quality Feedback:** Continue the work started last year to strengthen leadership skills and behaviours. Build a culture of high quality feedback, by delivering a programme of support for managers to grow capability to give and receive feedback.
- ▶ **Values Behavioural Framework:** To support the culture of feedback, the values behavioural framework will be refreshed, with clear statements about what behaving in line with the values looks like in practice.
- ▶ **Health & Wellbeing:** Mental Health support: In partnership with the charity Mind, we will deliver a programme for managers to equip them to support staff around mental health issues.

With these areas of focus, the Trust would expect to see improvements in the theme scores for Immediate Manager and Health & Wellbeing in the 2019 survey results, with specific improvements on the following questions:

- ▶ Q8c: My manager gives me clear feedback on my work
- ▶ Q8f: Immediate manager takes a positive interest in my health & wellbeing

The Trust will continue to provide regular opportunities for staff to give their feedback via the quarterly Staff Friends & Family Test and full census of National Staff Survey, reviewing key themes and taking action in response.

8.5 Sickness Absence

In 2018/2019, the Trust recorded an annual average sickness absence, across all clinical and corporate divisions, of 4.3%.

Trust management continues to work in partnership with Staff Side to explore opportunities to reduce this to 4%. Long term sickness continues to be the main cause of absence from work, and continues to be consistent at an average of 2.5% each month. The total number of days lost due to sickness for the year is 292,453.

The Trust is currently operating with two Electronic Staff Record systems which record sickness absence. There are variations in the top five reasons for sickness across the legacy trusts.

For the year-to-date the top five reasons for both long term and short term absence at Queen Elizabeth Hospital Birmingham are:

Absence Reason

1. Anxiety/stress/depression/other psychiatric illnesses
2. Other musculoskeletal problems
3. Cold, Cough, Flu - Influenza
4. Gastrointestinal problems
5. Injury, fracture

The year-to-date the top five reasons for both long term and short term absence at Heartlands, Good Hope and Solihull hospitals are:

Absence Reason

1. Anxiety/stress/depression/other psychiatric illnesses
2. Gastrointestinal problems
3. Cold, Cough, Flu - Influenza
4. Other musculoskeletal problems
5. Injury, fracture

Staff groups with absence consistently above average include Health Care Assistants and Facilities staff. Sickness cases are managed by managers with support from Human Resources staff.

The Trust currently has two Sickness Absence Policies and Procedures in place due to the two legacy trusts. These documents are being reviewed and consulted upon in the coming months, with one document to cover the whole Trust. Proposed changes include an increased focus on the health and well-being of staff and prevention of issues which typically result in absence.

Regular confirm and challenge meetings are in place across the Trust. The purpose of these meetings is to review sickness cases, both short and long term, and facilitate the progression of cases. This has helped to resolve some complex long term cases.

Managers are invited to attend sickness absence management training. These sessions are interactive and experiential; to better equip managers with the practical skills and knowledge to effectively manage attendance and absence. In addition, bespoke sickness absence management training is targeted at identified hot-spots. This training, tailored to the specific needs of departments and teams, will continue to be provided for targeted improvements. More generally, the link between good people management and good attendance is recognised in our review of departmental performance and more general people management and leadership training has been refreshed and delivered which we expect to embed work environments in which all staff can thrive.

UHB continues to actively promote health and wellbeing amongst its staff. National awareness days such as World Mental Health (October) and Time to Talk (February) have also been widely promoted with a series of activities to support awareness of key issues.

All staff members are able to self-refer to a number of activities and services and these include:

- ▶ Staff Support
- ▶ Staff Well Clinic
- ▶ Staff Physiotherapy
- ▶ Occupational Health
- ▶ Mindfulness
- ▶ Chaplaincy Support

The Staff Well Clinic has expanded and offers a complete health assessment for individuals with options to either refer back to the General Practitioner or refer within the Trust to the appropriate service. In conjunction with the onsite leisure centre The Morris Club, a 'passport' (worth up to £25) can be provided which allows the holder to use the gym, swimming pool or take classes (including Pilates and Yoga) at no cost to themselves.

8.6 Trade Union Facility Time Reporting Regulations

The Trade Union (Facility Time Publication Requirements) Regulations 2017 took effect on 1 April 2017. This means that the Trust is required to publish certain information on trade union officials and facility time on the Trust website and Government portal.

The information contained in this report relates to University Hospitals Birmingham NHS Foundation Trust for the 2018/19 financial year.

The regulations require the following information to be published:

- ▶ table 1: the number of employees who were relevant union officials during the relevant period, and the number of full time equivalent employees
- ▶ table 2: the percentage of time spent on facility time for each relevant union official
- ▶ table 3: the percentage of pay bill spent on facility time
- ▶ table 4: the number of hours spent by relevant union officials on paid trade union activities as a percentage of total paid facility time hours

Table 1

Relevant union officials

What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period - 57	Full-time equivalent employee number – 52.02
---	--

Table 2

Percentage of time spent on facility time

How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	0
1-50%	52
51%-99%	2
100%	3

Table 3

Percentage of pay bill spent on facility time

Total cost of facility time	£122,072.40
Total pay bill	£945,656,000.00
Percentage of the total pay bill spent on facility time, calculated as:	0.013%
(total cost of facility time ÷ total pay bill) x 100	

Table 4

Paid trade union activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: 23.49%
(total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100

8.7 Reporting high paid off-payroll arrangements

There were no high paid off-payroll arrangements in 2018/19.

8.8 Expenditure on consultancy

The expenditure on consultancy is £1,484,000 for the year. See note 7 in the accounts.

8.9 Analysis of staff costs

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

	Year ended 31 March 2019			Year ended 31 March 2018		
	Permanently		Other	Permanently		Other
	Total	Employed		Total	Employed	
	£000	£000	£000	£000	£000	£000
Short-term employee benefits – salaries and wages	741,659	702,056	39,603	341,879	308,755	33,124
Short-term employee benefits – social security costs	70,179	70,179	—	32,387	32,387	—
Post-employment benefits – employer contributions to NHS pension scheme	82,990	82,990	—	37,714	37,714	—
Pension cost – other contributions	107	107	—	32	32	—
Apprentice Levy	1,881	1,881	—	1,633	1,633	—
Termination benefits	143	143	—	87	87	—
Temporary staff – external bank	—	—	—	—	—	—
Temporary staff – agency/contract staff	51,728	—	51,728	11,869	—	11,869
Pay costs capitalised as part of assets	(3,031)	(3,031)	—	(1,688)	(1,688)	—
	945,656	854,325	91,331	423,913	378,920	44,993

8.10 Health and Safety

Incidents reported during the year (2018/19) included: 498 Inoculation injuries; 336 Slips, trips and falls and; 115 Musculoskeletal. Monitoring of inoculation incidents is performed by Directors of Operations, senior nursing staff and the Health and Safety Team who report to committee via quarterly divisional health and safety reports which include: details of inoculation incidents; action taken to prevent recurrence and; reports sent to the Health And Safety Executive (HSE).

A programme of inspections was undertaken in relation to health and safety issues and 195 inspections of clinical and non-clinical areas were completed by the Health And Safety Team. A further 26 health and safety inspections were performed by Directors/ Senior Managers. The programme of inspections includes: environmental inspections, safer sharps; slips, trips and falls; thermal comfort; noise etc. as well as general walk-around inspections.

Flu vaccination was again widely accessible with vaccinators delivering the vaccine to staff in their own clinical areas, reducing disruption to services. This year's campaign saw the Trust vaccinate 77% of staff (n=11,831) by mid-December 2018.

8.11 Countering fraud and corruption

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

As part of this responsibility, regular reviews into security around the Trust are conducted along with pro-active crime reduction initiatives to reduce the opportunities for crime to occur. The Trust has a contracted security service provided on each site, overseen by three NHS accredited Local Security Management Specialists (LSMSs). The LSMS is a post that is required under Secretary of State Directions. The Trust encourages a pro-security culture amongst its staff. The Trust actively investigates all reported criminal incidents and has a close working relationship with local police officers. All security equipment i.e. CCTV and Access Control are covered under comprehensive maintenance contracts to ensure any faulty equipment is repaired within a short timescale.

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

9 NHS Improvement's Single Oversight Framework

9.1 Explanation of the foundation trust's risk ratings

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

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

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

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

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

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

Segmentation

For the whole period since the Single Oversight Framework was introduced on 1 October 2016, the Trust has been in Segment 2. Consequently no enforcement action has been taken against the Trust over that period. This segmentation information is the Trust's position as at 31 March 2019. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website at <https://improvement.nhs.uk/resources/single-oversight-framework-segmentation/>

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above is not the same as the overall finance score here.



Dr David Rosser, Chief Executive
24 May 2019

Area	Metric	Explanation	2018/19 Q4 score	2017/18 Q4 score
Financial sustainability	Capital Service Cover	Can the Trust's income cover its longer term financial obligations	4	2
	Liquidity	Cash held to cover operating costs	4	2
Financial efficiency	I&E Margin	I&E surplus or (Deficit) as a proportion of total Income	4	1
Financial controls	I&E Variance From Plan	Actual year to date surplus compared to plan	1	1
	Agency Spend	Distance of actual spend from the annual agency cap set by NHS Improvement	3	1
Overall scoring			3	1

10 Remuneration Report 2018/19

10.1 Annual Statement on Remuneration

During the year ended 31 March 2019, in addition to focussing on delivering high-quality healthcare to patients in the face of increasing demand, both in terms of numbers and complexity, as well as limited resources, the Trust has commenced a period of post-acquisition integration, following its merger, by acquisition, with Heart of England NHS Foundation Trust (HEFT).

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

Accordingly, the Committee recognises that, in order to ensure optimum performance, it is necessary to have a competitive pay and benefits structure. The objective of the Trust's policy for remuneration of senior managers^[1] is to attract and retain suitably skilled and qualified individuals of high calibre, providing sufficient resources, strength and maintaining stability throughout the senior management team. Remuneration for such officers will be set and maintained at levels that remain competitive but affordable. The Committee considers that this is particularly so at present, when the demand for competent and effective senior leaders in the NHS is high, but the pool of suitable candidates is diminishing.

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

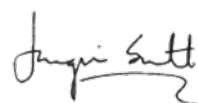
The Committee has reviewed the remuneration policy and the responsibilities and remuneration of the senior managers of the Trust (not including the Non-Executive Directors). Amendments to the policy were approved, recognising that remuneration must reflect the public service ethos and that, when vacancies occur, appropriately skilled, qualified and experienced appointments to such vacancies should be made in a timely fashion.

During the reporting period, the Committee considered and approved the levels of remuneration for the newly appointed Chief Executive, Chief Nurse and Medical Director, as part of the recruitment process for those posts. The Committee carried out a review of the remuneration of the Executive Directors, taking into account the recent merger with Heart of England NHS Foundation Trust. Additionally, the Committee approved a 2% pay increase for senior managers with effect from 1 April 2018.

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

Non-Executive Directors' fees are reviewed regularly with advice taken from independent consultants where appropriate.

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



Rt Hon Jacquie Smith
Chair of the Executive Appointments and Remuneration Committee
24 May 2019

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

10.2 Senior Managers' Remuneration Policy

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

The key goal of remuneration policy remains to recruit and retain competent and effective Senior Managers. This requires that the pay and benefits structure is competitive within the sector. The table below provides detail on each element of directors' remuneration packages for 2018/19:

Purpose and link to strategy	Operation (and changes if appropriate)	Maximum that could be paid in respect of that component
Salary		
Retains and motivates, takes account of complexity and scale of director's duties, and cognisance of market levels in the appropriate sector.	Salary levels are set with reference to responsibilities and the need to retain and recruit. With regard to the latter, a comparison against similar roles in an appropriate comparator group is used (the comparator group comprises Shelford Group trusts and local trusts).	As set out in the remuneration table on page 66, salaries are determined by the Trust's Executive Appointments & Remuneration Committee. Salaries will be reviewed during the year ending 31 March 2020. Any increases will take into account salary increases awarded to the wider workforce as well as other factors.
Pension		
Provides post-retirement remuneration and ensures that the total package is competitive.	Senior managers are eligible to become members of the NHS Pension Scheme. The benefits provided to Senior Managers through the NHS Pension Schemes are the same as for all other Trust employees. Where Senior Managers cease to accrue pensionable service in an NHS Pension Scheme due to reaching the lifetime allowance, they are entitled to a cash supplement equal to 10.5% of base salary. This policy remains unchanged from 2013/14.	The following Senior Managers withdrew from pensionable service on the dates shown: Dame Julie Moore on 31/03/2013, David Rosser on 01/04/2018, Kevin Bolger on 01/04/2018 and Julian Miller on 10/11/2018 No pensionable service in any NHS Pension Scheme has been accrued by these directors since these dates. They receive a cash supplement of 10.5% of base salary in lieu of pension accrual.

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

The table below provides detail on each element of non-executive directors' (including the Chair) remuneration for 2018/19:

Purpose and link to strategy	Operation (and changes if appropriate)	Maximum that could be paid in respect of that component	
Non-Executive Director fees Attracts, retains and motivates non-executive directors with the required knowledge, experience and ability.	Non-executive directors are paid a fee each year. Some non-executive directors with additional responsibilities may receive an additional fee, although none do at present.	Chair	£53,045
		Non-Executive Director	£13,975
		Fees are determined by the Council of Governors. Fees will be reviewed during the year ending 31 March 2020. Any increases will take into account salary increases awarded to the wider workforce as well as other factors.	

Notes:

There are no benefits in kind, performance related pay, nor severance payments (2018/19 - £nil) paid to any executive or non-executive. There are no payments to any past senior managers that relate to the function of the Board of Directors (2018/19 - £nil).

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

No new components of the remuneration package have been introduced.

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

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

As shown in the table on page 65, a number of the Trust's Senior Managers are paid more than £150,000. The Trust has, through the Executive Appointments and Remuneration Committee, satisfied itself that this remuneration is reasonable for the reasons set out in the annual statement on remuneration above and taking into account that competition for suitably qualified and able individuals to serve as Senior Managers will come not only from within the NHS sector, but from other organisations, both public and private sector and in the UK and abroad.

10.2.3 Service contracts obligations

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

10.2.4 Policy on payment for loss of office

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

There were neither termination payments nor compensation for loss of office made to senior managers during 2018/19.

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

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

10.3 Pensions

All the Executive Directors are members of the NHS Pensions Scheme, with the exception of Dame Julie Moore, Kevin Bolger, David Rosser and Julian Miller. Under this scheme, members are entitled to a pension based on their service and

final pensionable salary subject to HM Revenue and Customs' limits. The scheme also provides life assurance cover of twice the annual salary. The normal pension age for directors is 60. None of the Non-Executive Directors are members of the schemes. Details of the benefits for Executive Directors are given in the tables provided on page 69.

NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in the NHS 2015 Scheme. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement.

10.4 Annual Report on Remuneration

10.4.1 Service Contracts

Senior Managers (other than Non-Executive Directors) are on substantive contracts with a notice period of six months.

Name of Senior Manager	Date of Service Contract	Unexpired term	Details of Notice Period
Dame Julie Moore	04/03/2002	31/08/2018	Six months
Mike Sexton	26/10/2006	N/A	Six months
Dr Dave Rosser	01/12/2006	N/A	Six months
Tim Jones	13/06/2007	N/A	Six months
Kevin Bolger	15/06/2009	N/A	Six months
Lisa Stalley-Green	01/09/2018	N/A	Six months
Prof Simon Ball	01/09/2018	N/A	Six months
Jonathan Brotherton	01/04/2018	N/A	Six months
Cherry West	01/09/2014	N/A	Six months
Fiona Alexander	01/02/2006	N/A	Six months
David Burbridge	07/05/2007	N/A	Six months
Andrew McKirgan	01/09/2014	N/A	Six months
Lawrence Tallon	02/10/2017	N/A	Six months
Julian Miller	22/10/2018	N/A	Six Months
Mark Garrick	22/10/2018	N/A	Six months

10.4.2 Executive Appointments and Remuneration Committee

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

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

packages, for the appointment of the Executive Director posts on the Board of Directors.

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

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

Directors	No. of meetings attended
Rt Hon Jacqui Smith	7 out of 7
Dame Julie Moore	3 out of 4
David Rosser	3 out of 4

Angela Maxwell	1 out of 1
Prof Michael Sheppard	4 out of 6
Prof Jon Glasby	4 out of 6
David Waller	0 out of 1
Jane Garvey	2 out of 7
Harry Reilly	6 out of 7
Dr Catriona McMahon	7 out of 7
Dr Jason Wouhra	4 out of 7
Jackie Hendley	3 out of 6
Karen Kneller	3 out of 6
Mehrunnisa Lalani	2 out of 6

During the reporting period, the Committee considered and approved the levels of remuneration for the newly appointed Chief Executive, Chief Nurse and Medical Director, as part of the recruitment process for those posts.

The Committee carried out a review of the remuneration of the Executive Directors. Pay of the Executive Team was last substantially reviewed in 2014, when it was benchmarked against comparable Trusts. Since that time there has been one inflationary increase and Executive pay at the Trust had become out of line with national and local comparators. When reviewing Executive Team remuneration these were used to set remuneration levels which would enable the Trust to recruit and retain key staff, whilst not being excessive but reflecting the scale of the enlarged Trust, following the recent merger with Heart of England NHS Foundation Trust. As a result of this review, pay awards were made to members of the Executive Team. In determining the appropriate levels of remuneration, the Committee had regard to comparative data obtained from Shelford Group trusts, and other local trusts, and salary comparison information published by NHSI.

In December 2018, the Committee approved a 2% pay increase for senior managers with effect from 1 April 2018. When reaching its decision, the Committee took in to account the pay increase awarded under Agenda for Change and the ongoing negotiations with the Department of Health regarding the pay awards for medical and dental staff, subject to any differing increase being agreed at national level.

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

10.4.3 Council of Governors’ Remuneration and Nominations Committee for Non-Executive Directors

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

Details of membership and attendance of the Governors’ Remuneration and Nominations Committee for Non-Executive Directors are set out on page 49.

During the reporting period, the Governors’ Remuneration and Nominations Committee for Non-Executive Directors has not made any recommendations regarding the pay of the Chair and the Non-Executive Directors.

10.4.4 Disclosures required by Health and Social Care Act

Information on the Trust’s policy on pay and on the work of the Executive Appointments and Remuneration Committee are set out above.

Information on the remuneration of the directors is set out on page 66.

Expenses

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

Year ended 31 March 2019			
	Number in office	Number receiving expenses	Total £00
Directors	24	4	57
Governors	32	20	30

Year ended 31 March 2018			
	Number in office	Number receiving expenses	Total £00
Directors	18	4	27
Governors	22	6	6

10.4.5 Salary and Pension Entitlements of Senior Managers

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

A. Remuneration

Salary entitlements of senior managers 2018/19

Name and title	Year ended 31 March 2019					Total (bands of £5000) £000
	Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	
	(bands of £5000)	Total to nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2500)	
	£000	£00	£000	£000	£000	
Senior managers						
Dr David Rosser Chief Executive (commenced Sept 1 2018)	155-160				-	155-160
Dame Julie Moore Chief Executive (resigned Aug 31 2018)	105-110				-	105-110
Prof Simon Ball Executive Medical Director (commenced Jan 1 2019)	30-35				5.0-7.5	35-40
Mike Hallissey Executive Interim Medical Director Sep 1 - Dec 31 2018)	30-35				-	35-40
Dr David Rosser Executive Medical Director (resigned Aug 31 2018)	55-60				-	55-60
Kevin Bolger Executive Director of Strategic Operations	200-205				-	200-205
Jonathan Brotherton Executive Chief Operating Officer	175-180				312.5-315.0	490-495
Cherry West Executive Chief Transformation Officer	180-185				250.0-252.0	430-435
Tim Jones Executive Director of Innovation	200-205				112.5-115.0	315-320
Lisa Stalley-Green Executive Chief Nurse (commenced Sept 1 2018)	105-110				92.5-95.0	200-205
Michele Owen Executive Chief Nurse (resigned Aug 31 2018)	70-75				-	70-75

Name and title	Year ended 31 March 2019					
	Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	Total
	(bands of £5000)	Total to nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2500)	(bands of £5000)
	£000	£00	£000	£000	£000	£000
Mike Sexton Executive Chief Financial Officer	185-190				312.5-315.0	500-505
Fiona Alexander Director of Communications	150-155				92.5-95.0	245-250
David Burbridge Director of Corporate Affairs	150-155				145.0-147.5	295-300
Andrew McKirgan Director of Partnerships	150-155				195.0-197.5	345-350
Julian Miller Director of Finance (commenced Oct 22 2018)	85-90				140.0-142.5	225-230
Lawrence Tallon Director of Corporate Strategy, Planning and Performance	150-155				35.0-37.5	185-190
Mark Garrick Director of Quality and Development (commenced Oct 22 2018)	65-70				5.0-7.5	70-75
Non-executive directors						
Jacqui Smith – Chair	50–55					50–55
Dr Catriona McMahon	10–15					10–15
Harry Reilly	10–15					10–15
Jackie Hendley	10–15					10–15
Jane Garvey	10–15					10–15
Jason Wouhra	10–15					10–15
Prof Jon Glasby	10–15					10–15
Karen Kneller	10–15					10–15
Mehrunnisa Lalani	10–15					10–15
Prof Michael Sheppard	10–15					10–15
Angela Maxwell (resigned 30 Apr 2018)	0-5					0-5
David Waller (resigned 30 Apr 2018)	0-5					0-5

Salary entitlements of senior managers 2017/18

Name and title	Year ended 31 March 2018					
	Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	Total
	(bands of £5000)	Total to nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2500)	(bands of £5000)
	£000	£00	£000	£000	£000	£000

Senior managers

Julie Moore Chief Executive	255-260					255-260
Philip Norman Executive Chief Nurse (deceased 29 Aug 2017)	60-65					60-65
Michele Owen Executive Chief Nurse (with effect from Sept 1 2017)	70-75				55.0-57.5	125-130
Dr David Rosser Executive Medical Director	105-110				77.5-80.0	185-190
Tim Jones Executive Director of Delivery	150-155				72.5-75.0	225-230
Mike Sexton Executive Chief Financial Officer	165-170					165-170
Kevin Bolger Executive Director of Strategic Operations	160-165				30.0-32.5	190-195
Cherry West Executive Chief Operating Officer	150-155				55.0-57.5	205-210
Fiona Alexander Director of Communications	125-130				62.5-65.0	190-195
David Burbridge Director of Corporate Affairs	125-130				42.5-45	170-175
Lawrence Tallon Director of Corporate Strategy, Planning and Performance (commenced office Oct 2 2017)	60-65				32.5-35.0	95-100
Andrew McKirgan Director of Partnerships	125-130				55.0-57.5	180-185

Non-executive directors

Jacqui Smith – Chair	50-55					50-55
David Hamlett (left office May 31 2017)	0-5					0-5
Angela Maxwell	10-15					10-15
David Waller	10-15					10-15
Jane Garvey	10-15					10-15
Harry Reilly	10-15					10-15
Jason Wouhra	10-15					10-15
Dr Catriona McMahon	10-15					10-15

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

The Executive Medical Officers receive remuneration in both capacities of board director and medical consultant; the remuneration received for the role of board director only is disclosed in the tables above. The banding disclosures of their respective clinical roles are as follows:

Chief Medical Director	Year Ended 31 March 2019	Year Ended 31 March 2018
Professor Simon Ball, (from 01 Jan 2019)	25-30	n/a
Mike Hallissey, (from 01 Sep 2018 to 31 Dec 2018)	20-25	n/a
Dr David Rosser, (to 31 Aug 2018)	50-55	110-115

This clinical remuneration is only disclosed for the period to which the individual was also a board director. It does not include their clinical remuneration for the periods in which they were not acting in the capacity of Chief Medical Officer (interim or permanent).

Dr David Rosser became Chief Executive on 1 September 2018, from this date he no longer received any remuneration in a clinical capacity.

Jonathan Brotherton as at 1 April 2018 was already a board member of the former Heart of England NHS Foundation Trust and automatically became a Trust board director on the acquisition date. Julian Miller and Mark Garrick both joined the board on 22 October 2018. Lisa Stalley-Green joined the board on 1 September 2018, replacing Michele Owen.

The non-executive team was joined on the 1 May 2018 by the following former Heart of England NHS Foundation Trust members: Jackie Hendley, Professor Jon Glasby, Karen Kneller, Prof Michael Sheppard and Mehrunnisa Lalani. There were two departures in the year: David Waller and Angela Maxwell who resigned on 30 April 2018 when their terms expired.

There are no benefits in kind, performance related pay, nor severance payments (2017/18 - £nil) paid to any executive or non-executive. There are no payments to any past senior managers that relate to the function of the Board of Directors (2017/18 - £nil).

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


	Year Ended 31 March 2019	Year Ended 31 March 2018
Band of Highest Paid Director’s Total Remuneration (£’000)	270-275	255-260
Median Total Remuneration	28,995	28,687
Ratio	9.4	8.9

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

B. Pension Benefits

Name and title	Real increase in pension at age 60	Real increase in pension related lump sum at age 60	Total accrued pension at age 60 at 31 March 2019	Total accrued pension related lump sum at age 60 at 31 March 2019	Cash Equivalent Transfer Value at 31 March 2019	Cash Equivalent Transfer Value at 31 March 2018	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000	To nearest £100
Tim Jones, Executive Director of Delivery	5.0-7.5	7.5-10.0	60-65	150-155	1,239	984	201	N/A
Lisa Stalley-Green, Executive Chief Nurse	5.0-7.5	5.0-7.5	35-40	30-35	550	325	109	N/A
Mike Sexton, Chief Financial Officer	12.5-15.0	42.5-45.0	75-80	225-230	-	1,386	-	N/A
Jonathan Brotherton, Chief Operating Officer	15.0-17.5	32.5-35.0	45-50	115-120	801	472	289	N/A
David Burbridge, Director of Corporate Affairs	5.0-7.5	20.0-22.5	35-40	115-120	902	650	212	N/A
Simon Ball, Chief Medical Director	0-2.5	0-2.5	55-60	140-145	1,143	967	29	N/A
Julian Miller, Director of Finance	5.0-7.5	12.5-15.0	50-55	110-115	834	508	135	N/A
Mark Garrick, Director of Quality and Development	0-2.5	-	20-25	40-45	283	219	16	N/A
Fiona Alexander, Director of Communications	5.0-7.5	5.0-7.5	25-30	50-55	488	346	110	N/A
Cherry West, Chief Transformation Officer	10.0-12.5	35.0-37.5	70-75	210-215	1,673	1,233	376	N/A
Andrew McKirgan, Director of Partnerships	7.5-10.0	20.0-22.5	55-60	135-140	1,039	744	251	N/A
Lawrence Tallon, Director Corporate Planning	2.5-5.0	-	5-10	-	77	38	16	N/A

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



Dr David Rosser, Chief Executive
24 May 2019

11 Statement of the chief executive's responsibilities as the accounting officer of University Hospitals Birmingham NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require University Hospitals Birmingham NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of University Hospitals Birmingham NHS foundation trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care's Group Accounting Manual and in particular to:

- ▶ observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- ▶ make judgements and estimates on a reasonable basis
- ▶ state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ▶ ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- ▶ confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- ▶ prepare the financial statements on a going concern basis

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

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



Dr David Rosser, Chief Executive

24 May 2019

12 Annual Governance Statement

12.1 Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of University Hospitals Birmingham NHS Foundation Trust's (the "Trust") policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

12.2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

12.3 Capacity to handle risk

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

The Annual Plan sets out the Trust's principal aims for the year ahead. Each Executive Director has responsibility for identifying any risks that could compromise the Trust from achieving these aims. These strategic risks are contained in the Board Assurance Framework (BAF). The BAF maps the key controls employed to manage the strategic risks and provides the Board of Directors with assurance about the effectiveness of the controls and any gaps. The BAF is reviewed on a quarterly basis by Executive Directors and the Board of Directors.

The Risk Management Policy defines risk management structures, accountability and responsibilities and describes a framework for risk identification, escalation, reporting and monitoring. The Board of Directors' Risk Appetite Statement defines levels of acceptable risk for the Trust. As a result of the merger by acquisition of Heart of England NHS Foundation Trust in April 2018, the Trust's Risk Management Policy framework underwent a wholesale review. All operational risks were re-categorised and the Board's risk appetite for each was reviewed and approved at a bespoke Board seminar.

The Audit Committee monitors and oversees both internal control issues and the process for risk management. Both the Internal Auditors and External Auditors attend Audit Committee meetings.

Both the Board of Directors and the Clinical Quality Committee (CQC) receive reports that relate to clinical risks.

Nominated Managers (as defined in the Health & Safety Policy) attend the 'Managing Risks' course that covers the principles of risk assessment and the management of Risk Registers. The Trust's guidance documents, available to all staff via the Trust's intranet (Risk Management Policy and Procedure together with the Board of Directors' Risk Appetite Statement) sets out the processes for managing risk at all levels within the Trust. Risk Management is included, as appropriate, in Trust and Divisional Development programmes. Risk management is included, as appropriate, into the Corporate, Consultant, Junior Doctor and International Fellowship induction programmes. Bespoke training is also provided for divisional education development programmes.

Learning from incidents, RCA and good practice is discussed at the Clinical Quality Monitoring Group and the Chief Executive's RCA Meeting which reports to the Board of Directors. Learning is fed back to the Divisions via the Divisional Clinical Quality Group Framework.

12.4 The risk and control framework

The Board of Directors is responsible for the strategic direction of the Trust in relation to Risk Management. It is supported by the Audit Committee which provides assurance to the Board of Directors on risk management as identified in the Internal Audit Programme. In addition, the

Trust Executive and Non-Executive Directors carry out unannounced Board of Directors Governance visits. These are reported to the Clinical Quality Committee by the Director of Quality Development.

CQC

Compliance with the Care Quality Commission (CQC) Fundamental Standards of Quality and Safety, and other national requirements, is a natural by-product of the effective operations of the Trust's groups and committees which report to the Board of Directors through Executive Directors. The process and groups and committees that provide direct reports to the Board are detailed in the Trust's 'Procedure for Monitoring Compliance Against the Care Quality Commission Essential Standards of Quality and Safety'.

Based on the discussions at the Clinical Quality Monitoring Group the Executive Medical Director provides a regular exception report to the Board of Directors. In April the Director of Quality Development submits a draft Quality Report/Account to the Board and a Final Quality Report/Account is provided in May.

The Executive Chief Nurse provides a quarterly Patient Care Quality Report, which includes information regarding Infection Prevention and Control. She is also responsible for the annual report regarding the National Inpatient Survey and the annual Safeguarding Adults and Children report. The Executive Director Strategic Operations (and External Affairs) provides a six-monthly Emergency Preparedness Update Report to the Board.

The Board of Directors receives an Audit Committee Activity Report from the chair of the Audit Committee following each Audit Committee meeting and a quarterly report on the Board Assurance Framework, from the Director of Corporate Affairs.

The Director of Corporate Strategy, Planning & Performance provides a quarterly Performance Indicators report to the Board of Directors. The Clinical Quality Committee also receives a Performance Indicators report each time it meets.

Risk identification and evaluation

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

All areas within the Trust report incidents and near misses in line with the Trust's Incident Reporting Policy. All clinical incident trends are reported to the Divisional Clinical Quality Group meetings, Clinical Quality Monitoring Group (CQMG) and

ultimately the Clinical Quality Committee.

Risk Assessments are undertaken throughout the Trust. Identified risks at all levels are evaluated using a common methodology based on national standards and guidance.

Other methods of identifying risks are:

- ▶ Health and Safety and Infection Control Audits
- ▶ Complaints and Care Quality Commission reports and recommendations
- ▶ Inquest findings and recommendations from HM Coroners
- ▶ Medico-legal claims and litigation
- ▶ Ad hoc risk issues brought to either the Speciality Meetings/departmental meetings, Divisional Clinical Quality Group meetings, Health, Safety and Environment Committee, Clinical Quality Monitoring Group, Care Quality Group or Safeguarding Group
- ▶ Incident reports and trend analysis
- ▶ Internally generated reports by the Health Informatics Team
- ▶ Reviews by external regulators
- ▶ Internal and external audit reports

Identified risks are added to departmental/speciality Risk Registers and reviewed on a quarterly basis to ensure that action plans are being carried out and that risks are being managed or accepted, as appropriate. Any non-compliance is addressed with the appropriate Divisional Management Team and where required, Executive Directors escalate high level risks identified by the Divisional and Corporate Management Teams to the Board of Directors. These operational risks also inform the strategic risks listed on the Board Assurance Framework (BAF).

The Board of Directors undertakes a review of the Board Assurance Framework on a quarterly basis.

Risk Control

High level operational risks (both clinical and corporate) are reported directly to the Board of Directors through the Corporate Risk Report. The process of reporting of risks is monitored and overseen by the Audit Committee.

Information Governance

Risks to personal information are managed and controlled in accordance with the Trust's Information Governance (IG) Policy and the IG and IT Security Incident Management Procedure and reviewed during the Information Governance Group (IGG) meetings, chaired by the Director of Corporate Affairs, who has been appointed as the Senior Information Risk Officer. The Associate Medical Directors, as Caldicott Guardians, are responsible for the protection of patient

information. All information governance issues are integrated through the Information Governance Group. The Board of Directors receives a report regarding its systems of control for information governance. These include satisfactory completion of its annual self-assessment against the Data Security and Protection Toolkit, including privacy risk assessments, IG training compliance, mapping of data flows, monitoring and controlling of third party access to data, as well as technical controls such as penetration testing and acting on CareCERT alerts.

The Trust has completed the Data Security and Protection Toolkit (DSPT) assessment for 2018/19 and submitted at a level which requires some further work by the Trust during 2019/20 to become fully compliant with all requirements. This is due to significant changes to the DSPT requirements deriving from the General Data Protection Regulation (EU679/2016) and the introduction of cyber security standards. The internal audit of the DSPT submission confirmed the Trust's self-assessment score and identified some areas of good compliance.

To date, three serious incidents have been reported to the Information Commissioner's office (ICO) via the new incident reporting tool. One incident relates to patient related information being discussed in a car with members of the family present and recorded by a hidden recording device. The second incident relates to a nurse having taken home handover documents and patient medical records belonging to several local hospitals. The third incident relates to appointment details being shared with a patient's relative, causing distress to the patient. The first two incidents have been closed by the ICO and no further action has been taken. The third incident is still under investigation by the ICO.

Strategic Risks

The Board Assurance Framework (BAF) contains the organisation's major risks that may impact on the achievement of the Trust's overarching Strategic Priorities for 2018/2019. These are linked to the Annual Plan and the Care Quality Commission's Fundamental Standards. This process ensures that the Board is informed about the most serious risks faced by the Trust.

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

- ▶ Financial deficit in excess of planned levels
- ▶ Cash flow levels affecting day to day operations of the Trust
- ▶ Prolonged and/or substantial failure to meet operational performance targets
- ▶ Increasing delays in transfer of care from UHB sites in excess of agreed targets
- ▶ Unable to recruit, control and retain adequate staffing to meet the needs of patients
- ▶ Material breach of clinical and other legal standards leading to regulatory action
- ▶ Failure of IT systems to support clinical services and business
- ▶ Adverse impact of Brexit on Trust's innovation agenda
- ▶ Failure of commercial ventures
- ▶ Unable to maintain and improve quality and quantity of physical environment to support the required level of service
- ▶ Failure to realise the opportunities and benefits of merger with Heart of England NHS FT on 1 April 2018

Each strategic risk is carefully monitored, with risk updates, controls and assurances being reported to the Board on a quarterly basis.

Strategic risks associated with the exit from the European Union are embedded in the usual risk reviews. In addition, they are monitored via a specific task and finish group where Trust expertise is pooled in the areas of finance, supply chain, business continuity planning, workforce management and information governance.

The overall financial risk is and continue to be managed and mitigated through ongoing performance monitoring and reporting along with effective engagement with commissioners. Oversight will continue to be provided by the Board of Directors and relevant committees.

The Trust continues to be involved in strategic discussions with a range of organisations regarding the long term funding of complex specialist patient activity where costs are not fully covered by national tariffs.

Whilst discussions are ongoing about long term NHS provider sustainability and transformation, the Trust's existing cash balances and access to working capital loan facilities mean the Trust can expect to meet its working capital requirements (payments to staff and suppliers) over the next 12-18 months.

Current capacity pressures are resulting in risk to the delivery of services to tertiary patients, who need, for example, transplantation or complex cancer surgery, where the Trust is often the only

realistic provider available, and who are waiting longer for their treatment due to the lack of ward beds. The shortage of capacity is directly related to the volume of routine secondary care work, structural and policy changes and other external factors. The inability to recruit sufficient numbers of sufficiently skilled, trained and competent staff due to insufficient supply.

Potential breach of terms of NHS Provider Licence/non-compliance with external regulatory requirements due to activity growth, capacity constraints and the receipt of late referrals.

Clinical and Corporate Compliance Frameworks

The Clinical and Corporate Compliance Frameworks provide assurance that the Trust is compliant with all of its legal obligations. The Clinical Compliance Framework monitors compliance with clinical standards including but not limited to NICE guidance; CQC fundamental standards, national and local audits. Quarterly reports are received by the Audit Committee regarding the process and the Board of Directors regarding Trust wide performance.

The Corporate Compliance Framework ensures that Trust policies capture all relevant statutory/regulatory obligations, as well as best practice guidance (including NHSI's 'Managing conflict in the NHS') and monitors Trust wide adherence against these policies. It also provides oversight of the responsibilities of the Trust's various Committees/Groups and the effectiveness of the Trust's overall governance structure. It examines compliance with the CQC fundamental standards, NHS Provider Licence, Well led framework, Use of Resources framework and the FT Code of Governance. Evidence of assurance is analysed quarterly for completeness and quality purposes. Where the Trust is exposed to new compliance standards or recommendations (e.g. software as medical devices), these are cross-referenced to existing standards on the framework and any gaps in assurance highlighted. This ensures the collection of timely, accurate and relevant assurance data on any compliance risks. Any anomalies, gaps in assurance or concerns about the quality of available assurance are reported on an exception basis to the relevant Executive Director and the DCA Governance Group meetings. The DCA Governance Group meetings are chaired by the Director of Corporate Affairs who decides whether further escalation to the Audit Committee or Board of Directors is required.

Conflicts of interests are also addressed in this framework to ensure that the Trust meets its NHSI obligations under the 'Managing conflict

in the NHS' guidance. As part of this, mandatory declarations for decision making staff are being monitored and cross-referenced against external sources of assurance, for example records held by Companies House relating to individual directorships and the Association of British Pharmaceutical Institute for transfers of value from Pharmaceutical companies to individuals employed by the Trust. The results are published on an annual basis as required under the guidance.

