University College London Hospitals NHS
NHS Foundation Trust

Annual Report and Accounts 2010|11

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

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

Contents

The year in pictures

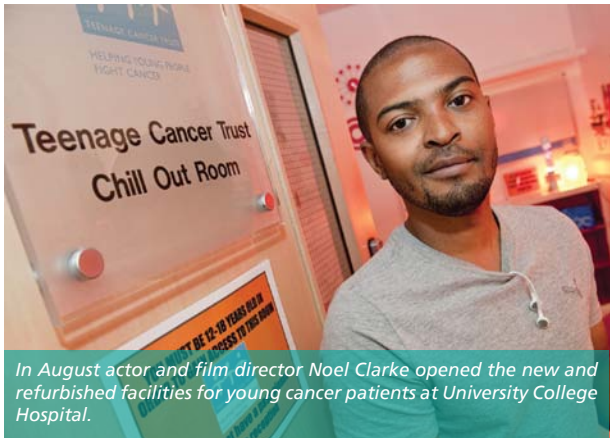
April

In April David Cameron, leader of the Conservative Party, visited the Trust to find out more about our services for children and young people with cancer.

May

In May Josephine Ford celebrated her successful breast cancer treatment at the end of a UCLH research trial that has seen treatments reduced from up to six weeks to a single operation.

August

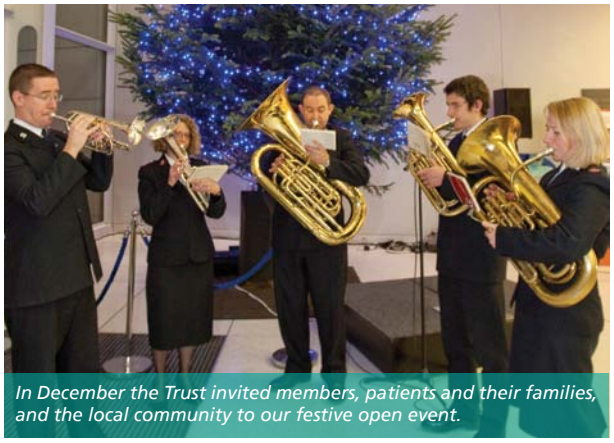


In August actor and film director Noel Clarke opened the new and refurbished facilities for young cancer patients at University College Hospital.

September

In September the Royal London Hospital for Integrated Medicine officially adopted its new name to better reflect the services it provides.

December



In December the Trust invited members, patients and their families, and the local community to our festive open event.

January

In January, BBC news featured deep brain stimulation treatment to combat cluster headaches at the National Hospital for Neurology and Neurosurgery.

June

In June London Mayor Boris Johnson helped the National Hospital for Neurology and Neurosurgery celebrate its 150th anniversary.

July

In July the Hyper Acute Stroke Unit went fully operational, improving outcomes for patients.

October

In October health secretary Andrew Lansley visited the University College Hospital Macmillan Cancer Centre construction site, which is due to open in 2012.

November

In November a UCLH project won an award and funding for their multi-disciplinary approach to treating homeless patients.

February

In February the Trust's quality and efficiency programme celebrated its first anniversary - ward of the week is one initiative that has helped the Trust achieve challenging financial targets whilst continuing to deliver high quality care.

March

In March the country's first dedicated Brain Tumour Unit opened at the Hospital for Neurology and Neurosurgery.

1 Foreword

The NHS is facing some of the greatest challenges in its history. Government reforms, coupled with the impact of the economic recession, mean NHS Trusts have to be more focused than ever.

Despite these challenges we have not lost sight of our mission to provide top quality patient care, excellent education and world-class research. Once again our staff have performed extremely well and we would like to thank them for their dedication and commitment.

We remain the best performing A&E in London against the four hour waiting time target. We are also among the highest rated Trusts in the Dr Foster Good Hospital Guide with one of the best mortality rates in the NHS. Our work as a founder member of the academic health science centre, UCL Partners, continues to lead to ground-breaking advances in research for the benefit of patients.

We must continue to hit these high standards with significant reductions in spending. Our Quality, Efficiency and Productivity programme has been a driving force in helping us to think more innovatively about the care we provide to our patients. Often improvements in hospital efficiency go hand-in-hand with improving the quality of care. For example, our enhanced recovery programme means patients spend less time in expensive hospital beds and return to the comfort of their homes more quickly. We have reduced our spend on agency staff, saving money for us and ensuring patients receive greater continuity of care.

The Trust has also made significant improvements in both the staff and inpatient national surveys. We are in the top 20 per cent of acute trusts for staff recommending their organisation as a place to work or receive treatment. Patients placed us in the top 20 per cent of acute trusts for their overall experience of care.

Despite these successes, there have been some disappointments. Whilst we reduced MRSA cases from 22 to 13, we still failed to achieve our target. This is an area where we will be focussing significant attention in the coming year.

Exciting times lie ahead. We are scheduled to open the new UCH Macmillan Cancer Centre – the most advanced facility of its kind in the UK – in 2012. The Olympics are also coming to London and we are proud to have been named as one of the designated 'Olympic hospitals'.

The challenges facing the NHS will continue - UCLH has £120 million to save over the next three years. However, based on the success of this year, we can look ahead with confidence and optimism.

Richard Murley
Chairman

Sir Robert Naylor
Chief Executive

2 Introduction

University College London Hospitals NHS Foundation Trust (UCLH), situated in the heart of London, is one of the most complex NHS trusts in England. We serve a large and diverse population. In July 2004 we were one of the first NHS trusts to achieve foundation trust status.

We provide academically led acute and specialist services, both locally and to patients from throughout the United Kingdom and abroad. We balance the provision of highly rated, specialist services with acute services to the local populations of Camden, Islington, Westminster Barnet, Enfield and Haringey.

Our mission is to deliver top quality patient care, excellent education and world-class research.

We have a turnover of £738 million and contracts with over 70 commissioning bodies. We see over 740,000 outpatients and admit over 115,000 patients each year.

The Trust is made up of six hospitals:

- University College Hospital (incorporating the Elizabeth Garrett Anderson Wing) (UCH)
- Eastman Dental Hospital (EDH)
- Hospital for Tropical Diseases (HTD)
- National Hospital for Neurology and Neurosurgery (NHNN)
- The Heart Hospital (HH)
- The Royal London Hospital for Integrated Medicine (RLHIM).

In December 2006, in partnership with University College London (UCL), we became one of the country's five comprehensive biomedical research centres. We are a member of UCL Partners which brings together five of Britain's world renowned medic al research centres and hospitals: UCL (University College London); Great Ormond Street Hospital for Children NHS Trust (GOSH): Moorfields Eye Hospital NHS Foundation Trust; the Royal Free Hampstead NHS Trust; and University College London Hospitals NHS Foundation Trust. UCL Partners was officially designated as one of the UK's first academic health science centres by the Department of Health in March 2009.

Alongside our close relationship with the Royal Free Hampstead NHS Trust and University College Medical School, we have good links with London South Bank and City universities which offer high quality training and education.

3 Performance overview

Highlights from 2010/11 include:

- A strong performance across a range of safety and outcome indicators in the Dr Foster Good Hospital guide, including: one of the best mortality rates in the NHS, a high percentage of patients given 'clot busting drugs' and a high percentage of patients with a fracture neck of femur primary diagnosis that have a related procedure within two days
- The best results for a non-single specialty hospital in London for the annual inpatient survey
- Delivery of the best A&E performance in London against the four hour waiting time target. We were also ranked fourth nationally against major A&E (type 1) providers
- University College London, our academic partner, maintained its fourth place in the QS world university rankings
- Delivery of our key financial targets, achieving a Monitor risk rating of four at the end of the year.

In our 2010/11 quality accounts we identified four priorities to improve patient safety, experience and outcomes, and have successfully met them, including:

- a 90% achievement of VTE risk assessment on admitted patients
- a reduction in reported hospital standardised mortality of 17%.