Risk management

Risk Management is well embedded throughout the organisation. The Trust's Risk Management Policy and Procedure' details how risks will be escalated from a local/departmental level to Speciality/Divisional/Executive and finally Board level. The Board of Directors establishes which risk tolerance is deemed to be acceptable to the Trust and publishes this on an annual basis in the Risk Appetite Statement.

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

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

When an incident occurs and there is a remaining risk, all practical and reasonable steps are taken to prevent re-occurrence. The line manager is responsible for the provision of primary support for staff involved in the incident and this is made available immediately. Any incidents which are considered to be 'severe' (as defined by the National Patient Safety Agency (NPSA) definition) are escalated by the Clinical Risk and Compliance Unit to the Clinical and Professional Review of Incidents Group, chaired by the Medical Director to decide whether the incident should be treated as a Serious Incident (SI).

All serious incidents (SIs) must be investigated using the Root Cause Analysis (RCA) methodology. All SIs are reported and managed in accordance with the national framework. All new and revised policies undergo an equality impact assessment as part of the approval process.

There are elements of risk management where public stakeholders are closely involved via the Patient, Carer and Community Council framework. Members of the Councils are encouraged to participate in visits to wards and departments identified by the Patient Experience Group and feed back comments from patients and staff. This feedback is reported to the Patient Experience Group and by exception to the Care Quality Group, Board and Council of Governors. There are patient representatives involved in the PLACE (Patient Led Assessment of the Care Environment) environmental visits. The Council of Governors is represented on the Care Quality Group and receives regular reports on care quality, including infection control, falls and safeguarding.

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

Robust workforce governance systems continued to be utilised and embedded in 2017/18 to ensure the Trust's compliance with legislative requirements and best practice. The Strategic Workforce Group and the Operational Workforce Group supported improved governance arrangements and oversight of performance, policies and practice across the Trust. As part of this, a range of workforce metrics, quality and outcomes indicators, as well as productivity measures were considered.

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

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

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

12.5 Review of Economy, Efficiency and Effective Use of Resources

The Trust's 2018/19 Financial Plan was approved by the Board of Directors and submitted to NHS

Improvement (NHSI) in April 2018. This was the first plan for the combined Trust following completion of the merger between University Hospitals Birmingham NHS Foundation Trust and Heart of England NHS Foundation Trust on 1 April 2018. The planned financial deficit for 2018/19 was (£61.8m) prior to £23.8m of Provider Sustainability Funding (PSF) made available to NHS providers who agree to financial and A&E performance targets. Including this non-recurring PSF income, the Trust planned to deliver a (£38.0m) deficit.

Within the plan there were a range of risks including:

- ▶ Delivery of £35.6m of Cost Improvement Plan (CIP) efficiency savings
- ▶ Delivery of the activity levels agreed with commissioners recognising that the hospital sites are operating at full capacity (beds, theatres, etc.) and there are challenges recruiting and retaining the required workforce
- ▶ The need to consolidate Trust wide processes including financial reporting during the first year of the merger, noting that some non-recurrent gains and benefits were expected post-merger to help support delivery of the agreed plan

The Trust has delivered the financial plan for 2018/19, which in turn has resulted in the Trust securing additional Provider Sustainability Funding allocations at the financial year end. The audited financial results for 2018/19 are set out elsewhere in the Annual Report and Accounts. As context, the majority (78%) of NHS acute providers remain in financial deficit, even after the Provider Sustainability Funding is included.

The Trust has a comprehensive and well-established framework for performance management of national targets and other indicators of the quality of care provided. This operates at multiple levels, but always with a clear line of sight from individual clinicians on the wards to the Board of Directors. Quality and performance are monitored regularly and at many levels, with clear routes of escalation and delegation. The Board of Directors continues to receive a suite of reports at each of its meetings, including clinical quality, experience of care, operational performance, and finance, which combine to give both a comprehensive overview of performance, and to highlight any exceptions that need to be escalated. The content and format of the performance report was significantly revised immediately following the merger to provide an overview of the whole Trust's performance and ensure that any exceptions that need to be escalated continue to be so. The Board is therefore able to triangulate performance across all domains and to assure areas of risk and approve mitigating actions. The content of

these performance reports will continue to be reviewed regularly and changed if new risks or exceptions emerge. In 2018/19, of the operational performance metrics included in the Single Oversight Framework, the Trust did not achieve the A&E 4 hour, 18 week RTT and 62 day cancer GP referral metrics and the case finding element of the Dementia assessment and referral metric.

Objectives contained in the Trust's Internal Audit Plan include ensuring the economical, effective and efficient use of resources and this consideration is applied across all of the work-streams carried out. The findings of internal audit are reported to the Board through the Audit Committee.

The effectiveness of the Board Sub-Committees, notably the Audit Committee and Executive Appointment and Remuneration Committee, are discussed in more detail in the Governance section of the Annual Report.

Quality Account

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

The content of the Trust's Quality Report for 2018/19 builds on the 2017/18 report and was agreed by the Board of Directors. The Quality Improvement Priorities for 2019/20 were selected with input from the Council of Governors, Clinical Quality Monitoring Group and Patient Experience Group.

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

During 2018/19, the Trust provided a mid-year progress update on the quality improvement priorities and other key indicators to the Council of Governors. Data included in the 2018/19 Quality Report has been checked by all teams involved and will be subject to additional sign off by responsible Directors prior to publication. In line with the Trust's commitment to transparency, the data included is not just limited to good performance.

12.6 Review of effectiveness

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

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

- ▶ the maintenance of a view of the overall position with regard to internal control by the Board of Directors through its routine reporting processes and review of the Board Assurance Framework
- ▶ The receipt of Internal and External Audit reports on the Trust's internal control processes by the Audit Committee
- ▶ personal input into the controls and risk management processes from all Executive Directors and Senior Managers and individual clinicians

The Board's review of the Trust's risk and internal control framework is supported by the Annual Head of Internal Audit opinion. The opinion is based upon and limited to their work performed on the overall adequacy and effectiveness of the Trust's risk management, control and governance processes.

KPMG's Head of Internal Audit Opinion is derived from the reviews of the key financial controls (treasury management; income and debtors; expenditure and creditors, fixed assets and general ledger), Payroll and the BAF and Risk Management all of which received the assurance rating 'significant assurance with minor improvement opportunities'. KPMG's Head of Internal Audit Opinion for 2018/19 states that "*significant with minor improvements assurance can be given on the overall adequacy and effectiveness of the*

Trust's framework of governance, risk management and control".

In 2018/19, the Trust's external auditor reviewed the effectiveness of some of the processes through which data is extracted and reported in the Quality Report. The content of the Trust's 2018/19 Quality Report was reviewed and the following three areas tested: Maximum 62 day wait for first treatment from urgent GP referral for suspected cancer; Accident & Emergency 4 hour waits and one local indicator recommended by NHS Improvement and approved by the Council of Governors: SHMI Summary Hospital-level Mortality Indicator. No significant issues were identified with the content review or the testing for the indicators. The Trust is currently reviewing the recommendations made by Deloitte and implementation will be monitored via the Audit Committee. The report provided by our external auditor is included in the Quality Account.

Conclusion

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



Dr David Rosser, Chief Executive

24 May 2019



Section 2

Quality Report 2018/19

This annual report covers the period 1 April 2018 to 31 March 2019

2018/19 Quality Report

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1 Chief Executive's Statement

The work to bring together Birmingham's two largest NHS trusts finally came to fruition on 1 April 2018 when the merger by acquisition of Heart of England NHS Foundation Trust (HEFT) by University Hospitals Birmingham NHS Foundation Trust (UHB) was formally agreed. The decision was approved by the trusts' respective Boards of Directors, with the decision cleared by both Councils of Governors. "Building healthier lives" is the vision of the enlarged organisation and demonstrates our commitment to the health of our population, before, during and after patients need hospital care - from maternity to the end of our lives.

The Trust has set out three key priorities:

- ▶ **To maintain high quality patient care** and NHS operational standards in each hospital and service, even in the face of rising demand
- ▶ **To integrate services across our hospitals and sites**, so that patients can expect the same high standards and joined up care wherever they enter our system, and so we use our new scale to operate as efficiently as possible
- ▶ **To transform the model of healthcare**, particularly using technology, so patients are cared for in the most appropriate place, with many more being seen in the community or virtually and hospitals concentrating on the most acute and specialised care

Maintaining high quality patient care is a key priority for the years ahead. During 2018/19, the Trust began reviewing and harmonising the systems and processes in place across the different hospital sites and community services. The Trust is aiming to have Trust-wide quality indicators agreed and in place across the main hospital sites by the end of 2019/20. This work will be dependent on the implementation of common electronic systems across the sites to enable the quality of care to be measured, monitored and improved.

Performance for the six quality improvement priorities set out for 2018/19 in the 2017/18 Quality Reports has been mixed:

- Priority 1:** Reducing grade 2 Trust-acquired avoidable pressure ulcers
- Priority 2:** Improving patient experience and satisfaction
- Priority 3:** Timely and complete observations and pain assessment
- Priority 4:** Reducing missed doses
- Priority 5:** Reducing harm from falls
- Priority 6:** Timely treatment for sepsis.

The Board of Directors has chosen to continue with these six overall priorities for improvement in 2019/20 with a different focus for each and associated targets to drive improvement.

UHB's focused approach to quality, based on driving out errors and making incremental but significant improvements, is driven by innovative and bespoke information systems which allow us to capture and use real-time data in ways which few other UK trusts are able to do. A wide range of omissions in care were reviewed in detail during 2018/19 at the regular Executive Care Omissions Root Cause Analysis (RCA) meetings chaired by the Chief Executive. Cases are selected for review from a range of sources including those put forward by senior medical and nursing staff, e.g., individual wards selected for review, missed or delayed medication, serious incidents, serious complaints, infection incidents, incomplete observations and cross-divisional issues.

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

A key part of the Trust's commitment to quality is being open and honest with our staff, patients and the public, with published information not limited to good performance. The Quality web pages provide up-to-date information on UHB's performance in relation to quality: <http://www.uhb.nhs.uk/quality.htm>.

The Trust's external auditors provide an additional level of scrutiny over key parts of the Quality Report. The Trust's external auditor Deloitte has reviewed the content of the 2018/19 Quality Report and undertaken testing for three indicators in line with the NHS Improvement guidance on external assurance:

1. Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.
2. Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.
3. Summary Hospital-level Mortality Indicator (SHMI).

The findings from this year's external audits were reported to the Audit Committee and Board of Directors in May 2019. No significant issues were identified with the content review or the testing for the indicators. Deloitte made three recommendations for improvement; the implementation of recommendations will be monitored via the Trust's Audit Committee. The report provided by our external auditor is included in Annex 3 of this report.

2019/20 will be a very challenging year for UHB as we work towards achieving the ambitious priorities set out above. The Trust will continue working with

regulators, commissioners, healthcare providers and other organisations as part of the Sustainability and Transformation Partnership (STP) to influence future models of care delivery and deliver further improvements to quality during 2019/20.

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



Dr David Rosser, Chief Executive
24 May 2019

Note regarding the merger by acquisition of Heart of England NHS Foundation Trust by University Hospitals Birmingham NHS Foundation Trust

On 1st April 2018, the merger by acquisition of Heart of England NHS Foundation Trust (HEFT) by University Hospitals Birmingham NHS Foundation Trust (UHB) was formally agreed. The decision was made the Trusts' respective Boards of Directors, with the decision cleared by both Councils of Governors.

For 2017/18, a Quality Report was written for each Trust. For 2018/19 there is now one Quality Report. UHB is working to align its systems and reporting, this is an ongoing process due to differing IT systems and priorities across the sites.

The former UHB is now known as Queen Elizabeth Hospital Birmingham site (QEHB), and the former HEFT sites are Heartlands Hospital (BHH), Good Hope Hospital (GHH) and Solihull Hospital (SH) – these acronyms are used throughout this Quality Report.

The enlarged Trust uses the University Hospitals Birmingham NHS Foundation Trust name (UHB).

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

2.1 Priorities for Improvement

The Trust’s 2017/18 Quality Report set out six priorities for improvement during 2018/19:

- ▶ **Priority 1:** Reducing grade 2 Trust-acquired avoidable pressure ulcers
- ▶ **Priority 2:** Improving patient experience and satisfaction
- ▶ **Priority 3:** Timely and complete observations and pain assessment
- ▶ **Priority 4:** Reducing missed doses
- ▶ **Priority 5:** Reducing harm from falls
- ▶ **Priority 6:** Timely treatment for sepsis.

Progress has been mixed across the priorities and across the different Trust sites. Further details for each priority are provided in the following pages. The Board of Directors has therefore chosen to continue with these six overall priorities for improvement in 2019/20 with a different focus for each and associated targets to drive improvement.

1	Reducing pressure ulcers	New national guidance on the categorisation of pressure ulcers was released at the start of 2019/20, so baseline data will be collected and targets agreed
2	Improving patient experience and satisfaction	To focus on areas highlighted via patient surveys and complaints – nutrition and hydration, and pain control in the emergency departments
3	Timely and complete observations including pain assessment	Targets to remain the same and a new indicator to be developed
4	Reducing missed doses	Certain indicators will remain as targets were not met during 2018/19. Others will be replaced by new indicators
5	Reducing harm from falls	To focus on reducing the overall number of falls and associated harm
6	Timely treatment for sepsis	This is no longer a CQUIN but remains a KPI

The improvement priorities for 2019/20 were confirmed by the Trust’s Clinical Quality Monitoring Group chaired by the Executive Medical Director, following consideration of performance in relation to patient safety, patient experience and effectiveness of care.

The focus of the patient experience priority was decided by the Patient Experience Group and the priorities for improvement in 2019/20 were then approved by the Board of Directors in March 2019. The priorities for 2019/20 will be presented to the Joint Consultative Committee (JCC) and cascaded to all staff via Team Brief in 2019.

They have also been discussed with, or there are plans to present at, various Trust groups including staff, patient and public representatives as shown in the table below.

Group	Key members
Care Quality Group	Executive Chief Nurse, Associate Directors of Nursing, Matrons, Senior Managers with responsibility for Patient Experience, and Patient Governors
Chief Operating Officer’s Group	Executive Chief Operating Officer, Deputy Chief Operating Officer, Directors of Operations, Divisional Directors, Director of Operational Finance, Deputy Chief Nurse, Director of Patient Services, Director of Estates and Facilities, Director of IT Services plus other Managers
Joint Consultative Committee	Executive Directors, Directors, Human Resources Managers, Divisional Directors of Operations, Staff Side Representatives
Chief Executive’s Team Brief (cascaded to all Trust staff)	Chief Executive, Executive Directors, Directors, Clinical Service Leads, Heads of Department, Associate Directors of Nursing, Matrons, Managers

Although some of the 2019/20 priorities have been in place for a number of years, the specific focus and targets within each priority are regularly reviewed and updated in line with changes in performance and in response to priorities within the Trust.

The performance for 2018/19 and the rationale for any changes to the priorities are provided in detail below. It might be useful to read this report alongside the Trust’s two Quality Reports for 2017/18.

Priority 1: Reducing grade 2 hospital-acquired pressure ulcers

Background

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

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

in a bed or sitting for prolonged periods of time. Some pressure ulcers also develop due to pressure from a device, such as tubing required for oxygen delivery.

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

(Please note that as of 2019/20, the categories will be replaced by a new system).

Grade	Description
1	Skin is intact but appears discoloured. The area may be painful, firm, soft, warmer or cooler than adjacent tissue.
2	Partial loss of the dermis (deeper skin layer) resulting in a shallow ulcer with a pink wound bed, though it may also resemble a blister.
3	Skin loss occurs throughout the entire thickness of the skin, although the underlying muscle and bone are not exposed or damaged. The ulcer appears as a cavity-like wound; the depth can vary depending on where it is located on the body.
4	The skin is severely damaged, and the underlying muscles, tendon or bone may also be visible and damaged. People with grade 4 pressure ulcers have a high risk of developing a life-threatening infection.
Ungradable (Depth unknown)	Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed.
Suspected Deep Tissue Injury (SDTI) (depth unknown)	Purple or maroon localized area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

National Pressure Ulcer Advisory Panel / European Pressure Ulcer Advisory Panel / Pan Pacific Pressure Injury Alliance (2014)

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

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

The target for QEHB and the target for Heartlands, Good Hope and Solihull Hospitals are different, as they are based on the targets set with the CCG (Clinical Commissioning Group) prior to the merger and these carried over into 2018/19.

QEHB had separate targets for device-related and non-device-related, Heartlands, Good Hope and Solihull Hospitals had one overall target.

Performance - QEHB

Non-device related

The target agreed with the CCG for 2018/19 was no more than 75 patients with non-device related hospital-acquired avoidable grade 2 pressure ulcers.

During 2018/19 QEHB reported 84 patients with such pressure ulcers. This compares to a total of 62 during 2017/18 and 71 during 2016/17. An exception report was provided to the CCG. For more information on actions taken, further detail is provided below.

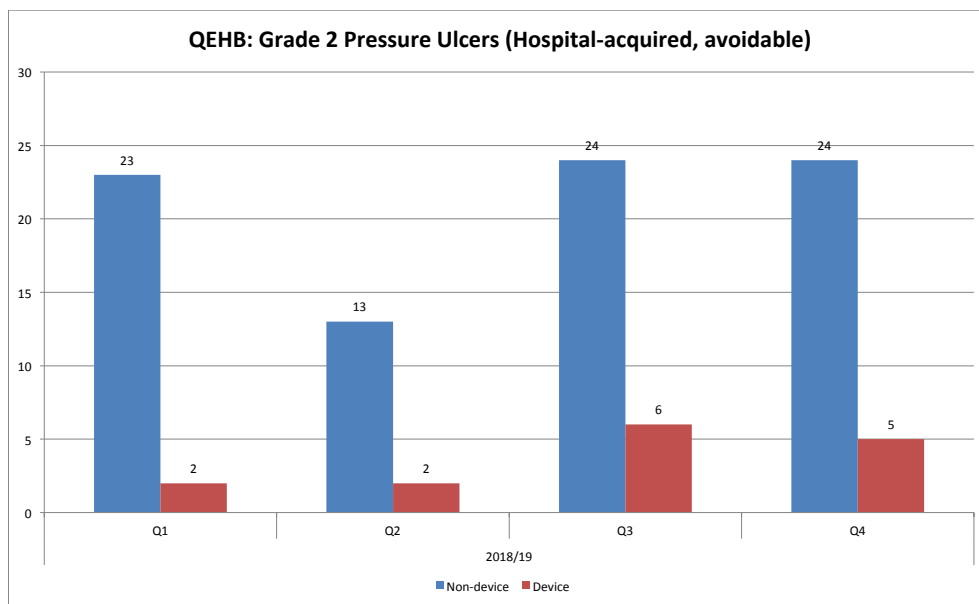
Device related

The target agreed with the CCG for 2018/19 was no more than 42 patients with device-related hospital-acquired avoidable grade 2 pressure ulcers.

During 2018/19 QEHB reported 15 patients with such pressure ulcers. This compares to a total of 14

during 2017/18 and 28 during 2016/17.

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



Performance - Heartlands, Good Hope and Solihull Hospitals

The target agreed with the CCG was a reduction of 20% on the number of hospital-acquired avoidable grade 2 pressure ulcers, over two years ending March 2019.

This is a reduction of 43.8% compared to 2016/17 (128), meeting the two year reduction target of 20%.

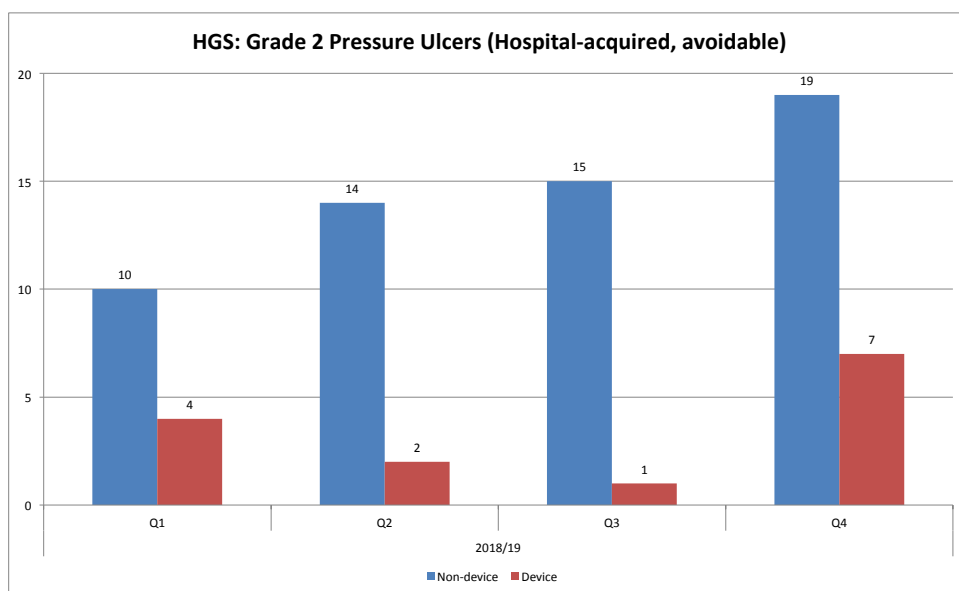
**March 2019 data included but subject to change following validation*

During 2018/19* Heartlands, Good Hope and Solihull Hospitals reported 72 such pressure ulcers (14 device related, and 58 non-device related).

This compares to a total of 108 during 2017/18. (Please note that this data has undergone final validation since the 2017/18 Quality Report and may have changed slightly).

Number of patients with grade 2 hospital-acquired, avoidable pressure ulcers, by Quarter*

**March 2019 data included but subject to change following validation*



Changes to improvement priority for 2019/20

The 2019/20 targets for pressure ulcers are currently being agreed with Birmingham & Solihull Clinical Commissioning Group (CCG).

It should be noted that to reflect the NHS Improvement recommendations, changes to definitions and terminology will be implemented during 2019/20. This will affect reporting of pressure ulcers and moisture lesions, and there will be a potential increase in figures.

It should also be noted that in line with the recent acquisition by merger of Heartlands, Good Hope and Solihull hospitals by UHB, all processes, policies and documentation relating to pressure ulcers are in the process of being aligned.

Initiatives implemented during 2018/19

- ▶ A leaflet promoting safe patient movement for seated patients was developed and launched in conjunction with Therapies.
- ▶ A Task and Finish group set up to determine the changes required to refocus on repositioning. These have included the development of a story board to show what good repositioning looks like, and the development of a MOVED campaign and poster that were launched Trust-wide as part of the International Stop the Pressure day in November 2018.
- ▶ The Tissue Viability team have been part of the collaborative initiative led by NHSI. This has involved Ward 411, Queen Elizabeth Hospital and Ward 12, Good Hope Hospital. Members of ward staff, therapies and the Tissue Viability Team attended events to share ideas and present changes in practice to colleagues.
- ▶ Tissue Viability quality audits and Back to the Floor visits have taken place to ensure all wards have React to RED discs and grading cards.
- ▶ A video and poster was devised and launched to promote the prevention of heel drag and this has been incorporated into educational activities and clinical practice. These were presented at divisional forums, Matron and Band 7 meetings, Link Nurse, Skin Champions and Patient Handling Champions days. The training is included in the pressure ulcer study days and on mandatory manual handling training. The campaign was shortlisted for a British Journal of Nursing award.
- ▶ New pressure relieving mattresses were successfully trialled and purchased.
- ▶ A pressure relieving mattress audit was carried out monthly by the mattress company. Offering bedside training to troubleshoot provision of equipment and any equipment problems. Equipment training is available via the intranet with self-verification forms as assurance. Re-training is expected every three years as part of the update of pressure ulcer competencies.

- ▶ The Tissue Viability team has worked in conjunction with other disciplines to link in with national campaigns e.g. “get up, get dressed, get moving”.
- ▶ Multidisciplinary approach employed with tissue viability, physiotherapy and manual handling working together to educate, demonstrate and promote safe side lying and documentation of repositioning.
- ▶ A poster regarding safe side lying was produced to inform on appropriate technique and optimal side lying position. This practice was promoted by link nurses, skin champions and patient handling champions days. The training is included in the pressure ulcer study days and on mandatory manual handling training.

Initiatives planned for 2019/20

The Trust plans to continue to build on the improvements seen in 2018/19, to further identify any common causes or reasons behind hospital-acquired pressure ulcers and to target training and resources accordingly. Initiatives to aid improvements include:

- ▶ Planning the Tissue Viability service provision for the whole of UHB
- ▶ Aligning Tissue Viability policies, processes and documentation across UHB
- ▶ Aligning Tissue Viability related patient information leaflets across UHB
- ▶ Standardising equipment and wound dressing formularies across UHB
- ▶ Agreeing and standardising the education provision, including competency based practice across UHB
- ▶ Continue to roll out the MOVED, heel drag, safe side lying and other campaigns throughout the Trust.
- ▶ Develop closer working relationships with other specialist teams, e.g. Infection Prevention and Control, Moving and Handling, and Therapies.
- ▶ Review of the PICS repositioning tool. Tissue Viability have met with PICS developer to implement changes discussed following the repositioning questionnaire and focus groups. First re-draft is in progress.

How progress will be monitored, measured and reported

- ▶ All hospital acquired category 2, 3 and 4, ungradable and DTI pressure ulcers are reported via the Trust’s incident reporting system Datix, and then reviewed by a Tissue Viability Specialist Nurse.
- ▶ All category 1 pressure ulcers and moisture lesions are reported via Datix.
- ▶ Monthly reports are submitted to the Trust’s Preventing Harms meeting, which reports to the Executive Chief Nurse’s Care Quality Group.
- ▶ Data on pressure ulcers also forms part of

the Clinical Risk report to the Clinical Quality Monitoring Group.

- ▶ Staff at QEHB can monitor the number and severity of pressure ulcers on their ward via the Clinical Dashboard.
- ▶ Introduction of a new standard operating procedure outlining the process for serious incident reporting. This includes a new reducing harm group chaired by the Deputy Chief Nurse.

Priority 2: Improving patient experience and satisfaction

The Trust measures patient experience via feedback received in a variety of ways, including local and national patient surveys, the NHS Friends and Family Test, complaints and compliments and online sources (e.g., the NHS website). This vital feedback is used to make improvements to our services. This quality priority focuses on improving scores in our local surveys, and also takes into account national survey results and correlations with insight gained from other sources.

Patient experience data from local surveys

Survey	No. responses 2018/19	Data Period: April 2018 to
Inpatient	25,371	March 2019
Emergency Department	836	March 2019
Outpatient	3,644	Mar 2019
Discharge	2,029	March 2019
Maternity	1,005	March 2019
Community	1,017	March 2019

In addition, UHB publishes findings from the National Inpatient Survey, run by the Picker Institute on behalf of the Care Quality Commission (CQC) – please see Part 3 of this Quality Report.

Methodology

The majority of local survey data collection is via paper surveys; in some instances these are postal surveys, but the majority are at the point of care.

Improvement targets

In setting the patient experience quality priorities for 2019/20, the first quality priorities to be set as a merged Trust, a different approach has been taken to previous years.

Historically UHB has set quality priorities based on a number of questions from local patient surveys where patients scored the Trust lower than the internal targets that had been set. However, Heartlands, Good Hope and Solihull hospital sites do not have such priorities in place, nor do they ask all of the same questions on their surveys. With that in mind, and to ensure that significant focus can be given to key priorities across all sites of the enlarged Trust, the Trust’s Patient Experience Group (which includes Trust Governors) has decided to focus its patient experience improvement for 2019/20 on two key aspects that patients have told us are important to them:

- ▶ Nutrition and hydration
- ▶ Pain control in our Emergency Departments

Update on the 2018/19 Patient Experience Priorities for QEHB

It is acknowledged that the majority of 2018/19 priorities were not met, and these will continue to be measured and improved via the ongoing patient surveys. Some questions, such as whether patients were offered a chaperone, are part of a specific project group which will also report to the Patient Experience Group so that progress can be tracked (see more information below under 2018/19 initiatives).

It is pleasing to see that patients told us that they had confidence and trust in nursing staff and this target was met.

Results from local patient surveys for 2018/19 patient experience priorities

This table shows results for 2017/18 and 2018/19.

	2017/18 Score	2018/19 Target	2018/19 Score	2018/19 no. of responses
Inpatient survey				
Sometimes in hospital a member of staff says one thing and another says something quite different. Has this happened to you?	8.6	9.0	8.3	7,972
If you needed attention, were you able to get a member of staff to help you within a reasonable time?	NA	9.3	8.8	6,979
Do you think the hospital staff did everything they could to help control your pain?	9.3	9.6	9.2	7,101
Did you have confidence and trust in the nurses treating you?	NA	9.6	9.6	6,359
Outpatient survey*				
How long after the stated appointment time did the appointment start?*	7.0	7.0	6.6*	1,820*
If you had an intimate examination/procedure performed during your outpatient appointment, were you offered a chaperone?*	NA	7.5	5.9*	380*
Emergency Department survey				
During your time in the Emergency Department did you feel well looked after by hospital staff?	8.8	9.0	8.4	437
How would you rate the courtesy of the Emergency Department reception staff?	8.7	9.0	8.2	399
Were you kept informed of what was happening at all stages during your visit?	8.1	8.5	7.4	440
Do you think the hospital staff did everything they could to help control your pain?	8.2	9.0	7.7	371
Discharge survey*				
Did you feel you were involved in decisions about going home from hospital?*	7.1	7.4	7.3*	1,394*

*postal surveys - data is not complete at time of writing due to time required for postal responses to be returned

Patient Experience initiatives in 2018/19

Initiative	Update
Increased identification and support of carers driven by the recently introduced Carer Coordinator role.	Since the appointment of two Carer Coordinators in February 2018 a range of resources and training has been developed and implemented across all four hospital sites. This has resulted in increased staff awareness of carer needs, signposting for further support and an additional route for further referral on for a Carers Assessment via third sector partners. Please see the annual report for more information.
Further development of feedback methods to ensure 'hard to reach' groups have a voice and their views are listened to and acted on.	Demographic information collected alongside patient experience feedback has been expanded to ensure compliance with the Stonewall LGBT guidance. Whilst further work is required to ensure this information is collected across all four sites this is a step forward and will assist in identifying groups of patients who are not feeding back or are having a different experience. Feedback has also been obtained from patients with a learning disability via a pilot of an easy read version of the friends and family test. The bespoke version will be rolled out across the Trust and can also be used by other patient groups requiring easy read where appropriate.
Develop work started around the use of chaperones, ensuring patients are informed and staff are educated to ensure chaperones are proactively offered and used appropriately in relevant situations	A survey was completed through which patients were asked whether they understood what a chaperone was, whether they were offered one for their appointment and if so what their experience was of having a chaperone. Results showed a lack of patient understanding in relation to what a chaperone was and why they might need one for certain intimate examinations or procedures. A task and finish group has been established to look at raising awareness and understanding for patients; and ensuring that access to a chaperone is provided in accordance with patient choice. The group is also reviewing staff training to support this.
Continued staff engagement in relation to patient experience, empowering multi-disciplinary team members to understand their role in influencing the overall patient experience, including production of a video highlighting the patient experience quality priorities.	<p>An overview is given to all staff during the main Trust Induction session and other patient experience related training of multi-disciplinary staff has continued throughout 2018/19. An exciting development has been the opportunity to teach on the Trainee Nursing Associate (TNA) curriculum with sessions provided relating to Patient Experience, Carers and Compassionate Care. Student Nurses are also being targeted whilst on placement with Compassionate Care workshops well attended; there are plans in place to extend this training as part of the University based curriculum similar to the TNA training mentioned above.</p> <p>A training video highlighting aspects of care relating to some of the 2018/19 patient experience priorities was made and successfully shared in a variety of forums, including the Trust's annual nursing conference.</p>
Introduction of tablet computers to all wards and some departments to make it easier for patients to provide feedback electronically.	This piece of work has suffered significant delays due to technical issues. In the interim a paper-based alternative is working well and enabling patients to be able to feed back on the services they have received.
Development of the information screen in the Emergency Department to include different pathways to help patients understand why they may wait different times, and the use of paracetamol as first line pain relief.	<p>Updated information is now showing on the Emergency Department television screen. This includes:</p> <ul style="list-style-type: none"> > Current longest waiting time to be assessed or treated > Information regarding the ED journey/pathway > Other treatment centre options e.g. Pharmacy or NHS Walk in Centres > Emergency dental care information > Self-help advice > Important public health messages e.g. increased measles prevalence > How to provide feedback about your experience

New Patient Experience Priorities for 2019/20

As indicated above, the two patient experience priorities for 2019/20 are ensuring good nutrition and hydration, particularly for those patients who need additional help, and pain control in emergency departments.

Nutrition and Hydration	
Survey questions	1a) If you needed help to eat your meals, who helped you? 1b) Did you get enough help? (filtered for those who needed help only) 2) During your time in hospital, did you get enough to drink?
Local target for 2019/20	Baseline data to be gathered in Quarter 1 2019/20 across all sites to enable a target to be set.
Initiatives for 2019/20	<ul style="list-style-type: none"> > Ensure consistent surveys across all sites to gain site and ward specific patient insight > New charts and guidance under development > Refresh of the Nutrition and Hydration Steering Group > Review mealtime leadership and support and develop consistent approach. > Review criteria for referral to dietetics > Roll out dedicated beverage trolleys across all sites > Roll out snack boxes across all sites > Increase the number of ward volunteers who provide the beverage trolley service > Develop urine colour charts for staff and patients > Nutrition and Hydration Steering Group 'rounds' (bi-monthly ward visits) > Pilot dining companions scheme and roll out if suitable > <i>Eat, drink, dress, move</i> programme to be rolled out across all sites

Pain control in Emergency Departments	
Survey question	1) Do you think the hospital staff did everything they could to control your pain?
Local target for 2019/20	9.0
Initiatives for 2019/20	<ul style="list-style-type: none"> > Undertake an in depth data analysis to further understand this issue and produce an action plan. > Increase volunteers in Emergency Department to improve collection of patient experience feedback > Quarterly audit of pain scores and time from assessment to analgesia given > Development of a dashboard to show Emergency Department assessment performance

How progress will be monitored, measured and reported

- ▶ This priority will be measured using results from the local surveys. Complaints and feedback from other sources will also be included.
- ▶ Pain control in the Emergency Departments will also be assessed via quarterly records audit.
- ▶ Patient feedback will be analysed alongside clinical data.
- ▶ Aspects of nutrition and hydration will be assessed during patient-led visits to clinical areas (PLACE-Lite visits)
- ▶ All sites already ask the question relating to pain control in the emergency department, therefore a target has already been set for this.
- ▶ Not all sites collect local patient experience data relating to nutrition and hydration. This will be added to all local inpatient surveys and baseline data collected in quarter one in order for targets to be set.
- ▶ Results will be published on the Trust's Patient Experience dashboard available to all staff.
- ▶ The Patient Experience Group monitors this priority via a bi-monthly report. The Patient Experience Group is led by the Executive Chief Nurse and attended by Governors from each hospital site. This Group reports to the Care Quality Group and onwards to Board and Council of Governors meetings.
- ▶ Reports will also be received by the Nutrition and Hydration Steering Group and the Emergency Department's management team.

The Friends and Family Test (FFT)

The Friends and Family Test (FFT) asks patients the following question to help us to listen to feedback from our patients:

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

Patients can choose from six different responses as follows:

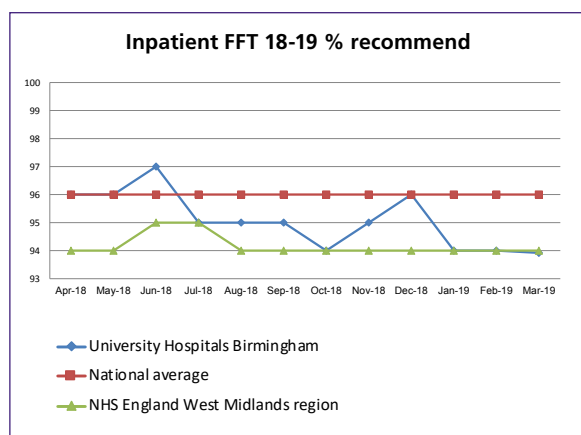
- ▶ Extremely likely
- ▶ Likely
- ▶ Neither likely or unlikely
- ▶ Unlikely
- ▶ Extremely Unlikely
- ▶ Don't know

This is asked via a number of methods, primarily via paper, tablet or SMS text messaging. The Trust follows the national guidance for undertaking and scoring of the FFT.

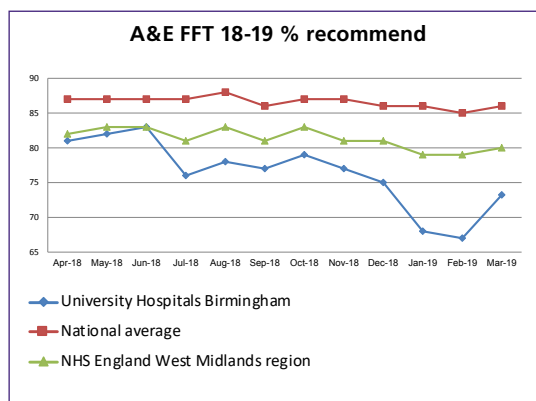
Response rates and positive recommendation percentages were closely monitored throughout 2018/19 against internal targets set and tracked against national and regional averages to benchmark against peers. The charts below show benchmark comparisons for the positive recommendation percentages for the Friends and Family Test for Inpatients, A&E, Outpatients, Maternity and Community Services.

Performance

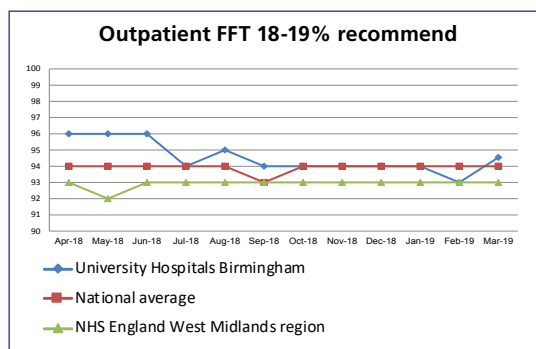
Inpatients: During 2018/19 the Trust maintained a positive recommendation rate that was above or equal to the West Midlands regional average. The Trust scored below or equal to the national average with the exception of June 2018.



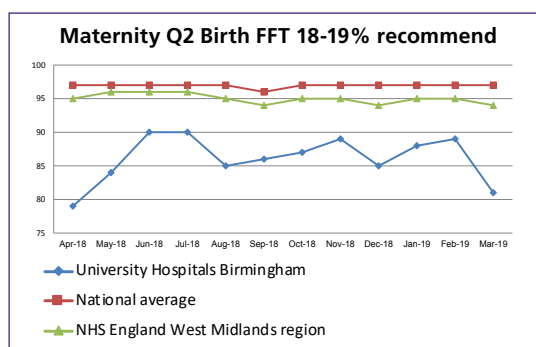
A&E: During 2018/19 the Trust's positive recommendation rate reduced over the year tracking the four-hour wait target. It remained below or equal to the West Midlands regional average and below the national average reflecting the challenges that the Trust has seen in this area.

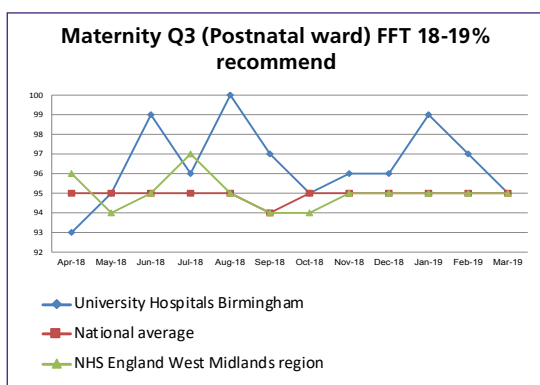


Outpatients: During 2018/19 the Trust maintained a positive recommendation rate, which for most months is significantly higher than the West Midlands regional average, and higher or equal to the national average. February 2019 saw a transient dip slightly below the national average but remaining equal to the regional average.

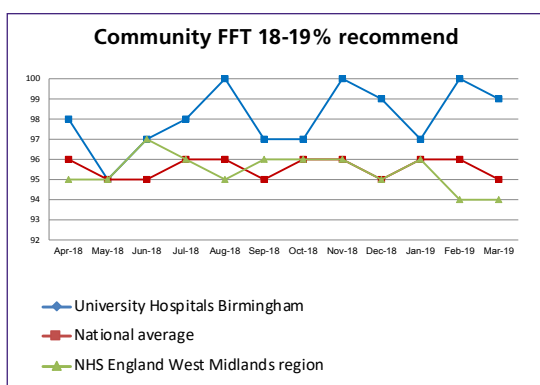


Maternity: During 2018/19 the Trust remained below the national and regional average for birth, but above the national and regional averages for postnatal care on the ward. Some additional focused work is being undertaken to understand these figures and actions will be implemented to improve the birth experience.





Community: During 2018/19 the Trust achieved a high positive recommendation rate for community services in Solihull, which is significantly higher or equal to both the West Midlands regional average, and the national average.



Complaints

The total number of complaints received in 2018/19 was 1950, an increase of 8.6% on the 1796 complaints received in 2017/18. The main subjects related to clinical treatment communication and patient care.

	2016/17	2017/18	2018/19
Total number of complaints	1,902	1,796	1,950

The table below compares complaints received against activity data. The number of inpatient, outpatient and emergency department complaints received in 2018/19 increased compared to the previous year, whilst activity also increased in all those areas. Whilst the complaints to activity ratios for inpatients and the emergency department were stable, there was an increase in the ratio of complaints to activity ratio for outpatients.

Rate of all complaints to activity		2016/17	2017/18	2018/19
Inpatients	FCEs*	494,152	503,631	539,603
	Complaints	902	879	900
	Rate per 1000 FCEs	1.8	1.7	1.7
Outpatients	Appointments	1,812,279	1,809,916	1,901,636
	Complaints	606	631	691
	Rate per 1000 appointments	0.3	0.3	0.4
Emergency Department	Attendances	382,247	389,726	408,310
	Complaints	341	272	304
	Rate per 1000 attendances	0.9	0.7	0.7

* FCE = Finished Consultant Episode – which denotes the time spent by a patient under the continuous care of a consultant

Learning from complaints

The table below provides some examples of how the Trust responded to complaints where serious issues were raised; a number of complaints were received about the same or similar issues or for the same location, or where an individual complaint resulted in specific learning and/or actions. The actions may have taken place in one department/site, but learning is shared across all sites to see if further improvements can be made Trust-wide.

Issue	Action taken
Hot stuffy waiting room conditions.	Dyson cooling fans ordered and installed in some of the outpatient departments.
Patient with ICD (implantable cardiac defibrillator) attended for colonoscopy but the procedure could not go ahead because appropriate staff to disable device not there on Sunday	Reminder to referring clinician of importance of highlighting such issues. Patient leaflet updated to highlight ICDs. Issue highlighted to other specialties to check whether changes need to be made to their processes and/or leaflets to take account of such situations.
Discharge and transfer arrangements from ward to hospice without advising patient's family.	Whiteboard in the discharge lounge to track patients' journeys through the lounge. Designated member of staff to be allocated areas in the lounge to ensure patients in that area have everything they need.

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

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

PHSO Involvement	2016/17	2017/18	2018/19
Cases which were not upheld following review by the PHSO	22	13	15
Cases which were partially upheld following review by the PHSO	22	13	5
Cases which were fully upheld following review by the PHSO	2	0	0
Total cases reported on following investigation by the PHSO	46	26	20

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

There was a significant reduction in the number of cases reported on by the Ombudsman in 2018/19.

Only five cases were upheld or partially upheld by the Ombudsman in 2018/19, a reduction on the 13 cases in the previous year. A further 15 cases were not upheld by the Ombudsman, compared to 13 last year. In every case, appropriate apologies were provided, action plans were developed where requested and learning from the cases shared with relevant staff.

Compliments

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

UHB consistently receives considerably more compliments than it does complaints. Overall however the Trust recorded fewer formal compliments in 2018/19 (1,970) than in 2017/18 (2,136)

The Patient Experience team provide support and guidance to divisional staff around the collation and recording of compliments received directly to wards and departments.

Compliment Categories	2016/17	2017/18	2018/19
Nursing care	306	468	531
Friendliness of staff	97	141	121
Treatment received	1,582	1,210	941
Medical care	88	101	174
Other	19	22	24
Efficiency of service	287	167	138
Information provided	28	25	39
Facilities	2	2	2
Total	2,409	2,136	1,970

Examples of compliments received during 2018/19:

“We wish to express our appreciation and gratitude to the ward staff at **Good Hope Hospital**, who provided exemplary care over the last 8 days of our mother’s life. The team were able to answer our questions and make the necessary arrangements for the administration of the antibiotics and eventual analgesics and anti-anxiety drug. Special thanks to staff who demonstrated exemplary compassion and care and made sure our mother was comfortable throughout her stay.”

“The **Heartlands Hospital** staff were wonderful. Some staff in particular were incredibly efficient, put me on medication straight away, kept me informed, and were compassionate and thoughtful.”

“It was a comfort to all of us to know that he had been receiving the best possible care when he was being looked after on your ward at **QEHB**. I would particularly like to thank the nurses who looked after him – you were so kind to him and to our family whenever we visited. What you do is so important and you do it with a huge amount of patience and generosity. Thank you. I would also like to thank the doctor who sat down with me a few weeks ago and talked me through the whole situation. I arrived at the hospital that day feeling extremely anxious about Dad and I left so much more assured that he had the best possible team looking out for him and that he was safe in your care.”

“The food at **Solihull Hospital** was of outstanding quality – it helped me to recover following surgery.”

Feedback received through The NHS Website, Care Opinion and Healthwatch websites

The Trust has a system in place to monitor feedback posted on three external websites; The NHS Website (previously NHS Choices), Care Opinion and Healthwatch. Feedback is sent to the relevant service / department manager for information and action. A response is posted to each comment received which acknowledges the comment and provides general information when appropriate. The response also promotes the Patient Advice and Liaison Service (PALS) as a mechanism for obtaining a more personalised response, or to ensure a thorough investigation into any concerns raised.

Feedback received by this method has shown a significant increase of 212 per cent during the year (from 183 in 2017/18 to 571 in 2018/19). These figures include feedback received via this method relating to all four hospital sites. Numbers remain low compared to other methods of feedback used by patients and carers although are increasing year on year. Most feedback posted on these external websites is positive; concerns raised via this method reflect themes raised via more direct methods, for example via PALS, complaints or locally received verbal feedback.

Priority 3: Timely and complete observations including pain assessment

Background – QEHB

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

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

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

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

Performance – QEHB

Indicator 1 (Full set of observations plus pain assessment recorded within 6 hours of admission or transfer to a ward)

As performance had improved during 2017/18 but did not quite meet the 95% target, this target was kept for 2018/19.

2018/19 improved compared to 2017/18 but did not quite meet the 95% target for the year, although there were individual months where this was achieved.

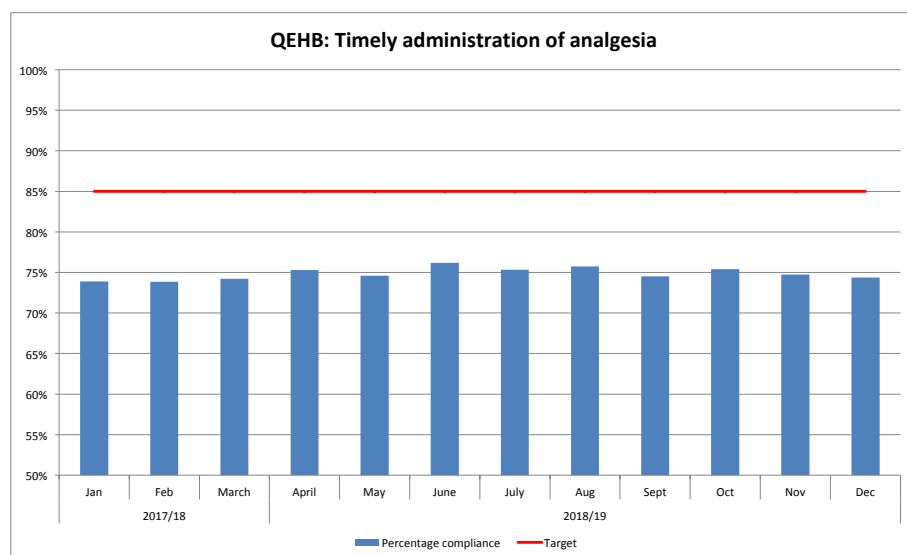
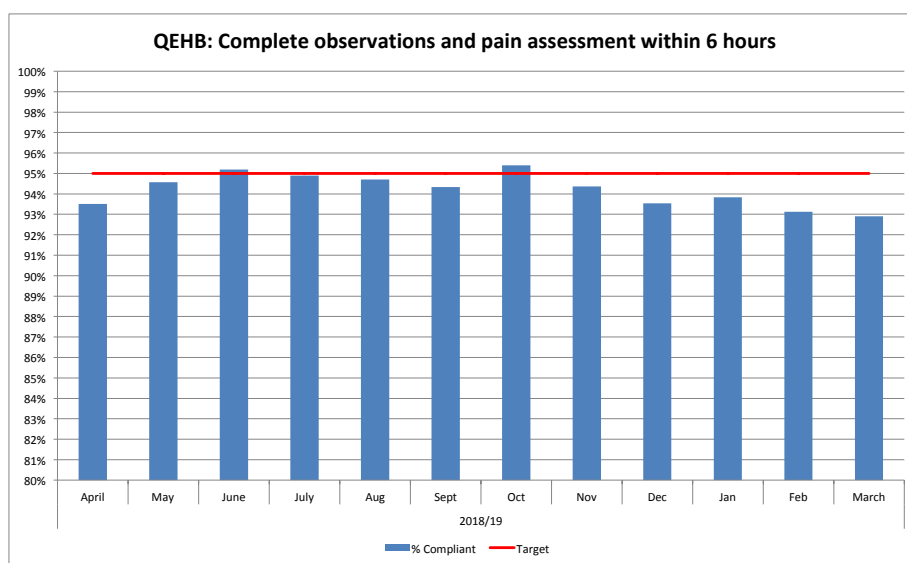
Indicator 2 (Analgesia administered within 30 minutes of a high pain score)

The target had not been achieved during 2017/18, so the same target of 85% was kept for 2018/19. Performance was again steady throughout the year, around 74% to 76% each month, however the target of 85% was not achieved – overall performance was 75%.

Table: Performance by quarter

	Indicator 1	Indicator 2
	Full set of observations plus pain assessment recorded within 6 hours of admission or transfer to a ward	Analgesia administered within 30 minutes of a high pain score
Performance 2014/15	71%	64%
Performance 2015/16	79%	76%
Performance 2016/17	90%	75%
Performance 2017/18	93%	75%
2018/19	Target	95%
	Q1	94.6%
	Q2	94.7%
	Q3	94.5%
	Q4	93.3%
	Year	94.3%
		85%
		75.3%
		75.2%
		74.8%
		74.7%
		75.0%

Graphs: Performance by month



Background – Heartlands, Good Hope and Solihull Hospitals

The Board of Directors agreed to introduce this Priority in the 2017/18 Quality Report.

When nursing staff carry out patient observations, it is important that they complete the full set of observations, as this allows them to calculate an early warning score which highlights if a patient's condition is starting to deteriorate. This allows patients to receive appropriate clinical treatment as soon as possible.

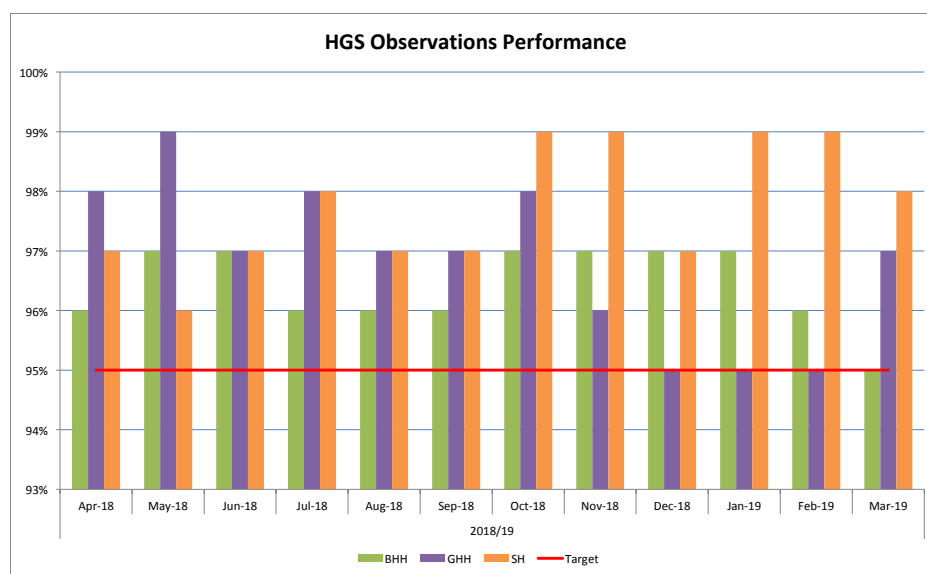
Currently at Heartlands, Good Hope and Solihull Hospitals, observations are recorded on paper charts, but there are plans to roll out PICS across the Heartlands, Good Hope and Solihull Hospitals sites and this will allow electronic recording of observations.

The data gathered for the Heartlands, Good Hope and Solihull Hospitals sites is drawn from a monthly audit of nursing notes across the wards, known as the Nursing Metrics. The score is based on an aggregate of various standards relating to observations.

Performance – Heartlands, Good Hope and Solihull Hospitals

The target is 95%, which has been met by each site and for Heartlands, Good Hope and Solihull Hospitals overall every month during 2018/19.

Performance is displayed in the graph below.



Initiatives implemented in 2018/19

- ▶ Wards' performance is monitored at a divisional and Trust level. Lower performing wards developed action plans to make improvements, and have been called to Executive Care Omissions Root Cause Analysis (RCA) meetings.
- ▶ Wards and Divisions have taken actions at their local level; these include:
 - Use of computers in handover to immediately identify any outstanding observations which have occurred
 - Ensuring PICS tablets are calibrated to the correct ward to avoid data errors
 - Training for HCAs to assist qualified nurses with observations
 - Spot-checks by Matrons
 - PICS team invited to give refresher training to ward staff

Changes to Improvement Priority for 2019/20

UHB is working on the implementation of NEWS2 (National Early Warning Score) – a new system that is to be used nationally. Once in place, the indicators will be checked, and if necessary updated, to reflect use of this new system.

QEHB

Indicator 1 - as the performance improved but did not achieve the target at the end of 2017/18, the Trust has chosen to keep the target for 2018/19:

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

QEHB Indicator 2 - as performance was steady throughout the year, meaning the target was not achieved, the Trust has chosen to keep the same

target for 2018/19:

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

UHB also plans to review the underlying data in more detail, to break the time down into prescription time and administration time to better identify the reasons that this indicator is not being achieved. Depending on the findings from this, the indicator may change to be more targeted.

Heartlands, Good Hope and Solihull Hospitals

The observations indicator will stay the same, pending introduction of PICS.

UHB will review the Nursing Metrics data to scope the development of an indicator relating to pain assessment for Heartlands, Good Hope and Solihull Hospitals pending introduction of PICS. Baseline data will be reviewed and targets set accordingly.

Initiatives to be implemented in 2019/20

- ▶ Wards performing below target will continue to be reviewed at the Executive Care Omissions Root Cause Analysis (RCA) meetings to identify where improvements can be made. Observations and pain assessment compliance will be monitored as part of the unannounced monthly Board of Directors' Governance Visits to wards.
- ▶ To include pain assessment for Heartlands, Good Hope and Solihull Hospitals sites.
- ▶ To review the data behind the timely analgesia indicator, to identify the time taken to prescribe and the time taken to administer the medication.

How progress will be monitored, measured and reported

- ▶ Progress will be monitored at ward, specialty and Trust levels through the Clinical Dashboard (QEHB) and Nursing Metrics (Heartlands, Good Hope and Solihull Hospitals). The Clinical Dashboard allows staff to compare their ward performance to the Trust as a whole, as well as seeing detailed data about which of the six observations or pain assessment were missed.
- ▶ Performance will continue to be measured using PICS data from the electronic observation charts, and data from the Nursing Metrics.
- ▶ Progress and exceptions will be reported to the Clinical Quality Monitoring Group and the Board of Directors in the Quality Performance report.
- ▶ Progress will be publicly reported in the mid-year Quality Report update published on the Trust's quality web pages.

Priority 4: Reducing missed doses

Background

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

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

In the absence of a national consensus on what constitutes an expected level of drug omissions, the Trust has set targets based on previous performance.

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

At Heartlands, Good Hope and Solihull Hospitals, drug prescriptions and administrations are recorded on a different electronic system, and the chosen indicator is the rate of missed doses of regular antibiotics.

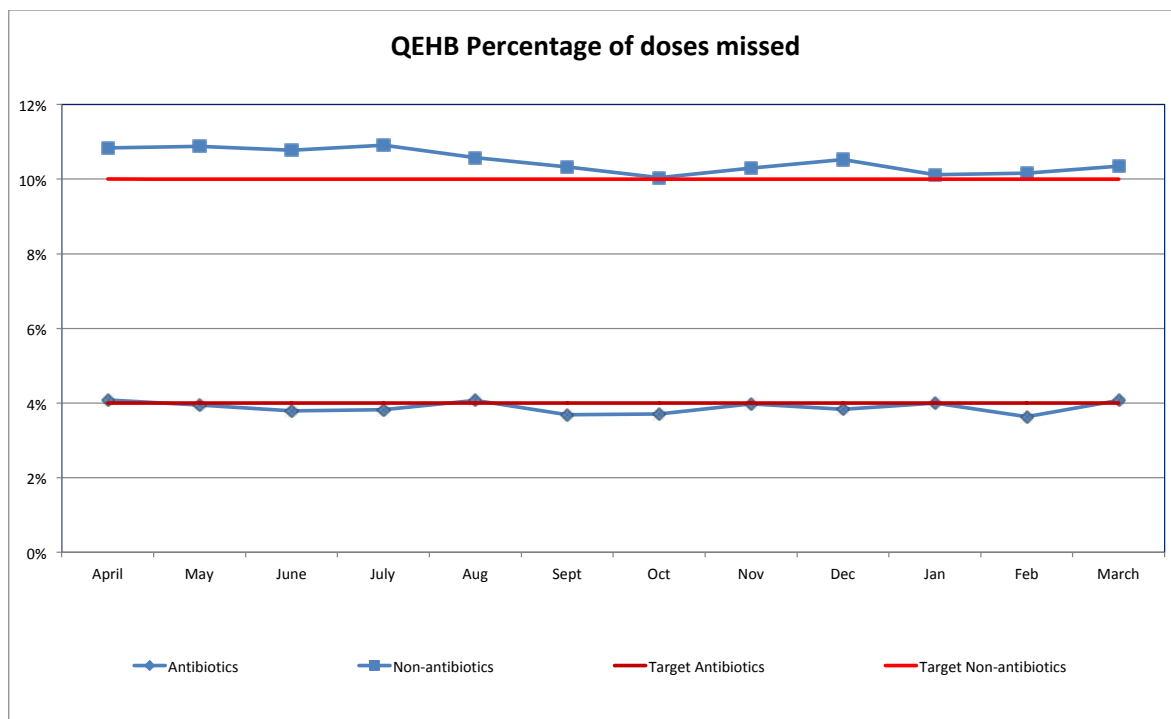
Performance - QEHB

Antibiotics: performance in the last quarter of 2017/18 was 4.4%, so in the 2017/18 Quality Report the Trust committed to reducing this to 4.0% by the end of 2018/19.

In 2018/19 QEHB achieved 3.9%, and also met the target every quarter.

Non-antibiotics: performance in the last quarter of 2017/18 was 11.8%, so in the 2017/18 Quality Report the Trust committed to reducing this to 10.0% by the end of 2018/19.

In 2018/19 QEHB achieved 10.5% for the year, and Quarter 4 was 10.2%. While this did not meet the target, performance improved compared to the previous year.



	Antibiotics	Non-antibiotics
Performance 2014/15	4.0%	10.5%
Performance 2015/16	3.9%	10.5%
Performance 2016/17	4.1%	10.6%
Performance 2017/18	4.5%	11.3%

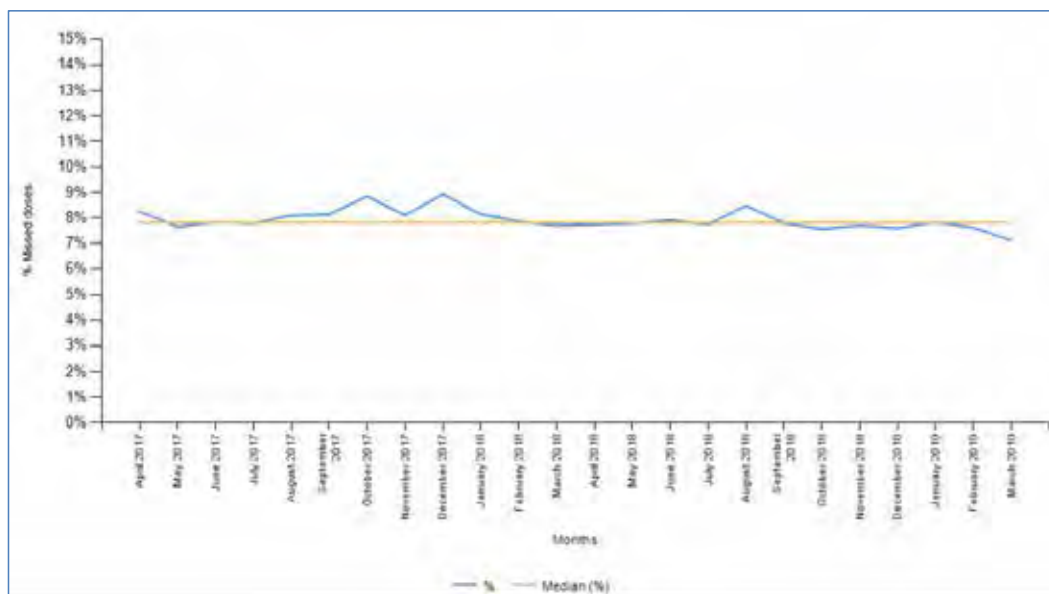
	Target	4% or lower	10% or lower
	2018/19		
	Q1	3.9%	10.8%
	Q2	3.9%	10.6%
	Q3	3.8%	10.3%
	Q4	3.9%	10.2%
	Year	3.9%	10.5%

Performance (Heartlands, Good Hope and Solihull Hospitals)

Performance has been steady at around 8-9% for the last two years.

For Heartlands, Good Hope and Solihull Hospitals, the Trust chose to measure the percentage of missed doses of regular antibiotics.

Graph: percentage of missed doses of regular antibiotics (Heartlands, Good Hope and Solihull Hospitals)



Initiatives implemented during 2018/19

- ▶ Reports which display rates of missed doses, and missed doses due to medication being intermittently out of stock, continued to be used to identify cases for review at the Executive Care Omissions RCA meetings (Executive RCAs).
- ▶ Wards that are identified as exceptions for missed doses have been called to the Executive RCAs, where they talk through their data, any problems identified and actions taken.
- ▶ Development of a ‘missed doses training pack’ to ensure information on missed doses is fully recorded on PICS, to allow for analysis and identification of trends.
- ▶ Development of indicators that monitor timely administration of Parkinson’s medications, and ensuring these are aligned across the hospital sites.
- ▶ Wards and Divisions have taken actions at their local level, these include:
 - › Establishing regular in-depth reviews of their data to identify trends.
 - › Ensuring that missed doses form part of the handover between staff.
 - › Continuing to roll out PGD training (Patient Group Directions) which allow nurses with the relevant competencies to give certain painkillers without the need for a prescription from a doctor.
- › Reminding staff to use the dropdown box on the electronic drugs chart to accurately record the reason for a drug being recorded as missed. This will help identify common problems.
- › Continuation of monthly assurance meetings where a ward presents their performance against a number of indicators, and discusses actions taken to make improvements. Attendees include senior nurses for the area, and lead nurses for Pharmacy and Standards.

Changes to Improvement Priority for 2019/20

- ▶ The focus will change from missed doses of antibiotics to reducing consecutive missed doses, and missed doses of selected high risk medicines (to be agreed).
- ▶ Missed doses of antibiotics will continue to be monitored internally.
- ▶ The indicator on missed non-antibiotics will be retained along with the 10% target. Work will be undertaken to measure this on all four hospital sites.

Initiatives to be implemented in 2019/20

- ▶ UHB will scope the development of new indicators that measure omissions of selected high risk medications, and consecutive missed doses.
- ▶ Individual cases will continue to be selected for further review at the Executive Care Omissions RCA meetings.
- ▶ Multi-disciplinary work will continue to identify further opportunities to reduce missed doses.

How progress will be monitored, measured and reported

- ▶ Progress will continue to be measured at ward, specialty, divisional and Trust levels using information recorded electronically.
- ▶ Data on missed drug doses will continue to be made available to clinical staff. This will also be monitored at divisional, specialty and ward levels.
- ▶ Progress and exceptions will be reported to the Clinical Quality Monitoring Group and the Board of Directors in the Quality Performance report.
- ▶ Progress will be publicly reported in the mid-year Quality Report update published on the Trust's quality web pages.

Priority 5 – Reducing harm from falls

This quality improvement priority was originally proposed by the Council of Governors and approved by the Board of Directors. It was first included in the 2016/17 Quality Report.

Background

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

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

When a fall occurs at UHB, the staff looking after the patient submit an incident form via Datix, the Trust's incident reporting system. All falls incidents are reviewed by the Trust's Falls Team, a team of clinical nurse specialists. The lead for the area where the fall happened, usually the Senior Sister /

Charge Nurse, investigates the fall and reports on the outcome of the fall, and whether there is any learning or if any changes in practice / policy need to be made.

Most falls do not result in any harm to the patient. Any falls resulting in severe harm undergo an RCA (root cause analysis) process to identify any issues or contributory factors. Falls resulting in specific harm, e.g., a fractured neck of femur (broken hip), are also reported to the local Clinical Commissioning Group and externally reported via STEIS (the system used to report and monitor the progress of Serious Incident investigations across the NHS).

For all severe falls an initial investigation is undertaken within three days of the fall in order to highlight any immediate actions required, a round table clinical review is then held within thirty days following a more in-depth investigation. The review is multidisciplinary and includes the senior nurse for the clinical area, the matron and the falls coordinator, therapy staff and medical staff where appropriate. Details from this review are then incorporated into the detailed RCA (root cause analysis) that is signed off at the relevant Nursing Incident Quality Assurance meeting where the senior nurse is challenged by the Head Nurse to ensure that all learning from the incident has been incorporated into the RCA, and implemented across the clinical team.

Falls prevention

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

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

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

Performance – QEHB

For QEHB, the Trust has chosen to measure ‘percentage of falls resulting in harm’.

(This refers to all levels of harm, from minor to catastrophic/death).

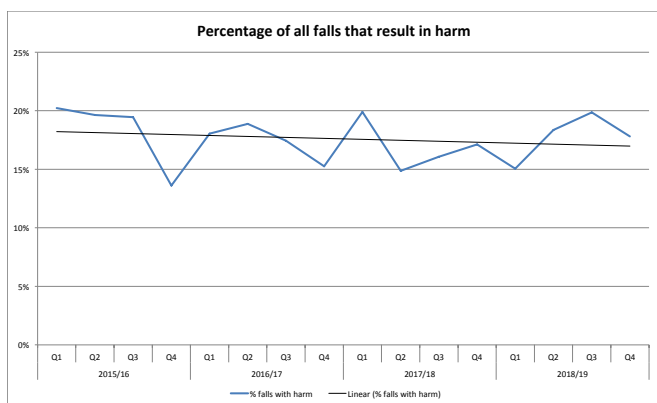
While staff take precautions to prevent falls from occurring, it is not possible to prevent all falls, therefore it is also important to attempt to minimise the harm that occurs due to falls.

Data for the last three years is presented below:

Year	Quarter	Percentage of falls with harm
2016/17	Q1	18.1%
	Q2	18.9%
	Q3	17.4%
	Q4	15.3%
	Year	17.4%
2017/18	Q1	19.9%
	Q2	14.9%
	Q3	16.1%
	Q4	17.1%
	Year	17.0%
2018/19	Q1	15.1%
	Q2	18.4%
	Q3	19.9%
	Q4	17.8%
	Year	17.8%

The Trust decided to set a target of 16.9% by the end of 2018/19 – this was a 1.5% reduction on the Quarter 4 2017/18 data.

At the end of Quarter 4 2018/19, the target was not met.



Performance – Heartlands, Good Hope and Solihull Hospitals

For Heartlands, Good Hope and Solihull Hospitals, the Trust chose to measure ‘percentage of all falls that are injurious’, i.e., the number of falls that result in harm that must be reported nationally; these include falls that result in a fractured neck of femur (broken hip), and certain head injuries (i.e. those deemed to be severe harm).

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

As the injurious harm rate at Heartlands, Good Hope and Solihull Hospitals is already low, the Trust chose to set a maintenance target for 2018/19, i.e., to stay at or below the performance reported for the previous year (1.7%).

For 2018/19, the rate of injurious falls was 1.4%, meeting the target of 1.7% or lower.

Data for the last three years is presented below:

Year	Quarter	Percentage (%) of all falls that are injurious
2016/17	Q1	1.3%
	Q2	1.1%
	Q3	1.5%
	Q4	2.0%
	Year	1.5%
2017/18	Q1	1.4%
	Q2	2.5%
	Q3	1.9%
	Q4	1.0%
	Year	1.7%
2018/19	Q1	1.9%
	Q2	1.0%
	Q3	1.4%
	Q4	1.2%
	Year	1.4%

(Please note that this data has undergone final validation since the 2017/18 Quality Report and may have changed slightly).

It should also be noted that there has been an increase in activity across the Trust, so when other measures are used (for example, number of falls as a rate against 1000 bed days), performance has improved, i.e., the rate has dropped.

Initiatives implemented during 2018/19

- ▶ QEHB and Heartlands, Good Hope and Solihull Hospitals are now using a merged RCA tool and are following the same standardised RCA investigation process
- ▶ The falls team held a falls summit in March 2019 where key stakeholders from across the Trust have identified and agreed on several work streams that will inform and assist with a falls strategy for 2019/20
- ▶ In January 2019 the Royal College of Physicians National Inpatient Falls Audit commenced which the Trust is participating in

Initiatives to be implemented during 2019/20

- ▶ The falls team are working collaboratively with key stakeholders across the Trust in the development of a UHB strategy for achieving further reductions in falls and falls with harm during 2019/20
- ▶ The falls team continue to raise the profile of the Trust Falls Prevention Team, for example by ensuring active engagement in Back to the Floor visits, attendance at Divisional Preventing Harm meetings, supporting clinical staff in implementing falls prevention strategies, audit of falls assessment compliance and interventions, problem solving, and RCA completion and action planning
- ▶ The falls team are working collaboratively with the Trust clinical education team to review and plan falls training so that it remains targeted and appropriate, whilst aligning with the wider educational strategy
- ▶ Continue to monitor and re-evaluate the Trust compliance with NICE guidelines CG161 and Falls Quality Standards 2017, and implement any actions identified
- ▶ Assist with the development and implementation of a combined Trust-wide falls Datix (incident reporting) form and explore how this can be incorporated into existing IT systems to ensure a more efficient and effective method of capturing incident information and investigation
- ▶ To work with commissioners on improving the patient pathway on discharge from hospital, including discharge information and appropriate referral processes

Changes to Improvement Priority for 2019/20

The Trust has chosen to focus on reducing the overall number of falls that occur and associated harm.

In 2018/19, 6123 inpatient falls occurred at UHB. Therefore the Trust has chosen to set a target of no more than 5817 falls during 2019/20, which is equivalent to a 5% reduction.

How progress will be monitored, measured and reported

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

Priority 6 – Timely treatment for sepsis

This important quality improvement priority remained in place during 2018/19.

Background

Sepsis is a potentially life-threatening condition and is recognised as a significant cause of mortality and morbidity in the NHS, with almost 37,000 deaths in England attributed to sepsis annually. Of these it is estimated that 11,000 could have been prevented.

Sepsis has been on the national agenda as a high priority area for the Commissioning for Quality and Innovation (CQUIN) system and in 2016/17 certain trusts had a key target to implement systematic screening for sepsis of appropriate patients and where sepsis is identified, to provide timely and appropriate treatment and review. This CQUIN was extended into the 2017–19 plan, and UHB sites participated in this by submitting separate data to the CCG (NHS England 2015).

The purpose of the CQUIN was to embed a systematic approach towards the prompt identification and appropriate treatment of life-threatening infections, while at the same time reducing the chance of the development of strains of bacteria that are resistant to antibiotics.

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

Sepsis is common and can be treatable if it is recognised early and appropriately managed. It can be difficult to diagnose sepsis early and if recognition is delayed and appropriate treatment not instituted (usually oxygen, intravenous fluids and antibiotics), significant harm or even death can occur.

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

The Trust’s aim for 2018/19 was to improve the early recognition and management of patients with sepsis.

Performance

Indicator 2a: Timely identification of sepsis in emergency departments and acute inpatient settings.

Quarterly audit of 150 emergency admissions and 150 inpatients that met the criteria for screening for sepsis as per local protocol.

Target: over 90% of patients to have evidence of screening for sepsis using the Trust screening tool.

Indicator 2b: Timely treatment of sepsis in emergency departments and acute inpatient settings.

Quarterly audit of patients identified as having sepsis from part 2a above. Time between diagnosis of sepsis and antibiotics administered is then assessed.

Target: over 90% to be given with 60mins.

		Indicator 2a: Timely identification of sepsis			Indicator 2b: Timely treatment of sepsis		
		Emergency Departments	Acute Inpatient	Overall	Emergency Departments	Acute Inpatient	Overall
Q1	BHH/ GHH/SH	57.1%	63.2%	59.7%	53.8%	68.6%	60.8%
	QEHB	95.2%	99%	97%	88.7%	89.1%	88.8%
Q2	BHH/ GHH/SH	62.5%	83.7%	70.5%	46.7%	69.2%	57.1%
	QEHB	85.7%	98%	91%	93.4%	92.5%	93%
Q3	BHH/ GHH/SH	65%	82.7%	74.3%	56.6%	73%	66.1%
	QEHB	82.6%	96%	88.9%	86.9%	86.7%	86.9%
Q4	BHH/ GHH/SH						
	QEHB						

At time of writing, Quarter 4 is not yet available.

It should be noted that at the start of 2018/19, different audit methodologies and screening criteria were in place at the QEHB site and the Heartlands, Good Hope and Solihull sites. This has since been addressed but means that performance should not be compared for this time period.

For 2019/20, the CQUIN is not in place but the Trust will continue to aim to meet the Key Performance Indicator targets set out above and will report these quarterly to the CCG in line with national 2019/20 contract.

Initiatives implemented during 2018/19

- ▶ A Trust Sepsis Group was created in August 2018 and now meets monthly with the two “local” sepsis teams from across the merged UHB

sites. Work has been undertaken to align audit methodologies, standards and education.

- ▶ A sepsis learning module for MOODLE has been developed and will form part of mandatory training plus optional modules for those looking for a more in-depth knowledge
- ▶ At QEHB a screening question was implemented in PICS at the beginning of July 2018. This tool was updated on 31st January 2019 with the introduction of the NEWS2 score, which replaced the SEWS score.
- ▶ The QEHB Sepsis guidelines were reviewed and updated in line with new NEWS2 score.
- ▶ The QEHB antimicrobial guideline underwent a major review in key sections such as sepsis of unknown origin, community and hospital acquired pneumonia, pyelonephritis and complicated UTI, promoting the use of narrower spectrum antibiotics.

- ▶ At QEHB audits on the management of sepsis and implementation of the elements of sepsis bundle were undertaken in a few specialist areas.
- ▶ At Heartlands, Solihull and Good Hope Hospitals a sepsis nurse was appointed in the autumn which has led to better quality audits, with sufficient numbers reviewed and an increasing role in education on the wards. A new audit tool was developed to capture timings and increased collaboration with Critical Care Outreach Team who are now recording audit data in real time.
- ▶ At Heartlands, Solihull and Good Hope Hospitals there was the successful roll-out of NEWS2 with new paper observation charts and education required.

Initiatives to be implemented during 2019/20

- ▶ Datix incidents will be completed for all identified instances of non-compliance with sepsis screening and delay in administration of antibiotics over 60 minutes.
- ▶ The education tools will be completed with annual refreshes and updates on cases.
- ▶ A sepsis dashboard will be created, where performance can be monitored in real time at ward level, initially at QEHB.
- ▶ The role of the sepsis nurse will be reviewed and defined with probable four site working.
- ▶ Further work will be undertaken to align tools and processes across the four sites.
- ▶ Moving to the requirements of the KPI whilst developing a quality surveillance and education framework for the care of the deteriorating patient (Heartlands, Good Hope and Solihull Hospitals)
- ▶ Improving online resources to allow wards to undertake their own Quality Improvement Priorities (QIPs) for sepsis.