More information can be found in appendix 1.

Regulatory ratings

In 2010/11 we highlighted two risks to our governance rating.

MRSA

For 2010/11 the Department of Health applied a new methodology to set targets for MRSA bacteraemia. We were set a target of no more than eight cases, which required us to make a reduction of over 60% on the 22 cases of MRSA bacteraemia at UCLH in 2009/10. We set a quarterly trajectory which required us to have no cases in quarters three and four. While we stayed within our annual trajectory in quarters one and two, we breached our annual threshold of eight during quarter three, triggering points against our governance score for Q3. Monitor decided that in the light of our action plan for 2010/11 and the overall improvement in MRSA bacteraemia cases that they would not take any further action.

62 day cancer waiting time

In relation to the 62 day screening indicator we alerted Monitor to the fact that low numbers of patients treated against this indicator and lack of control over patient choice issues meant that there was a risk that we would not be routinely compliant with this threshold, but that this non-compliance did not reflect any material weaknesses in UCLH governance and performance management arrangements. We subsequently breached the target in quarters two, three and four.

In early 2009/10 our performance for the 62 day GP indicator was below the operational standard but towards the end of the year improvements were introduced that enabled us to reach the required standard. Given breaches of the target in 2009/10 and a range of legitimate patient delays (complex diagnostics, patients taking time to consider their treatment options, patients seeking a second opinion elsewhere before embarking on treatment, or patients choosing to honour planned holidays) we alerted Monitor to the fact that the operational standard may not be met in some quarters in 2010/11. We subsequently missed the target in Q2 and Q3. Many

of the delays occurred on urology pathways, and a detailed action plan was introduced that brought us back into compliance for Q4.

Other than the risks alerted to Monitor as part of the 2010/11 planning process, the only other breach of indicators occurred in Q4 2010/11, when we narrowly missed the 93% standard for providing an appointment within 14 days for patients with symptoms of breast cancer. All breaches of the standard were on account of patient choice.

We delivered the financial risk ratings according to the plan we set out at the beginning of 2010/11.

Hospital acquired infections

We remain focused on minimising the number of hospital acquired infections. As a result there were 62 cases of Clostridium difficile, an improvement of 30% on the previous year which is well within our threshold of 119 cases. We reduced cases of MRSA by 45% (13 cases recorded) in 2010/11, although we were disappointed that we were not able to stay within our threshold of eight cases for MRSA bacteraemia.

We are prepared for demanding targets for MRSA and Clostridium difficile in 2011/12, as well as targets for other types of infection such as E.coli and MSSA.

Our Service Commitment continues to underpin the determination of our staff to delivering excellent, compassionate care to patients. Their commitment is recognised by our results in the annual inpatient survey conducted independently by the Care Quality Commission (CQC). For the second year running we enjoyed the top results in London for a non-specialist Trust. Our weekly surveys of patients keep us sensitive to issues that can emerge in the care provided to patients across all our hospitals, helping us stop small problems from becoming bigger ones and enabling us to share best practice across wards.

Table 1: regulatory ratings analysis

		Actual performance			
	Annual Plan 2009/10	Q1 2009/10	Q2 2009/10	Q3 2009/10	Q4 2009/10
Financial risk rating	3	3	4	4	4
Governance risk rating	No risks declared	Green	Amber	Amber	Green

		Actual performance			
	Annual Plan 2010/11	Q1 2010/11	Q2 2010/11	Q3 2010/11	Q4 2010/11
Financial risk rating	4	3	4	4	4
Governance risk rating	Highlighted risks against: • delivery of MRSA • 62 day screening • A&E indicators	Green	Amber-Green	Amber-Red	Amber-Red

Waiting times

We have continued to deliver very strong performance against the A&E four hour waiting time target. In 2010/11 we again delivered the best results for any acute trust in London, the second year running, and the fourth best type 1 performance nationally out of 153 trusts. Our annual performance against the national four hour standard was 98.5%, one of only three trusts in London to keep its performance above the old national standard of 98%. It was particularly notable given the continuing increase in A&E attendances, which grew by 6% during the year. The efficiency with which we manage the flow of patients through the hospital has also been reflected in the cancellation of fewer operations (down by 0.31 percentage points) and a reduction in length of stay for a number of key conditions.

In 2010/11 we provided our patients with access to services

within national referral to treatment waiting times across the full range of national targets. We were compliant every month with the 18 week referral to treatment targets for admitted and non-admitted pathways. We also made good progress in delivering compliance with the standards for each of our specialties, bringing neurosurgery, neurology, gastroenterology and orthopaedics to a position where they are now more consistently compliant with 18 week targets.

We have delivered against most of the cancer waiting time targets, including the 14 day standard for a first appointment following a GP referral and all four of the 31 day standards for treatment following diagnosis.

We have however struggled to deliver against the 62 day standard for treatment following referral from GPs and screening centres. A significant number of the cases we treat under the 62 day GP standard are for prostate cancer. The Department of Health agrees that it is not as appropriate to fast-track some cases of prostate cancer since decisions about treatment carry significant implications for patients and the decisions don't need to be rushed. We have also failed to meet consistently the 62 day screening standard. Again, our workload is dominated by referrals for possible cases of bowel cancer or by referrals from the screening service – where it is not as appropriate to fast-track treatment since the patient's condition is usually less clinically urgent, patients have yet to develop symptoms, and it is appropriate to allow patients to choose appointments in their own time. Our performance against the 90% threshold for this standard is also extremely challenging on account of the low numbers of cases involved, with a single breach of the standard in any quarter meaning that we are not compliant.

There are of course elements of both the GP and screening pathways that we could improve upon, and as a result we have taken action in access to diagnostic imaging and surgical facilities during the course of the year. We will continue to identify areas for improvement that are within our control. Improvement of our reported performance against both of these standards will continue to be a top priority for us during 2011/12.

As a result of not meeting the national cancer waiting time targets, and our performance against the MRSA target, we had an 'amber-red' governance rating under the Monitor compliance framework in quarters two, three and four.

We have delivered our key financial targets for 2010/11, and at year end achieved a Monitor financial risk rating of four. This included delivering savings of £31.2m, just over 4% of our turnover. While this demonstrates our sound financial management, we are clear that along with all other NHS organisations, we face some very challenging financial years ahead. We are preparing for extremely demanding efficiency targets over the next few years, with around 6% of new savings to be identified and be delivered each year. Combined with changes in the commissioning environment, we face a period of enormous challenge.

Table 2: A&E waiting times performance for Q2 - Q4; % patients waiting less than four hours

	Performance year to date from start of Q2*
England average	95.6%
London average	95.7%
UCLH	98.5%

** Due to the change of operational standard from 98% to 95% in late June 2010, the 'year to date' figure in national reporting has been reset starting w/e 4th July 2010.*

740,000
outpatients are seen every year

Performance against our 2010/11 objectives

We set ourselves 10 objectives in 2010/11, and the table below summarises how we performed against them. The table also includes details of where to find more information about our performance against each of the objectives.