How progress will be monitored, measured and reported

- ▶ Performance against the KPIs will be reported to the Trust's Sepsis Group and local sepsis groups, in addition to the Clinical Commissioning Group (CCG).
- ▶ Progress and exceptions will also be reported to the Clinical Quality Monitoring Group and the Board of Directors in the Quality Performance report.
- ▶ Progress will be publicly reported in the mid-year Quality Report update published on the Trust's quality web pages.

2.2 Statements of assurance from the Board of Directors

2.2.1 Service income

During 2018/19 the University Hospitals Birmingham NHS Foundation Trust provided and/or sub-contracted 74 relevant health services.

The Trust has reviewed all the data available to them on the quality of care in 74 of these relevant health services*.

The income generated by the relevant health services reviewed in 2018/19 represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2018/19.

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

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

2.2.2 Information on participation in clinical audits and national confidential enquiries

During 2018/19, 47 national clinical audits and 4 national confidential enquiries covered relevant health services that UHB provides. During that period UHB participated in 96% (45 of 47) national clinical audits and 100% (4 of 4) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that UHB was eligible to participate in during 2018/19 are as follows: (see tables below).

The national clinical audits and national confidential enquiries that UHB participated in during 2018/19 are as follows: (see tables below).

The national clinical audits and national confidential enquiries that UHB participated in, and for which data collection was completed during 2018/19, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits

National Audit UHB eligible to participate in	UHB participation 2018/2019	Percentage of required number of cases submitted
Adult Cardiac Surgery	Yes	100%
Adult Community Acquired Pneumonia	Yes	Data collection ongoing.
BAUS Urology Audit- Cystectomy	Yes	99%
BAUS Urology Audit- Female Stress Urinary Incontinence (SUI)	Yes	100%*
BAUS Urology Audit- Nephrectomy	Yes	100%*
BAUS Urology Audit- Percutaneous Nephrolithotomy	Yes	100%
BAUS Urology Audit- Radical Prostatectomy	Yes	82%
Cardiac Rhythm Management (CRM)	Yes	>80%
Case Mix Programme	Yes	100%
Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	80%
Feverish Children (care in emergency departments)	Yes	Report not yet published.
Inflammatory Bowel Disease programme/ IBD Registry	Yes	Data collection ongoing.
Major Trauma Unit (TARN)	Yes	91%
Maternal, Newborn and Infant Clinical trauma Review Programme	Yes	100%
Myocardial Ischaemia National Audit Project (MINAP)	Yes	95%
National Asthma and COPD Audit Programme	Yes	Still in pilot stage.
National Audit of Breast Cancer in Older People	Yes	100%
National Audit of Cardiac Rehabilitation	Yes	100%
National Audit of Care at the End of Life (NACEL)	Yes	Data collection not yet started.
National Audit of Dementia	Yes	N/A
National Audit of Percutaneous Coronary Interventions (PCI)	Yes	100%
National Audit of Seizures and Epilepsies in Children and Young People	Yes	Data collection ongoing.
National Bariatric Surgery Registry (NBSR)	Yes	100%
National Bowel Cancer Audit (NBOCA)	Yes	83%
National Cardiac Arrest Audit (NCAA)	No	UHB did not participate.
National Clinic Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	Yes	100%
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	Yes	100%
National Comparative Audit of Blood Transfusion programme	Yes	100%
National Congenital Heart Disease (CHD)	Yes	92.5%
National Diabetes Audit	No	100% (Note: UHB only participated in certain aspects of the Diabetes Audit Programme.)
National Emergency Laparotomy Audit (NELA)	Yes	98%
National Heart Failure Audit	Yes	89.5%
National Joint Registry (NJR)	Yes	83.23% (1461 cases)
National Lung Cancer Audit (NLCA)	Yes	68%
National Maternity and Perinatal Audit (NMPA)	Yes	100%
National Neonatal Audit Programme (NNAP)	Yes	91%
National Oesophago-gastric Cancer (NAOGC)	Yes	85.7%

National Audit UHB eligible to participate in	UHB participation 2018/2019	Percentage of required number of cases submitted
National Ophthalmology Audit	Yes	100%
National Paediatric Diabetes Audit (NPDA)	Yes	87.25%
National Prostate Cancer Audit	Yes	98%
National Vascular Registry	Yes	88.4%
Neurosurgical National Audit Programme	Yes	100.0%
Non-Invasive Ventilation- Adults	Yes	Data collection ongoing.
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes	100%
Seven Day Hospital Services	Yes	100%
UK Cystic Fibrosis Registry	Yes	63.5%
Vital Signs in Adults (care in emergency departments)	Yes	Reports not yet published.
VTE Risk in lower limb immobilisation (care in emergency department)	Yes	Reports not yet published.

* these audits have submitted a higher number of cases than the minimum required.

National Confidential Enquiries (NCEPOD)

National Confidential Enquiries (NCEPOD)	UHB participation 2018/19	Percentage of required number of cases submitted
Perioperative Diabetes	Yes	100%
Pulmonary Embolism	Yes	100%
Bowel Obstruction	Yes	100%
Long Term Ventilation	Yes	On-going Study: 23% completed

Percentages given are the latest available figures.

The reports of 16 national clinical audits were reviewed by the provider in 2018/19 and UHB intends to take the following actions to improve the quality of healthcare provided: (see separate clinical audit appendix published on the Quality web pages: <http://www.uhb.nhs.uk/quality.htm>).

The reports of 353 local clinical audits were reviewed by the provider in 2018/19 and UHB intends to take the following actions to improve the quality of healthcare provided (see separate clinical audit appendix published on the Quality web pages: <http://www.uhb.nhs.uk/quality.htm>).

At UHB a wide range of local clinical audits are undertaken. This includes Trust-wide audits and specialty-specific audits which reflect local interests and priorities. A total of 1301 clinical audits were registered with UHB's clinical audit team during 2018/19. Of these audits, 457 were completed during the financial year (see separate clinical audit appendix published on the Quality web pages: <http://www.uhb.nhs.uk/quality.htm>).

2.2.3 Information on participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by UHB in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was:

NIHR portfolio studies	15,068
Non-NIHR portfolio studies	972
Total	16,040

For more information on research carried out at UHB and other highlights, please see the relevant section of the Annual Report.

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

A proportion of UHB income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between UHB and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2018/19 and for the following 12-month period are available electronically at <http://www.uhb.nhs.uk/quality-reports.htm>

The amount of UHB income in 2018/19 which was conditional upon achieving quality improvement and innovation goals was £13.6m* (QEHB) and £12.7m* (BHH/GHH/SH). Final payment for 2018/19 will not be known until June 2019.

* These figures represent the amount of income achievable based on the contract plans for NHS England and West Midlands CCGs. They are not precise figures for the following reasons;

- ▶ CQUIN would also be payable on any over-performance against these contracts
- ▶ CQUIN is also payable on out of area contracts
- ▶ A provision has been made in the accounts for non-delivery of some CQUINS
- ▶ CQUIN adjustments will also be applied for any adjustments made to the final outturn positions agreed with commissioners for 2018/19.

A proportion of UHB income in 2017/18 was conditional on achieving quality improvement and innovation goals. The Trust received £11.7m (QEHB) and £11.8m (BHH/GHH/SH) in payment for 2017/18.

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

UHB is required to register with the Care Quality Commission and its current registration status is registered without compliance conditions.

The Care Quality Commission has not taken enforcement action against UHB during 2018/19.

UHB has not participated in any special reviews or investigations by the CQC during 2018/19.

Inspection Ratings Grids

The CQC carried out a regular yearly inspection of some of the Trust's Core Services during October 2018. As a result of the inspection the Trust was rated as 'good' overall and full details of the Trust's ratings are below.

As the CQC have not yet inspected every area of Birmingham Heartlands Hospital, Good Hope Hospital or Solihull Hospital, there is not a rating for all services or an overall site rating for these three hospitals.

Queen Elizabeth Hospital Birmingham (QEHB)						
Domain:	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Services	Good	Good	Good	Requires Improvement	Good	Good
Medical Care	Requires Improvement	Good	Good	Outstanding	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical Care	Good	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
End of Life Care	Good	Good	Good	Outstanding	Good	Good
Outpatient and diagnostic imaging	Good	N/A	Good	Requires Improvement	Good	Good
Sexual Health Services	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Birmingham Heartlands Hospital (BHH)						
Domain:	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Services	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement
Medical Care	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Surgery	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement
Maternity	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

Good Hope Hospital (GHH)						
Domain:	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Services	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Medical Care	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Surgery	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement
Maternity	Requires Improvement	Good	Good	Good	Good	Good
Solihull Hospital (SH)						
Domain:	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Services	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Medical Care	Requires Improvement	Good	Good	Good	Good	Good
Surgery	Requires Improvement	Good	Good	Good	Good	Good
Maternity	Good	Good	Good	Good	Requires Improvement	Good

2.2.6 Information on the quality of data

Secondary Uses Service data

UHB submitted records during 2018/19 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

QEHB

- ▶ which included the patient's valid NHS Number was*:
 - > 99.33% for admitted patient care
 - > 99.76% for outpatient care
 - > 97.84% for accident and emergency care
- ▶ which included the patient's valid General Medical Practice Code was*:
 - > 99.98% for admitted patient care
 - > 99.64% for outpatient care
 - > 99.63% for accident and emergency care

Heartlands, Good Hope and Solihull Hospitals

- ▶ which included the patient's valid NHS Number was*:
 - > 99.70% for admitted patient care
 - > 99.91% for outpatient care
 - > 98.83% for accident and emergency care
- ▶ which included the patient's valid General Medical Practice Code was*:
 - > 99.99% for admitted patient care
 - > 100% for outpatient care
 - > 99.93% for accident and emergency care

*Figures cover the latest available period: 1st April 2018 to 31st January 2019.

Information Governance Assessment Report / Data Security & Protection (DSP) Toolkit

As of 1st April 2018 the Information Governance Toolkit Assessment has been replaced by the Data Security & Protection (DSP) toolkit. Under this new framework, the overall outcome for UHB for 2018/19 is "due to the exceptional circumstances of the Trust (notably the merger of UHB and HEFT) not all standards have been fully met, however an improvement plan with scheduled updates was agreed upon and has been accepted by NHS Digital."

Payment by Results clinical coding audit

UHB was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission.

(Note: the Audit Commission has now closed and responsibility now lies with NHS Improvement).

Actions to improve data quality

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

- ▶ Continue to drive forward the UHB Coding Training programme to further improve training
- ▶ Continue to monitor data quality through the Ward Clerk quality monitoring and management programme.
- ▶ Ensure continued compliance with the Data Protection & Security Toolkit minimum Level 2 for data quality standards and accuracy checks.
- ▶ Review the Data Quality Policy and develop associated procedures.
- ▶ Continue to support improvement of the data quality programme for the operational teams by providing data in relation to 18 week referral to treatment time (RTT).
- ▶ Continue to report timeliness against the target of within two hours for Admissions, Discharges and Transfers (ADT) via the links on the Data Quality (DQ) SharePoint site for use by Heartlands, Good Hope and Solihull Hospitals operational inpatient areas.
- ▶ Continue to provide a monthly Data Quality ADT matrix report detailing the top three areas of concern across Heartlands, Good Hope and Solihull Hospitals monthly to Matrons and Lead Nurses.
- ▶ The Data Quality team will continue to focus on any areas of concern that require improvement and ensure actions are put in place to enable the accurate reporting of data in a timely fashion using the six dimensions of the data quality model.
- ▶ A suite of Data Quality indicators form part of monthly Directorate reports with action plans being put in place to improve on performance where areas of concern are identified. Sections of which are reported on a quarterly basis to the Information Governance Group.

2.2.7 Learning from deaths

Since January 2014, UHB has taken part in an 'early adopter' project involving the introduction of the Medical Examiner role at the Trust. UHB currently has a team of Medical Examiners who are Consultant-level staff and are required to review the vast majority of inpatient deaths. The role includes reviewing medical records and liaising with bereaved relatives to assess whether the care provided was appropriate and whether the death was potentially avoidable.

The Trust implemented the Reviewing Inpatient Deaths Policy and associated procedure in October 2017. All deaths must be given a stage one review by a Medical Examiner, except for those meeting defined exception criteria such as forensic deaths where the medical records will not be available to Trust staff.

Any death where a concern has been raised by the Medical Examiner will be escalated for further review, either to a specialty mortality & morbidity meeting, or directly to the Trust's Clinical and Professional Review of Incidents Group (CaPRI). The outcomes of stage two reviews are reported to the Trust's Clinical Quality Monitoring Group where a decision will be made on whether further review or investigation is required.

1. During 2018/19 5345 of UHB patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:
 - > 1270 in the first quarter
 - > 1229 in the second quarter
 - > 1358 in the third quarter
 - > 1488 in the fourth quarter
2. By 1st April 2019, 4226 case record reviews and 60 investigations have been carried out in relation to 4252 of the deaths included in item 1. In 34 cases a death was subjected to both a case record review and an investigation.

The number of deaths in each quarter for which a case record review or an investigation was carried out was:

 - > 984 in the first quarter
 - > 972 in the second quarter
 - > 1092 in the third quarter
 - > 1204 in the fourth quarter
3. 19, representing 0.36% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

 - > 8 representing 0.63% for the first quarter
 - > 6 representing 0.49% for the second quarter
 - > 5 representing 0.37% for the third quarter
 - > 0 representing 0% for the fourth quarter

These numbers have been obtained based on the findings of thorough, independent investigations of all deaths considered potentially avoidable after case record review, using recognised root cause analysis tools and a human factors perspective.
4. As part of every investigation a detailed report that includes all learning points and an in-depth action plan is produced. Each investigation can produce a number of recommendations and changes, and each individual action is specifically designed on a case by case basis to ensure that the required changes occur. The implementation of these actions and recommendations is robustly monitored to ensure ongoing compliance.

Actions are varied and may include changes to, or introductions of, policies and guidelines, changing systems or changing patient pathways.

Similarly, the outcomes of every case record review are monitored and ongoing themes and trends are reported and escalated as required to ensure any and all required changes are made.

5. As described in item 4, each investigation involves the creation of a detailed, thorough action plan which will involve numerous actions per investigation. These actions are specifically tailored to individual cases and monitored on an ongoing basis to ensure the required changes have been made. Examples of actions include:
 - > Ensure learning from the incident is communicated to all relevant staff
 - > To provide feedback to the patient's family on the outcome of the investigation
 - > To provide feedback to staff involved in the incident
 - > The colorectal multi-disciplinary team should consider preoperative CT angiography to clarify the anatomical position of the colonic vessels in complex cases
 - > All patients for elective percutaneous coronary intervention on the Ambulatory Care Unit must be prescribed a loading dose of blood thinning medication so that it can be given before the procedure
 - > There must be a review of the expected timeframes for CT scans that are marked as urgent. This must include consideration of whether the timeframe and process changes according to the day of the week. A clear standard of terminology (e.g. emergency, urgent, routine) and associated timeframes must be established
 - > There must be a process to ensure that there is monitoring and tracking in place for all patients entered on the Somerset Cancer Register irrespective of their diagnosis
6. All actions are monitored to ensure they have had the desired impact. If this has not happened, actions will be reviewed and altered as necessary to ensure that sustainable and appropriate change has been implemented.
7. 41 case record reviews and 17 investigations completed after 1st April 2018 which related to deaths which took place before the start of the reporting period.
8. 3 representing 0.19% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

These numbers have been obtained based on the findings of thorough, independent investigations of all deaths considered potentially avoidable after case record review, using recognised root cause analysis tools and a human factors perspective.
9. 5 representing 0.17% of the patient deaths during 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3 Performance against national core set of quality indicators

A national core set of quality indicators was jointly proposed by the Department of Health and Monitor (now NHS Improvement) for inclusion in trusts' Quality Reports from 2012/13. The data source for all the indicators is NHS Digital (formerly the Health and Social Care Information Centre, or HSCIC). The Trust's performance for the applicable quality indicators is shown in Appendix A for the latest time periods available. Further information about these indicators can be found on the NHS Digital website: <http://content.digital.nhs.uk/>

3 Other information

3.1 Overview of quality of care provided during 2018/19

The tables below show the Trust's latest performance for 2018/19 and the last two financial years for a selection of indicators for patient safety, clinical effectiveness and patient experience. The Board of Directors has chosen to include the same selection of indicators as reported in the Trust's 2017/18 Quality Report to enable patients and the public to understand performance over time.

The patient safety and clinical effectiveness indicators were originally selected by the Clinical Quality Monitoring Group because they represent a balanced picture of quality at UHB. The patient

experience indicators were selected in consultation with the Care Quality Group which has Governor representation to enable comparison with other NHS trusts.

The latest available data is shown below and has been subject to the Trust's usual data quality checks by the Health Informatics team. Benchmarking data has also been included where possible.

The Trust is working towards aligning data and indicators, currently some are available at Trust level ("UHB"), and others by site or group of sites.

Patient safety indicators
(March data not yet validated – figures may change before final Quality Report is published.)

Indicator	Site/s	Data source	2016/17	2017/18	2018/19	Peer Group Average (where available)
1a. Patients with MRSA infection / 100,000 bed days > (includes all bed days from all specialities) > Lower rate indicates better performance	QEHB	> Trust MRSA data reported to PHE, > HES data (bed days)	1.01	0.00	1.47 (UHB) April – December 2018	2.31 April – December 2018 Acute trusts in West Midlands
	BHH / GHH / SH		1.9	0.4		
1b. Patients with MRSA infection / 100,000 bed days > (aged >15, excluding Obstetrics, Gynaecology and elective Orthopaedics) > Lower rate indicates better performance	QEHB	> Trust MRSA data reported to PHE, > HES data (bed days)	1.01	0.00	1.39 (UHB) April – December 2018	2.17 April – December 2018 Acute trusts in West Midlands
	BHH / GHH / SH		0.4	0.4		
2a. Patients with C. difficile infection / 100,000 bed days > (includes all bed days from all specialities) > Lower rate indicates better performance	QEHB	> Trust CDI data reported to PHE, > HES data (bed days)	21.73	19.05	10.79 (UHB)	8.08 April – December 2018 Acute trusts in West Midlands
	BHH / GHH / SH		16.0	12.4		
2b. Patients with C. difficile infection / 100,000 bed days > (aged >15, excluding Obstetrics, Gynaecology and elective Orthopaedics) > Lower rate indicates better performance	QEHB	> Trust CDI data reported to PHE, > HES data (bed days)	21.85	18.94	10.17 (UHB)	7.65 April – December 2018 Acute trusts in West Midlands
	BHH / GHH / SH		6.8	13.8		
3a. Patient safety incidents > (reporting rate per 1000 bed days) > Higher rate indicates better reporting	QEHB	> Datix > (incident data), > Bed days data	63.6	65.4	68.3	44.5 April – December 2018 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
	BHH / GHH / SH		34 (NRLS data April – Sept 2016)	49.3	46.7	
3b. Never Events > The number of Never Events that occurred during the time period > Lower number indicates better performance	QEHB	> Datix > (incident data)	1	6	9	Not available
	BHH / GHH / SH		2	8	(UHB)	
4a. Percentage of patient safety incidents which are no harm incidents > Higher % indicates better performance	QEHB	> Datix > (incident data)	83.1%	85.1%	88.9%	78.5% April – September 2018 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
	BHH / GHH / SH		75% (NRLS data April – Sept 2016)	97.6%	97.7%	

Indicator	Site/s	Data source	2016/17	2017/18	2018/19	Peer Group Average (where available)
4b. Percentage of patient safety incidents reported to the National Reporting and Learning System (NRLS) resulting in severe harm or death > Lower % indicates better performance	QEHB	> Datix > (patient safety incidents reported to the NRLS)	0.12%	0.22%	0.26%	0.34% April – September 2018
	BHH / GHH / SH		0.6% (NRLS data April – Sept 2016)	0.84%	0.64%	Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
4c. Number of patient safety incidents reported to the National Reporting and Learning System (NRLS)	QEHB	> Datix > (patient safety incidents reported to the NRLS)	22,532	24,568	26,342	5,583 (6 months) April – September 2018
	BHH / GHH / SH		7,899 (NRLS data April – Sept 2016)	19,664	21,811	Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)

Clinical effectiveness indicators

(March data not yet validated – figures may change before final Quality Report is published.)

Indicator	Site/s	Data source	2016/17	2017/18	2018/19	Peer Group Average (where available)
5a. Emergency readmissions within 28 days (%) (Medical and surgical specialties - elective and emergency admissions aged >17) % > Lower % indicates better performance	QEHB	HED data	14.14%	13.87%	15.39% April – December 2018	15.35% April – December 2018
	BHH / GHH / SH		14.09%	14.03%	14.72% April – December 2018	University hospitals
5b. Emergency readmissions within 28 days (%) (all specialties) > Lower % indicates better performance	QEHB	HED data	14.10%	13.84%	15.56% April – December 2018	12.70% April – December 2018
	BHH / GHH / SH		11.85%	12.25%	13.06% April – December 2018	University hospitals
5c. Emergency readmissions within 28 days of discharge (%) > Lower % indicates better performance	QEHB	Internal SUS data	10.80%	11.35%	11.84% April 2018 – February 2019	Not available
	BHH / GHH / SH	PMS 2	15.09%	15.22%	15.60%	

Indicator	Site/s	Data source	2016/17	2017/18	2018/19	Peer Group Average (where available)
6. Falls (incidents reported as % of patient episodes) > Lower % indicates better performance	QE	Datix (incident data),	2.2%	2.2%	2.0%	Not available
	BHH / GHH / SH	Trust admissions data	0.98%	1.00%	0.94%	
7. Stroke in-hospital mortality > Lower % indicates better performance	QE	SSNAP data	1.8%	5.9%	12.6%	13.7% 2016/17
	BHH / GHH / SH		11.0%	12.2%	10.8%	England & Wales SSNAP crude mortality data
8. Percentage of beta blockers given on the morning of the procedure for patients undergoing first time coronary artery bypass graft (CABG) > Higher % indicates better performance	QE	Trust PICS data	97.4%	94.8%	92.6%	Not available

Notes on patient safety & clinical effectiveness indicators

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

1a, 1b

- ▶ Peer group figures are not final.

1a, 1b, 2a, 2b:

- ▶ From 2018/19, these figures are now for the whole Trust (UHB) rather than split by site. For MRSA (1a and 1b), the reporting has also changed and includes all cases of MRSA, not just those that are just deemed to be Trust-acquired.
- ▶ These indicators use HES data for the bed days, as this allows trusts to benchmark against each other. UHB also has an internal measure of bed days which uses a different methodology, and this number may be used in other, similar, indicators in other reports.
- ▶ Receipt of HES data from the national team always happens two to three months later, these indicators will be updated in the next report.

3a

- ▶ The NHS England definition of a bed day (“KH03”) differs from UHB’s usual definition. For further information, please see this link: > <http://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/>.
- ▶ NHS England have also reduced the number of peer group clusters (trust classifications), meaning UHB is now classed as an ‘acute (non specialist)’ trust and is in a larger group. Prior to this, UHB was classed as an ‘acute teaching’ trust which was a smaller group.

3b

- ▶ UHB had nine Never Events during 2018/19 in the following categories: Missed naso-or oro-gastric tube (2), Retained foreign object post procedure (2), Unintentional connection of a patient requiring oxygen to an air flow meter (2), Wrong site surgery (1), Wrong implant/prosthesis (1), Overdose of insulin due to abbreviations or incorrect device (1).
- ▶ Immediate corrective actions have been undertaken, and the patients have received the correct procedures where appropriate. An apology has been given to the patients and families. All cases have been investigated and an action plan put in place to reduce the risk of future recurrence.

4c

- ▶ The number of incidents shown only includes those classed as patient safety incidents and reported to the National Reporting and Learning System.

5c

- ▶ The data source is the Trust's patient administration system. The data for previous years has been updated to include readmissions from 0 to 27 days and exclude readmissions on day 28 in line with the national methodology. Any changes in previously reported data are due to long-stay patients being discharged after the previous years' data was analysed.

5a, 5b, 5c

- ▶ QEHB - The increase in readmissions is due to patients in the Emergency Observation Unit (EOU) being recorded as inpatients from November 2017.
- ▶ BHH/GHH/SH: figures differ from the previous Quality Reports for Heart of England NHS Foundation Trust, as the data in this table has been generated using the same methodology as the QE data.

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- ▶ QEHB – there has been a small change to the 2017/18 data since the 2017/18 Quality Report, as the data source (national SSNAP data) was refreshed after publication.
- ▶ It should also be noted that the 2016/17 and 2017/18 figures are not accurate, as some patients who died within 24 hours had not been included in the data collection and submission; this was picked up during 2017/18. In-hospital mortality following stroke is expected to be 10-15% , and the 2018/19 data reflects this.

8

- ▶ QEHB indicator only as cardiac surgery is not carried out at the other sites.
- ▶ Beta blockers are given to reduce the likelihood of peri-operative myocardial infarction and early mortality. This indicator relates to patients already on beta blockers and whether they are given beta blockers on the day of their operation. All incidences of beta blockers not being given on the day of operation are investigated to understand the reasons why and to reduce the likelihood of future omissions.

Patient experience indicators

The National Inpatient Survey is run by the Picker Institute on behalf of the Care Quality Commission (CQC); the QEHB and Heartlands, Good Hope and Solihull Hospitals results for selected questions are shown below. The 2018 survey report has not been published at the time of writing, so the text and table below refer to the latest available results, which are from the 2017 survey. Information on the 2018 results will be added

to the published Quality Account once it is available. Alternative patient experience data and indicators are also available in *Priority 2: Improving patient experience* above, these are taken from the Trust's local patient surveys.

Data is presented as a score out of 10; the higher the score for each question, the better the Trust is performing.

Patient survey question	Site/s	2015/16		2016/17		2017/18	
		Score	Comparison with other NHS trusts in England	Score	Comparison with other NHS trusts in England	Score	Comparison with other NHS trusts in England
Overall were you treated with respect and dignity	QEHB	9.2	About the same	9.2	About the same	9.2	About the same
	BHH/GHH/SH	8.8	About the same	8.9	About the same	8.8	About the same
Involvement in decisions about care and treatment	QEHB	7.5	About the same	7.4	About the same	7.4	About the same
	BHH/GHH/SH	7.1	About the same	7.2	About the same	7.0	About the same
Did staff do all they could to control pain	QEHB	8.2	About the same	8.3	About the same	8.0	About the same
	BHH/GHH/SH	7.9	About the same	7.9	About the same	7.6	Worse
Cleanliness of room or ward	QEHB	9.2	About the same	9.2	About the same	9.1	About the same
	BHH/GHH/SH	8.7	About the same	8.8	About the same	8.6	About the same
Overall rating of care	QEHB	8.4	About the same	8.3	About the same	8.3	About the same
	BHH/GHH/SH	7.9	About the same	8.0	About the same	8.0	About the same
Time period & data source:		2015 Trust's Survey of Adult Inpatients 2015 Report, CQC		2016 Trust's Survey of Adult Inpatients 2016 Report, CQC		2017 Trust's Survey of Adult Inpatients 2017 Report, CQC	

Response rates were 37% for QEHB (441 respondents), 30% for Heartlands, Good Hope and Solihull Hospitals (368 respondents), compared to a national response rate of 41%.

3.2 Performance against indicators included in the NHS Improvement Single Oversight Framework

Indicator	Target	Performance	
		2017/18	2018/19
A&E maximum waiting time of 4 hours from arrival to admission/transfer/discharge ¹	95%	80.8%	76.7%
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway ^{1,2}	92%	91.6%	88.2%
All cancers – maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	85%	80.8%	78.9%
All cancers – maximum 62-day wait for first treatment from NHS cancer screening service referral	90%	94.9%	91.2%
<i>C. difficile</i> : variance from plan	≤ 125 cases judged to be lapses in care	18 judged lapses in care (139 total)	30 judged lapses in care (153 total)
Maximum 6-week wait for diagnostic procedures	99%	99.4%	99.5%
Venous thromboembolism (VTE) risk assessment	95%	98.3%	98.3%

The data above is for the whole enlarged Trust, therefore only the current year and one previous year is available.

For the SHMI, please refer to the Mortality section of this Quality Report (3.3).

Notes: **1:** Indicators audited by the Trust's external auditor Deloitte as part of the external assurance arrangements for the 2018/19 Quality Report.

3.3 Mortality

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

The Trust has not included comparative information due to concerns about the validity of single measures used to compare trusts.

Summary Hospital-level Mortality Indicator (SHMI)

NHS Digital first published data for the Summary Hospital-level Mortality Indicator (SHMI) in October 2011. This is the national hospital mortality indicator which replaced previous measures such as the Hospital Standardised Mortality Ratio (HSMR). The SHMI is a ratio of observed deaths in a trust over a period time divided by the expected number based on the characteristics

of the patients treated by the trust. A key difference between the SHMI and previous measures is that it includes deaths which occur within 30 days of discharge, including those which occur outside hospital.

The SHMI should be interpreted with caution as no single measure can be used to identify whether hospitals are providing good or poor quality care¹. An average hospital will have a SHMI around 100; a SHMI greater than 100 implies more deaths occurred than predicted by the model but may still be within the control limits. A SHMI above the control limits should be used as a trigger for further investigation.

Hospital Standardised Mortality Ratio (HSMR)

UHB has concerns about the validity of the HSMR which was superseded by the SHMI but it is included here for completeness. The validity and appropriateness of the HSMR methodology used to calculate the expected range has been the subject of much national debate and is largely discredited²³. UHB continues to robustly monitor mortality in a variety of ways as detailed above.

	QEHB	BHH / GHH / SH	Data period
SHMI, calculated by UHB Informatics	102 - within tolerance	87 - within tolerance	April - December 2018
SHMI, from NHS Digital website	100 - within tolerance	88 - within tolerance	April - September 2018
HSMR, calculated by UHB Informatics	102	102	April - December 2018

¹ Freemantle N, Richardson M, Wood J, Ray D, Khosla S, Sun P, Pagano, D. Can we update the Summary Hospital Mortality Index (SHMI) to make a useful measure of the quality of hospital care? An observational study. *BMJ Open*. 31 January 2013.

² Hogan H, Healey F, Neale G, Thomson R, Vincent C, Black, N. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review. *BMJ Quality & Safety*. Online First. 7 July 2012.

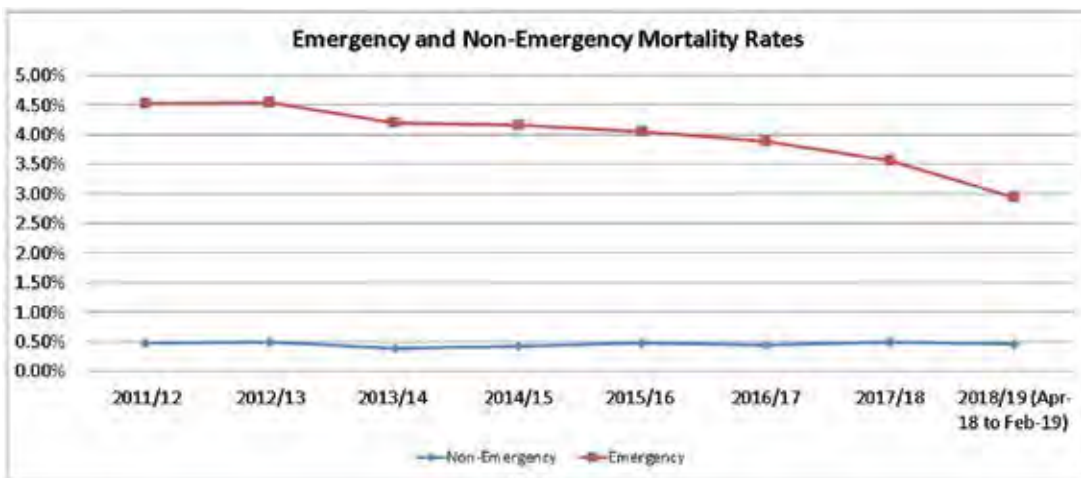
³ Lilford R, Mohammed M, Spiegelhalter D, Thomson R. Use and misuse of process and outcome data in managing performance of acute and medical care: Avoiding institutional stigma. *The Lancet*. 3 April 2004.

Crude Mortality – QEHB

The first graph below shows the QEHB site’s crude mortality rates for emergency and non-emergency (planned) patients. The second graph shows the QEHB site’s overall crude mortality rate against activity (patient discharges) by quarter. The crude mortality rate is calculated by dividing the total number of deaths by the total number of patients discharged from hospital in any given time period. The crude mortality rate does not take into account complexity, case mix (types of patients) or seasonal variation.

QEHB’s overall crude mortality rate for 2018/19 (up to February 2019) is 2.47%, which is a decrease compared to 2017/18 (2.85%) and 2016/17 (2.96%).

Emergency and Non-emergency Mortality Graph (QEHB)



Overall Crude Mortality Graph (QEHB)

(Quarter 4 data not available at time of writing)



Note: the increase in discharges is largely due to patients in the Emergency Observation Unit (EOU) being recorded as inpatients from November 2017.

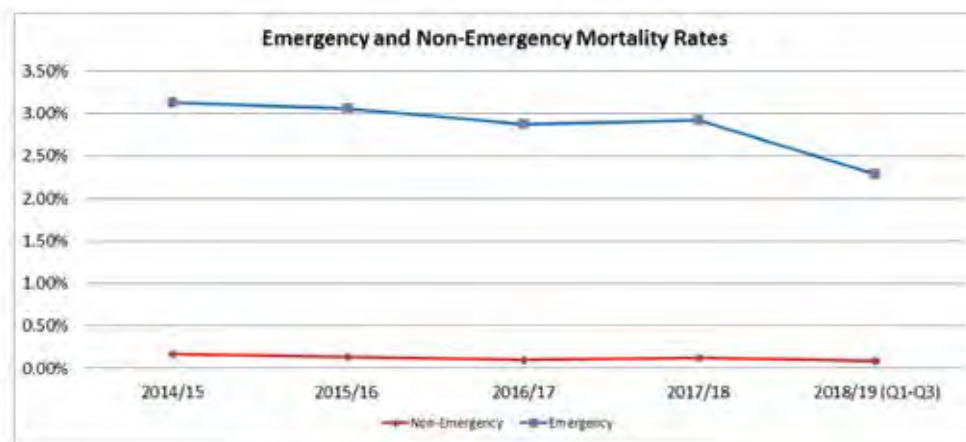
Crude Mortality – Heartlands, Good Hope and Solihull Hospitals

The first graph below shows the combined crude mortality rate for the Heartlands, Good Hope and Solihull Hospitals sites for emergency and non-emergency (planned) patients. The second graph shows the Heartlands, Good Hope and Solihull Hospitals sites' overall crude mortality rate against activity (patient discharges) by quarter. The crude mortality rate is calculated by dividing the total number of deaths by the total number of patients discharged from hospital in any given time period.

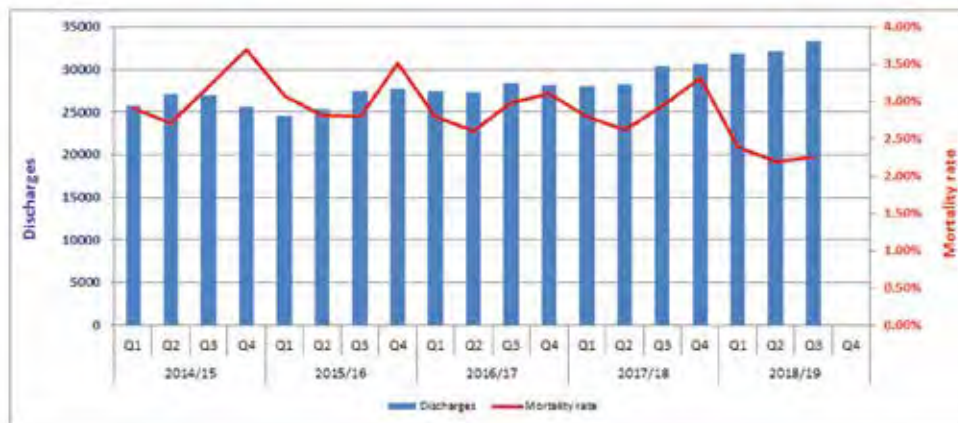
The crude mortality rate does not take into account complexity, case mix (types of patients) or seasonal variation.

Heartlands, Good Hope and Solihull Hospitals' crude mortality rate for emergency admitted patients in 2018/19 (up to February 2019) is 1.77%, this has decreased compared to 2017/18 (2.25%) and 2016/17 (2.19%).

Emergency and Non-emergency Mortality Graph (Heartlands, Good Hope and Solihull Hospitals)



Emergency Crude Mortality Graph (Heartlands, Good Hope and Solihull Hospitals) (Quarter 4 data not available at time of writing)



3.4 Statement on the implementation of the priority clinical standards for seven day hospital services

The Academy of Medical Royal Colleges have agreed a number of principles which are set out in three patient-centred standards to deliver consistent inpatient care irrespective of the day of the week. NHS England's previous National Medical Director set out a plan to drive seven day services across the NHS, starting with urgent care services and supporting diagnostics.

Ten clinical standards have been identified, of which four are priority standards:

1. Time to consultant review
2. Diagnostics
3. Interventions
4. On-going review

UHB has taken the following actions to implement the above standards:

Provision for consultant review

Consultant job planning in the trust makes provision for a consultant-led ward round on every ward every day through formal provision which includes on-call out-of-hours.

Consultant directed diagnostics

For patients admitted as an emergency with critical care and urgent needs the following diagnostic tests are usually or always available on site: CT, Microbiology, Echocardiograph, Upper GI Endoscopy, MRI and Ultrasound.

Consultant directed interventions

Patients have 24 hr access to consultant directed interventions 7 days a week either on site or via formal network arrangements for the following interventions: Critical Care, Primary Percutaneous Coronary Intervention (PPCI), Cardiac Pacing, Thrombolysis Stroke, Emergency General Surgery, Interventional Endoscopy, Interventional Radiology, Renal Replacement and Urgent Radiotherapy.

On-going review

Daily board reviews (using live interactive boards with details regarding patients on each ward) and daily consultant reviews are in place meaning sick patients are identified and reviewed daily.

3.5 Encouraging staff to Speak Up

The appointment of Freedom to Speak Up Guardians was a recommendation of the Francis Report. UHB's Freedom to Speak Up Guardian is Professor Julian Bion, Honorary Consultant in Critical Care Medicine. Professor Bion is supported by twenty-two Confidential Contacts from across

the Trust, who are also a point of contact for raising concerns.

Freedom to Speak Up Guardians have a key role in helping to raise the profile of concerns within the Trust and provide confidential advice and support to staff in relation to concerns they have about, for example, patient safety and/or the way their concern has been handled. Freedom to Speak Up Guardians do not get involved with investigations or complaints, but help to facilitate the process of raising a concern where needed, ensuring policies are followed correctly.