Table 3: UCLH objectives 2010/11

Top ten objectives	Deliverable	Progress made
Deliver excellent **clinical outcomes**	Complete the Quality Strategy and prepare annual Quality Accounts	✓✓
	Show year on year reduction in the Hospital Standardised Mortality Ratio (HSMR)	✓✓
	Implement Patient Reported Outcome Measures (PROMS)	✓✓
Improve **patient safety**	Deliver the 2010/11 infection prevention strategy, reducing levels of MRSA and Clostridium difficile in line with national objectives	✓
	Achievement of NHSLA Level 3 in 2010/11	✗ (we did not apply for level 3)
	Reduce avoidable harm through evidence based care, including VTE risk assessment	✓✓
Deliver high quality **patient experience**	Show year on year improvement in patient experience as measured by patient survey	✓
	Develop programme for patient involvement to ensure compliance with the NHS Constitution	✓✓
	Implement delivery plan to virtually eliminate mixed sex accommodation across all hospital sites	✓✓
Work with partners to improve **patient pathways**	Subject to Board approval, implement plans for reconfiguration of: Hyper Acute Stroke Unit (HASU) & Stroke, Pancreatic Cancer Surgery, Neurosurgery, and ENT	✓✓
	Work with colleagues in the North Central London (NCL) service and organisational review to develop proposals for service reconfiguration in local health economy, including proposals for integrating community services	✓
	Build the cancer centre, redesigning pathways to deliver improved care and submit a case for the UK's first Proton Beam Therapy centre to be based at UCLH	✓✓
Develop **UCLP** through world-class **Research and Development** (R&D) and excellent **education**	Develop, approve and implement monitoring of research performance metrics to evidence return on investment	✓✓
	Develop and approve an aligned clinical, research and education strategy for each of the major clinical specialties	✓✓
	Successfully respond to tender from commissioners to become a provider of clinical education	Through UCLP

Top ten objectives	Deliverable	Progress made
Deliver cost savings through the **Quality & Efficiency Programme (QEP)**	Implement clear governance arrangements for the delivery of the QEP savings	✓✓
	Deliver QEP savings in 2010/11 as agreed by the Board, with plans for generating additional savings at a similar level in 2011/12	✓
	Develop and approve a strategic approach to deliver productivity and efficiency savings over the next five years	✓
Achieve sustainable **financial health**	Achieve income, expenditure, efficiency and cash targets as agreed by the Board	✓✓
	Implement service line recharging and assign overhead/asset responsibilities leading to specific targets for return on assets	✓
	Implementation of patient level costing	✓
Develop and enable **staff** to maximise their potential	Develop and implement a plan for improving working lives, evidenced by year-on-year improvements in staff survey results and appraisal rate completion	✓
	Develop and implement a management development programme	✓
	Deliver the Electronic Staff Records (ESR) implementation programme to enable effective and timely workforce planning	✓
Deliver **national wait times**	Deliver 18 week Referral to Treatment (RTT) targets at specialty level	✓✓
	Ensure maximum wait of four hours in A&E from arrival to admission, discharge or transfer, for at least 98% of patients	✓✓
	Meet the two week, 31 days and 62 days cancer waiting times targets within threshold	✓
Develop **Governance** and Risk Management Strategy	Ensure that the Trust has appropriate governance arrangements in place to meet its terms of authorisation and Trust objectives	✓✓
	Implement phase two of the Information and Communications Technology (ICT) Strategy, including compliance with Information Governance standards and implementation of a Management Information Strategy	✓✓
	Set up and test plans to respond effectively to major incidents in line with national guidance on emergency preparedness	✓✓

Key:

Good progress made: ✓✓
Some progress made, but not fully achieved: ✓
Not achieved: ✗

115,000
patients are admitted every year

Risks that we faced in 2010/11

As an organisation we are increasingly managing risk proactively to deliver better care for our patients. The executive board supported by the risk co-ordination board, has led further improvements to the approach to risk, embedding risk management across the Trust with defined roles for the Trust board, clinical boards and divisions. There is a clear line of governance through to our board of directors to enable us to analyse and manage risks, identify recurring themes and put action plans in place to mitigate them. Our internal auditors consider our risk rating as 'risk managed', just one step away from the top rating of 'risk enabled'.

During the year we worked hard to manage risk in a number of areas:

Financial risks

Within the Trust financial plan for 2010/11 there were inherent risks around delivery of planned activity levels, including for example, the changing landscape of NHS commissioning (thereby presenting an income risk). Delivery of the ambitious cost efficiency target also represented a risk. During 2010/11 we successfully managed these risks.

Environment

Much of our estate is modern as a result of capital investment, including the PFI initiative to build UCH phase one and two. Parts of our estate do however require investment. We have developed a three year programme, which started in 2010/11, that is designed to manage any risks associated with maintenance of our estate.

Patient safety

We have continued to effectively manage those issues which are a current and ongoing challenge to all healthcare providers: medication errors, hospital acquired infections (although we did not stay within our threshold for MRSA, we did significantly improve our performance in 2010/11), venous thrombo-embolisms and pressure ulcers. Appendix 1, the quality report provides more detail on these important improvements.

Future uncertainties

As described in section four - the strategic context, the NHS is facing a period of enormous change and uncertainty. During 2010/11 the North Central London (NCL) sector faced major financial challenges that posed significant risks to our own financial position. We successfully managed this risk in collaboration with our commissioners. Financial challenges will only intensify during 2011/12. The move to GP commissioning, the 'any willing provider' model for service competition and the requirement that all providers be Foundation Trusts by 2014 creates significant uncertainty in the coming few years, which may necessitate future changes in our strategic direction. The Trust is involved in senior level key discussions about proposed changes which will help us prepare for and manage future changes as best we are able.

National targets

UCLH met the majority of national targets in 2010/11 but as we predicted in our annual plan submission to Monitor we faced difficulties in delivering performance within the threshold for MRSA and cancer 62 day waits. There were also risks to achieving NHSLA Level 3, CQC registration and the four hour A&E target. We have invested significant energy and resources into managing the risks associated with these targets during 2010/11. By the end of the year we had breached our MRSA bacteraemia threshold but had brought our cancer waiting times performance into a more robustly compliant position.

Other

As is the case with many other healthcare providers we face an ongoing range of risks that require careful management. Examples include Human Resources (HR) risks, policy compliance, information governance, potential medication errors and risks to our reputation.

Information risks

The Trust is required to report information risks and data losses. The tables below give the details of three incidents, all of which involve the loss or theft of electronic equipment, devices or paper documents outside of the Trust. We take all incidents seriously and they are investigated to ensure that we improve our processes and to prevent further incidents.

Table 4: summary of serious incidents involving personal data as reported to the information commissioner's office in 2010/11

Date	Nature of incident	Nature of data involved	Number of people potentially affected	Notification steps
October 2010	Loss of inadequately protected electronic stored device	Name Address Clinical Details	750	ICO notified, patients not notified, see explanation below.
Further action on information risk	An unencrypted memory stick with details relating to a clinical audit was recovered from another NHS Trust. The data was therefore not disclosed outside of NHS professionals and was fully recovered. Therefore, there was no risk of further public disclosure of this information. In response to this incident a detailed action plan was produced. This included further awareness raising activities, changes to policy and strengthened technical measures to restrict the transfer of personal data.			

Table 5: summary of other personal data related incidents in 2010/11

Category	Nature of incident	Total
I	Loss of inadequately protected electronic equipment devices or paper documents from secured NHS premises	0
II	Loss of inadequately protected electronic equipment devices or paper documents from outside secured NHS premises	3
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents.	0
IV	Unauthorised disclosure	0
V	Other	0

0.9%

of elective admissions cancelled at short notice – the first time our annual position has been under one per cent

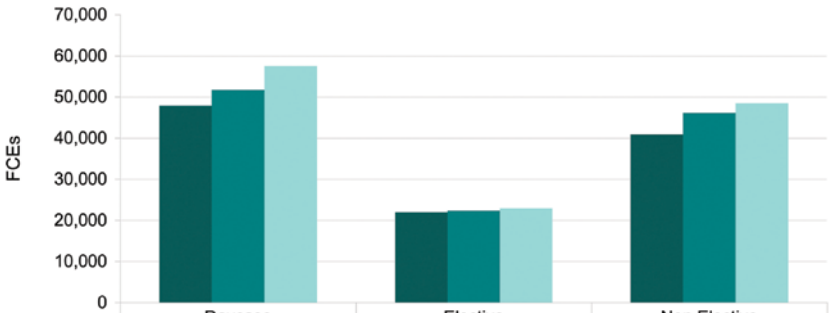
Activity at a glance 2010/11

In 2010/11 we provided over 48,000 non-elective finished consultant episodes (FCEs), up 5.1% from 2009/10. The number of elective FCEs also increased in 2010/11. Elective growth was higher in daycases (11.3%) than elective inpatient FCEs (2.7%), reflecting an improvement in efficiency: our daycase rate improved from 69.8% in 2009/10 to 71.5% in 2010/11.

The number of new outpatient attendances in 2010/11 also increased by 7,300 (4.1%) compared to 2009/10. Follow-up outpatient attendances increased to 571,000 in 2010/11, up by 39,000 from 2009/10 (7.4%).

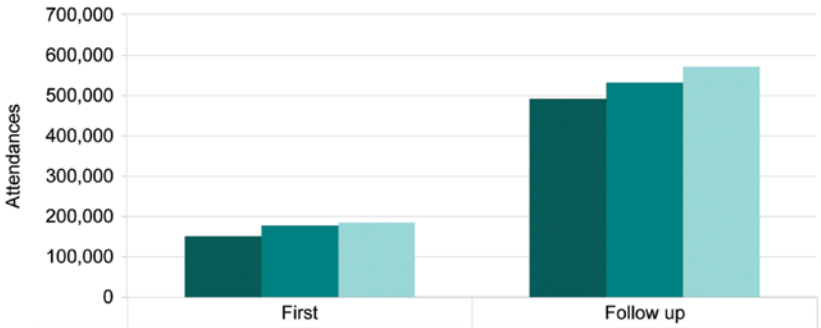
In 2010/11 around 55% of our referrals were from PCTs within North Central London (NCL), 28% from other London PCTs and 17% from non-London PCTs. The number of referrals from beyond our immediate locality - 46% - gives an indication of the importance of the tertiary and specialist services we provide.

Inpatient activity at UCLH



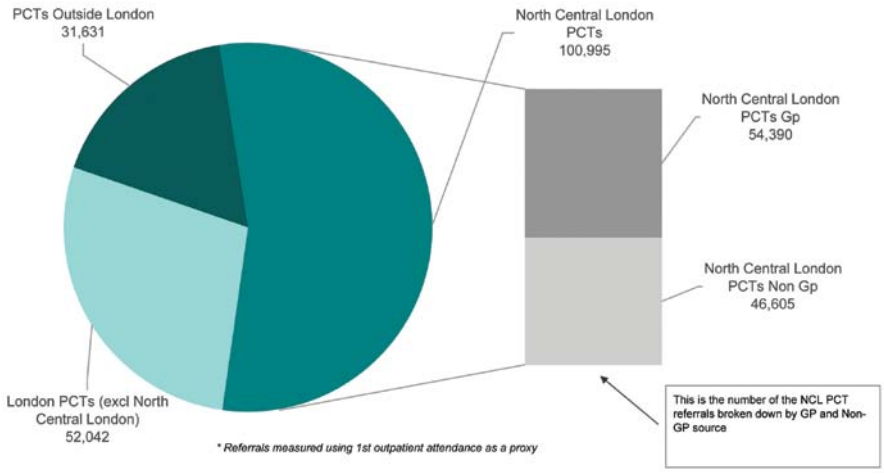
	Daycase	Elective	Non Elective
2008/09	47,872	21,969	40,851
2009/10	51,735	22,354	46,193
2010/11	57,587	22,965	48,526

Outpatient activity at UCLH



	First	Follow up
2008/09	150,352	491,998
2009/10	177,316	532,078
2010/11	184,668	571,439

Source of referrals* 2010/11



4 The strategic context

Health economy

The coalition government has set out policies and funding plans that create opportunities and pose challenges for the NHS as a whole and in the North Central London (NCL) sector in particular. In response to concerns about the content and pace of the reforms, the government is currently pausing to engage more with stakeholders and there are likely to be changes to its proposals.

The NHS has, to a degree, been protected from the significant cuts to funding in other parts of the public sector. Nonetheless in January 2011 NCL was predicting a deficit in the sector of £730m by 2014/15 if no action was taken to change the delivery of services to the local health economy. NCL commissioners set out ambitious plans for the reconfiguration of certain services and for driving hospital efficiency within the sector. In response we have developed new ways of partnership working and new services that support their plans. The development of stroke, cardiac and cancer services are particular priorities for UCLH in the coming years. We will work closely with commissioners to implement schemes which will genuinely save costs across the NHS. In particular we will work with commissioners to help move services out of hospitals and closer to the community in local primary care facilities.

As a result of these changes we predict having to find new savings of around 6% delivered in each of the next few years. Our challenge will be to continue to improve quality while delivering these demanding savings. We have established a quality, efficiency and productivity (QEP) programme that will help our clinical divisions

and corporate teams to make fundamental changes in service delivery. We are clear that we must review quality and efficiency together, with a focus on improving the processes that deliver improved outcomes, safety and experience.

In a period of funding constraint, it is more likely that increased efficiency will be achieved through reductions in cost rather than increased output within the same resources. Our QEP programme reflects both kinds of efficiencies and is set out in more detail in section 5 – Financial review.

GP commissioning

The government proposals put GPs at the heart of commissioning. We have already seen clear benefits from working more closely with GPs as part of the commissioning process. The proposed reforms have also prompted a careful consideration of where we can do more to support GPs in the services that we all provide for their patients. These initiatives are described in more detail in section 6 – Our staff and partners.

Patient choice and 'any willing provider'

The concept of 'any willing provider' provides the opportunity for all healthcare providers to supply specific services for which they are accredited. This clearly represents a challenge to existing providers, although one that we feel in a strong position to meet as the quality of our clinical services is high. We are also encouraged by recent clarifications that competition between providers must not be based purely on cost.

Quality

During this period of transition and financial difficulty the NHS has been challenged to continue to improve the quality of the services that it provides. The first NHS Outcomes Framework was published in December 2010. From 2012/13, the framework will be used to hold the NHS Commissioning Board to account for improving quality and delivering better health outcomes for people using NHS services. New 'levels of ambition' for improvement will be negotiated between the Secretary of State and the NHS Commissioning Board once it is in place. For the coming year, we will take heed of its direction of travel towards a focus on outcomes. We will collect data and establish baselines for all indicators wherever possible and, in doing so, identify how we can improve the quality of the services that we provide. The quality standards will provide authoritative definitions of what high quality care looks like for a particular pathway of care. The NHS Commissioning Board will use them to develop an outcomes framework for GP consortia and associated incentives, including high quality commissioning.

2,256
nurses and midwives

In 2010/11, Commissioning for Quality and Innovation (CQUIN) incentives provided UCLH with around £7.5m of income and they will continue to be a driver for quality services in 2011/12. CQUIN incentives have proved to be a positive force for improvement where hospitals and commissioners are able to design the indicators collaboratively and agree stretching but realistic targets.

The quality of services that hospitals provide – measured by clinical outcomes, patient surveys, infection rates and other safety measures – will continue to underpin the choices that patients and GPs make when choosing where to go for treatment.

Future targets

The Department of Health has issued new standards for A&E departments in 2011/12. Given our success in improving our processes in A&E in recent years we are confident that we will rise to the new challenges during 2011/12.

During the year the Department of Health signalled a move to median waits as the preferred method for measuring waiting times. We perform reasonably well against median waits for inpatient and outpatient care, although during 2011/12 we need to improve the quality of the data that we use to manage our waiting lists: currently problems with data management mean that we are shown as not performing well for waiting times for patients who are currently waiting for treatment. This is a priority for us to fix.