Staff can contact the Freedom to Speak Up Guardian and the Confidential Contacts using a dedicated email address, and there is also an internal webpage with further contact information.

All concerns raised through Confidential Contacts are reviewed by the Freedom to Speak Up Guardian and presented quarterly to the Chief Executive and Trust Board of Directors. The full group discuss patterns, trends and look for solutions and remedies to increase staff support and influence a culture of 'speaking up'.

Raised concerns are also reported quarterly to the CQC (the regulator and monitor of Freedom to Speak Up Guardians nationally), which helps to identify the national picture in terms of the source and types of concerns.

The Freedom to Speak Up Guardian also has regular meetings with Human Resources (HR) and Occupational Health.

3.6 Statement regarding junior doctor rota

The Trust has appointed a Guardian of Safe Working (GSW), an experienced consultant who is supported by the Junior Doctors Monitoring Office (JDMO). The JDMO administers the following functions, amongst others:

- ▶ Junior doctor rota templates (as issued with work schedules)
- ▶ Hours of work/working patterns
- ▶ Exception reporting (e.g. if doctors experience differences in hours of work / rest breaks / the work pattern itself)

It is a requirement of the 2016 Junior Doctor contract that the GSW holds responsibility for ensuring that issues of compliance with safe working hours are addressed in accordance with the terms and conditions of the new Junior Doctor contract - this includes the overall responsibility for overseeing the Junior Doctors' Exception Reporting (ER) process. The GSW is required to submit a report at least quarterly, on the analysis of the

exception reports submitted by junior doctors. A final extended Annual Report is presented at the end of each academic year to the Trust's Board of Directors.

Information is available to staff on the Trust Intranet, this includes guidance, contacts and a link for junior doctors to report exceptions.

Template rotas are set at the minimum levels to reflect expected numbers of junior doctors, however with rotas in excess of 150 across the Trust, gaps are inevitable. Reasons include:

- ▶ Posts not filled by HEE (Health Education England), or variation in specialty numbers
- ▶ Failure to recruit to Junior Specialist Doctor/other doctor posts
- ▶ Less than full time trainees occupying full time rota slots
- ▶ Unplanned leave, e.g. sickness, maternity, paternity, special leave
- ▶ Special occupational health reasons where some doctors are unable to undertake certain duties, e.g. on-call, night working

Rota gaps are highlighted in quarterly Guardian of Safe Working Reports. When gaps do arise, out of hours duties are filled using locum staff to ensure that junior doctors are not mandated to work in excess of their contracted hours.

Recent actions taken to address rota gaps include:

- ▶ Recruitment of locum staff and junior specialist doctors
- ▶ Review of rotas by deputy GSWs with the Clinical Services Leads, to ensure that work patterns match clinical need
- ▶ Consideration of appointment of Advanced Clinical Practitioners (ACPs) and Physicians Associates to take on some of the junior doctors' work
- ▶ Coaching on 'handover' techniques to reduce the amount of time staff need to work over at the end of a shift
- ▶ Consideration of funding for administrative support for rota management and exception reporting

3.7 Glossary of Terms

Term	Definition
A&E	Accident & Emergency – also known as the Emergency Department
Acute Trust	An NHS hospital trust that provides secondary health services within the English National Health Service
ADT	Admissions, discharges and transfers
Analgesia	A medication for pain relief
BAUS	British Association of Urological Surgeons
Bed days	Unit used to calculate the availability and use of beds over time
Benchmark	A method for comparing (e.g.) different hospitals
Beta blockers	A class of drug used to treat patients who have had a heart attack, also used to reduce the chance of heart attack during a cardiac procedure
BHH	Birmingham Heartlands Hospital
Back to the Floor	Senior members of staff taking on junior, patient facing roles for a shift or period of time
CABG	Coronary Artery Bypass Graft
CaPRI	Trust's Clinical and Professional Review of Incidents Group
CCG	Clinical Commissioning Group
CDI	<i>Clostridium difficile</i> infection
Chief Executive's Advisory Group	An internal group, chaired by the Chief Executive
Chief Operating Officer's Group	An internal group for senior management staff
Clinical Audit	A process for assessing the quality of care against agreed standards
Clinical Coding	A system for collecting information on patients' diagnoses and procedures
Clinical Dashboard	An internal website used by staff to measure various aspects of clinical quality
Commissioners	See CCG
Congenital	Condition present at birth
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQG	Care Quality Group; a group chaired by the Executive Chief Nurse, which assesses the quality of care, mainly nursing
CQMG	Clinical Quality Monitoring Group; a group chaired by the Executive Medical Director, which reviews the quality of care, mainly medical
CQUIN	Commissioning for Quality and Innovation payment framework
CRM	Cardiac Rhythm Management
Datix	Database used to record incident reporting data
Deloitte	The Trust's external auditor
Division	Specialties are grouped into Divisions
DQ	Data Quality
DTI	Deep tissue injury
Duty of Candour	Requirement for trusts to be open and transparent with services users about care and treatment, including failures
Echo / echocardiogram	Ultrasound imaging of the heart
ED	Emergency Department (also known as A&E)
Elective	A planned admission, usually for a procedure or drug treatment
Episode	The time period during which a patient is under a particular consultant and specialty. There can be several episodes in a spell
FFFAP	Falls and Fragility Fractures Audit Programme

Term	Definition
FFT	The Friends and Family Test; a questionnaire to determine how likely a patient is to recommend the services used
Foundation Trust	Not-for-profit, public benefit corporations which are part of the NHS and were created to devolve more decision-making from central government to local organisations and communities.
GHH	Good Hope Hospital
GI	Gastro-intestinal
GP	General Practitioner
HCA	Healthcare Assistant
Healthwatch	An independent group who represent the interests of patients
HEFT	Heart of England NHS Foundation Trust
HES	Hospital Episode Statistics
HSCIC	Health and Social Care Information Centre – now known as NHS Digital
HSMR	National Hospital Mortality Indicator
Informatics	Team of information analysts
IT	Information Technology
JCC	Joint Consultative Committee
KPI	Key performance indicator: a measurable value demonstrating how effectively targets are being met
MINAP	Myocardial Ischaemia National Audit Project
Missed Dose	A dose of prescribed medication not given to the patient
Monitor	Independent regulator of NHS Foundation Trusts – now replaced by NHS Improvement
MOODLE	A digital learning platform used for obtaining training courses and information
Mortality	A measure of the number of deaths compared to the number of admissions
MOVED	A campaign to increase movement and repositioning of patients to reduce pressure ulcers
MRI	Magnetic Resonance Imaging – a type of diagnostic scan
MRSA	Meticillin-resistant Staphylococcus aureus
Myocardial Infarction	Heart attack
NBSR	National Bariatric Surgery Registry
NCAA	National Cardiac Arrest Audit
NCEPOD	National Confidential Enquiry into Patient Outcome and Death - a national review of deaths usually concentrating on a particular condition or procedure
NELA	National Emergency Laparotomy Audit
Never Events	An incident that has the potential to cause serious harm/death
NEWS2	National Early Warning Score a new national system for identifying patients at risk of deterioration.
NHS	National Health Service
NHS Digital	Formerly HSCIC - Health and Social Care Information Centre. A library of NHS data and reports
NHS Improvement	The national body that provides the reporting requirements and guidance for the Quality Report
NICE	The National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NJR	National Joint Registry
NLCA	National Lung Cancer Audit
NNAP	National Neonatal Audit Programme

Term	Definition
NPDA	National Paediatric Diabetes Audit
NRLS	National Reporting and Learning System
Observations	Measurements used to monitor a patient's condition e.g. pulse rate, blood pressure, temperature
Ombudsman	Public independent advocate charged with presenting the interests of the public by addressing complaints or violations of rights
OOH	Out Of Hours
PALS	Patient Advice and Liaison Service
PCCC	Primary Care Commissioning Committee
PCI	Percutaneous Coronary Interventions
Peri-operative	Period of time prior to, during, and immediately after surgery
PGD	Patient Group Direction
PHE	Public Health England
PHSO	Parliamentary and Health Service Ombudsman
PICS	Prescribing Information and Communication System
PLACE-Lite	Patient-led assessments of the care environment (i.e. wards and clinics)
PPCI	Primary Percutaneous Coronary Intervention; a surgical treatment for myocardial Infarction (heart attack)
Pressure Ulcers	Area of damaged skin also known as pressure sores or bedsores
Preventing Harm Meeting	Internal group to review incidents reported through Datix
QEHB	Queen Elizabeth Hospital Birmingham
QIPs	Quality Improvement Priorities
QuORU	Quality and Outcomes Research Unit
RCA	Root Cause Analysis
Readmissions	Patients who are readmitted after being discharged from hospital within a short period of time e.g., 28 days
RTT	Referral to Treatment
SDTI	Suspected Deep Tissue Injury. A pressure ulcer of unknown depth
Sepsis	A potentially life-threatening condition resulting from a bacterial infection of the blood
SEWS	Standardised Early Warning System – being replaced by NEWS 2
SH	Solihull Hospital
SHMI	Summary Hospital-level Mortality Indicator
SHOT	Serious Hazards of Transfusion
SSNAP	The Sentinel Stroke National Audit Programme
STEIS	System used to report and monitor the progress of Serious Incident investigations across the NHS
STP	Sustainability and Transformation Partnership
TARN	Trauma Audit and Research Network
Team Brief	Meeting open to all staff, where directors present information to staff, and information is then cascaded to colleagues
TNA	Trainee Nursing Associate
TV / TVT	Tissue viability / Tissue Viability Team
UHB	University Hospitals Birmingham NHS Foundation Trust
UTI	Urinary tract infection
VTE	Venous thromboembolism, also known as a blood clot

Appendix A: Performance against core indicators

The Trust's performance against the national set of quality indicators jointly proposed by the Department of Health and Monitor (now NHS Improvement) is shown in the tables below. There are eight indicators which are applicable to acute trusts. The data source for all the indicators is NHS Digital (formerly the Health and Social Care Information Centre, or HSCIC) and performance is shown for the most recent periods available. Data for the latest two time periods is included for each indicator and is displayed in the same format as NHS Digital. National comparative data is included where available.

Where available, data for the whole Trust (UHB) has been provided, otherwise QEHB and Heartlands, Good Hope and Solihull Hospitals are provided separately.

Further information about these indicators can be found on the NHS Digital website: <http://content.digital.nhs.uk/qualityaccounts>

1. Mortality

	Previous Period (Oct 2016 - Sept 2017)		Current period (Oct 2017 - Sept 2018)		
	UHB	UHB	National Performance		
			Overall	Lowest	Highest
(a) Summary Hospital-level Mortality Indicator (SHMI) value	0.99	0.97	1.00	0.69	1.27
(a) SHMI banding	2	2	-	3	1
(b) Percentage of patient deaths with palliative care coded at diagnosis or speciality level	28.42	26.30	33.36	14.18	59.47

The Trust considers that this data is as described for the following reasons as this is the latest available on the NHS Digital (HSCIC) website.

The Trust intends to take the following actions to improve this indicator, and so the quality of its services, by continuing with the technical approach UHB takes to improving quality detailed in this report. The Trust does not specifically try to reduce mortality as such but has robust processes in place, using more recent data, for monitoring mortality as detailed in Part 3 of this report. It is important to note that palliative care coding has no effect on the SHMI.

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

	Previous Period (April 2016 - March 2017)		Current period (April 2017 - Sept 2017 (i/ii)) (April 2017 - March 2018 (iii/iv))				
	QEHB	BHH/ GHH/SH	QEHB	BHH/ GHH/SH	National Performance		
					Overall	Best	Worst
(i) Groin hernia surgery	0.098	0.092	0.065	0.096	0.089	0.136	0.029
(ii) Varicose vein surgery	N/A	0.116	N/A	0.124	0.096	0.134	0.035
(iii) Hip replacement surgery	N/A	0.393	N/A	0.426	0.458	0.549	0.357
(iv) Knee replacement surgery	N/A	0.309	N/A	0.328	0.337	0.406	0.254

The Trust considers that this data is as described for the following reasons as it is the latest available on the NHS Digital (HSCIC) website.

The Trust intends to take the following actions to improve this data, and so the quality of its services, by continuing to focus on improving participation rates for the pre-operative questionnaires which we have control over.

3. Readmissions to hospital within 28 days

	Previous Period* (April 2010 - March 2011)		Current period (April 2011 – March 2012)*				
	QEHB	BHH/ GHH/ SH	QEHB	BHH/ GHH/ SH	National Performance		
					Overall (England)	Best (Acute Teaching Providers)	Worst (Acute Teaching Providers)
(i) Patients aged 0-15 readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust (Standardised percentage)	-	11.39	-	10.85	10.01	5.86	12.50
(ii) Patients aged 16 or over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust (Standardised percentage)	11.60	14.06	11.54	12.81	11.45	10.64	13.55

The Trust considers that this data (standardised percentages) is as described for the following reasons as this is the latest available on the NHS Digital (HSCIC) website. UHB is however unable to comment on whether it is correct as it is not clear how the data has been calculated.

The Trust intends to take the following actions to improve this data (standardised percentages), and so the quality of its services, by continuing to review readmissions which are similar to the original admission on a quarterly basis. UHB monitors performance for readmissions using more recent Hospital Episode Statistics (HES) data as shown in Part 3 of this report.

3(i) is not applicable to QEHB as the Trust does not provide a Paediatrics service

*The Trust has included the latest data available on the NHS Digital/HSCIC website – this has not been updated since the previous Quality Report.

4. Responsiveness to the personal needs of patients

	Previous Period (2016/17)		Current period (2017/18)				
	QEHB	BHH/ GHH/ SH	QEHB	BHH/ GHH/ SH	National Performance		
					Overall	Best	Worst
Trust’s responsiveness to the personal needs of its patients – average weighted score of 5 questions from the National Inpatient Survey (Score out of 100)	72.5	65.1	70.1	63.4	68.6	85.0	60.5

The Trust considers that this data is as described for the following reasons as it is the latest available on the NHS Digital (HSCIC) website.

The Trust intends to take the following actions to improve this data, and so the quality of its services, by continuing to collect real-time feedback from our patients as part of our local patient survey. The Board of Directors has again selected improving patient experience and satisfaction as a Trust-wide priority for improvement in 2019/20 (see Part 2 of this report for further details).

5. Staff who would recommend the trust as a provider of care to their family and friends

	Previous Period (2017)		Current period (2018)			
	QEHB	BHH/ GHH/SH	UHB	National Performance		
				Average	Best	Worst
Staff employed by, or under contract to, the Trust who would recommend the Trust as a provider of care to their family or friends.	81%	60%	72%	71%	87%	40%
Performance shown is based on staff who agreed or strongly agreed.						

The Trust considers that this data (scores) is as described for the following reasons as it is the latest available on the NHS Digital (HSCIC) website.

The Trust intends to take the following actions to improve this data, and so the quality of its services, by trying to maintain performance for this survey question.

6. Venous thromboembolism (VTE) risk assessment

	Previous Period (Q2 2018/19)		Current period (Q3 2018/19)		
	UHB	UHB	National Performance		
			Overall	Best	Worst
Percentage of admitted patients risk-assessed for VTE	98.22%	98.28%	95.65%	100%	54.86%

The Trust considers that this data (percentages) is as described for the following reasons as UHB has consistently performed above the national average for the past few years.

The Trust intends to take the following actions to improve this data, and so the quality of its services, by continuing to ensure our patients are risk assessed for venous thromboembolism (VTE) on admission using electronic systems in place at its hospitals.

7. *C. difficile* infection

	Previous Period (2016/17)		Current period (2017/18)				
	QEHB	BHH/ GHH/SH	QEHB	BHH/ GHH/SH	National Performance		
					Overall (England)	Best	Worst
<i>C. difficile</i> infection rate per 100,000 bed-days (patients aged 2 or over)	24.5	15.2	20.4	12.7	13.7	0	91.0

The Trust considers that this data is as described for the following reasons as it is the latest available on the NHS Digital (HSCIC) website.

The Trust intends to take the following actions to improve this rate, and so the quality of its services, by continuing to reduce *C. difficile* infection through the measures outlined in Priority 5: Infection prevention and control in its earlier Quality Reports.

8. Patient Safety Incidents

	Previous Period (Oct 2016 - March 2017)		Current period (October 2017 – March 2018)				
	QEHB	BHH/ GHH/SH	QEHB	BHH/ GHH/SH	National Performance (Acute Non-Specialist Trusts)		
					Overall	Best	Worst
Incident reporting rate per 1,000 bed days	59.1	33.8	70.0	35.0	-	24.2	124
Number of patient safety incidents that resulted in severe harm or death	15	60	19	48	-	0	99
Rate of patient safety incidents that resulted in severe harm or death rate per 1,000 bed days	0.08	0.23	0.10	0.17	-	0	0.55

The Trust considers that this data is as described for the following reasons as the data is the latest available on the NHS Digital (HSCIC) website.

The Trust intends to take the following actions to improve this data and so the quality of its services, by continuing to have a high incident reporting rate by actively encouraging staff to report both clinical and non-clinical incidents. Although this table refers to 'best' and 'worst', a high incident reporting rate can be reflective of a good, open reporting culture. The Trust routinely monitors incident reporting rates and the percentage of incidents which result in severe harm or death as shown in Part 3 of this report.

Annex 1: Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

The Trust has shared its 2018/19 Quality Report with

- ▶ Birmingham and Solihull Clinical Commissioning Group,
- ▶ Healthwatch Birmingham,
- ▶ Healthwatch Solihull,
- ▶ Birmingham Health & Social Care Overview and Scrutiny Committee, and
- ▶ Solihull Health & Social Care Overview and Scrutiny Committee.

These organisations have provided the statements below.

Statement provided by Birmingham and Solihull Clinical Commissioning Group

- 1.1 NHS Birmingham and Solihull Clinical Commissioning Group, as coordinating commissioner for University Hospitals Birmingham NHS Foundation Trust (UHB), welcomes the opportunity to provide this statement for inclusion in the Trust's 2018/19 quality account.
- 1.2 A draft copy of the quality account was received by the CCG on the 26th April 2019 and this statement has been developed from the information presented to date.
- 1.3 This is the first quality account for the merged Trust, the merger by acquisition was in place from 1st April, 2018, however it is to be noted that the Trust is continuing to review and harmonise its systems and processes across the four hospital sites. The current reporting arrangements may differ by site but work is in place for there to be Trust wide quality indicators by the end of 2019/20.
- 1.4 In the version of the quality account we viewed, some full year data was not yet available, and so we have not been able to validate those areas; we assume, however, that the Trust will be populating these gaps in the final published edition of this document.
- 1.5 In compiling the quality account, the Trust has presented the reader with a well-balanced and clear picture regarding performance against the 2018/19 priorities. The report describes the six quality priorities, the initiatives which have been implemented, and has identified areas where the Trust requires further improvement and how the Trust aims to achieve the priorities for 2019/20.
- 1.6 The Trust has made a decision to continue with the six priorities for improvement previously identified in 2018/19. All targets for these priorities have been reviewed and the CCG supports the Trust's review of progress and setting of either revised or continuation of targets.
- 1.7 It is disappointing that the Trust did not meet its target for reducing grade 2 hospital-acquired pressure ulcers, but the commissioners are pleased to see that this remains high on the Trust's quality agenda. A significant amount of work has been undertaken across all hospital sites to reduce the numbers of grade 2 pressure ulcers, these initiatives include the setting up of a task and finish group to determine the changes required to practice, development of the MOVED campaign and the involvement of the tissue viability team in the collaborative initiative lead by NHSI. The CCG carried out an assurance visit in April 2019 and were able to see first-hand the initiatives introduced to help reduce the numbers of grade 2 pressure ulcers.
- 1.8 The Trust did not meet the majority of the patient experience priorities set for 2018/19, and these will continue to be monitored for 2019/20. However, it is good to note that overall patients feel that they had confidence and trust in the nursing staff and this target was met. It is pleasing to note that the Trust is working to ensure that it receives feedback from all groups of patients and has expanded the demographic information collected alongside patient experience to ensure compliance with Stonewall LGBT guidance. Additionally, an easy read version of the FFT has been developed to make it easier to obtain feedback from patients with a learning disability. The Trust has identified two new patient experience priorities for 2019/20, they are: ensuring good nutrition and hydration, particularly for those patients who need additional help, and pain control in emergency departments. The CCG are pleased that the Trust has developed these based on previous feedback from patients.
- 1.9 It is encouraging that the Trust has improved its position for recording of a full set of patient observations, reaching 94.3% against a target of 95%, this was an improvement from 93% the previous year. This will remain as a quality priority. Currently 75% of patients with a high pain score have analgesia administered within 30 minutes. The Trust has acknowledged there is more work needed to improve this area of care and has

developed a series of actions to improve this over the next twelve months.

- 1.10 It was noted in section 2.2.5 that the Care Quality Commission undertook a core services visit during October 2018 and as a result of this inspection the Trust was overall rated good.
- 1.11 Learning from deaths section 2.2.7 outlines the systems and processes that the Trust has in place, this includes being an 'early adopter' of the Medical Examiner in Trust.
- 1.12 The CCG felt the quality account gave little information about the challenges regarding managing patients with cancer. Given the Trust's ongoing capacity challenges, it would be helpful to add in the robust and regular oversight by clinical leads to ensure that patients are managed in the best way possible.
- 1.13 The quality account contained limited information regarding the serious incidents and never events at the Trust. It is acknowledged that the never event position had improved from 14 for 2017/18 across the two previous organisations to 9 during 2018/19 at the merged Trust, however it would have been appropriate to include some more narrative to explain what learning was gained from reviewing the events and how this has been embedded across the Trust.
- 1.14 As Commissioners we have worked closely with UHB over the course of 2018/19, meeting with the Trust regularly to review the organisations' progress in implementing its quality improvement initiatives. We are committed to engaging with the Trust in an inclusive and innovative manner and are pleased with the level of engagement from the Trust. We hope to continue to build on these relationships as we move forward into 2019/20.



Phil Johns
Deputy CEO
Birmingham and Solihull CCG

Statement provided by Healthwatch Birmingham

Healthwatch Birmingham welcomes the opportunity to provide our statement on the Quality Account for University Hospital Birmingham (UHB) NHS Foundation Trust. We recognise the work the Trust has focused on over the year in order to integrate services across the Queen Elizabeth Hospital Birmingham (QEHB), Good Hope Hospital (GHH), Birmingham Heartlands Hospital (BHH) and Solihull Hospital (SH). We welcome plans to ensure that there is a Trust-wide agreement on quality indicators and to align systems and reporting. We hope to see the impact of this on the standards of care across the Trust.

We note that the Trust does not yet have an overall CQC rating, although from previous inspections QEHB has a rating of 'good'. However, its rating is requires improvement in the safe (medical care) and responsive (urgent and emergency services, and outpatient and diagnostic imaging). We also note that CQC yearly inspection of core services has rated:

- ▶ BHH as requires improvement in urgent and emergency services, medical care, surgery and maternity;
- ▶ GHH requires improvement in urgent and emergency services, medical care, surgery and good in maternity; and
- ▶ SH requires improvement in urgent and emergency services and was rated as good in medical care, surgery and maternity.

We would have liked to see outlined in the draft Quality Account specific actions to specific issues raised by the CQC. We hope to see these included in the published Quality Account. In addition, that the work outlined in the Quality Account will lead to an improved in future CQC inspections.

We appreciate our continued close working relationship with the Trust. For example, through our online feedback centre 'right to respond' function, our patient and public involvement (PPI) quality standard and our recent waiting room study. We are pleased with the Trust's response to our recommendations in that report. We hope to continue to work with the Trust to improve the experiences of patients and carers as they access the Trusts services.

Patient and Public Involvement

We welcome the various initiatives that were implemented during 2018/19 under the patient experience priority. These include the introduction of a Carer Coordinator role, which led to the development of training for staff. We are pleased that this has increased staff awareness of carer's

needs, and the ability to signpost for further support (e.g. carer's assessment). It is positive to see that the Trust is developing feedback methods to ensure that it is listening to 'hard to reach' groups by making the necessary changes so that the views of these groups are reflected in changes and improvements. For instance, changes made to ensure that demographic information collected by the Trust is compliant with the Stonewall LGBT Guidance and the planned pilot of an easy read Friends and Family Test (FFT) survey to collect experience from patients with a learning disability. We look forward to reading about the impact of these initiatives in the 2019/20 Quality Account. We would also like to read the impact on numbers of patients leaving feedback following the introduction of tablet devices to all wards to enable patients to feedback electronically.

At Healthwatch Birmingham, we believe that having a staff team that understands the Trust's strategic approach for patient experience is important for developing a shared vision around the use of patient experience and feedback. We, therefore, welcome continued staff engagement in relation to patient experience. In particular, the inclusion of sessions on patient experience, carer support and compassionate care during Trust staff induction and Trainee Nursing Associate training sessions.

Regarding the Friends and Family Test (FFT) scores, we note that the Trust continues to face challenges in meeting the target for A & E positive recommender score. Since 2016/17, the positive recommender score for A & E has decreased year on year and over the past year has been mostly below or equal to the West Midland average of about 80%. Equally, the positive recommender for maternity (birth) has remained below the national and West Midlands average throughout the past year. The positive recommender scores for inpatients, outpatients, and especially community tend to perform better than A & E. This reflects the experiences people have told Healthwatch Birmingham over the past year. We note that the Trust is planning to review scores for maternity. We would like to read about the themes that have been identified from the review of these scores and the impact of the actions taken. We encourage the Trust to extend this review to A & E scores to understand better the challenges being faced, and why the introduction of an information screen in A & E has not had the desired impact on the score.

We are unable to comment on the patient experience indicators, as the National Inpatient Survey results for 2018 are not yet published. However, we note that the scores across the different questions asked have remained the

same from 2015/16 to 2017/18 and lower in at least three cases. It is disappointing that the score for the *'involvement in decisions about care and treatment'* question has remained on average 7.4 against the score of 10 for the past three years.

Equally, there has been a decrease in the scores for the Trust's responsiveness to the personal needs of patients. According to the National Inpatient Survey, there has been a decrease in the responsiveness to patients for QEHB (from 72.5% in 2016/17 to 70.1% in 2017/18) and for BHH/GHH/SH (from 65.1% in 2016/17 to 63.4% 2017/18). With the different activities around engagement the Trust has outlined in the Quality Account, we would have hoped to see an improvement in this. We would like to read in the 2019/20 Quality Account the actions taken following the collection and evaluation of patient experience the Trust is planning to carry out.

Healthwatch Birmingham believes that the Trust should consider taking a structured approach towards its PPI activities. The best way for the Trust to improve on its scores, such as the patient experience indicators and responsiveness to personal needs, is to understand these needs. This can only be done by listening to what these needs are from patients, service users and carers. We therefore still believe that the Trust would benefit from developing a Patient Public Involvement (PPI) Strategy that would ensure that engagement activities are equitable and representative of the localities the Trust works in. A PPI strategy would outline:

- ▶ Why the Trust is listening
- ▶ What the Trust is listening for
- ▶ How the Trust listens
- ▶ Who the Trust wants to hear from (including 'seldom-heard' groups)
- ▶ How the Trust will use what it hears
- ▶ Clear arrangements for collating feedback and experience.

Over the past year, Healthwatch Birmingham has worked with clinical commissioning groups (CCGs) and trusts to benchmark their patient and public involvement (PPI) processes using Healthwatch Birmingham's Quality Standard. Thus enabling them to identify areas of good PPI practice or areas that need to improve. This has led to the development of actions aimed at embedding systems for delivering consistently high-quality PPI. Healthwatch Birmingham has been in contact with the patient experience staff at UHB on this project and we hope to continue supporting the Trust's PPI activities in 2019/20.

Regarding the NHS Staff Survey, the Trust should provide more information on how many responded to the survey, including BAME Staff. More information could have been given on how staff are engaged apart from through the 'speak up guardian' and how staff view the Trust as a place to work. We note that 72% of the staff would recommend the Trust as a provider of care for their family and friends. This is significantly lower than the FFT positive recommender scores. We ask the Trust to look into the difference between staff and patient views and feed the findings into service improvement.

Trust Performance 2018/2019

Quality Priorities 2018/19

It is disappointing that performance on the 2018/19 priorities has been inconsistent and mixed across priorities and across different sites.

During 2018/19, QEHB has seen an increase in the number of reported incidents of grade 2 pressure ulcers (non-device related) from 62 during 2017/18 to 84 in 2018/19. This is above the agreed target with the CCG of 75. Regarding device related grade 2 pressure ulcers, we note that although there was a slight increase from 14 to 15, this was below the agreed target of 42. We note that in Quarter 2 both non-device and device-related pressure ulcers were lower than the other quarters. The Trust needs to investigate this and see what led to this difference and feed the findings into service improvement.

We note that BHH, GHH and SH have surpassed the target set by the CCG of a reduction of 20% for grade 2 pressure ulcers reducing this by 43.8%. What lessons are being shared across the Trust in terms of practices that led to this reduction? We are, however, still concerned that incrementally the number of grade 2 ulcers increased quarter on quarter within these three hospital sites.

We note the changes in definitions and terminology to be implemented in 2019/20, which could potentially affect numbers. In addition, that the Trust is in the process of aligning policies, documentation and tissue viability processes across the Trust. We still hope that the Trust's actions, as outlined in the Quality Account, have been developed with these changes in mind and are challenging enough to lead to an improvement in this area. We, therefore, hope to read in the 2019/20 Quality Account the impact of the leaflet promoting patient movement, the revised Prescribing Information and Communication System (PICS) repositioning tool, and the various campaigns planned such as the safe side lying or moved, heel drag.

Regarding the timely and complete observation and pain assessment priority, we note that whilst BHH/GHH/SH met the target of 95% (within six hours of admission or transfer) consistently during 2018/19, QEHB did not. We, however, are mindful that this was an improved score (94.3%) on 2017/18 (93%). It is concerning that the indicator for patients (QEHB) receiving pain relief medication following a high pain score has remained between 74% and 75% throughout 2018/19, below the target of 85%. We would like to read in the 2019/20 Quality Account, the actions taken following the review of this data to identify reasons the indicator is not being achieved.

We note the initiatives that the Trust plans to implement in 2019/20 to address the 'timely treatment for sepsis' priority. In particular, we note the introduction of a sepsis dashboard where performance can be monitored in real time at ward level. We would like to read about the impact of these in the 2019/20 Quality Account.

Patient Safety Indicators

We note that there has been some improvement in some indicators such as patients with C.difficile infection /100,000 bed days from 19.05 (QEHB) and 12.4 (BHH/GHH/SH) to 10.79 across the Trust. However, whilst we acknowledge the impact changes in reporting might have had on numbers, we note that there has been an increase in the number of patients with MRSA infection/100,000 bed days from 0.4 (BHH, GHH, SH) and 0 at QEHB in 2017/18 to 1.47 across the Trust in 2018/19 (although still lower than peer group average).

The Trust reports that there have been nine never events across the Trust in 2018/19. There were six (QEHB) and eight (BHH/GHH/SH) never events in 2017/18. We note the categories of never events the Trust has provided (e.g. retained foreign object post procedure, unintentional connection of a patient requiring oxygen to an air flow meter, wrong site surgery). We welcome that the Trust took immediate corrective actions and the patients have received the correct procedures where appropriate. We would like to read in the 2019/20 Quality Account the impact of the actions implemented on practice and patients safety.

We are concerned that there appears to be an upward trend in the level of safety indicators:

- ▶ The number of patient safety incidents reported to the National Reporting and Learning System has increased 24,568 (2017/18) to 26,342

(2018/19) at QEHB and 19,664 (2017/18) to 21,811 (2018/19) at BHH/GHH/SH. We however do recognize that higher levels of reporting represent a good culture of openness and reporting within the Trust but also supports local learning. We would like to read in the 2019/20 Quality Account examples of learning that has taken place following reviews and the impact on practice.

- ▶ The percentage of safety incidents leading to severe harm has increased at QEHB from 0.22 to 0.26%.
- ▶ Emergency readmissions within 28 days of discharge (medical and surgical specialties) have increased across the Trust, from 13.87% (2017/18) to 15.39 % (2018/19) at QEHB and from 14.03% (2017/18) to 14.72% (2018/19) at GHH/BHH/SH. Similarly, emergency readmissions within 28 days of discharge (all specialties) – 13.84 to 15.56 at QEHB and 12.25 to 13.06% at BHH/GHH/SH.
- ▶ Percentage of patients receiving beta-blockers on the morning of the procedure for patients undergoing first-time coronary bypass graft (CABG) has decreased from 94.8% (2017/18) to 91.9% (2018/19).

We ask the Trust to investigate these areas further, to reflect Trust plans to investigate why the number of patients receiving beta-blockers is decreasing. This will help the Trust understand the lack of improvement and use the findings to inform service improvement.

Learning from deaths

During 2018/19, 5345 of the Trust's outpatients died and by April 2019 4226 case record reviews and 60 investigations were carried out. Thirty-four cases were subject to both a case review and an investigation. Nineteen cases (representing 0.36%) of patient deaths were judged by the Trusts review process to have been more likely than not caused by problems in the care provided. We note that various actions have been implemented in response and this has included responses to individual cases, changes or introduction of policies or guidelines, changing systems and patient pathways. We note action to communicate learning to relevant staff, provide feedback to family and staff involved in the incident, review of timeframes for CT scans and ensure that there is monitoring and tracking for patients entered on the Somerset Cancer Register. We hope to read on the impact of these in the 2019/20 Quality Account especially on changes to practice to ensure high-quality care.

Learning from Audits

We note the number of national (47) and local (4) clinical audits in which the Trust has participated in 2018/19. We note that the Trust carried out reviews of these audits and has developed actions to improve the quality of healthcare. It would be helpful to the public if the Trust included some examples of the actions to be taken especially on audit reviews that are relevant to the 2019/20 priorities.

Complaints and Compliments

Patients and carers do tell us positive experiences of care, but they have also told us negative experiences of accessing the Trust's services. The concerns raised by patients and carers to Healthwatch Birmingham are reflected in the complaints reported in the Quality Account. Over the year, we have heard about issues with waiting times, delays in clinics, the waiting room environment, poor A & E treatment, poor follow up checks (e.g. cancer test screening), poor communication with carers, the quality of treatment, poor attitude of staff, poor communication, lack of advice and support. We share real-time patient and carer experiences with the Trust and provide them with the right to respond to feedback left on our online feedback centre. We note the actions that are being taken to address these issues. We would like to see examples and the impact of follow on actions developed in the 2019/20 Quality Accounts.

The Trust's Priorities for 2019/20

Healthwatch Birmingham has taken note of the Trust's priorities for 2019/20. We are pleased that the priorities have been discussed or are to be presented at various Trust groups including to staff, patient and public representatives. We hope this process will help the Trust to develop further the priorities so that they effectively meet the various challenges facing the Trust and reflect the needs of the population. We welcome plans to include experience data relating to nutrition and hydration in all local inpatient surveys to measure success in 'improving patient experience' priority. We look forward to collaborating with the Trust on these priorities over the coming year.



Andy Cave
CEO
Healthwatch Birmingham

Statement provided by Healthwatch Solihull

Healthwatch Solihull welcomes the opportunity to review and comment on University Hospitals Birmingham Quality Accounts 2018/19. We also welcome that patient experience gathering through direct patient engagement is being set as a priority area of focus for Trust and congratulate the Trust on the steps it has taken in relation to this area.

The report format ensures that the priorities for the year ahead are identified as the ongoing programme of work. However, Healthwatch Solihull are unable to validate the priorities as they have not been involved in specific stakeholder consultation around these priorities.

In relation to the Trust patient experience priorities for improvement for 2019/20, service user contributions are key and Healthwatch Solihull would welcome the opportunity to work collaboratively with the trust to focus on improving patient experience and supporting the Trust in the achievement of its aims.

Healthwatch Solihull looks forward to closer dialogue with University Hospitals Birmingham NHS Foundation Trust and to reviewing progress against the forthcoming years priorities and to reviewing outcomes measured in the 2019/20 Quality Report to be able to assess how the quality initiatives have impacted on the residents of Solihull.

Kind Regards

Anthony Martlew
Manager
Healthwatch Solihull

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

The Birmingham Health and Social Care Overview Scrutiny Committee has indicated that it is not in a position to provide a statement on the University Hospitals Birmingham NHS Foundation Trust draft Quality Account 2018/19.

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

The Solihull Health & Social Care Overview and Scrutiny Committee has confirmed that it is not in a position to provide a statement on the 2018/19 Quality Report.

Annex 2: Statement of directors' responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare quality accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- ▶ the content of the Quality Report meets the requirements set out in the *NHS foundation trust annual reporting manual 2018/19* and supporting guidance *Detailed requirements for quality reports 2018/19*
- ▶ the content of the Quality Report is not inconsistent with internal and external sources of information including:
 - ▶ board minutes and papers for the period April 2018 to May 2019
 - ▶ papers relating to quality reported to the board over the period April 2018 to May 2019
 - ▶ feedback from the commissioners dated 21/05/2019
 - ▶ feedback from governors dated 28/03/2019
 - ▶ feedback from local Healthwatch organisations dated 15/05/2019 (Solihull) and 21/05/2019 (Birmingham)
 - ▶ feedback from Overview and Scrutiny Committee dated 15/03/2019 (Solihull) and 21/05/2019 (Birmingham)
 - ▶ the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2019
- ▶ the 2017 national patient survey June 2018; this is the latest available survey.
- ▶ the 2018 national staff survey, February 2019
- ▶ the Head of Internal Audit's annual opinion of the trust's control environment dated April 2018
- ▶ CQC inspection report dated 15/05/2015 (QEHB) and 23/02/2019 (Heartlands, Good Hope and Solihull Hospitals).
- ▶ the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- ▶ the performance information reported in the Quality Report is reliable and accurate
- ▶ there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- ▶ the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- ▶ the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.


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

By order of the board

Date: 24th May 2019

..... Chair

Date 24th May 2019

.....Chief Executive

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

Independent auditor's report to the council of governors of University Hospitals Birmingham NHS Foundation Trust on the quality report

We have been engaged by the council of governors of University Hospitals Birmingham NHS Foundation Trust to perform an independent assurance engagement in respect of University Hospitals Birmingham NHS Foundation Trust's quality report for the year ended 31 March 2019 (the 'quality report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of University Hospitals Birmingham NHS Foundation Trust as a body, to assist the council of governors in reporting University Hospitals Birmingham NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the council of governors as a body and University Hospitals Birmingham NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge;
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers, reported in accordance with the 2016 National Cancer Breach Allocation Guidance.