Research and innovation

Academic health science centres will continue to be at the heart of NHS innovation, enabling research to benefit patients quickly. Our role in UCL Partners and our continuing designation as a comprehensive biomedical research centre will help UCLH build on its position as a world-leader in research. We will strengthen our ties with partner hospital trusts – Royal Free Hampstead NHS Trust, Great Ormond Street Hospital for Children NHS Trust and Moorfields Eye Hospital NHS Foundation Trust – and we will work to develop more integrated pathways for patients at our hospitals.

Sustainability

UCLH has a board endorsed carbon reduction and sustainability management plan in place and compliance is measured against this and regulatory and other targets. The policy is reviewed annually and a performance report is generated to review progress.

The executive board monitors compliance with the management plan on a periodic basis including a full annual review.

The Carbon Reduction and Innovation Group (CRIG) has been in place for a year and achievements include:

- 60 carbon champions who audit and raise awareness across the Trust and report progress into the CRIG
- Collaboration with key partners to reduce carbon outside UCLH and within the local community, using opportunities for centralised systems to share resources and apply economies of scale
- Active involvement in partnerships, steering groups and initiatives to help continually improve performance and influence carbon impact.

Examples of engagement:

- Neutral Vendor – procurement and transport collective initiative
- Patient Transport Optimisation Scheme
- Sustainable food development working with local suppliers and contract service providers
- London Borough of Camden
  - Climate Change Alliance
  - cross sector steering and implementation group

Table 6: sustainability performance for UCLH Foundation Trust, 2010/11

		UCLH Non-financial data (applicable metric)	UCLH Non-financial data (applicable metric)	UCLH Non-financial data (applicable metric)		UCLH Financial data (£000's)	UCLH Financial data (£000's)	UCLH Financial data (£000's)
		2008/9	2009/10	2010/11		2008/9	2009/10	2010/11
* Waste minimisation and management	Absolute values for total amount of waste produced by the Trust.	2,922 tonnes	3,110 tonnes	3,528 tonnes	Expenditure on waste disposal.	£1119	£1197	£1058
*Finite Resources	Water	402480 m3	330690 m3	211,684 m3	Water	£558	£554	£372
	Electricity	42,210,319 kWh	42,498,231 KWh	42,736,882 KWh	Electricity	£4,418	£3,824	£3,752
	Gas	46,153,694 kWh	41,449,843 KWh	48,362,141 KWh	Gas	£1,745	£1,618	£1,689

** Note data supplied for 2008/9 may differ from those supplied in the original ERIC 2008/9 return. This is as a result of a subsequent data validation exercise.*

Sustainability achievements in 2010/11 include:

- A reduced carbon footprint from 31,671 to 27, 438 tonnes (4,324 tonnes of carbon saved)
- A 13.65% reduction our carbon footprint against the 2009-10 baseline (normalised)
- Accreditation to the Carbon Trust Standard (one of a small number of NHS trusts)
- Exceeding our 10:10 target to reduce carbon emissions by 10% in 2010.
- Improving our Good Corporate Citizenship rating to 'excellent' whilst meeting and surpassing all targets required to date.

10%
cut in carbon emissions

Table 7: UCLH carbon reduction figures

Baseline Footprint 2008-9 tCO2e	Target	Actual	Year 1 2009-10 tCO2e	Target	Actual	Year 2 2010-11 tCO2e
35,186 *	10%	9.99% (3,515t carbon reduction)	31,671	10% 10:10 target	13.65% (4,324t carbon reduction)	27,348 **

Recycling Year 2008-9 Baseline	Year 2009-10	Year 2010-11	Direct Cost Saving (year 10/11)	Carbon Savings (year 10/11)
0.8t (est.)	24t	519t (actual)	£119,000	1,416t (2,062% carbon reduction)

* Carbon footprint reassessed 2008/09 and scoped to GHG scope 2 emissions, carbon impact related to procurement is currently being assessed in conjunction with Department of Health P4CR NHS SCO2PE and public sector carbon disclosure programme.
** Normalised (degree day adjusted – gas and electricity) (activity adjusted for wastes).

Accolades for 2010/11 include:

- Outstanding Contribution to Environmental Sustainability in Camden by the London Borough of Camden Climate Change Alliance
- London Green 500 Diamond award
- Good Food on the Public Plate awarded by Sustain
- 'Carbon Champion' award by London Borough of Camden
- Commended in the Healthcare Business Awards for Sustainable Development
- 2 shortlists for Health Service Journal and Building Better Healthcare Awards in carbon management and sustainable development

Table 8: UCLH objectives 2011/12

Objectives	
Deliver excellent clinical outcomes	Improve performance on hospital mortality
	Reduce avoidable emergency readmissions
	Achieve 100% participation in national and locally mandated clinical audits
Improve patient safety	Reduce infections, including MRSA, Clostridium difficile, MSSA, e-coli, surgical site and central venous line infections
	Reduce numbers of blood clots
	Eliminate hospital-acquired pressure ulcers and significantly reduce patient falls.
Deliver high quality patient experience	Enable patients to manage their appointments easily and with confidence
	Achieve patient experience results in the upper quartile in the national inpatient survey
	Improve patient experience for cancer, maternity and outpatient services.
Build strong relationships with GPs	Improve the patient pathways of five key conditions, as agreed with GPs.
	Improve the timeliness and quality of discharge letters to GPs
	Make it easier for patients and GPs to contact hospital staff.
Achieve sustainable financial health	Achieve agreed income, expenditure and cash targets
	Deliver service line management/reporting and patient level costing
	Replace the existing financial management system by mid-2012/13
Deliver cost savings through the Quality & Efficiency Productivity (QEP) Programme	Deliver QEP savings in 2011/12
	Develop and implement a plan for long-term productivity and efficiency savings
	Rationalise corporate and clinical support services across UCL Partners
Develop R&D and education through UCLP	Get the UCLH clinical research facility running at full capacity
	Achieve re-designation as a comprehensive biomedical research centre
	Implement a leadership staff college.
Develop and enable staff to maximise their potential	Reduce stress in the workplace and set a zero tolerance towards violence against staff
	Aim to appraise all staff and double mandatory training compliance by the end of the year.
	Ensure that all staff roles are fit for purpose and affordable

30%
reduction in cases of C.diff

Objectives	
Deliver wait times in line with contract	Deliver patient waiting times agreed with commissioners
	Deliver standards for timeliness and quality of care in A&E
	Meet the cancer waiting time targets
Develop clinical services within available resources	Succeed in our bid for Proton Beam Therapy
	Improve care for cancer patients by redesigning pathways and commissioning the Cancer Centre
	Progress plans for phase 4 development

5 Financial review

Finance Director's report for the year ended 31 March 2011

We are pleased as a Trust to be able to report that our underlying financial results (prior to exceptional items) for the year ending 31 March 2011 were better than plan and similar to the previous year. Unsurprisingly given the public spending climate, our income growth was at a lower level than that of recent years, and this trend is expected to continue.

Overall our turnover increased by 6% on the previous year to £738m (09/10 £700m), NHS clinical income increased 8% to £533m (09/10 £493m), and earnings before interest, tax, depreciation and amortisation (EBITDA) increased 6% to £67m (09/10 £63m). Our surplus (before exceptional items) of £11.4m was more than £2m ahead of plan and very similar to last year (09/10 £11.5m). This resulted in an overall financial risk rating of 4 for the Trust, indicating strong financial performance on the scale from 1 to 5 against which the Trust is measured by the Foundation Trust regulator, Monitor.

Throughout 2010/11 there has been a strong focus within the Trust on its Quality, Efficiency and Productivity (QEP) programme, which aims to improve the efficiency with which we deliver healthcare to our patients, reducing waste and making financial savings whilst maintaining or improving our high standards of quality and safety. The Trust has successfully achieved 98% of its QEP saving requirement in 2010/11.

Aside from operational factors, the modest improvement in London property values resulted in an upward revaluation of our estate, requiring us to reverse £5.1m of the impairments suffered in recent years (09/10 -£22.5m), distorting our reported surplus/deficit (post exceptional items) from an £11.0m deficit in 09/10 to a £16.6m surplus in 10/11. Removing the impact of these revaluations shows that the pre-exceptional, underlying surplus was broadly the same in both years.