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

Respective responsibilities of the directors and auditors

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

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

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation Trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified below:
 - board minutes for the period April 2018 to April 2019;
 - papers relating to quality reported to the board over the period March 2018 to April 2019;
 - feedback from governors dated 28th March 2019;
 - feedback from Healthwatch Solihull, dated 15th May 2019;
 - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 24th April 2019;
 - the 2017 national patient survey;
 - the 2018 national staff survey;
 - Care Quality Commission inspection report, dated 13th February 2019; and

- the Head of Internal Audit's annual opinion over the Trust's control environment, dated April 2019;
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation Trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS foundation Trust annual reporting manual' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with the documents listed above and specified in the detailed guidance for external assurance on Quality Reports (collectively the 'documents').

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

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS foundation Trust annual reporting manual' to the categories reported in the quality report; and
- reading the documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these

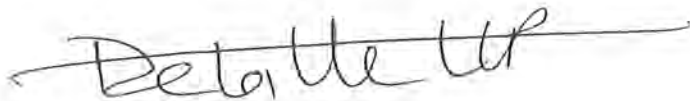
criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation Trust annual reporting manual'.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by University Hospitals Birmingham NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation Trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in 2.1 of the 'NHS Improvement Detailed requirements for external assurance for quality reports 2018/19' for foundation Trusts; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation Trust annual reporting manual' and supporting guidance.



Deloitte LLP
Birmingham
United Kingdom
24 May 2019



Section 3
Consolidated Financial Statements
2018/19

This annual report covers the period 1 April 2018 to 31 March 2019

University Hospitals Birmingham NHS Foundation Trust – Consolidated Financial Statements 2018/19

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Foreword to the Financial Statements

University Hospitals Birmingham NHS Foundation Trust

These financial statements for the year ended 31 March 2019 have been prepared by the University Hospitals Birmingham NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.



Dr David Rosser, Chief Executive
24 May 2019

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

Report on the audit of the financial statements

Opinion

In our opinion the financial statements of University Hospitals Birmingham NHS Foundation Trust (the 'foundation trust') and its subsidiaries (the 'group'):

- **give a true and fair view of the state of the group's and foundation trust's affairs as at 31 March 2019 and of the group's and foundation trust's income and expenditure for the year then ended;**
- **have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and**
- **have been prepared in accordance with the requirements of the National Health Service Act 2006.**

We have audited the financial statements which comprise:

- the consolidated statement of comprehensive income;
- the group and foundation trust statements of financial position;
- the group and foundation trust statements of cash flow;
- the group and foundation trust statements of changes in taxpayers' equity; and
- the related notes 1 to 34.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the group and the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Summary of our audit approach

Key audit matters	The key audit matters that we identified in the current year were: <ul style="list-style-type: none"> • <i>Recognition of NHS clinical revenue;</i> • <i>Property valuations; and</i> • <i>Financial sustainability and going concern including value for money.</i>
Materiality	The materiality that we used for the group financial statements was £16.1m which was determined on the basis of revenue.
Scoping	The focus of audit work was on the foundation trust, with work performed at the Trust's head offices in Birmingham directly by the audit engagement team, led by the audit partner. Our audit covered all of the entities within the Group, including the Trust's subsidiaries.
Significant changes in our approach	Following the acquisition of Heart of England NHS Foundation Trust on 1 April 2018 the scope of our audit includes the larger combined foundation trust and its subsidiaries. We have reflected the more complex nature of the foundation trust's operations in our calculation of materiality.

Conclusions relating to going concern

We are required by ISAs (UK) to report in respect of the following matters where:



- the accounting officer’s use of the going concern basis of accounting in preparation of the financial statements is not appropriate; or
- the accounting officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the group’s or the foundation trust’s ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.





We have nothing to report in respect of these matters.

Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team.

These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

NHS revenue and provisions	
<p>Key audit matter description</p> 	<p>As described in note 1 Accounting Policies and note 1.28, Critical Accounting Judgements and Key Sources of Estimation Uncertainty, there are significant judgements in recognition of revenue from care of NHS patients and in provisioning for disputes with commissioners due to:</p> <ul style="list-style-type: none"> • the complexity of the Payment by Results regime, in particular in determining the level of over performance and revenue to recognise; and • the judgemental nature of accounting for disputes, including in respect of outstanding over performance income for quarters 3 and 4. • the risk of revenue not being recognised at fair value due to adjustments agreed in settling current year disputes and agreement of future year contracts. <p>Details of the Group’s income, including £1,384.7m of Commissioner Requested Services (2018: £695.8), details are shown in note 4 to the financial statements. NHS and DHSC debtors are shown in note 20 to the financial statements.</p> <p>The Group earns revenue from a wide range of commissioners, increasing the complexity of agreeing a final year-end position.</p>
<p>How the scope of our audit responded to the key audit matter</p> 	<p>We evaluated the design and implementation of controls over recognition of Payment by Results income.</p> <p>We performed detailed substantive testing on a sample basis of the recoverability of overperformance income and adequacy of provision for underperformance through the year, and evaluated the results of the NHS wide agreement of balances exercise.</p>

	<p>We challenged key judgements around specific areas of dispute and actual or potential challenge from commissioners and the rationale for the accounting treatments adopted. In doing so, we considered the historical accuracy of provisions for disputes and reviewed correspondence with commissioners.</p>
<p>Key observations</p> 	<p>Based on the audit evidence obtained, we concluded that NHS revenue is appropriately recognised.</p>
Property valuation	
<p>Key audit matter description</p> 	<p>The Group holds property assets within Property, Plant and Equipment at a modern equivalent use valuation of £649.3m (2017/18: £433.3m). As described in note 1.28 Critical Accounting Judgements and Key Sources of Estimation Uncertainty the valuations are by nature significant estimates which are based on specialist and management assumptions, these include:</p> <ul style="list-style-type: none"> • the floor areas for a Modern Equivalent Asset; • alternative site for the former Heart of England NHS Foundation Trust assets which have been consolidated into the foundation trust's accounts; • the basis for calculating build costs; • the level of allowances for professional fees and contingency; and • the remaining life of the assets, which can be subject to material changes in value. <p>The Trust's revaluation has resulted in a downwards revaluation of buildings by £1.8m (2017/18: £27.9m with an additional land impairment of £15.2m). The change is primarily a result of changes in market value and location and build cost index factors during 2018/19.</p>
<p>How the scope of our audit responded to the key audit matter</p> 	<p>We evaluated the design and implementation of controls over property valuations, and tested the accuracy and completeness of data provided by the Group to the valuer.</p> <p>We used Deloitte valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the Group's properties.</p> <p>We have reviewed the disclosures in notes 1.5 Property, plant and equipment and 1.28 and evaluated whether these provide sufficient explanation of the basis of the valuation and the judgements made in preparing the valuation.</p> <p>We assessed whether the valuation and the accounting treatment of the impairment were compliant with the relevant accounting standards, and in particular whether impairments should be recognised in the Income Statement or in Other Comprehensive Income.</p>
<p>Key observations</p> 	<p>Based on the audit evidence obtained, we conclude that the valuation of the Trust's estate is appropriate. We did not identify any issues with the assumptions and inputs used.</p>

Financial sustainability and going concern including value for money

Key audit matter description



The foundation trust is required to make proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

We identified financial sustainability and going concern as a key audit matter on account of the foundation trust’s acquisition of the Heart of England NHS Foundation Trust on 1 April 2018, which included all assets and liabilities of this organisation.

The foundation trust’s performance and reported pre-Provider Sustainability Funding (PSF) deficit for the year of £61.3m was broadly in line with plan (£61.8m deficit). Core PSF funding was £6.2m lower than planned due to non-achievement against A&E targets during the year. However, this has been more than offset by the additional £12.2m of incentive and bonus funding received at the year-end (2017/18 performance: surplus of £7.2m in 2017/18, including impairment gains and losses and STF income).

The foundation trust reported achievement of 96% of its CIP target for the year, however it recognised that nearly half of this (47%) had been met non-recurrently. Historically the foundation trust has not recognised non-recurrent CIP, however following the acquisition this changed.

The foundation trust has a Single Oversight Framework Use of Resource (UoR) rating of 3 (1 in 2017/18), this was in line with the plan.

The foundation trust has agreed its control total for 2019/20 and is forecasting a breakeven position with no further cash support required.

Further details regarding the merger and going concern are disclosed in the Consolidated Statement of Comprehensive Income and note 1 to the financial statements.

How the scope of our audit responded to the key audit matter



We evaluated the design and implementation of relevant controls in place around management’s assessment and monitoring of the foundation trust’s financial sustainability and going concern.

We reviewed the foundation trust’s financial performance during the year and outturn position as well as reviewing and challenging management’s assessment of going concern.

We reviewed the foundation trust’s forecasts and Cost Improvement Plans set out within its 2019/20 operational plan.

We have reviewed management’s cashflow forecast over the next 12 months and understood management’s progress in identifying a solution to ensure long term sustainability.

We have reviewed the foundation trust’s board minutes and board assurance framework to assess whether risks in relation to sustainability are appropriately recognised and mitigating controls are being implemented.

We have considered the adequacy of disclosures made in note 1 to the financial statements concerning the foundation trust’s ability to continue as a going concern.

Key observations



We have no matters to report by exception in regard to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Our application of materiality

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

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

	Group financial statements	Foundation trust financial statements
Materiality	£16.1m (2017/18: £17.2m)	£15.3m (2017/18: £16.3m)
Basis for determining materiality	1% of revenue (2017/18: 2% of revenue) We reassessed the percentage used in the context of our cumulative knowledge and understanding the audit risks at the Group and our assessment of those risks for this year.	1% of revenue (2017/18: 2% of revenue) We reassessed the percentage used in the context of our cumulative knowledge and understanding the audit risks at the foundation trust and our assessment of those risks for this year.
Rationale for the benchmark applied	Revenue was chosen as a benchmark as the group is a non-profit organisation, and revenue is a key measure of financial performance for users of the group financial statements.	Revenue was chosen as a benchmark as the foundation trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the foundation trust financial statements.



We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £300k (2017/18: £250k), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit

Our group audit was scoped by obtaining an understanding of the Group and its environment, including group-wide controls, and assessing the risks of material misstatement at the Group level. Our audit covered all of the entities within the Group, including the Trust's subsidiaries Pharmacy@QEHB Limited, UHB Facilities Limited, Assure Dialysis Limited and Professional Activity Limited which account for 100% of the Group's net assets, revenue and surplus (2017/18: 100%).

Our audit work was executed at levels of materiality applicable to each individual entity which were lower than group materiality. The range of materiality used was £6.4m to £15.3m.

Other information

The accounting officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon.

We have nothing to report in respect of these matters.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

Responsibilities of accounting officer

As explained more fully in the accounting officer's responsibilities statement, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the group's and the foundation trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the accounting officer either intends to liquidate the group or the foundation trust or to cease operations, or has no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Directors' Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

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

We have nothing to report in respect of these matters.

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

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Council of Governors and Board of Directors ("the Boards") of University Hospitals Birmingham NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the foundation trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.



Gus Miah (Senior statutory auditor)
for and on behalf of Deloitte LLP
Statutory Auditor
Birmingham, United Kingdom
29 May 2019

Consolidated statement of comprehensive income

		Year Ended 31 March 2019	Year Ended 31 March 2018
	Notes	Total £000	Total £000
Revenue from patient care activities	3	1,409,642	713,596
Other operating revenue	4	203,929	144,358
Total revenue		1,613,571	857,954
Operating expenses	5	(1,620,780)	(806,405)
Impairment / (reversal of impairment) charged / credited to operating expenses	5	(710)	(21,900)
Total operating expenses		(1,621,490)	(828,305)
Operating (deficit) / surplus		(7,919)	29,649
Finance income	9	766	208
Finance expense	9	(23,968)	(22,584)
PDC Dividends payable	11	(739)	-
Net finance expense		(23,941)	(22,376)
Loss on disposal	10	(231)	(19)
Gain from the transfer by absorption	15	165,013	-
Taxation	12	(90)	(29)
Retained surplus for the year		132,832	7,225
Other comprehensive income			
Will not be reclassified to income and expenditure			
Impairment losses on property, plant and equipment	14	(4,384)	(4,056)
Revaluation (decrease) / increase on property, plant and equipment	14	3,278	(17,193)
Other comprehensive loss		(1,106)	(21,249)
Total comprehensive (loss) / income for the year		131,726	(14,024)
Adjusted financial performance (control total basis):			
Retained surplus for the year		132,832	7,225
Remove net impairments not scoring to the Departmental expenditure limit		710	21,900
Remove (gains) / losses on transfers by absorption		(165,013)	-
Remove I&E impact of capital grants and donations		(45)	(4,377)
Remove 2016/17 post audit STF reallocation (2017/18 only)		-	(419)
Adjusted financial performance (deficit) / surplus		(31,516)	24,329

All income and expenditure is derived from continuing operations.

On 1 April 2018, the Trust acquired the Heart of England NHS Foundation Trust, including all assets and liabilities of this organisation via a Grant of Acquisition issued by NHS Improvement. The results for the reporting period include a full year of the revenue and expenditure of the former provider, including the separate disclosure of the gain from the transfer by absorption. The gain is equal to the net assets of the former provider as at the acquisition date. The results of the comparative year are those of the Trust prior to the acquisition,

there is no restatement of comparatives, see note 15 to the financial statements on page XLVI for further information on this event.

All income and expenditure is attributable to the Group, there are no minority interests. The Group has taken advantage of the exemption afforded by the Companies Act 2006 to not disclose the parent Trust SoCI and related notes, the Trust retained surplus for the reporting year was £132,160,000 (2017/18 - £6,984,000).

The notes on pages XVII-LXIV are an integral part of these financial statements.

Consolidated statement of financial position

	Notes	Group		Foundation Trust	
		31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Assets					
Non-current assets					
Intangible assets	13	12,800	5,295	12,649	5,144
Property, plant and equipment	14	740,462	472,087	737,878	469,280
Trade and other receivables	20	8,366	4,946	8,366	4,946
Investments	16	-	-	151	151
Deferred tax asset	24	113	125	-	-
		761,741	482,453	759,044	479,521
Current assets					
Inventories	19	35,476	19,061	30,511	16,565
Trade and other receivables	20	122,843	92,814	126,511	104,458
Cash and cash equivalents	21	62,941	85,490	61,938	83,692
		221,260	197,365	218,960	204,715
Total assets		983,001	679,818	978,004	684,236
Liabilities					
Current liabilities					
Borrowings	25	(13,184)	(12,123)	(13,184)	(12,123)
Trade and other payables	22	(263,485)	(139,338)	(260,798)	(145,401)
Current tax liabilities	12	(80)	(60)	-	-
Provisions	28	(3,353)	(1,165)	(3,353)	(1,165)
Other liabilities	23	(33,434)	(25,744)	(33,441)	(25,720)
		(313,536)	(178,430)	(310,776)	(184,409)
Total assets less current liabilities		669,465	501,388	667,228	499,827
Non-current liabilities					
Borrowings	25	(497,050)	(472,342)	(497,050)	(472,342)
Provisions	28	(7,456)	(3,039)	(7,183)	(2,773)
Deferred tax liabilities	24	(46)	(25)	-	-
Other liabilities	23	(2,484)	(4,461)	(2,260)	(4,213)
		(507,036)	(479,867)	(506,493)	(479,328)
Total liabilities		(820,572)	(658,297)	(817,269)	(663,737)
Net assets		162,429	21,521	160,735	20,499
Taxpayers' equity					
Public dividend capital		367,500	193,305	367,500	193,305
Revaluation reserve		151,428	93,705	151,428	93,705
Income and expenditure reserve		(356,499)	(265,489)	(358,193)	(266,511)
Total taxpayers' equity		162,429	21,521	160,735	20,499

The financial statements on pages XII to LXIV were approved by the Board of Directors on 24 May 2019 and were signed on its behalf by:



Dr David Rosser, Chief Executive

Consolidated statement of changes in taxpayers' equity

Group	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Total
	£000	£000	£000	£000
Balance at 1 April 2017	186,210	114,954	(272,714)	28,450
Surplus for the year	-	-	7,225	7,225
Public dividend capital received	7,095	-	-	7,095
Net impairments	-	(4,056)	-	(4,056)
Revaluations - property, plant and equipment	-	(17,193)	-	(17,193)
Balance at 31 March 2018	193,305	93,705	(265,489)	21,521
Surplus for the year	-	-	132,832	132,832
Transfers by absorption: transfers between reserves	165,013	60,131	(225,144)	-
Public dividend capital received	9,182	-	-	9,182
Transfers between reserves	-	(1,302)	1,302	-
Net impairments	-	(4,384)	-	(4,384)
Revaluations - property, plant and equipment	-	3,278	-	3,278
Balance at 31 March 2019	367,500	151,428	(356,499)	162,429
Trust	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Total
	£000	£000	£000	£000
Balance at 1 April 2017	186,210	114,954	(273,495)	27,669
Surplus for the year	-	-	6,984	6,984
Public dividend capital received	7,095	-	-	7,095
Net impairments	-	(4,056)	-	(4,056)
Revaluations - property, plant and equipment	-	(17,193)	-	(17,193)
Balance at 31 March 2018	193,305	93,705	(266,511)	20,499
Surplus for the year	-	-	132,160	132,160
Transfers by absorption: transfers between reserves	165,013	60,131	(225,144)	-
Public dividend capital received	9,182	-	-	9,182
Transfers between reserves	-	(1,302)	1,302	-
Net impairments	-	(4,384)	-	(4,384)
Revaluations - property, plant and equipment	-	3,278	-	3,278
Balance at 31 March 2019	367,500	151,428	(358,193)	160,735

Consolidated statement of cash flows

	Group		Foundation Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	Total	Total	Total	Total
Notes	£000	£000	£000	£000
Cash flows from operating activities				
Operating (deficit) / surplus for the year	(7,919)	29,649	(8,872)	29,139
Depreciation and amortisation	36,386	22,083	35,995	21,748
Net impairment / (reversals of impairments) charged to operating expenses	710	21,900	710	21,900
Income recognised in respect of capital donations	(1,859)	(6,039)	(1,859)	(6,039)
Amortisation of PFI deferred income	(4,448)	-	(4,448)	-
(Increase) in inventories	(6,045)	(4,096)	(3,576)	(3,353)
Decrease / (increase) in trade and other receivables	5,819	(24,753)	13,826	(28,569)
Increase in trade and other payables	18,231	10,513	9,377	12,900
Increase in other liabilities	5,324	4,829	5,348	4,557
(Decrease) / increase in provisions	(1,488)	387	(1,489)	388
Tax	(37)	(24)	-	-
Net cash generated from operating activities	44,674	54,449	45,012	52,671
Cash flows from investing activities				
Interest received	827	284	1,012	515
Payments to acquire property, plant and equipment	(47,402)	(24,300)	(47,130)	(23,950)
Receipts from sale of property, plant and equipment	53	7,300	53	7,300
Receipt of cash donations to purchase capital assets	600	4,831	600	4,831
Purchase of investments	-	-	-	(151)
Payments to acquire intangible assets	(1,052)	(151)	(1,052)	-
Net cash used in investing activities	(46,974)	(12,036)	(46,517)	(11,455)
Cash flows from financing activities				
Public dividend capital received	9,182	7,095	9,182	7,095
Movement in loans from the Department of Health and Social Care	(129)	-	(129)	-
Capital element of finance lease obligations	(194)	(47)	(194)	(47)
Interest element of finance lease obligations	(94)	(20)	(94)	(20)
Capital element of PFI obligations	(12,324)	(12,228)	(12,324)	(12,228)
Interest element of PFI obligations	(23,325)	(22,552)	(23,325)	(22,552)
Interest on loans from the Department of Health and Social Care	(428)	-	(428)	-
PDC dividend (paid)	(4,242)	-	(4,242)	-
Net cash used in financing activities	(31,554)	(27,752)	(31,554)	(27,752)
Net (decrease) / increase in cash and cash equivalents	(33,854)	14,661	(33,059)	13,464
Cash and cash equivalents at 1 April	85,490	70,829	83,692	70,228
Adjustments to cash in year				
Cash and cash equivalents transferred by absorption	11,305	-	11,305	-
Cash and cash equivalents at 31 March	62,941	85,490	61,938	83,692

Notes to the Financial Statements

1 Accounting policies

1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.1.2 Going concern

These accounts have been prepared on a going concern basis. After making enquiries, the directors have a reasonable expectation that the NHS foundation trust has adequate resources to continue in operational existence for the foreseeable future. Based on the financial performance detailed in these financial statements and the revised financial plan for 2019/20 submitted to NHS Improvement on 23 May 2019, where the Trust has again signed up to the NHS Provider Sustainability Fund, the Trust is forecasting that its cash balances will remain sufficient to continue meeting its working capital requirements for the immediate future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

On 1 April 2018, the Trust acquired the Heart of England NHS Foundation Trust, including all assets and liabilities of this organisation via a Grant of Acquisition issued by NHS Improvement.

The combined Trust is currently planning for a breakeven position in 2019/20. As with most similar NHS organisations, future financial performance is subject to changes in national policy, NHS funding allocations and national tariffs for providers of healthcare. The Trust has £62.9m of cash at the reporting date and access to a £75m working capital loan to ensure it can continue to meet its obligations to staff and suppliers.

These financial statements were authorised for issue on the 24 May 2019, there were no events arising after the end of the reporting period up to which this date qualifies for disclosure.

1.1.3 Consolidation

The Group financial statements consolidate the financial statements of the Trust and all of its subsidiary undertakings made up to 31 March 2019. Under IFRS 10, an entity controls an investee when it is exposed to, or has rights to, variable returns from its involvement with the investee and has the ability to affect those returns through its power over the investee. The income, expenses, assets, liabilities, equity and reserves of the subsidiaries have been consolidated into the Trust's financial statements and group financial statements have been prepared.

All intra-group transactions, balances, income and expenses are eliminated on consolidation. Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material, however there are no such differences at the reporting date. In accordance with the GAM 2018/19 a separate income statement for the parent (the Trust) has not been presented.

The GAM 2018/19 requires the consolidation of any NHS charity that meets the criteria of control under IFRS 10. The Queen Elizabeth Hospital Birmingham Charity is not considered to be a subsidiary of the Trust under IFRS 10 and consequently is not consolidated within these financial statements. The charity is a separate legal entity with an independent Board of Trustees and the benefits from its activities are shared between the Trust, University of Birmingham and Royal Centre of Defence Medicine.

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the

arrangement. The joint venture is accounted for using the equity method. The Trust has no joint operations nor any associate entities.

1.2 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

1.2.1 Revenue from NHS Contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction

price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty. The Trust does not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price. An estimate of readmissions is made at the year end and this portion of revenue is deferred as a contract liability.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner which affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

1.2.2 Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

1.2.3 NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

1.2.4 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.2.5 Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.3 Expenditure on employee benefits

Short term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from the employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that the employees are permitted to carry forward leave into the following period.

Post employment benefits - pension costs

Past and present employees of the Trust are covered by the provisions of the two NHS Pensions Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. The commercial subsidiaries operate a defined contribution scheme with Standard Life and the Government's NEST scheme, employees of these companies do not have access to the NHS Pension Schemes.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined

at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a. Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b. Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

1.4 Expenditure on other goods and services

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

1.5 Property, plant and equipment

Recognition

Property, plant and equipment assets are capitalised where:

- ▶ They are held for use in delivering services or for administration purposes
- ▶ It is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- ▶ They are expected to be used for more than one financial year
- ▶ The cost of the item can be measured reliably
- ▶ Individually they have a cost of at least £5,000; or
- ▶ They form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- ▶ They form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost

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

Valuation

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

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

reporting period. Fair values are measured as follows:

- ▶ Land and non specialised buildings - existing use value
- ▶ Specialised buildings - depreciated replacement cost

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

For all categories of non-property assets/intangible assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be a realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

Revaluation

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

Subsequent expenditure

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

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- ▶ The asset is available for immediate sale
- ▶ Management are committed to a plan to sell
- ▶ The sale is highly probable
- ▶ An active programme has begun to find a buyer and complete the sale
- ▶ The asset is being actively marketed at a reasonable price
- ▶ The actions required to complete the planned sale indicate that it is unlikely that the plan will be significantly changed or withdrawn.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.6 Intangible assets

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

1.7 Depreciation, amortisation and impairments

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

where shorter, the lease term.

The estimated useful economic lives of property, plant and equipment and intangible assets are as follows:

- ▶ Buildings are depreciated over 10 to 67 years
 - ▶ Dwellings are depreciated over 5 to 25 years
 - ▶ Land and assets under construction are not depreciated
 - ▶ Plant and machinery is depreciated over 5 to 15 years
 - ▶ Information technology is depreciated over 2 to 10 years
 - ▶ Furniture and fittings are depreciated over 5 to 10 years
- Intangible software and licences / trademarks are depreciated over 2 to 5 years

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

In accordance with the DH GAM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of other impairments are treated as revaluation gains.

1.8 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to revenue. The revenue is recognised in full in the reporting year the asset is received, unless the donor imposes a condition that the future economic benefits embodied in the donation are to be consumed in a manner specified by the donor. In which case the donation would be deferred within liabilities carried forward to future years to the extent that the condition has not yet been met. Donated assets continue to be valued, depreciated and impaired as described for purchased assets.

1.9 Government grants

The revenue is recognised when the foundation trust becomes entitled to the grant, unless the grantor imposes a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the grantor. In which case the grant would be deferred within liabilities carried forward to future years to the extent that the condition has not yet been met. Granted assets continue to be capitalised at their fair value upon receipt and are valued, depreciated and impaired as described for purchased assets.

1.10 Leases

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

The Trust as lessee

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

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

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

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

The Trust as lessor

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

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

1.11 Private Finance Initiatives (PFI) transactions

Recognition

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

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

The Trust therefore recognises the PFI asset as an item of property, plant and equipment on the Statement of Financial Position together with a liability to pay for it. The PFI assets recognised, including the Queen Elizabeth Hospital Birmingham, are detailed in note 27.1 to the financial statements on page LIV. The services received under the contract are recorded as operating expenses.

Valuation

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

The estimation technique of the Modern Equivalent Asset (the 'Depreciated Replacement Value') includes the assumption that any replacement PFI hospital would be VAT recoverable. VAT is recoverable on PFI builds under HMRC guidelines whereas traditional NHS estate construction is not recoverable and therefore valued gross of VAT. It is recognised that a modern equivalent asset, would be another PFI on the same Edgbaston site, hence VAT would be recoverable on any cost. The DH GAM states the circumstances where it is appropriate to value assets exclusive of VAT, detailed in Chapter 4 Annex 4 - Valuation issues, paragraph 8: provision of a fully managed and serviced building under a PFI agreement, where the service potential would be replaced by the PFI provider.

The PFI lease obligations due at the reporting date are detailed in note 27.1 to the financial statements on page LIV.

Subsequent expenditure

The annual contract payments are apportioned, using appropriate estimation techniques between the repayment of the liability, a finance cost, lifecycle replacement and the charge for services. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

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

The fair value of services received in the year is recognised under the relevant operating expenses headings within note 5 to the financial statements on page XXXIII.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

The lifecycle prepayment recognised at the reporting date is detailed in note 20 to the financial statements on page XLIX.

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

Other assets contributed by the Trust to the operator

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

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

1.12 Inventories

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

1.13 Cash and cash equivalents

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

1.14 Finance income and costs

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

1.15 Financial assets and financial liabilities

Recognition and de-recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation has been discharged, cancelled or has expired.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are classified as subsequently measured at amortised cost. Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and

obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy 1.10 for leases (IAS 17).

PDC Capital is not considered a financial instrument and the accounting treatment (historical cost) is described in accounting policy 1.21.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses. The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate. Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the

net carrying value of the financial asset in the Statement of Financial Position.

1.16 Contract receivables

Contract receivables are recognised and carried at original invoice amount less expected credit losses for impairment. A credit loss for impairment of trade receivables is established when there is objective evidence that the Trust will not be able to collect all amounts due according to the original terms of receivables. The movement of the expected credit loss is recognised in the Statement of Comprehensive Income (operating expenses).

1.17 Deferred income

Deferred income represents grant monies received where the expenditure is expected to take place in a future period. The deferred income is included in current liabilities unless the expenditure, in the opinion of management, will take place more than 12 months after the reporting date, which are classified in non-current liabilities.

1.18 Borrowings

The Trust has acquired two DHSC loans via the acquisition of the former Heart of England NHS Foundation Trust, borrowings as at the reporting date also include obligations under finance leases and the several PFI schemes, including the 'Queen Elizabeth Hospital Birmingham' Private Finance Initiative contract.

1.19 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the reporting date on the basis of the best estimate of the expenditure required to settle the probable obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of +1.14% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of +0.29% in real terms.

Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed in note 28 to the financial statements on page LVII, but is not recognised in the Trust's financial statements.

Non-Clinical Risk Pooling

The Trust participates in the Property Expenses

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

1.20 Contingencies

Contingent liabilities are not recognised but are disclosed in note 29 to the financial statements on page LVIII, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

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

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 29 to the financial statements on page LVIII where an inflow of economic benefits is probable.

1.21 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32. At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility and (iii) any PDC dividend balance receivable or payable. In

accordance with the requirements laid down by the DHSC (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the pre-audit version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.22 Research and Development

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

Research and development activity cannot always be separated from patient care activity and is considered to be a part of the core NHS healthcare operating segment within the Trust. It is therefore not separately disclosed.

1.23 Value Added Tax

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

1.24 Corporation Tax

The Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to disapply the exemption in relation to specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the future scope of income tax in respect of activities where income is received from a non public sector source.

The tax expense on the surplus or deficit for the year comprises current and deferred tax due to the Trust's trading commercial subsidiaries, see note 12 to the financial statements on page 40. Current tax is the expected tax payable for the year, using tax rates enacted or substantively enacted at the balance sheet date, and any adjustment to tax payable in respect of previous years.

Deferred tax is provided using the balance sheet liability method, providing for temporary differences between the carrying amounts of the assets and liabilities for financial reporting purposes and the amounts used for taxation purposes. Deferred tax is not recognised on taxable temporary differences arising on the initial recognition of goodwill or for temporary

differences arising from the initial recognition of assets and liabilities in a transaction that is not a business combination and that affects neither accounting nor taxable profit.

Deferred taxation is calculated using rates that are expected to apply when the related deferred tax asset is realised or the deferred taxation liability is settled. Deferred tax assets are recognised only to the extent that it is probable that future taxable profits will be available against which the assets can be utilised.

1.25 Foreign exchange

The functional and presentational currency of the Trust is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March 2019. Resulting exchange gains and losses for either of these are recognised in the Statement of Comprehensive Income in the period in which they arise.

1.26 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the financial statements in accordance with the requirements of GAM 2018/19, disclosed in note 33 to the financial statements on page LXIII.

1.27 Losses and Special Payments

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

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS foundation trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.28 Critical accounting judgements and key sources of estimation uncertainty

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

The critical accounting judgements and key sources of estimation uncertainty that have a significant effect on the amounts recognised in the financial statements are detailed below:

Modern equivalent asset valuation of property - key sources of estimation uncertainty

As detailed in accounting policy note 1.5 'Property, plant and equipment - valuation', GVA LLP provided the Trust with a valuation of the land and building assets (estimated fair value and remaining useful life). The significant estimation being the specialised building - depreciated replacement value, using modern equivalent asset methodology, of the new PFI hospital (the 'Queen Elizabeth Hospital Birmingham') and the acquired NHS estates of the former Heart of England NHS Foundation Trust. The result of this valuation, based on estimates provided by a suitably qualified professional in accordance with HM Treasury guidance, is disclosed in note 14.2 to the financial statements on page XLIV. Future revaluations of the Trust's property may result in further material changes to the carrying values of non-current assets.

Impairments and the estimated lives of assets - key sources of estimation uncertainty

As detailed in accounting policy note 1.7 'Depreciation, amortisation and impairments', the Trust is required to review property, plant and equipment for impairments and the accuracy of estimated useful lives. In between formal valuations by qualified surveyors, management make judgements about the condition of assets and review their estimated lives.

Provision for expected credit loss of contract receivables - critical accounting judgement

Management will use their judgement to decide when to write-off receivables or to provide against the probability of not being able to collect debt. There are significant judgements in recognition of revenue from care of patients and in provisioning

for disputes with commissioners and customers. This arises from the complexity of the Payments by Results regime (NHS), the judgemental nature of over performance activity levels and partially completed spells not yet agreed with commissioners (NHS), commercial pricing regime (private patients) and overseas patients seeking NHS healthcare.

Provisions - critical accounting judgement

Management will use their judgement to decide when to make provisions for probable legal and constructive obligations of uncertain timing or amount as at the reporting date. These are based on estimates using relevant and reliable information as is available at the time the financial statements are prepared. These provisions are estimates of the actual costs of future cash flows and are dependent on future events. Any difference between expectations and the actual future liability will be accounted for in the period when such determination is made.

The carrying amounts of the Trust's provisions are detailed in note 28 to the financial statements on page LVII.

1.29 Accounting standards, interpretations and amendments adopted in the year

All new, revised and amended standards and interpretations, which are mandatory as at the reporting date, have been adopted in the year. None have had a material impact on the Trust's financial statements, but the following changes have occurred:

IFRS 9 'Financial Instruments' - recognition and measurement

- ▶ There is no change in the prior year comparatives of the Trust. The only change resulting from this standard is the disclosure of accrued interest payable at the reporting date on loans from the Department of Health. The standard requires this balance to be disclosed in borrowings, rather than trade payables on the Statement of Financial Position. The transfer by absorption of Heart of England NHS FT on 1 April 2018 which had two such loans, required this non-material balance (£81,000) to be transferred from trade payables to borrowings at the date of acquisition.

IFRS 15 'Revenue from Contracts with Customers'

- ▶ There is no change in the prior year comparatives of the Trust, other than the comparative disclosures for revenue being split between income accounted for under IFRS 15 (Revenue from Contracts with Customers) and that accounted for under other standards (eg grant income under IAS 20). The revenue in the reporting year has not changed due to the application of IFRS 15 other than what is disclosed under the new standard versus other standards.

1.30 Accounting standards, interpretations and amendments to published standards not yet adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2018-19:

- IFRS 16 'Leases'

- ▶ Following the release of the 2019/20 Department of Health and Social Care Group Accounting Manual in February 2019, the Trust is assessing the likely impact of IFRS 16 upon all leases. The Trust in particular is reviewing all operating leases in preparation for and the consequences of their addition to the Statement of Financial Position of the Trust in 2020/21, (restatement of comparatives will also be required at 31 March 2020).

No other accounting standards, interpretations and amendments to published standards not yet adopted is predicted to have a material consequence on the Trust's financial statements.

2 Segmental analysis

The analysis by business segment is presented in accordance with IFRS 8 Operating segments, on the basis of those segments whose operating results are regularly reviewed by the Board (the Chief Operating Decision Maker or 'CODM' as defined by IFRS 8), as follows:

Healthcare services - QE and HGS

NHS Healthcare is the core activity of the Trust - the 'mandatory services requirement' as set out in the Trust's Terms of Authorisation issued by Monitor and defined by legalisation. This activity is primarily the provision of NHS healthcare, either to patients and charged to the relevant NHS commissioning body, or where healthcare related services are provided to other organisations by contractual agreements. Healthcare services also includes the hosting of the Royal Centre for Defence Medicine (Ministry of Defence) and the treatment of private patients.

The acquisition of the former Heart of England NHS Foundation Trust on 1 April 2018 has resulted in two healthcare segments being reported separately to the 'CODM', each with their own executive Chief Operating Officer on the Board. These consist of the original Queen Elizabeth Hospitals site (the 'QE') and the acquired Heartlands, Good Hope and Solihull sites (the 'HGS'). In addition, the regulator NHS Improvement has set separate financial targets for the QE and HGS segments under the Provider Sustainability Funding mechanism for this reporting period, see note 4 to the financial statements on page XXXII.

The healthcare and related support services as described are all provided directly by the Trust, which is a public benefit corporation. These services have been aggregated into two operating segments based on their location and reporting lines, as noted above, but they have similar economic characteristics: the nature of the services they offer are the same (the provision of healthcare), they have similar customers (public and private sector healthcare organisations) and have the same regulators (NHS Improvement, Care Quality Commission and the Department of Health). The overlapping activities and interrelation between direct healthcare services and supporting medical research and education suggests that aggregation is applicable within these two location based segments. However, other healthcare support services are provided by separate trading companies:

Commercial subsidiaries -

There are four trading companies that are all wholly owned subsidiaries of the Trust: (i) Pharmacy@QEHB Limited provides an Outpatient Dispensary service, (ii) UHB Facilities Ltd provides a fully managed healthcare facility, (iii) Assure Dialysis Services Ltd provides renal dialysis healthcare and (iv) Professional Activity Ltd has been acquired to enable the Trust to develop and use its medical locum booking software. As trading companies, subject to additional legal and regulatory regimes (over and above that of the Trust), these activities are considered to be a third distinct business segment whose individual operating results are reviewed by the Trust Board (the Chief Operating Decision Maker).

A significant proportion of these companies' revenues are inter group trading with the Trust which is eliminated upon the consolidation of these group financial statements. The monthly performance report to the Chief Operating Decision Maker reports financial summary information in the format of the table overleaf.

Year ended 31 March 2019	QE Healthcare services £000	HGS Healthcare services £000	Commercial subsidiaries £000	Inter-Group Eliminations £000	Total £000
Total segment revenue	910,379	704,073	57,585	(58,466)	1,613,571
Total segment expenditure	(865,560)	(757,054)	(56,631)	58,465	(1,620,780)
Net impairments	8,252	(8,962)	-	-	(710)
Operating surplus	53,071	(61,943)	954	(1)	(7,919)
Net financing	(22,533)	(478)	(192)	1	(23,202)
PDC dividends payable	3,161	(3,900)	-	-	(739)
Gains on disposal of assets	(55)	(176)	-	-	(231)
Gain from the transfer by absorption	165,013	-	-	-	165,013
Taxation	-	-	(90)	-	(90)
Retained surplus	198,657	(66,497)	672	-	132,832
Reportable segment assets	664,416	313,588	15,463	-	993,467
Eliminations	-	-	-	(10,466)	(10,466)
Total assets	664,416	313,588	15,463	(10,466)	983,001
Reportable segment liabilities	(600,032)	(217,237)	(13,769)	-	(831,038)
Eliminations	-	-	-	10,466	10,466
Total liabilities	(600,032)	(217,237)	(13,769)	10,466	(820,572)
Net assets	64,384	96,351	1,694	-	162,429
Year ended 31 March 2018	QE Healthcare services £000	HGS Healthcare services £000	Commercial subsidiaries £000	Inter-Group Eliminations £000	Total £000
Total segment revenue	858,502		46,048	(46,596)	857,954
Total segment expenditure	(807,463)		(45,538)	46,596	(806,405)
Impairment charged to operating expenses	(21,900)		-	-	(21,900)
Operating surplus	29,139		510	-	29,649
Net financing	(22,136)		(240)	-	(22,376)
Gains on disposal of assets	(19)		-	-	(19)
Taxation	-		(29)	-	(29)
Retained surplus	6,984		241	-	7,225
Reportable Segment assets	684,236		17,880	-	702,116
Eliminations	-		-	(22,298)	(22,298)
Total assets	684,236		17,880	(22,298)	679,818
Reportable Segment liabilities	(663,737)		(16,858)	-	(680,595)
Eliminations	-		-	22,298	22,298
Total (liabilities)	(663,737)		(16,858)	22,298	(658,297)
Net (liabilities) / assets	20,499		1,022	-	21,521

Transfers by absorption do not require the restatement of prior year figures therefore, the year to 31 March 2018 does not include the financials of the former Heart of England NHS Foundation Trust.