The summary year-end position is shown in the table below.

Table 9: Summary year-end position

£ million	2010/11 Plan	2010/11 Actual	2009/10 Actual
Operating income	716.9	737.8	700.1
Operating expenditure	(652.0)	(670.6)	(636.8)
EBITDA	**64.9**	**67.2**	**63.3**
Depreciation costs	(20.7)	(20.1)	(18.8)
PDC dividend	(9.0)	(8.5)	(8.2)
Interest income and costs	(26.2)	(27.1)	(24.9)
PRE-EXCEPTIONAL SURPLUS	**8.9**	**11.4**	**11.5**
Impairment losses and reversals	0	5.1	(22.5)
Surplus/(deficit) for the financial year	**8.9**	**16.6**	**(11.0)**

Note – all figures rounded to nearest £0.1m

Specialist Hospitals and Medicine Clinical Boards delivered strong financial results, while Surgery and Cancer board struggled to deliver against a challenging plan. Our overall EBITDA margin, an important measure of productivity, was 9.1%. This was exactly on plan and consistent with last year (9%).

Our balance sheet remains strong, with a cash balance at the end of the year of £107m, although this includes the draw down of £20m of a loan to partially offset the costs incurred on the construction of the new UCH Macmillan Cancer Centre, due to open in April 2012. The cash balance also includes the sale of estate, which will be partially used to provide funding to enable the re-provision of pathology facilities during 2011/12.

6%
increase in A&E attendances

Forward Look

Moving forwards into 2011/12, pressures on our financial sustainability will increase significantly and it is in this context that the Trust is planning a break-even financial position for the next three years, with much lower activity growth than has been the case in recent years. This will have a consequent knock-on effect upon the Trust's cash plan and the ability to re-invest financially in service developments and develop the innovative, research-led care that we strive to provide.

The Trust will be impacted adversely in 2011/12 not only by a significant reduction in the tariff price chargeable for treating our patients and the introduction of strict restrictions upon payments for patients 're-admitted' within 30 days of being discharged from hospital, but also by a material reduction in the Market Forces Factor (MFF) funding that compensates for the additional costs of providing services in a high cost area such as London.

We currently estimate that the level of cost saving that we will need to deliver in 2011/12 will be at least £45m (or 6.3% of turnover). In common with most healthcare providers, our target significantly exceeds the value of savings delivered in recent years. Unlike many areas of the public sector, the opportunities within a major hospital to save money through cutting or reducing services are limited, as our income is based upon the amount of activity that we do. The emphasis, therefore, has to be upon providing the same service at the same or better quality but at a significantly lower cost, a tough challenge to our staff at all levels.

We continue to cooperate with commissioners in their programme of demand management, aiming to treat patients in primary care where this is the most clinically appropriate setting, rather than in acute hospitals such as ours. As a PFI-funded modern hospital there is also a strong argument that greater efficiency for the taxpayer would be achieved with increased rather than decreased patient flow through our main UCH facility, and we will continue to work with those planning sector, regional and national service provision to ensure the maximum utility of all our facilities.

2011/12 will also see the full roll-out of a patient level costing system (PLICS) to enable us to better understand the costs of delivering care to our patients – this system is now producing its first detailed results which will need to go through an extensive validation process. The system will support a much clearer understanding of what drives costs across the Trust at a detailed level and help us identify opportunities for efficiencies in the care we provide to patients. The Trust also made significant progress in its development of Service Line Management, further empowering clinicians in financial leadership and enabling them to make informed financial decisions in line with the trust's devolved and clinically-led management structure.

We are also working jointly with the Royal Free Hospital to implement a new financial system. Working to common processes and standards across the two organisations will help create further efficiencies and improvements in quality. A project to explore synergies like these between all members of UCLP (University College London Partners) has now been running for a year and represents a significant part of our drive for future savings alongside quality improvement.

2010/11 Annual Accounts

The Annual Accounts are attached at appendix 5.

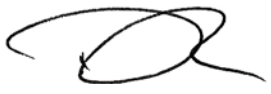
Auditors

The Trust's Auditors are:
PricewaterhouseCoopers LLP
7 More London Riverside
London
SE1 2RT

As far as the directors are aware there is no relevant audit information of which the auditors are unaware and the directors have taken all reasonable steps to make themselves aware of relevant audit information and to establish the auditors are aware of that information. The finance director and his senior staff have provided the auditors and the Audit Committee with all relevant information they are aware of, and have through the financial year raised and discussed such issues with the auditors.

Going Concern

After making enquiries, the directors have a reasonable expectation that University College London Hospitals NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.



Richard Alexander
Finance Director
University College London
Hospitals NHS Foundation Trust
Date

Our efficiency programme

Given the national challenge in improving quality and reducing cost that will face all organisations over the next five years, in January 2010 we put in place a quality, efficiency and productivity (QEP) programme to help the organisation achieve the challenging financial targets while continuing to delivery high quality care.

The year one programme required savings of £31.7m (note: formal Monitor 2010/11 Trust plan cost improvement plan target of £26.5m excluded £5.2m of locally managed savings) and we achieved 98% of this demanding target. Our board of directors monitors very closely the interplay between how we save money and the quality of the services that we provide. Currently quality metrics are performing strongly, including improvements in patient satisfaction rates and HMSR rates which were recently at an all time low. With a savings target for 2011/12 at £45m we still aim to make improvements in quality. Savings requirements in 2011/12 and future years will be closely assessed for their potential impact on the quality of the services we provide to our patients.

The success of the programme has been due to commitment across the organisation and the delivery of many schemes at local level, driven by clinicians and local management.

The work was taken forward through five major strands plus considerable local activity. We are using the same structure for year two of the QEP programme in 2011/12, including:

- workforce: minimising the

use of agency staff, which has been halved during the year
- productive clinical services: making our clinical teams as efficient and productive as they can be, with a focus on reducing length of stay, cutting out unnecessary steps on the patient pathway and improving the efficiency within outpatient clinics
- procurement: getting the best value for money out of the contracts we have with all our suppliers, and ensuring that we get the best value with new purchases
- asset utilisation: getting the best use out of the buildings that we own and lease, including estate rationalisation
- back office services: making our Trust processes more efficient including the use of business process management software, and looking to see if any of our administrative or clinical support services can be shared across UCL Partners or taken on by alternative arrangements to deliver a better value service.

The programme's approach is based on five guiding principles:

- make life simple
- keep patients safe
- get everyone involved
- use the evidence
- spend money wisely.

Each strand and clinical and corporate team has agreed savings targets in support of the QEP programme and these are reported on through the QEP project management office to executive board and the board. In year two we are using the same approach and structure to achieve £45 million in savings at the time of writing. We are close to identifying schemes for all of this target, although this represents a significant challenge in terms of delivery.

We have agreed our five year strategic approach to QEP in a strategy document called 'Thriving Through the Downturn'. The strategy was approved by the executive board in December 2010 and communicated to all staff during a major QEP week of events in March 2011. These events celebrated the hard work and results achieved in the first year and focused on the task ahead in year two and beyond.

6 Our staff and partners

Our workforce continues to be our most valuable asset and underpins our future success. We recognise and acknowledge the correlation between high quality human resources (HR) practices and improved patient outcomes and safety. We also believe there is a direct correlation between the experience of our staff and the patient experience.