All activities are based in the UK.

3 Revenue from contracted patient care activities

	Year Ended 31 March 2019	Year Ended 31 March 2018
	£000	£000
By commissioner		
Foundation Trusts	1,791	104
NHS Trusts	2,604	1,058
NHS England	586,606	421,141
Clinical Commissioning Groups (CCGs)	762,192	256,014
Department of Health and Social Care	13,877	-
Local Authorities	17,633	17,503
NHS Other	10,884	7,376
Private patients	4,887	4,290
Overseas patients	2,267	1,868
NHS Injury Cost Recovery scheme	6,740	3,936
Non NHS other	161	306
	1,409,642	713,596

The responsibility for commissioning nationally funded NHS healthcare 'specialist healthcare activity' lies with NHS England which is the parent body of the CCGs. NHS England is the single largest commissioner of healthcare from the Trust under the new Social Care Act of 2012.

The significant increase in healthcare revenue in the reporting year is due to the transfer by absorption of the former Heart of England NHS FT on 1 April 2018. Prior year comparatives are not restated, however the segmental reporting note 2 on page XXVIII of the financial statements shows the split of the reporting year by QE and HGS sites. There have been no material changes to the healthcare services provided by the newly combined Trust in the reporting year.

IFRS 15 'Revenue from Contracts with Customers' has been applied to these financial statements for the first time in this reporting period. Following an assessment of the adoption of IFRS 15 there is

no material change to the patient care activities revenue disclosed for the current or prior reporting period. All revenue from patient care activities is considered to come under IFRS 15 - eg contracts are made directly with NHS Commissioners or private / overseas patients at standard prices.

The revenue from the Department of Health and Social care is the pay award funding - due to the NHS 2018/19 pay award being finalised after the original reporting year annual planning exercise. This revenue, therefore missed the 2018/19 tariff pricing and had to be funded separately.

NHS Injury Cost Recovery scheme income, received from commercial insurance providers, is subject to a provision for impairment of receivables of 21.89% (2017/18 - 22.84%) to reflect expected rates of collection.

	Year Ended 31 March 2019	Year Ended 31 March 2018
	£000	£000
By activity		
Elective	195,268	102,463
Non elective	357,529	130,740
Outpatients	177,571	81,746
A&E	49,019	14,864
Other NHS clinical	602,354	373,383
Private patients	4,887	4,290
Other non-NHS clinical	23,014	6,110
	1,409,642	713,596

3.1 Overseas visitors (patients charged directly by the Trust)

	Year Ended 31 March 2019	Year Ended 31 March 2018
	£000	£000
Income recognised this year	2,267	1,868
Cash payments received in-year	486	164
Amounts added to provision for impairment of receivables	(2,500)	(2,460)
Amounts written off in-year	(1,353)	(933)

3.2 Commissioner requested services

	Year Ended 31 March 2019	Year Ended 31 March 2018
	£000	£000
Commissioner requested services		
Revenue derived from NHS clinical activity in England	1,384,703	695,820
Non-commissioner requested services		
NHS Other (including Wales, Scotland and Northern Ireland)	10,884	7,376
Non-NHS derived clinical activity	14,055	10,400
	24,939	17,776
Revenue from patient care activities	1,409,642	713,596
Commissioner requested services as a percentage of revenue	98.23%	97.51%

With the exceptions of private and overseas patient, NHS injury cost recovery scheme and Ministry of Defence income, all of the revenue from clinical activities arises from NHS services within the United Kingdom.

Following changes to the Health and Social Care Act 2012 (the 'Act'), Monitor removed the requirement for foundation trusts to limit private patients revenue as a percentage of total revenue from activities. In its place, the Act requires that a foundation trust's principal activity is to deliver goods and services for the purposes of the National Health Service in England. These 'commissioner requested services' (as defined in the Trust's provider licence) are disclosed separately as a percentage of all healthcare revenue.

4 Other operating revenue

	Year Ended 31 March 2019	Year Ended 31 March 2018
	£000	£000
Other operating income recognised in accordance with IFRS 15:		
Research and development	34,687	21,789
Education and training	51,997	28,878
Provider Sustainability Funding revenue	29,872	25,810
Non-patient care services to other bodies	19,236	14,873
Support from DHSC for mergers	-	3,000
Other revenue	58,195	40,600
	193,987	134,950
Other operating income recognised in accordance with other standards:		
Donations / grants of physical assets (non-cash)	1,371	644
Cash grants for the purchase of capital assets	488	5,395
Charitable and other contributions to expenditure	1,493	1,056
Rental revenue from operating leases	2,142	2,313
Amortisation of PFI deferred income / credits	4,448	-
	9,942	9,408
Other operating income	203,929	144,358

The significant increase in other operating income in the reporting year is due to the transfer by absorption of the former Heart of England NHS FT on 1 April 2018. Prior year comparatives are not restated, however the segmental reporting note 2 on page XXVIII of the financial statements shows the split of the reporting year by QE and HGS sites. There have been no material changes to the other operating income activities provided by the newly combined Trust in the reporting year.

IFRS 15 'Revenue from Contracts with Customers' has been applied to these financial statements for the first time in this reporting period. Following an assessment of the adoption of IFRS 15 there is no material change to the other operating income activities revenue disclosed for the current or prior reporting period. A majority of revenue from other operating income activities is considered to come under IFRS 15 - eg contracts are made directly with NHS, government and commercial entities, or private individuals at standard prices.

The non-IFRS 15 revenue is limited to donations of and grant funding for property, plant and equipment (IAS 20); other charitable donations to support expenditure (IAS 20), rental income from property leases (IAS 17) and the amortisation of PFI deferred income.

The Provider Sustainability Funding (PSF) revenue is allocated to individual NHS Trusts, conditional upon

their meeting certain financial and clinical targets. UHB was originally allocated a sum of £23,761,000 under the PSF scheme for the reporting year. The Trust has exceeded its planned annual financial performance (see annual report for details) and as a consequence is due additional incentive and bonus amounts for this performance.

Other IFRS 15 revenue includes £3,416,000 from Clinical Excellence Awards (2017/18 - £3,403,000); recharges of £2,781,000 to the Ministry of Defence to fund the training expenditure of Nurses along with catering and car parking costs associated with the military contract (2017/18 - £2,587,000); £3,343,000 from Clinical Testing (2017/18 - £2,001,000); and funding of £1,633,000 (2017/18 - £1,676,000) for the organ retrieval service. The remainder of other income is largely made up of service level agreements with other West Midlands NHS trusts (not commissioners) for the supply of clinical and other supporting services.

Revenue recognised in the reporting year under IFRS 15 that was previously included in the contract liability - deferred income balance is £21,744,000 (2017/18 - not restated). As at the reporting date, there is contract liability - deferred income of £31,034,000 that is expected to be recognised as revenue in the 2019/20 financial year.

Revenue is almost totally from the supply of services. Revenue from the sale of goods is immaterial.

5 Operating expenses

	Year Ended 31 March 2019	Year Ended 31 March 2018
	£000	£000
Recurring		
Purchase of healthcare from NHS and DHSC bodies	6,188	4,976
Purchase of healthcare from non-NHS and non-DHSC bodies	28,309	19,240
Directors' costs	2,788	1,938
Non executive directors' costs	189	150
Staff costs	942,725	421,888
Drugs costs	227,879	138,871
Supplies and services - clinical	178,289	105,242
Supplies and services - general	20,438	9,339
Consultancy services	1,484	1,372
Establishment	9,792	5,003
Research and development (non staff)	12,287	6,609
Education and training (non staff)	8,639	5,434
Transport	7,802	2,252
Operating lease expenditure	2,139	1,035
Premises	68,628	27,522
Movement in credit loss allowance: contract receivables	957	2,207
Depreciation on property, plant and equipment	34,697	21,611
Amortisation on intangible assets	1,689	472
Audit services - statutory audit	214	103
Other auditor remuneration - audit of subsidiaries	20	20
Other auditor remuneration - other assurance services	138	79
Internal audit services	200	106
Clinical negligence	38,733	11,813
Legal fees	1,054	882
Other	25,502	18,241
	1,620,780	806,405
Non-recurring		
Net impairments of property, plant and equipment	710	21,900
	710	21,900
Total operating expenses	1,621,490	828,305

The significant increase in operating expenditure in the reporting period is due to the transfer by absorption of the former Heart of England NHS FT on 1 April 2018. Prior year comparatives are not restated, however the segmental reporting note 2 on page XXVIII of the financial statements shows the split of the reporting year by QE and HGS sites.

Other expenditure includes £16,690,000 (2017/18 - £15,764,000) in relation to payments to the Trusts' PFI partners for services provided.

The Trust's contract with its external auditor, Deloitte LLP, provides for a limitation of the auditors liability of two million pounds sterling. Other audit remuneration - other services includes £48,000 (2017/18 - £24,000) due to audit assurance of the Quality Report and £90,000 (2017/18 - £55,000) due to Local Counter Fraud Services.

An element of operating expenses arises from the charge of £710,000 (2017/18 - £21,900,000 charge) due to net impairments. See note 14.2 to the financial statements on page XLIV for details of the reporting year and prior year impairments.

6 Operating leases

6.1 As lessee

Payments recognised as an expense	Year Ended 31 March 2019	Year Ended 31 March 2018
	£000	£000
Minimum lease payments - charged to operating expenses	2,139	1,035

Total future minimum lease payments	Year Ended 31 March 2019	Year Ended 31 March 2018
	£000	£000
Payable		
Not later than one year	2,260	938
Between one and five years	4,699	3,001
After 5 years	2,130	2,850
Total	9,089	6,789

The Group holds various non-cancellable operating lease agreements, covering leasehold buildings (warehousing and renal dialysis) plus transport vehicles and general office equipment.

6.2 As lessor

Rental revenue	Year Ended 31 March 2019	Year Ended 31 March 2018
	£000	£000
Rents recognised as income in the period	2,142	2,313

Total future minimum lease payments	Year Ended 31 March 2019	Year Ended 31 March 2018
	£000	£000
Receivable		
Not later than one year	2,142	2,394
Between one and five years	7,867	8,790
After 5 years	17,592	20,085
Total	27,601	31,269

The lease rental revenue is due from the Ministry of Defence and University of Birmingham for their occupation of facilities within the PFI hospital ('Queen Elizabeth Hospital Birmingham').

7 Employee costs and numbers

7.1 Employee costs

	Year Ended 31 March 2019			Year Ended 31 March 2018		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Short term employee benefits - salaries and wages	741,659	702,056	39,603	341,879	308,755	33,124
Short term employee benefits - social security costs	70,179	70,179	-	32,387	32,387	-
Post employment benefits - employer contributions to NHS pension scheme	82,990	82,990	-	37,714	37,714	-
Pension cost - other contributions	107	107	-	32	32	-
Apprentice Levy	1,881	1,881	-	1,633	1,633	-
Termination benefits	143	143	-	87	87	-
Temporary staff - agency/contract staff	51,728	-	51,728	11,869	-	11,869
Pay costs capitalised as part of assets	(3,031)	(3,031)	-	(1,688)	(1,688)	-
	945,656	854,325	91,331	423,913	378,920	44,993

Employee costs include those of staff and directors, but exclude non executive director costs. The latter are disclosed separately in operating expenses, see note 5 to the financial statements on page XXXIII. The termination benefits included above are disclosed within 'other' operating expenses in note 5 to the financial statements on page XXXIII. Pay costs capitalised are part of the Global Digital Exemplar program within the NHS.

7.2 Key management compensation

	Directors		Non-executives	
	Year Ended 31 March 2019	Year Ended 31 March 2018	Year Ended 31 March 2019	Year Ended 31 March 2018
	£000	£000	£000	£000
Salaries and short term benefits	2,291	1,583	176	139
Social Security Costs	302	207	13	11
Employer contributions to NHS Pensions Agency	195	148	-	-
	2,788	1,938	189	150

Key management compensation consists entirely of the emoluments of the Board of Directors of the Trust. Full details of Directors' and non-executives' remuneration and interests are set out in the Remuneration Report which is a part of the annual report and financial statements.

7.3 Retirements due to ill-health

During the year to 31 March 2019 there were 13 early retirements from the Trust agreed on the grounds of ill-health (2017/18 - 7). The estimated additional pension liabilities of these ill-health retirements will be £502,000 (2017/18 - £453,000). The cost of these ill-health retirements will be borne by the NHS Pensions Agency.

8 Better payment practice code

8.1 Measure of compliance

	Year Ended 31 March 2019		Year Ended 31 March 2018	
	Number	£000	£000	£000
Trade				
Total trade bills paid in the year	166,149	613,803	121,195	563,272
Total trade bills paid within target	160,460	606,065	119,085	559,913
Percentage of trade bills paid within target	96.58%	98.74%	98.26%	99.40%
NHS				
Total NHS bills paid in the year	8,562	216,251	7,196	197,056
Total NHS bills paid within target	7,753	212,070	6,607	195,967
Percentage of NHS bills paid within target	90.55%	98.07%	91.81%	99.45%

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

8.2 The late payment of commercial debts (interest) Act 1998

£Nil interest (2017/18 - £nil) was charged to the Trust in the year for late payment of commercial debts.

9 Finance income and costs

	Year Ended 31 March 2019	Year Ended 31 March 2018
	£000	£000
Financing income		
Interest receivable	766	208
	766	208
Financing costs		
Interest on loans from the DHSC - Capital	(56)	-
Interest on loans from the DHSC - Revenue support	(478)	-
Interest on obligations under PFI contracts	(23,325)	(22,552)
Interest on obligations under finance leases	(94)	(20)
Other financing charges	(15)	(12)
	(23,968)	(22,584)
Net finance expense	(23,202)	(22,376)

The acquisition of the former Heart of England NHS FT on 1 April 2018 transferred to the Trust two Department of Health loans held by then provider - a capital loan of £3,100,000 and a revenue support loan of £31,792,000 - with respective interest rates of 1.84% and 1.5%.

10 Gains on disposal of non-current assets

	Year Ended 31 March 2019	Year Ended 31 March 2018
	£000	£000
Profit on disposal of non-current assets	53	-
Loss on disposal of non-current assets	(284)	(19)
	(231)	(19)

11 Public dividend capital dividends

Public dividend capital ('PDC') dividends paid and due to the Department of Health amounted to £739,000 (2017/18 - £nil). PDC dividends are calculated as a percentage (3.5%) of average net relevant assets. The Trust had negative net relevant assets in prior years, but due to the transfer of absorption of the former Heart of England NHS FT assets and liabilities on 1 April 2018, net relevant assets in the current reporting period are now positive.

12 Tax recognised in Statement of Comprehensive Income

Recognised in the income statement	Year Ended 31 March 2019	Year Ended 31 March 2018
	£000	£000
Current tax expense		
Current year	80	60
Adjustments in respect of prior years	(23)	(41)
	57	19
Deferred tax expense		
Origination and reversal of temporary differences	-	-
Adjustments in respect of prior years	33	10
Reduction in tax rate	-	-
	33	10
Total tax (credit)/expense recognised in income statement	90	29

Tax recognised in other comprehensive income is £nil (2017/18 - £nil).

Tax recognised directly in equity is £nil (2017/18 - £nil).

Reconciliation of effective tax rate	Year Ended 31 March 2019	Year Ended 31 March 2018
	£000	£000
Operating surplus before taxation – subsidiaries only *	672	270
Tax at the standard rate of corporation tax in the UK 19% (2017/18 - 19%)	113	51
Change in tax rate	-	-
Other	-	-
Adjustments in respect of prior years	(23)	(22)
Total tax expense / (credit)	90	29

*Liability for corporation tax only arises from the activity of the commercial subsidiaries whose combined operating surplus before taxation is disclosed in the segmental analysis note 2 to the financial statements on page XXVIII. The activities of the Trust do not incur corporation tax, see accounting policy note 1.24 for detailed explanation.

The Finance (No 2) Act 2015, which provides for reductions in the main rate of corporation tax from 20% to 19% effective from 1 April 2017 and to 18% effective from 1 April 2020, was substantively enacted on 26 October 2015. Subsequently, the Finance Act 2016, which provides for a further reduction in the main rate of corporation tax to 17% effective from 1 April 2020, was substantively enacted on 6 September 2016.

13 Intangible assets

Group	Computer software – purchased £000	Licences and trademarks £000	Intangible assets under construction £000	Total £000
Cost				
At 1 April 2017	2,365	1,004	-	3,369
Additions	-	-	151	151
Reclassifications	3,432	26	-	3,458
Disposals	-	-	-	-
At 31 March 2018	5,797	1,030	151	6,978
Transfers by absorption	14,253	-	192	14,445
Additions	1,067	-	-	1,067
Reclassifications	5,427	647	(192)	5,882
Disposals	(14)	-	-	(14)
At 31 March 2019	26,530	1,677	151	28,358
Amortisation				
At 1 April 2017	992	219	-	1,211
Charged for the year	349	123	-	472
Disposals	-	-	-	-
At 31 March 2018	1,341	342	-	1,683
Transfers by absorption	12,212	-	-	12,212
Charged for the year	1,509	180	-	1,689
Reclassifications	(12)	-	-	(12)
Disposals	(14)	-	-	(14)
At 31 March 2019	15,036	522	-	15,558
Net book value				
At 31 March 2019	11,494	1,155	151	12,800
At 31 March 2018	4,456	688	151	5,295
At 1 April 2017	1,373	785	-	2,158

The transfer by absorption is the intangible assets of the former Heart of England NHS FT on 1 April 2018. See note 15 to the financial statements on page XLVI, prior year comparatives are not restated.

The valuation basis is described in accounting policy note 1.6. There is no active market for the Group's intangible assets and there is no revaluation reserve.

The estimated useful economic lives of the Group's intangible assets range from two to five years and each asset is being amortised over this period, as described in accounting policy note 1.7.

Trust	Computer software – purchased	Licences and trademarks	Intangible assets under construction	Total
	£000	£000	£000	£000
Cost				
At 1 April 2017	2,365	1,004	-	3,369
Additions	-	-	-	-
Reclassifications	3,432	26	-	3,458
Disposals	-	-	-	-
At 31 March 2018	5,797	1,030	-	6,827
Transfers by absorption	14,253	-	192	14,445
Additions	1,067	-	-	1,067
Reclassifications	5,427	647	(192)	5,882
Disposals	(14)	-	-	(14)
At 31 March 2019	26,530	1,677	-	28,207
Amortisation				
At 1 April 2017	992	219	-	1,211
Charged for the year	349	123	-	472
Disposals	-	-	-	-
At 31 March 2018	1,341	342	-	1,683
Transfers by absorption	12,212	-	-	12,212
Charged for the year	1,509	180	-	1,689
Reclassifications	(12)	-	-	(12)
Disposals	(14)	-	-	(14)
At 31 March 2019	15,036	522	-	15,558
Net book value				
At 31 March 2019	11,494	1,155	-	12,649
At 31 March 2018	4,456	688	-	5,144
At 1 April 2017	1,373	785	-	2,158

The transfer by absorption is the intangible assets of the former Heart of England NHS FT on 1 April 2018. See note 15 to the financial statements on page XLVI, prior year comparatives are not restated.

The valuation basis is described in accounting policy note 1.6. There is no active market for the Trust's intangible assets and there is no revaluation reserve.

The estimated useful economic lives of the Trust's intangible assets range from two to five years and each asset is being amortised over this period, as described in accounting policy note 1.7.

14 Property, plant and equipment - 2018/19

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost									
At 31 March 2018	30,399	415,075	1,158	182	108,931	11	14,185	1,800	571,741
Transfers by absorption	24,649	191,369	775	11,069	90,632	99	33,765	6,966	359,324
Additions purchased / leased	-	8,406	-	6,811	12,962	-	9,252	27	37,458
Additions donated / granted	-	1,054	-	-	714	-	6	70	1,844
Reclassifications	-	(18,928)	(179)	(9,107)	134	(4)	(4,728)	96	(32,716)
Impairments charged to the revaluation reserve	-	(4,384)	-	-	-	-	-	-	(4,384)
Reversal of impairments credited to operating expenses	-	9,650	51	-	-	-	-	-	9,701
Impairments charged to operating expenses	-	(10,411)	-	-	-	-	-	-	(10,411)
Revaluations	12	3,231	35	-	-	-	-	-	3,278
Disposals / derecognition	-	-	-	-	(5,557)	-	(30)	(28)	(5,615)
At 31 March 2019	55,060	595,062	1,840	8,955	207,816	106	52,450	8,931	930,220
Depreciation									
At 31 March 2018	-	13,265	94	-	75,123	10	9,719	1,443	99,654
Transfers by absorption	-	-	-	-	55,587	99	25,239	6,635	87,560
Provided during the year	-	16,092	85	-	14,710	2	3,619	189	34,697
Reclassifications	-	(26,651)	(179)	-	15	(5)	13	(15)	(26,822)
Revaluations	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(5,276)	-	(30)	(25)	(5,331)
At 31 March 2019	-	2,706	-	-	140,159	106	38,560	8,227	189,758
Net book value									
Owned	27,294	252,225	1,828	8,955	62,020	-	13,890	596	366,808
Donated	-	4,596	12	-	5,500	-	-	108	10,216
Government granted	-	13,348	-	-	-	-	-	-	13,348
Private Finance Initiative	-	312,472	-	-	-	-	-	-	312,472
Finance Lease	27,766	9,715	-	-	137	-	-	-	37,618
At 31 March 2019	55,060	592,356	1,840	8,955	67,657	-	13,890	704	740,462

The significant increase across the reporting period is due transfer by absorption of the property, plant and equipment of the former Heart of England NHS FT on 1 April 2018. See note 15 to the financial statements on page XLVI for details of the balance transferred, prior year comparatives are not restated.

Property, plant and equipment – 2017/18

Group	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant and equipment machinery £000	Transport Information and technology £000	Furniture and fittings £000	Total £000
Cost								
At 31 March 2017	45,625	433,313	1,250	858	104,836	11	1,743	599,332
Additions purchased / leased	-	3,858	-	174	7,075	-	5,916	17,023
Additions donated / granted	-	5,395	-	-	644	-	-	6,039
Reclassifications	-	379	(39)	(850)	364	-	115	(3,458)
Impairments charged to the revaluation reserve	-	(4,056)	-	-	-	-	-	(4,056)
Reversal of impairments credited to operating expenses	-	239	-	-	-	-	-	239
Impairments charged to operating expenses	-	(22,139)	-	-	-	-	-	(22,139)
Revaluations	(15,226)	(1,914)	(53)	-	-	-	-	(17,193)
Disposals / derecognition	-	-	-	-	(3,988)	-	(58)	(4,046)
At 31 March 2018	30,399	415,075	1,158	182	108,931	11	14,185	571,741
Depreciation								
At 31 March 2017	-	2,089	-	-	69,884	8	1,372	82,070
Provided during the year	-	11,176	94	-	9,224	2	1,002	21,611
Revaluations	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(3,985)	-	(42)	(4,027)
At 31 March 2018	-	13,265	94	-	75,123	10	9,719	99,654
Net book value								
Owned	2,633	79,703	1,051	182	29,923	1	4,466	118,316
Donated	-	3,210	13	-	3,702	-	-	6,925
Government granted	-	13,185	-	-	-	-	-	13,185
Private Finance Initiative	-	305,712	-	-	-	-	-	305,712
Finance Lease	27,766	-	-	-	183	-	-	27,949
At 31 March 2018	30,399	401,810	1,064	182	33,808	1	4,466	472,087

Property, plant and equipment – 2018/19

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and equipment	Transport Information technology	Furniture and fittings	Total	
	£000	£000	£000	£000	£000	£000	£000	£000	
Cost									
At 31 March 2018	30,399	412,689	1,158	8	107,981	11	14,120	1,572	567,938
Transfers by absorption	24,649	191,369	775	11,069	90,632	99	33,765	6,966	359,324
Additions purchased / leased	-	8,406	-	6,811	12,794	-	9,252	27	37,290
Additions donated	-	1,054	-	-	714	-	6	70	1,844
Reclassifications	-	(18,929)	(179)	(8,933)	(98)	(4)	(4,728)	96	(32,775)
Impairments charged to the revaluation reserve	-	(4,384)	-	-	-	-	-	-	(4,384)
Reversal of impairments credited to operating expenses	-	9,650	51	-	-	-	-	-	9,701
Impairments charged to operating income	-	(10,411)	-	-	-	-	-	-	(10,411)
Revaluations	12	3,231	35	-	-	-	-	-	3,278
Disposals / derecognition	-	-	-	-	(5,557)	-	(30)	(28)	(5,615)
At 31 March 2019	55,060	592,675	1,840	8,955	206,466	106	52,385	8,703	926,190
Depreciation									
At 31 March 2018	-	12,807	94	-	74,783	10	9,682	1,282	98,658
Transfers by absorption	-	-	-	-	55,587	99	25,239	6,635	87,560
Provided during the year	-	15,930	85	-	14,551	2	3,606	132	34,306
Reclassifications	-	(26,651)	(179)	-	(44)	(5)	13	(15)	(26,881)
Revaluations	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(5,276)	-	(30)	(25)	(5,331)
At 31 March 2019	-	2,086	-	-	139,601	106	38,510	8,009	188,312
Net book value									
Owned	27,294	250,458	1,828	8,955	61,228	-	13,875	586	364,224
Donated	-	4,596	12	-	5,500	-	-	108	10,216
Government granted	-	13,348	-	-	-	-	-	-	13,348
Private Finance Initiative	-	312,472	-	-	-	-	-	-	312,472
Finance Lease	27,766	9,715	-	-	137	-	-	-	37,618
At 31 March 2019	55,060	590,589	1,840	8,955	66,865	-	13,875	694	737,878

The significant increase across the reporting period is due transfer by absorption of the property, plant and equipment of the former Heart of England NHS FT on 1 April 2018. See note 15 to the financial statements on page XLVI for details of the balance transferred, prior year comparatives are not restated.

Property, plant and equipment – 2017/18

Trust	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant and equipment machinery £000	Transport Information and technology £000	Furniture and fittings £000	Total £000
Cost								
At 31 March 2017	45,625	430,927	1,250	858	104,062	11	1,515	595,879
Additions purchased / leased	-	3,858	-	-	6,899	-	5,916	16,673
Additions donated	-	5,395	-	-	644	-	-	6,039
Reclassifications	-	379	(39)	(850)	364	-	115	(3,458)
Impairments charged to the revaluation reserve	-	(4,056)	-	-	-	-	-	(4,056)
Reversal of impairments credited to operating expenses	-	239	-	-	-	-	-	239
Impairments charged to operating income	-	(22,139)	-	-	-	-	-	(22,139)
Revaluations	(15,226)	(1,914)	(53)	-	-	-	-	(17,193)
Disposals / derecognition	-	-	-	-	(3,988)	-	(58)	(4,046)
At 31 March 2018	30,399	412,689	1,158	8	107,981	11	1,572	567,938
Depreciation								
At 31 March 2017	-	1,792	-	-	69,648	8	1,268	81,409
Provided during the year	-	11,015	94	-	9,120	2	989	21,276
Revaluations	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(3,985)	-	(42)	(4,027)
At 31 March 2018	-	12,807	94	-	74,783	10	1,282	98,658
Net book value								
Owned	2,633	77,775	1,051	8	29,313	1	4,438	115,509
Donated	-	3,210	13	-	3,702	-	-	6,925
Government granted	-	13,185	-	-	-	-	-	13,185
Private Finance Initiative	-	305,712	-	-	-	-	-	305,712
Finance Lease	27,766	-	-	-	183	-	-	27,949
At 31 March 2018	30,399	399,882	1,064	8	33,198	1	4,438	469,280

14.1 Estimated useful economic lives

The estimated useful economic lives of the Group's property, plant and equipment are as follows with each asset being depreciated over this period, as described in accounting policy note 1.7.

	Minimum life Years	Maximum life Years
Buildings (excluding dwellings)	10	67
Dwellings	5	25
Plant and Machinery	5	15
Information technology	2	10
Furniture and fittings	5	10

14.2 Valuation at the reporting date – Group and Trust

The land, buildings and dwellings were valued at the reporting date by an independent valuer, GVA LLP. The purpose of this exercise being to determine a fair value for Trust property, as detailed in accounting policy notes 1.5 'Property, plant and equipment - valuation' and 1.28 'Critical accounting judgements and key sources of estimation uncertainty'.

The revaluation exercise resulted in reversals of prior impairments being credited to operating expenses, inline with the Department of Health Group Accounting Manual, within the consolidated statement of comprehensive income.

Impairments of property, plant and equipment	Year Ended 31 March 2019	Year Ended 31 March 2018
	£000	£000
Impairments		
Queen Elizabeth Hospital - PFI facility	1	-
Queen Elizabeth Hospital - non PFI estate	2	(21)
Bordesley, Good Hope and Solihull estate	3	(10,390)
	(10,411)	(14,600)
Reversals of impairments		
Queen Elizabeth Hospital - PFI facility	1	7,353
Queen Elizabeth Hospital - non PFI estate	2	920
Bordesley, Good Hope and Solihull estate	3	1,428
	9,701	239
Net (impairment)	(710)	(21,900)

There are no movements on revaluation for assets owned by the subsidiaries, only the Trust's estate is revalued as there are no land or buildings owned by the subsidiaries.

All impairments and reversals of impairments are due to changes in market prices only.

1 - The valuation of the 'Queen Elizabeth Hospital Birmingham' PFI hospital gave rise to an reversal of a previous impairment resulting from the difference between the fair value in operational use (depreciated replacement cost), as measured at 31 March 2019 compared to 31 March 2018. The estimation technique of the Modern Equivalent Asset incorporates the current cost of household and commercial property construction and is the main factor behind the valuation process. The reversal of impairment is disclosed within operating expenses, see note 5 to the financial statements on page XXXIII.

2 - The valuation of the non PFI estate at the Edgbaston site gave rise to reversals of previous impairments on the Regent Court, Yardley Court and Institute of Translational Medicine buildings. These are also due to the differences between the fair values at the reporting date compared to the prior year, see note 5 to the financial statements on page XXXIII.

3 - Within the estate acquired by the absorption of the former Heart of England NHS Foundation Trust - the Bordesley, Good Hope and Solihull sites, there are both impairments and reversals of impairments. The £920k of reversals are due to the theatre blocks at Bordesley and Good Hope; while the (£10,390k) of impairments are across the majority of buildings at each of these three sites (the largest reductions at Bordesley and Good Hope), reflecting the age of the estates acquired, see note 5 to the financial statements on page XXXIII.

The surpluses and deficits upon the revaluation exercise resulted in the following gains and losses being charged to the revaluation reserve, see the Statement of Changes in Taxpayers' Equity on page XV.

Revaluation gains/(losses) on property, plant and equipment Group	Year Ended 31 March 2019	Year Ended 31 March 2018
	£000	£000
Revaluation gains/(losses) recognised in other comprehensive income		
Queen Elizabeth Hospital - non PFI estate	1,425	(17,193)
Bordesley, Good Hope and Solihull estate	1,853	-
	3,278	(17,193)
Impairments charged to the revaluation reserve		
Queen Elizabeth Hospital - non PFI estate	(366)	(4,056)
Bordesley, Good Hope and Solihull estate	(4,018)	-
	(4,384)	(4,056)
Net decrease to revaluation reserve	(1,106)	(21,249)

The revaluation gains and losses on property, plant and equipment for the Group are the same as for the Trust.

14.3 Assets held under finance leases and PFI arrangements – Group and Trust

	PFI assets	Assets held under finance leases	Total
	£000	£000	£000
Cost			
At 1 April 2017	325,314	43,699	369,013
Additions	1,998	-	1,998
Revaluations	-	(15,234)	(15,234)
Impairments charged to operating expenses	(14,600)	-	(14,600)
At 31 March 2018	312,712	28,465	341,177
Transfer by absorption	3,768	9,300	13,068
Additions	2,785	-	2,785
Reclassifications	-	-	-
Revaluations	-	675	675
Reversal of impairments credited to operating expenses	7,207	-	7,207
At 31 March 2019	326,472	38,440	364,912
	10,622		
Depreciation			
At 1 April 2017	-	470	470
Charged for the year	7,000	46	7,046
Revaluations	-	-	-
At 31 March 2018	7,000	516	7,516
Transfer by absorption	39	-	39
Charged for the year	6,961	306	7,267
Reclassifications	-	-	-
At 31 March 2019	14,000	822	14,822
Net book value			
At 31 March 2019	312,472	37,618	350,090
At 31 March 2018	305,712	27,949	333,661
At 1 April 2017	325,314	43,229	368,543

The Private Finance Initiative assets are the Queen Elizabeth Hospital Birmingham and two smaller schemes acquired via the former Heart of England NHS Foundation Trust as detailed in note 27.1 to the financial statements on page LIV.

A separate schedule for the Trust's finance lease and PFI assets has not been produced as the subsidiaries have no assets classified as such. Within finance leased assets is land with a fair value of £27,766,000 (31 March 2018: £27,766,000), this is the Edgbaston site land leased from the Calthorpe Estate over a 999 year term.

Transfer by absorption - HGS PFI and finance leased assets

14.4 Capital commitments

Commitments under capital expenditure contracts at the end of the period, not otherwise included in these financial statements, were £9,537,000 (31 March 2018: £3,901,000) for both Group and Trust. This amount relates entirely to property, plant and equipment, there are nil contracted capital commitments for intangible assets.

15 Transfer by absorption

On 1 April 2018, University Hospitals Birmingham NHS Foundation Trust acquired the Heart of England NHS Foundation Trust, including all assets and liabilities of this organisation via a Grant of Acquisition issued by NHS Improvement. There was no consideration paid for this acquisition.

As this date of acquisition was the first day of the reporting period, the current year Statement of Comprehensive Income and Other Comprehensive Income contain the full twelve months of revenue and expenditure of the acquired Trust. There is no restatement of comparatives for the period ending 31 March 2018 because this is not required when accounting for a transfer by absorption.

The assets and liabilities of the acquired Trust were transferred to the Statement of Financial Position of University Hospitals Birmingham NHS FT on 1 April 2018 at their book value on that date, the same value as the acquired Trust reported on its Statement of Financial Position as at 31 March 2018. The gain on transfer by absorption as disclosed in the Statement of Comprehensive Income in the reporting year, is the same as the book value of the acquired Trust's assets and liabilities on 1 April 2018. The book value of these acquired assets and liabilities as at 1 April 2018 are:

Heart of England NHS Foundation Trust - SoFP	Opening SoFP	IFRS 15 opening adjustments	IFRS 9 opening adjustments	Opening SoFP
	1 April 2018	1 April 2018	1 April 2018	1 April 2018
	£000	£000	£000	£000
Assets				
Non-current assets				
Intangible assets	2,233	-	-	2,233
Property, plant and equipment	271,764	-	-	271,764
Trade and other receivables	1,044	-	-	1,044
	275,041	-	-	275,041
Current assets				
Inventories	10,370	-	-	10,370
Trade and other receivables	32,055	-	-	32,055
Cash and cash equivalents	11,305	-	-	11,305
	53,730	-	-	53,730
Total assets	328,771	-	-	328,771
Liabilities				
Current liabilities	-	-	-	-
Borrowings	(600)	-	(81)	(681)
Trade and other payables	(112,533)	-	81	(112,452)
Provisions	(1,383)	-	-	(1,383)
Other liabilities	(4,837)	-	-	(4,837)
	(119,353)	-	-	(119,353)
Total assets less current liabilities	209,418	-	-	209,418
Non-current liabilities				
Borrowings	(37,710)	-	-	(37,710)
Provisions	(6,695)	-	-	(6,695)
	(44,405)	-	-	(44,405)
Total liabilities	(163,758)	-	-	(163,758)
Net assets	165,013	-	-	165,013
Taxpayers' equity				
Public dividend capital	197,197	-	-	197,197
Revaluation reserve	60,131	-	-	60,131
Other reserves	(169)	-	-	(169)
Income and expenditure reserve	(92,146)	-	-	(92,146)
Total taxpayers' equity	165,013	-	-	165,013

16 Subsidiaries and investments

The Trust's subsidiary undertakings and investments as included in the consolidation as at the reporting date are set out below. The reporting date of the financial statements for the subsidiaries is the same as for these group financial statements - 31 March 2019. The registered office of the subsidiaries is the same as that of the Trust.

Pharmacy@QEHB Limited

The company is registered in the UK, company no. 07547768, with a share capital comprising one share of £1 which is 100% owned by the Trust. The company provides an Outpatients Dispensary service to the Trust at the Queen Elizabeth and Heartlands hospital sites.

UHB Facilities Limited

The company is registered in the UK, company no. 08642236, with a share capital comprising one share of £1 which is 100% owned by the Trust. The company provides a managed renal healthcare facility to the Trust.

Assure Dialysis Services Limited

The company is registered in the UK, company no. 08642238, with a share capital comprising one share of £1 which is 100% owned by the Trust. The company provides of renal dialysis healthcare nursing service to the Trust.

Birmingham Systems Limited

The company is registered in the UK, company no. 07136767, with a share capital comprising one share of £1 which is 100% owned by the Trust. The company is dormant and has not yet traded, there are £nil assets and liabilities to consolidate into the Trust's financial statements.

Professional Activity Limited

The company is registered in the UK, company no. 08078932, with a share capital comprising £25,050 wholly owned by the Trust. The company has not yet traded, it is developing software to support the booking of locum shifts for the Trust's clinical work scheduling.

Investments

The Trust's investments in the subsidiaries above is £151,503 (2017/18 - £151,503) the cost of the original share purchases. In the group financial statements these subsidiaries are consolidated under IFRS 10.

The Trust has one other investment comprising a 12% shareholding in a company 'Sapere Systems Limited', registered in the UK, company no. 7171338, the Trust's shareholding purchased for £12. This company is dormant and has not yet traded, therefore the investment is recognised in the Trust's statement of financial position at cost.