Key achievements during 2010/11 include:

- A reduction in agency spend of £11.5m from £24.8m in 2009/10
- The highest staff bank fill rate on record: 91% in March 2011, an improvement of 21% from the same period in 2010
- More than 1,000 additional bank workers have been recruited since the 1 April 2010 giving the Trust even greater flexibility in workforce planning and management
- Maximising the use of technology in order to reduce the length of time to hire. This has resulted in an average from receipt of request to advertise to conditional offer taking 9.6 weeks
- Recruitment activity in 2010/11 has been considerable: 47,537 applicants applied for 1,750 (whole time equivalent) posts. This was underpinned by a number of key initiatives that enabled the Trust to develop new services and re-configure existing services
- Key recruitment focus has been on providing positive support to enable the opening of Hyper Acute Stroke Unit and the Brain Tumour Unit and to reconfigure services through internal relocation of services
- Assessment centres for appointing to large scale advertisements, for example healthcare assistants. An event in September resulted in 22 whole time equivalent posts being appointed to
- An Electronic Criminal Records Bureau checking system was implemented in January 2011 and is delivering turnaround times of four working days on average in recruitment checking
- Significantly reducing the average cost of management of employment relations.

Keeping staff informed

The Trust is committed to keeping staff up-to-date with news and developments through various internal communications channels:

- Team briefing: staff receive the chief executive's core brief every month
- Inside Story: the Trust's monthly staff magazine is attached to payslips
- Insight: the intranet is kept up-to-date to provide staff with information that is important and/or of interest
- Daily news emails: staff receive a daily update on Trust news and developments by email every day
- Chief executive roadshows: the chief executive visits individual hospitals and gives a presentation on strategic developments and operational issues, including updates on how the financial and economic climate is affecting the performance of the Trust. This is followed by a question and answer session where staff can ask the chief executive questions about the Trust or any aspect of their working lives.

A monthly management forum is attended by the Trust's divisional clinical directors and divisional managers which provides an opportunity to discuss key strategic and operational issues and developments.

At a local level staff are informed about matters affecting them at team meetings. An established team meeting structure sees medical directors meeting with divisional managers and divisional clinical directors in their clinical board on a regular basis. Divisions have a structure of team meetings.

We have implemented an internal communications plan to keep staff systematically up to date on our QEP programme, so that they are aware of the impacts to the workforce and can get involved – see section four for more information.

There is a programme of corporate and local induction and orientation for new starters which aims to improve staff retention.

In 2010/11, a new approach to Team Briefing was introduced to ensure that staff remain informed and engaged in Trust activities and have the opportunity to have their say.

Support for staff

The staff psychological and welfare service provides support to all staff, to help them cope with change, support career development and enable access to a range of services.

During 2010/11 Trust staff continued to be involved in a range of working groups and projects aimed at supporting Trust

98.5%
of patients seen, admitted or discharged from A&E within four hours

objectives. The Trust reviewed, published and implemented policies in relation to:

- Adoption Leave
- Appraisal
- Control of Substances Hazardous to Health (COSHH)
- Disclosure of Confidential Information
- Display Screen Equipment (and Eye Testing)
- Disruption to Public Transport
- Falls, Slips and Trips Prevention
- First Aid
- Flexible working incorporating Home/Term Time Working, Job Share etc.
- Grievance
- Healthcare Workers with HIV, Hep B and Hep C
- Management of Work Related Stress
- Managing Performance
- Maternity and New and Expectant Mothers at Work.
- Parental / Paternity
- Pre-Appointment and In-Post Checks
- Probationary Periods
- Recruitment and Selection, Retirement
- Safer Handling
- Sharps and other Occupational Exposure to Blood and Body Fluids
- Smoke-Free Environment.

These policies were developed in partnership with Staff Side colleagues.

The Trust remains committed to engaging with staff and unions to deliver improvements to services, improvements to working conditions and to work with them to manage change. We are committed to promoting health and wellbeing, providing staff benefits, delivering training and protecting the health and safety of our workforce and those who access our services. The contribution by Staff Side this year has been significant and is highly valued by the Trust.

Developing our workforce

We are committed to developing leaders at all levels across the organisation so they are confident and competent in their roles. Following consultation and discussion with a range of internal stakeholders, we have adopted a new framework for the development of staff and managers which will be implemented in the coming year.

Our ability to develop staff depends upon effective appraisal. A new policy was launched in 2011/12 to ensure managers are aware of their responsibility to appraise their staff and to equip staff with the tools they need to get the most out of their appraisal.

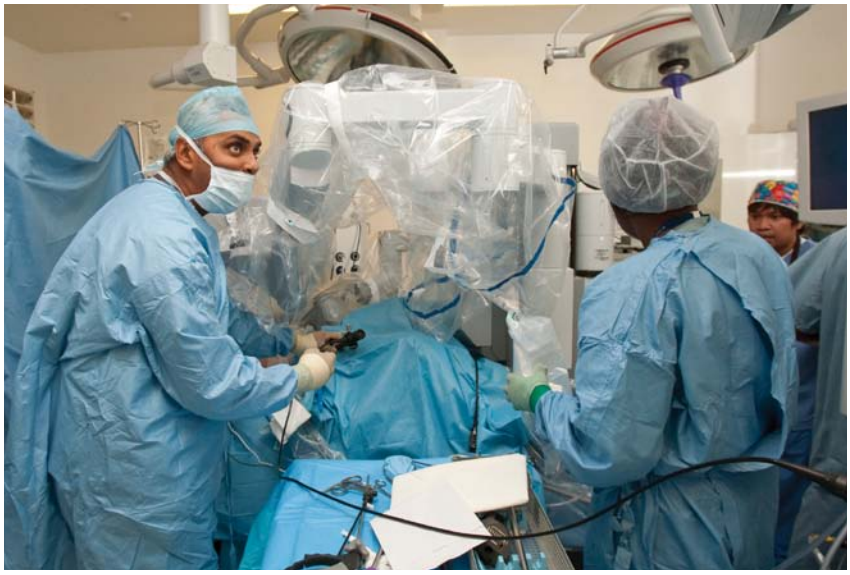
The introduction of probationary periods for all new starters will continue to underpin good staff practices including induction and performance management.

Education

In 2008 UCLH set out a new education strategy that focused on developing the correct culture and behaviours to ensure patient safety and enhance patient experience. The four fundamentals of this strategy were:

- To create and maintain a great culture
- To assure commitment to service excellence
- To continuously develop great leaders
- To hardwire success through systems of accountability.

To achieve this, a director of education was appointed in 2008. Since then the approach to education within the Trust has been refocused. Firstly, the UCH Education Centre was opened to provide the UK's leading facility for delivering simulated learning. Within this a replica hospital has been built to deliver



the most realistic clinical training environment available, using professional role players.

Within the Education Centre a series of innovative programmes have been developed and delivered to address open communication, team working and leadership. These are delivered to UCLH staff, as well as to staff from other trusts due to the reputation for high quality that the programmes have achieved. This was reinforced in December 2010 by the achievement of the NHS London 2010 'STeLI Excellence in Education Innovation Award'. In March 2011, three of the programmes developed in the Education Centre were finalists in the Health Service Journal Patient Safety Awards.

The most recent programme has been a Staff College developed for UCL Partners to promote and develop high level leadership skills. This has been developed with ex-members of the Armed Forces, building on their experience of identifying and developing leadership potential. Many of the principles are the same, but the tailoring of the programme to healthcare needs has resulted in extremely positive feedback and strong interest in taking this to both national and international domains.

In addition to innovation within education, there has also been a strong emphasis on ensuring that we are covering all the necessary basic core skills required by our staff. A complete review of all statutory and mandatory training has been undertaken with the development of specific e-learning modules to make this training both interesting and flexible. We have also developed a training programme for managers, 'Leading for Improvement' which will be launched during the coming year. As greater requirements are placed on the Trust to ensure that training is both comprehensive and effective, we are committed to delivering this in a high quality, cost effective manner.

Overall the objectives of the education strategy review in 2008 are being met through a commitment to excellent education in all its forms. Education is a constant process with excellence resulting from continuous practice and reinforcement.