17 Joint Venture - Innovating Global Health China Limited

The Trust has established the following company as a joint venture between the Trust and Innovating Global Health SA (IGH): Innovating Global Health China Limited (IGHC) incorporated in Hong Kong. This was established for the identification, development and pursuit of healthcare opportunities in China. This is a private company limited by shares, with Trust and IGH each owning a 50% shareholdings. The partner company (IGH) is registered / organised under the laws of Switzerland. The joint venture is accounted for using the equity method and is now trading.

18 Non-current assets held for sale

The Trust has no non-current assets held for sale at the reporting date (31 March 2018: £nil).

19 Inventories

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	Total	Total	Total	Total
	£000	£000	£000	£000
Consumables	16,461	8,567	11,557	6,126
Drugs	18,780	10,489	18,719	10,434
Other	235	5	235	5
	35,476	19,061	30,511	16,565

The significant increase across the reporting period is due to the transfer by absorption of the inventories of the former Heart of England NHS FT on 1 April 2018. See note 15 to the financial statements on page XLVI for details of the balance transferred, prior year comparatives are not restated.

The Group expensed £405,692,000 of inventories during the year (2017/18 - £240,989,000). The Group charged £476,000 to operating expenses in the year due to write-downs of obsolete inventories (2017/18 - £28,000).

20 Trade and other receivables

Current	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	Total	Total	Total	Total
	£000	£000	£000	£000
Contract receivables (IFRS 15): invoiced	73,670		74,392	
Contract receivables (IFRS 15): not yet invoiced	27,852		27,931	
Allowance for impaired contract receivables	(13,211)		(13,211)	
Allowance for impaired other receivables	-	(7,246)	-	(7,246)
NHS receivables		61,028		61,028
Receivables with other related parties		8,161		6,075
Commercial trade receivables		8,383		15,384
PFI prepayments - lifecycle (capital)	14,917	11,736	14,917	11,736
Prepayments	10,075	5,514	10,012	5,453
PDC Receivable	3,161	-	3,161	-
Accrued income		1,281		1,281
Other receivables - revenue	5,879	3,393	8,809	10,183
Other receivables - capital	500	564	500	564
	122,843	92,814	126,511	104,458
Non-current	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	Total	Total	Total	Total
	£000	£000	£000	£000
Allowance for impaired contract receivables	(2,423)		(2,423)	
Allowance for impaired other receivables	-	(1,464)	-	(1,464)
Contract receivables (IFRS 15): not yet invoiced	10,789		10,789	
Other receivables - revenue	-	6,410	-	6,410
	8,366	4,946	8,366	4,946
Of which receivable from NHS and DHSC group bodies:				
Current	76,814	61,170	76,814	61,170
Non current	-	-	-	-

The increase across the reporting period is due in part to the transfer by absorption of the trade receivables of the former Heart of England NHS FT on 1 April 2018. See note 15 to the financial statements on page XLVI for details of the balance transferred, prior year comparatives are not restated.

IFRS 15 'Revenue from Contracts with Customers' has been applied to these financial statements for the first time in this reporting period. Following an assessment of the adoption of IFRS 15 there is no material change to the receivables disclosed at the reporting date or prior year. The receivables and associated impairment provisions of previous years have now been split into two separate elements:

- ▶ IFRS 15 'Revenue from Contracts with Customers' has been applied to these financial statements for the first time in this reporting period. Following an assessment of the adoption of IFRS 15 there is no material change to the receivables disclosed at the reporting date or prior year. The receivables and associated impairment provisions of previous years have now been split into two separate elements:

- ▶ Non-IFRS 15 receivables - revenue governed by other accounting standards. Examples includes capital amounts owed (an exclusion from IFRS 15), government grants owed (IAS 20) and VAT owed by HMRC (statutory, not contracted).

Within IFRS 15 receivables are balances owed by NHS bodies in England and other related parties of the HM Government 'Whole Government Accounts'. Related party transactions are detailed in note 31 to the financial statements on page LVIII.

Included within trade and other receivables of both Group and Trust are balances with a carrying amount of £13,479,000 (31 March 2018: £12,434,000) which are past due at the reporting date but for which no specific provision has been made as they are considered to be recoverable based on previous trading history.

Allowance for credit losses 2018/19	Group		Trust	
	Contract receivables	Other receivables	Contract receivables	Other receivables
	£000	£000	£000	£000
Balance at 1 April				
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	8,710	(8,710)	8,710	(8,710)
Transfers by absorption	12,142	-	12,142	-
New allowances arising	957	-	957	-
Utilisation of allowances (write offs)	(6,175)	-	(6,175)	-
	15,634	(8,710)	15,634	(8,710)

Allowance for credit losses (doubtful debts) - 2017/18	Group	Trust
	All receivables	All receivables
	£000	£000
Requirements of IFRS 7 prior to IFRS 9 adoption - result in a different format to the current period disclose		
Balance at 1 April	6,786	6,786
Transfers by absorption	-	-
Increase in provision	6,598	6,598
Amounts utilised	(283)	(283)
Unused amounts reversed	(4,391)	(4,391)
	8,710	8,710

The transfer by absorption is the allowance for credit losses (both contract and other) of the former Heart of England NHS FT on 1 April 2018. See note 15 to the financial statements on page XLVI, prior year comparatives are not restated.

21 Cash and cash equivalents

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	Total	Total	Total	Total
	£000	£000	£000	£000
At 1 April	85,490	70,829	83,692	70,228
Transfers by absorption	11,305	-	11,305	-
Net change in year	(33,854)	14,661	(33,059)	13,464
At 31 March	62,941	85,490	61,938	83,692
Made up of				
Cash with Government Banking Service	60,297	13,811	60,297	13,811
Commercial banks and cash in hand	2,644	71,679	1,641	69,881
Cash and cash equivalents as in statement of financial position	62,941	85,490	61,938	83,692
Cash and cash equivalents as in statement of cash flows	62,941	85,490	61,938	83,692

The transfer by absorption of the cash and cash equivalents of the former Heart of England NHS FT on 1 April 2018 is £11,305,000. See note 15 to the financial statements on page XLVI, prior year comparatives are not restated.

22 Trade and other payables

Current	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	Total	Total	Total	Total
	£000	£000	£000	£000
NHS payables	16,790	10,220	16,790	10,220
Amounts due to other related parties	12,241	5,857	12,234	5,855
Commercial trade payables	79,169	40,732	71,707	43,364
Trade payables - capital	6,090	3,534	6,193	3,533
Taxes payable	21,067	9,304	21,005	9,252
Other payables	3,959	1,939	8,420	5,267
Accruals	119,987	62,959	120,267	63,117
Receipts in advance	4,182	4,793	4,182	4,793
	263,485	139,338	260,798	145,401

The significant increase across the reporting period is due to the transfer by absorption of the trade payables of the former Heart of England NHS FT on 1 April 2018. See note 15 to the financial statements on page XLVI for details of the balance transferred, prior year comparatives are not restated.

NHS payables consist of balances owed to NHS bodies in England, amounts due to other related parties consist of balances owed to other HM Government organisations including pensions. Included within amounts due to other related parties are NHS pension contributions owed of £11,419,000 (31 March 2018: £5,431,000).

Non current trade and other payables are nil (31 March 2018: £nil).

23 Other liabilities

Current	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	Total	Total	Total	Total
	£000	£000	£000	£000
Deferred income	33,434	25,744	33,441	25,720

The increase across the reporting period is due in part to the transfer by absorption of the current deferred income of the former Heart of England NHS FT on 1 April 2018. See note 15 to the financial statements on page XLVI for details of the balance transferred, prior year comparatives are not restated. There was no non-current deferred income liability held by the acquired trust.

Non-current	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	Total	Total	Total	Total
	£000	£000	£000	£000
Deferred income	2,484	4,461	2,260	4,213

24 Deferred tax

An analysis of the movements in the deferred tax liabilities and assets recognised by the group is set out below:

Group only*	Capital allowances	Tax losses	Total
	£000	£000	£000
At 1 April 2017	82	(192)	(110)
(Credit) / charge to the income statement	(57)	67	10
At 31 March 2018	25	(125)	(100)
Charge to the income statement	21	12	33
At 31 March 2019	46	(113)	(67)

* Liability for corporation tax only arises from the activity of the commercial subsidiaries, the activities of the Trust do not incur corporation tax, see accounting policy note 1.24 for detailed explanation.

Deferred tax assets and liabilities are to be recovered / settled after more twelve months. The amounts are as follows:

	Year Ended 31 March 2019	Year Ended 31 March 2018
	£000	£000
Deferred tax assets	(113)	(125)
Deferred tax liabilities	46	25
Net non current deferred tax asset	(67)	(100)

There are no unrecognised deferred tax assets or liabilities in the current or prior year.

25 Borrowings

Group and Trust	Current		Non-Current	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	Total	Total	Total	Total
	£000	£000	£000	£000
Loans from the DHSC - Capital	135	-	2,842	-
Loans from the DHSC - Revenue support	100	-	31,792	-
Obligations under finance leases	221	50	1,216	172
Obligations under Private Finance Initiative contracts	12,728	12,073	461,200	472,170
	13,184	12,123	497,050	472,342

The Private Finance Initiative obligation relates to the schemes as detailed in note 27.1 to the financial statements on page LIV.

The Trust has transferred by absorption from the former Heart of England NHS FT on 1 April 2018 two Department of Health and Social Care loans, prior year comparatives are not restated:

In 2017/18 the former Heart of England NHS FT signed an agreement with the Department of Health and Social Care for a £3,100,000 loan relating to fund the enabling works for the ACAD capital scheme. The interest rate is 1.84% and the loan is payable over 24 years in 6 monthly tranches, commencing in August 2018.

In 2017/18 the former Heart of England NHS FT set up a working capital facility of £31,792,000 using the Department of Health and Social Care's Distressed Financing regime to support revenue costs. The interest rate is 1.5% and the loan is payable over 5 years, commencing in 2019/20.

25.1 Reconciliation of liabilities arising from financing activities

Group and Trust	Loans from DHSC	Finance leases	PFI schemes	Total
	£000	£000		£000
At 1 April 2018	-	222	484,243	484,465
Cash movements:				
Financing cash flows - principal	(129)	(194)	(12,324)	(12,647)
Financing cash flows - interest	(428)	(94)	(15,355)	(15,877)
Non cash movements:				
Transfers by absorption	34,892	1,409	2,009	38,310
Impact of IFRS 9 implementation on 1 April absorption transfers	81	-	-	81
Application of effective interest rate	453	94	15,355	15,902
At 31 March 2019	34,869	1,437	473,928	510,234

26 Finance lease obligations (other than PFI)

Group and Trust	Minimum lease payments		Present value of minimum lease payments	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Gross lease liabilities	1,739	266	1,739	266
Of which liabilities are due:				
Not later than one year	302	66	302	66
Later than one year, not later than five years	949	200	949	200
Later than five years	488	-	488	-
Net finance charges allocated to future periods	(302)	(44)	(302)	(44)
Net lease liabilities	1,437	222	1,437	222
Not later than one year	221	50	221	50
Later than one year, not later than five years	779	172	779	172
Later than five years	437	-	437	-

The finance lease obligations disclosed relate to medical equipment and buildings. The Edgbaston site land is a long term finance lease, detailed in note 14.3 to the financial statements on page XLV, this has a nominal charge as the land is covenanted for the 'provision of healthcare and education' to the city of Birmingham.

The Trust has three on-statement of financial position PFI schemes:

- ▶ The Queen Elizabeth Hospital Birmingham (PFI 1)
- ▶ The main entrance and retail facility at Heartlands Hospital (PFI 2)
- ▶ The provision of energy management services at Heartlands Hospital (PFI 3)

27 Private finance initiative contracts

Total finance lease obligations for on-statement of financial position PFI contracts due:

27.1 PFI schemes on-statement of financial position – Group and Trust

Total finance lease obligations for on-statement of financial position PFI contracts due: Group and Trust	Year Ended	Year Ended
	31 March 2019	31 March 2018
	£000	£000
Gross PFI lease liabilities	717,981	749,247
Of which liabilities are due:		
Not later than one year	27,450	27,493
Later than one year, not later than five years	109,676	110,009
Later than five years	580,855	611,745
Net finance charges allocated to future periods	(244,053)	(265,004)
Net PFI lease liabilities	473,928	484,243
Not later than one year	12,728	12,073
Later than one year, not later than five years	54,752	52,376
Later than five years	406,448	419,794
Net PFI lease liabilities by scheme:		
The Queen Elizabeth Hospital Birmingham	472,116	484,243
The main entrance and retail facility at Heartlands Hospital	312	-
The provision of energy management services at Heartlands Hospital	1,500	-
	473,928	484,243

Those PFI schemes based at the Heartlands Hospital site were transferred by absorption to the Trust from the former Heart of England NHS Foundation Trust on 1 April 2018. Prior year comparatives are not restated.

The Queen Elizabeth Hospital Birmingham

A contract for the development of the new hospital was signed by the Trust and its PFI partner on 14 June 2006. The purpose of the scheme was to deliver a modern, state of the art acute hospital facility on the QE site which is now fully operational as at the reporting date. This is part of a wider PFI deal between the Trust, Birmingham & Solihull Mental Health Trust and a consortium led by Consort Healthcare (Birmingham) Limited. The ownership of the consortium entity is as follows:

Balfour Beatty Infrastructure Investments Ltd (40%), InfraRed Infrastructure Yield Fund (30%) and Infrastructure Investments Holdings Limited, a subsidiary of HICL Infrastructure Company Limited (30%).

The contracted value of the new PFI hospital is £584,600,000 (of which £484,889,000 is capital and £99,711,000 are fees and finance costs incurred prior to 15 June 2010). The 'Queen Elizabeth Hospital Birmingham' was completed on 11 October 2011.

The Trust will be committed to the full unitary payment till the contract expires on 14 August 2046, at which time the building will revert to the ownership of the Trust. The unitary payment is subject to change based on movements in the Retail Prices Index.

The Trust has the rights to use the Queen Elizabeth Hospital Birmingham for the length of the Project Agreement and has the rights to expect provision of the range of allied and clinical support services, including facilities management and lifecycle maintenance. In addition, the Trust has the rights to possible deductions from the unitary payment due to the non availability of the infrastructure or under performance regarding the services provided.

At the end of the Project Agreement the assets will transfer back to the Trust's ownership.

The main entrance and retail facility at Heartlands Hospital

This is a 25 year contract with BHE (Heartlands) Limited which commenced in August 2005. The contract states that the service provision must be made available for users of the Heartlands Hospital including patients, visitors and staff.

The contract contains a range of measures upon which deficiency points are allocated if pre-agreed levels are not achieved. The deficiency points are valued and deducted retrospectively from the Trust unitary payment at the end of the following quarter. At the end of the contract, ownership of the Main Entrance structure transfers to the Trust, at this point the Trust is not liable to provide any compensation payment and the contract is deemed to have reached its natural termination. The Trust is entitled to terminate the contract voluntarily with 12 months written notice and there are specific circumstances such as hospital closure or significant reconfiguration.

The provision of energy management services at Heartlands Hospital

This is a 15 year contract with Ener-G Combined Power Limited which commenced in August 2007.

The contract is for the provision of combined heat and power facilities at the Heartlands Hospital. If either party terminates the contract before the end of the agreement, there is provision for either party to be liable to pay compensation as detailed within the contract. The assets are transferred at the end of the agreement and become assets of the Trust. The service provision is implicitly for the patients, visitors and staff of Heartlands Hospital. There is a payment mechanism that allows for deductions to be made to the unitary payment where the quality standards set out in the contract are not met.

Unitary payments payable to service concession operators Group and Trust	Year Ended	Year Ended
	31 March 2019	31 March 2018
	£000	£000
Consisting of:		
Interest charge	15,355	15,810
Repayment of finance lease liability	12,324	12,228
Service element and other charges to operating expenditure	16,690	15,764
Capital lifecycle maintenance	2,075	1,284
Contingent rent	7,970	6,742
Addition to lifecycle prepayment - capital	3,182	3,249
Total amounts paid to service concession operators	57,596	55,077

The Trust is committed to making the following unitary payments for on-statement of financial position PFI commitments during the next reporting year and until the contract expires:

	31/03/2019			Total £000
	PFI 1 £000	PFI 2 £000	PFI 3	
2nd to 5th years (inclusive)	-	-	400	400
11th to 15th years (inclusive)	-	48	-	48
26th to 30th years (inclusive)	58,649	-	-	58,649

	31/03/2018			Total £000
	PFI 1 £000	PFI 2 £000	PFI 3	
2nd to 5th years (inclusive)	-	-	400	400
11th to 15th years (inclusive)	-	48	-	48
26th to 30th years (inclusive)	57,148	-	-	57,148

27.2 PFI schemes off-statement of financial position

The Trust did not have an off-statement of financial position PFI scheme until the transfer by absorption of such a scheme from the former Heart of England NHS Foundation Trust on 1 April 2018. Prior year comparatives are not restated.

- ▶ The provision of energy management services at Solihull Hospital (PFI 4)

The Trust holds a second PFI agreement with EnerG Combined Power Limited for the provision of energy services at Solihull Hospital. The scheme commenced in April 2010 and a unitary payment

of £748,000 was paid in the reporting year (£724,000 in 2017/18). This is a 15 year agreement.

The Trust is accounting for this scheme as an off Statement of Financial Position PFI contract using the NHS Finance, Performance and Operations Guidance on "Accounting for PFI under IFRS" and also has been classified as a non finance lease under IAS 17.

In accordance with SIC 29 (Service Concession Arrangements), the Trust is committed to make the following payments for the service charge element of off-SoFP service concessions:

Group and Trust	Year Ended 31 March 2019	Year Ended 31 March 2018
	£000	£000
payable:		
Not later than one year	748	-
Later than one year, not later than five years	3,222	-
Later than five years	867	-

28 Provisions

Group	Current		Non current	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Pensions - early departure costs	113	42	965	466
Pensions - injury benefits	278	122	4,508	2,307
Legal claims	817	377	273	266
Redundancy	745	624	-	-
Other	1,400	-	1,710	-
	3,353	1,165	7,456	3,039

	Pensions - early departures	Pensions - injury benefits	Legal claims	Redun- dancy	Other	Total
	£000	£000			£000	£000
At 1 April 2018	508	2,429	643	624	-	4,204
Transfers by absorption	714	2,788	227	-	4,349	8,078
Change in the discount rate	(11)	(97)	-	-	-	(108)
Arising during the year	18	78	420	295	200	1,011
Used during the year	(113)	(278)	(141)	(112)	(1,099)	(1,743)
Reversed unused	(40)	(141)	(65)	(62)	(340)	(648)
Unwinding of discount	2	7	6	-	-	15
At 31 March 2019	1,078	4,786	1,090	745	3,110	10,809

Expected timing of cash flows:

Within one year	113	278	817	745	1,400	3,353
Between one and five years	451	1,110	-	-	1,710	3,271
After five years	514	3,398	273	-	-	4,185

Trust	Current		Non current	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Pensions - early departure costs	113	42	965	466
Pensions - injury benefits	278	122	4,508	2,307
Legal claims	817	377	-	-
Redundancy	745	624	-	-
Other	1,400	-	1,710	-
	3,353	1,165	7,183	2,773

	Pensions - early departures	Pensions - injury benefits	Legal claims	Redun- dancy	Other	Total
	£000	£000			£000	£000
At 1 April 2018	508	2,429	377	624	-	3,938
Transfers by absorption	714	2,788	227	-	4,349	8,078
Change in the discount rate	(11)	(97)	-	-	-	(108)
Arising during the year	18	78	420	295	200	1,011
Used during the year	(113)	(278)	(141)	(112)	(1,099)	(1,743)
Reversed unused	(40)	(141)	(65)	(62)	(340)	(648)
Unwinding of discount	2	7	6	-	-	15
At 31 March 2019	1,078		824	745	3,110	10,543
Expected timing of cash flows:						
Within one year	113	278	817	745	1,400	3,353
Between one and five years	451	1,110	-	-	1,710	3,271
After five years	514	3,398	-	-	-	3,912

The provisions for Pensions - early departure costs and injury benefits have been calculated on guidance received from the NHS Business Services Authority - Pensions Division. Employers and public liability have been calculated based on information received from NHS Resolution taking into account indications of uncertainty and timing of payments.

The provisions included under 'legal claims' consist of employers and public liability £652,000 (31 March 2018: £357,000) and other claims notified by the Trust's solicitors £nil (31 March 2018: £20,000).

The provisions included under 'other' include an amount of £2,809,000 at the reporting date in respect of environmental corrections required within the estate of the former Heart of England NHS FT, which was transferred to the Trust on 1 April 2018. The values of all provisions transferred by absorption to the Trust on 1 April 2018 are disclosed in the 'transfers by absorption' line, prior year comparatives are not restated.

The Group provision includes an amount of £273,000 (31 March 2018: £266,000) in respect of UHB Facilities Ltd and a tenant's dilapidations contractual commitment for the Rabone Lane site.

Provisions within the annual accounts of NHS Resolution at 31 March 2019 include £255,970,000 in respect of clinical negligence liabilities of the Trust (31 March 2018: £101,721,000).

29 Contingencies

There are £72,000 of contingent liabilities at the reporting date which relate to amounts notified by NHS Resolution for potential employer and public liability claims over and above the amounts provided for in note 28 to the financial statements on page LVII (31 March 2018: £32,000). There are no contingent assets at the reporting date (31 March 2018: £nil).

30 Events after the reporting period

These financial statements were authorised for issue on the 24 May 2019, there were no events arising after the end of the reporting period up to which this date qualifies for disclosure.

31 Related party transactions

University Hospitals Birmingham NHS Foundation Trust is a corporate body established by order of the Secretary of State for Health.

The Trust has taken advantage of the partial exemption provided by IAS 24 'Related Party Disclosures', where the Government of the United Kingdom is considered to have ultimate control over the Trust and all other related party entities in the public sector.

The Trust considers other NHS Foundation Trusts to be related parties, as they and the Trust are under the common performance management of NHS Improvement - part of the NHS in England. During the year the Trust contracted with certain other Foundation Trusts for the provision of clinical and non clinical support services.

The Department of Health is also regarded as a related party. During the year University Hospitals Birmingham NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities of the NHS in England to which the Department is regarded as the parent organisation.

The Trust has had a number of material transactions with other Government Departments and local Government bodies.

These related parties are summarised below by Government Department, with disclosure of the total balances owed and owing as at the reporting date and total transactions for the reporting year with the Trust:

Group and Trust	Receivables £000	Payables £000	Revenue £000	Expenditure £000
NHS in England				
NHS Birmingham and Solihull CCG	11,201	2,131	610,238	52
NHS South Worcestershire CCG	146	-	4,636	70
NHS Dudley CCG	447	37	8,432	-
NHS Redditch And Bromsgrove CCG	117	206	13,684	-
NHS Sandwell And West Birmingham CCG	2,035	-	37,031	-
NHS South East Staffs and Seisdon Peninsular CCG	3,853	-	46,106	-
NHS Warwickshire North CCG	42	166	8,484	-
NHS Walsall CCG	80	662	10,810	-
NHS England (specialised commissioning)	7,531	-	565,421	-
NHS England (Cancer Drugs Fund)	2,274	-	10,173	-
NHS England (West Midlands)	388	216	18,775	-
Health Education England	875	1	50,577	16
Public Health England	225	1,172	1,087	5,819
Birmingham and Solihull Mental Health NHS Foundation Trust	447	576	753	3,021
The Royal Orthopaedic Hospital NHS Foundation Trust	810	935	3,020	1,227
Birmingham Women's and Children's Hospital NHS FT	5,019	3,839	9,054	4,835
Birmingham Community Healthcare NHS Foundation Trust	1,146	786	2,254	773
Sandwell and West Birmingham Hospitals NHS Trust	3,171	3,101	3,324	2,856
The Royal Wolverhampton NHS Trust	1,051	58	5,040	159
Department of Health	109	-	29,939	-
NHS Litigation Authority	-	101	-	38,733
NHS England - Core (inc. sustainability & transformation fund)	19,467	912	35,282	95
Other	13,131	4,744	53,851	8,715
	73,565	19,643	1,527,971	66,371
Other related parties – Whole of Government Accounts				
Ministry of Defence	1,259	155	4,522	38
NHS Pension Scheme	-	11,419	-	82,990
Birmingham City Council	12	159	15,065	-
NHS Wales	450	-	9,141	-
NHS Blood and Transport	88	306	2,256	-
HMRC	4,626	21,193	116	72,150
Other	1,787	202	3,502	107
	8,222	33,434	34,602	155,285

The Trust has also received revenue and capital payments from the University Hospital Birmingham Charities totalling £3,352,000 (2017/18 - £1,698,000).

The financial statements of the parent (the Trust) are presented together with the consolidated financial statements and any transactions or balances between group entities have been eliminated on consolidation. The following directors of the Trust are also board members of the trading subsidiaries, roles as stated:

Trust director	Professional Activity Ltd	Pharmacy@QEHB Ltd	UHB Facilities Ltd	Assure Dialysis Ltd
Mike Sexton	-	chair	non-executive	-
Kevin Bolger	-	non-executive	-	-
David Burbidge	co. secretary	co. secretary	co. secretary	co. secretary
Mark Garrick	director	-	-	-

The four subsidiaries do not have any transactions with any NHS or other Government entity except those with its parent (the Trust) and HMRC (payroll and social security taxes). The Trust's receivables and payables includes the following:

The Trust's receivables include £382,000 (31 March 2018 - £7,119,000) owed by and payables include £3,215,000 (31 March 2018 - £3,274,000) owed to Pharmacy@QEHB Ltd. The Trust's revenue includes £1,020,000 (31 March 2018 - £883,000) received from and expenditure includes £53,913,000 (31 March 2018 - £42,591,000) paid to Pharmacy@QEHB Ltd.

The Trust's receivables include £3,654,000 (31 March 2018 - £3,672,000) owed by and payables includes £286,000 (31 March 2018 - £278,000) owed to UHB Facilities Ltd. The Trust's revenue includes £199,000 (31 March 2018 - £266,000) received from and expenditure includes £2,581,000 (31 March 2018 - £2,224,000) paid to UHB Facilities Ltd.

The Trust's receivables include £1,103,000 (31 March 2018 - £71,000) owed by and payables includes £nil (31 March 2018 - £nil) owed to Assure Dialysis Services Ltd. The Trust's revenue

includes £86,000 (31 March 2018 - £17,000) received from and expenditure includes £852,000 (31 March 2018 - £790,000) paid to Assure Dialysis Services Ltd.

There are no transactions or balances in the reporting year between the Trust and Professional Activity Ltd.

32 Financial instruments and related disclosures

The fair value of a financial instrument is the price at which an asset could be exchanged, or a liability settled, between knowledgeable, willing parties in an arms-length transaction. All the financial instruments of the Trust are initially measured at fair value on recognition and subsequently at amortised cost. IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

The following tables are a categorisation of the carrying amounts and the fair values of the Trust's financial assets and financial liabilities:

Carrying values of financial assets:	Notes	Group		Trust	
		Held at amortised cost £000	Total book value £000	Held at amortised cost £000	Total book value £000
Carrying values of financial assets as at 31 March 2019 under IFRS 9					
Trade and other receivables excluding non financial assets	1	97,609	97,609	94,346	94,346
Cash and cash equivalents	1	62,941	62,941	61,938	61,938
As at 31 March 2019		160,550	160,550	156,284	156,284

	Notes	Group		Trust	
		Loans and receivables cost	Total book value	Loans and receivables cost	Total book value
		£000	£000	£000	£000
Carrying values of financial assets as at 31 March 2018 under IAS 39					
Trade and other receivables excluding non financial assets	1	72,041	72,041	85,832	85,832
Cash and cash equivalents	1	85,490	85,490	83,692	83,692
As at 31 March 2018		157,531	157,531	169,524	169,524

Carrying values of financial liabilities:

	Notes	Group		Trust	
		Held at amortised cost	Total book value	Held at amortised cost	Total book value
		£000	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9					
Loans from the DHSC	2	34,869	34,869	34,869	34,869
Obligations under finance leases	2	1,437	1,437	1,437	1,437
Obligations under PFI service concession contracts	2	473,928	473,928	473,928	473,928
Trade and other payables excluding non financial liabilities	1	226,793	226,793	224,176	224,176
Provisions under contract	1	4,945	4,945	4,672	4,672
As at 31 March 2019		741,972	741,972	739,082	739,082

	Notes	Group		Trust	
		Held at amortised cost	Total book value	Held at amortised cost	Total book value
		£000	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39					
Loans from the DHSC	2	-	-	-	-
Obligations under finance leases	2	222	222	222	222
Obligations under PFI service concession contracts	2	484,243	484,243	484,243	484,243
Trade and other payables excluding non financial liabilities	1	125,241	125,241	131,356	131,356
Provisions under contract	1	1,267	1,267	1,001	1,001
As at 31 March 2018		610,973	610,973	616,822	616,822

The fair value on all these financial assets and financial liabilities equates to their carrying value.

Maturity of financial liabilities

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
In one year or less	242,939	138,365	240,322	144,480
In more than one year but not more than two years	21,026	12,464	21,026	12,464
In more than two years but not more than five years	68,523	40,084	68,523	40,084
In more than five years	409,484	420,060	409,211	419,794
	741,972	610,973	739,082	616,822

(1) Fair values of cash, trade receivables, trade payables and provisions under contract are assumed to approximate to cost due to the short-term maturity of the instruments.

(2) Fair values of borrowings - DHSC loans, finance leases and private finance initiative contracts, are carried at amortised cost. Fair values are estimated by discounting expected future contractual cash flows using interest rates implicit in the contracts. The maturity profile of both finance lease and private finance initiative contract liabilities are disclosed in notes 26 and 27.1 to the financial statements on page LIV.

The financial assets and financial liabilities of cash and cash equivalents, finance leases and private finance initiative contracts all equate to the amounts disclosed on the statement of financial position and supporting notes to the financial statements. Trade receivables, trade payables and provisions include non-financial assets and liabilities not disclosed in the table above. The reconciling amounts are as follows:

- ▶ Trade receivables includes prepayments which are not a financial instrument, see note 20 to the financial statements on page XLIX.
- ▶ Trade payables includes receipts in advance and PDC payable which are not financial instruments, see note 22 to the financial statements on page LI.
- ▶ Provisions includes liabilities incurred under legislation, rather than by contract - early retirements due to ill health or injury. These are not considered by HM Treasury to fit the definition of a financial instrument, see note 28 to the financial statements on page LVII.

Risk management policies

The Trust's activities expose it to a variety of financial risks, though due to their nature the degree of the exposure to financial risk is substantially reduced in comparison to that faced by business entities. The financial risks are mainly credit and inflation risk, with limited exposure to market risks (currency and interest rates) and to liquidity risk.

Financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to

change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Investment Committee. The main responsibilities of the Trust's treasury operation are to:

- ▶ ensure adequate liquidity for the Trust
- ▶ invest surplus cash; and
- ▶ manage the clearing bank operations of the Trust

(i) Credit risk

As a consequence of the continuing service provider relationship that the Trust has with NHS Commissioners and the way those organisations are financed, the Trust is exposed to a degree of customer credit risk, but substantially less than that faced by business entities. In the current financial environment where NHS Commissioners must manage increasing healthcare demand and affordability within fixed budgets, the Trust regularly reviews the level of actual and contracted activity with the NHS Commissioners to ensure that any income at risk is discussed and resolved at a high level at the earliest opportunity available.

As a majority of the Trust's income comes from contracts with other public sector bodies, see note 2 to the financial statements on page XXVIII, there is reduced exposure to credit risk from individuals and commercial entities. The maximum exposures to trade and other receivables as at the reporting date, are disclosed in note 20 to the financial statements on page XLIX, including details of the amounts owing on the sale of surplus land.

The Trust mitigates its exposure to credit risk through regular review of receivables due and by calculating a bad debt provision.

In accordance with the Trust's treasury policy, the Trust's cash is held in current accounts at UK banks only. There are no cash or cash equivalent investments held, the result being to minimise the counter party credit risk associated with holding cash at financial institutions.

(ii) Inflation risk

The Trust's has exposure to annual price increases of medical supplies and services (pharmaceuticals, medical equipment and agency staff) arising from its core healthcare activities. The Trust mitigates this risk through,

for example, transferring the risk to suppliers by contract tendering and negotiating fixed purchase costs (including prices set by nationally agreed frameworks across the NHS) or reducing external agency staff costs via operation of the Trust's own employee 'staff bank'.

The unitary payment of the new 'Queen Elizabeth Hospital Birmingham' private finance initiative contract is subject to change based on movements in the Retail Prices Index (RPI), as disclosed in note 27.1 to the financial statements on page LIV. For the reporting year the relevant RPI index was 278.1 (annualised rate of 3.6%) fixed at February 2018. The sensitivity of the Trust's retained surplus and taxpayers equity to changes in this RPI inflation rate are set out in the following table:

RPI sensitivity analysis	Year Ended 31 March 2019		Year Ended 31 March 2018	
	£000	£000	£000	£000
	+1.0%	-1.0%	+1.0%	-1.0%
Retained surplus/(deficit)	(586)	586	(533)	533
Taxpayers' equity	(586)	586	(533)	533

(iii) Market risk

The Trust has limited exposure to market risk for both interest rate and currency risk:

Currency risk - the Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations nor investments and all Trust cash is held in Sterling at UK banks: Barclays bank and the Government Banking Service 'GBS'. The Trust therefore has minimal exposure to currency rate fluctuations.

Interest rate risk - other than cash balances, the Trust's financial assets and all of its financial liabilities carry nil or fixed rates of interest. Cash balances at UK banks earn interest linked to the Bank of England base rate. The Trust therefore has minimal exposure to interest rate fluctuations.

(iv) Liquidity risk

The Trust's net operating costs are incurred under annual service agreements with Clinical Commissioning Groups and NHS England, which are financed from resources voted annually by Parliament. The Trust ensures that it has sufficient cash or committed loan facilities to meet all its commitments when they fall due. This is regulated by the Trust's compliance with the 'Continuity of Services Risk Rating' system created by NHSI, the Independent Regulator of NHS Foundation Trusts. The Trust is not, therefore, exposed to significant liquidity risks.

(v) Capital management risk

The Trust's capital is 'Public Dividend Capital' (PDC) wholly owned and controlled by the Department of Health, there is no other equity. The 3.5% cost of capital - the 'PDC dividend' is disclosed in note 11 to the financial statements on page XXXVII. Therefore, the Trust does not manage its own capital. Liquidity risk and the funding of the Trust's activities are described above.

33 Third party assets

The Trust and Group held £10,570 of cash at the reporting date (31 March 2018: £2,963) which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

34 Losses and Special Payments

	Year Ended 31 March 2019		Year Ended 31 March 2018	
	Number	£000	Number	£000
Losses				
Cash losses	15	2	27	9
Bad debts and claims abandoned	884	1,530	1,217	1,056
Damage to property and stores losses	31	731	2	21
	930	2,263	1,246	1,086
Special payments				
Ex gratia payments	245	243	168	56
	245	243	168	56
Total losses and special payments	1,175	2,506	1,414	1,142

There were no clinical negligence, fraud, personal injury, compensation under legal obligation or fruitless payment cases where the net payment or loss for the individual case exceeded £300,000.

The Trust losses and special payments disclosed are the same as the Group, there have been no equivalent payments made by the subsidiaries.

These amounts are stated on an accruals basis but exclude any provisions for future losses.

NATIONAL HEALTH SERVICE ACT 2006

DECISION BY MONITOR IN RESPECT OF NHS FOUNDATION TRUSTS' ANNUAL REPORTS

Monitor, in exercise of powers conferred on it by paragraph 26 of schedule 7 to the National Health Service Act 2006, hereby directs that:

1. The annual report of each NHS foundation trust shall be in the form and provide such information as laid down in the annual reporting guidance for NHS foundation trusts within the NHS Foundation Trust Annual Reporting Manual (FT ARM) that is in force for the relevant financial year.
2. The annual report of each NHS foundation trust shall be submitted in accordance with the requirements specified in the FT ARM or equivalent document as to when such reports must be sent to Monitor.
3. The following sections contained in each annual report shall be signed and dated by the chief executive of the NHS foundation trust to which it relates:
 - > The performance report
 - > The accountability report
 - > The remuneration report
 - > The annual governance statement
 - > The statement on quality from the chief executive (part 1 of the quality report)
4. The statement of directors' responsibilities in respect of the quality report contained in each annual report shall be signed and dated by the chair and chief executive of the NHS foundation trust to which it relates.

Signed by authority of Monitor

Signed:

Name: **Ian Dalton (Chief Executive)**

Dated: November 2018

National Health Service Act 2006

Direction by Monitor, in Respect Of Foundation Trusts' Annual Reports and the Preparation Of Annual Reports

Monitor, with the approval of the Secretary of State, in exercise of powers conferred on it by paragraphs 24(1A) and 25(1) of schedule 7 to the National Health Service Act 2006 (the '2006 Act'), hereby gives the following Directions:

1. Application and Interpretation

- (1) These Directions apply to NHS foundation trusts in England.
- (2) In these Directions:
 - a. references to "the accounts" and to the "the annual accounts" refer to:
 - > for an NHS foundation trust in its first operating period since being authorised as an NHS foundation trust, the accounts of an NHS foundation trust for the period from point of licence until 31 March
 - > for an NHS foundation trust in its second or subsequent operating period following initial authorisation, the accounts of an NHS foundation trust for the period from 1 April until 31 March
 - > for an NHS foundation trust in its final period of operation and which ceased to exist as an entity during the year, the accounts of an NHS foundation trust for the period from 1 April until the end of the reporting period
 - b. "the NHS foundation trust" means the NHS foundation trust in question.

2. Form of accounts

- (1) The accounts submitted under paragraph 24(1) of Schedule 7 to the 2006 Act must comply with the requirements of the Department of Health Group Accounting Manual (DH GAM) in force for the relevant financial year.

3. Annual accounts

- (1) The annual accounts submitted under paragraph 25 of schedule 7 to the 2006 Act shall show, and give a true and fair view of, the NHS foundation trust's gains and losses, cash flows and financial state at the end of the financial period.
- (2) The annual accounts shall follow the requirements as to form and content set out in chapter 1 of this manual and meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual (FT ARM) in force for the relevant financial year.
- (3) The annual accounts shall comply with the accounting requirements of the Department of Health and Social Care Group Accounting Manual (DHSC GAM) as in force for the relevant financial year.
- (4) The Statement of Financial Position shall be signed and dated by the chief executive of the NHS foundation trust.

4. Statement of accounting officer's responsibilities

- (1) The statement of accounting officer's responsibilities in respect of the accounts shall be signed and dated by the chief executive of the NHS foundation trust.

5. Annual accounts: Foreword to accounts

- (1) The foreword to the accounts shall be signed and dated by the chief executive of the NHS foundation trust.

Signed by the authority of Monitor

Signed:

Name: **Ian Dalton (Chief Executive)**

Dated: November 2018