Our workforce in the future

In 2011/12 we will continue to make improvements to our core workforce and to the quality of support we provide to our clinical boards and corporate teams. We will use comprehensive performance measures to track effectiveness and ensure they offer value for money. We will focus on five key areas of development in 2011/12 to help improve patient care, meet customer needs and value for money – these are:

1. **Reduce workforce costs** through reduction of our pay bill and deriving better value from bank and agency contracts
2. **Engage staff** in a range of working groups and projects aimed at supporting Trust objectives and encouraging staff feedback
3. **Enhancing leadership** by developing leaders across the organisation so that they are confident and competent in their roles through a new framework for staff development, management and leadership development and staff development and appraisal.
4. **Improve compliance and performance** by developing metrics to include reporting and levels of sickness absence, mandatory training, appraisals and induction. Work will also focus on non-clinical

support service programme (back office), recruitment and mandatory training compliance

5. **Simplify and standardise workforce processes** making it easier for managers to manage and leaders to lead through improved employee management (development of an electronic staff record – ESR), procurement and implementation of a whole staff e-rostering system and implementation of probationary period.

Employee relations

We will continue to foster positive employee relations and work to further reduce the incidence of grievances and disciplinary procedures that we have to deal with. We will streamline processes and train and develop managers to be more accountable and autonomous. We will continue to invest time in training our managers in how to avoid and manage the most common causes of complaints against us.

The NHS Staff Survey

We are committed to ensuring frequent and structured staff engagement including feedback on key staff issues.

The NHS staff survey results for 2010/11 demonstrate the Trust performed significantly better on 10 key findings of the 38 compared to the same period the previous year, see appendix 2, staff survey results. The Trust scored highly in areas relating to staff engagement 92% of respondents agreeing that their role makes a difference to patients. 77% reported feeling satisfied with the quality of work and patient care they are able to offer. In addition, the score for

staff recommending the Trust as a place to work or receive treatment has improved and is in the top 20% of all acute Trusts.

In 2009, the Trust increased the survey size from 850 to 2,000 in order to increase the usefulness and reliability of the information received The Trust response rate in 2009 was 43% but this has improved to 58.1% for the 2010 staff survey. The larger sample size has allowed robust local divisional action plans to be developed to ensure that improving working lives is embedded throughout the organisation.

A 10-point action plan is being developed to address some of the challenging results reported in areas relating to reduction of workplace stress, further reduce incidents of bullying, harassment and all cases of violence, increasing appraisal rates and compliance with statutory and mandatory training. The plan also seeks to increase the uptake of equality and diversity training, introduce a range of staff benefits schemes, conduct regular staff surveys on key topics and to promote a fit organisation, linking into the Trust's work with the London 2012 Olympic and Paralympic Games.

Consultation

Medicine board: The HR team supported four consultations within the Clinical Support and Medical Specialties Divisions introducing more efficient management and administration structures and support. The outcome has been improved cross departmental deployment of management and administration. A similar consultation exercise was supported in Critical Care where administration was reconfigured across the division.

Surgery & Cancer board: Over the past year, the board has led several initiatives to improve patient pathways and improve the efficiency of the services

- restructuring the nursing function in theatres has improved how the team is working and has had a positive impact on staff as detailed in the latest survey results
- Imaging has also improved service delivery through the sustainability project; an in house investment initiative

to increase asset utilisation and capacity of CT and MRI scanners to provide a better service for patients and clinicians
- two events took place where we invited a wide range of interested parties including patients and their representatives, governors and relevant charities to consult on the transfer of brain cancer surgery work from the Royal Free Hampstead NHS Trust to UCLH and the transfer of hepatopancreaticobiliary surgery from UCLH to the Royal Free Hampstead NHS Trust. The NCL sector was informed and communicated with the local authority overview and scrutiny committees.

Extensive planning is also underway for the new UCH Macmillan Cancer Centre which will open in 2012. The partnership with Macmillan is an opportunity to understand more about the pathway of cancer patients and focus the service model for staff in the Cancer Centre. Initial work has started in planning the possible transfer of the Royal National Throat, Nose and Ear Hospital services from the Royal Free Hampstead NHS Trust to UCLH to create an integrated service. We anticipate this could be complete by 2012 and may involve the transfer of up to 400 staff. UCLH has also established a partnership with a commercial firm to form a joint venture for reporting services for radiology.

Specialist Hospitals board: The HR team supported consultations across the Specialist Hospitals board (SHB) including:

- review of working patterns and practices at the Eastman Dental Hospital
- consultation within neuro-radiology at Queen Square resulting in admin service team restructure
- consultation resulting in a move from weekly to monthly payroll in order to reduce the number of pay runs from 64 to just 12 per annum.
- the Heart Hospital theatres moved to six day working
- review the reception service with proposals to introduce a contracted site security to replace the current night service provision cover on the reception and portering service
- restructure of midwifery management which concluded in June 2010 to improve reporting lines and to increase senior clinical presence within maternity departments
- a consultation took place within the midwifery team which concluded in April 2010. This consultation affected community midwifery teams and changed working patterns to promote continuity of care for women and their babies.

Corporate: Similarly within the corporate workforce there were three consultations focused on improving efficiency and structure within the finance, research and development and ICT training departments.

Health and Safety

The Trust's Health and Safety Committee meets every month and receives and reviews information on incidents or injuries involving violence, moving and handling, falls, and security. Incidents involving exposure to blood borne viruses (i.e. sharps injuries and splashes) are reviewed by the Trust Infection Control Committee which meets quarterly. Key health and safety policies have been reviewed and revised.

During 2010/11, improvements to the risk assessment process have continued and monitoring and audit arrangements have been strengthened. There has been an audit of the organisation's risk assessment process, including staff and visitor slips, trips and falls, manual handling, violence and aggression, Control of Substances Hazardous to Health (COSHH), and stress. The audit checked whether divisions had up to date risk assessments in place and audited the quality of the risk assessments and whether they had been risk-rated and placed on the appropriate register.

An action plan has been developed to build on good practice and tackle the issues and concerns raised by this audit. This has included providing better information to managers on the risk assessment process to improve compliance and quality. A lone worker audit has also been conducted. The Health and Safety Committee is focusing on violence and aggression towards staff as this is the main type of incident reported for staff and is now analysing each physical assault to better understand what can be done to reduce the number of assaults. This also addresses a key issue raised in the 2010 NHS Staff Survey.

There has been a continued reduction in the number of injuries caused by needles as a result of improved education, training and the introduction of safer needles.

97%
of patients said they would recommend the hospital to family and friends

Equality and diversity

The Trust is committed to the principles of diversity, equality and human rights and aims to encourage and value this diversity. The Trust recognises that talent and potential are distributed across the population. All policies applied within the Trust are equality impact assessed. This process is an analysis of a policy, service or function which enables the Trust to assess the implications of its decisions on the whole community in order to eliminate discrimination, tackle inequality and develop a better understanding of the community we serve and support. In addition it enables the Trust to target resources efficiently and adhere to the transparency and accountability element of the public sector equality duty.

The Trust has continued to meet its relevant publication duties, and all the equality schemes, and annual workforce reports (containing employment monitoring statistics and the results of the race equality impact assessments) are published on the Trust website. The policies that govern full and fair consideration of applications for employment made by disabled people are the Trust-wide recruitment and selection procedure, the pre-employment and post-employment checks policy and the diversity, equality and human rights policy. In addition, the Single Equality Scheme (SES) 2010-13 provides a framework within which the Trust operates, with regard to disabled people.

The policies that apply to employees who have become disabled during the last financial year are:

- the SES 2010-13 (see above).

For continuing employment, training and career development and promotions, the following policies apply:

- the pre-employment and post -employment checks policy
- sickness absence and attendance policy and procedure
- management of stress at work policy
- risk assessment procedure
- risk management purpose and strategy
- disclosure of confidential information procedure
- retirement procedure
- statutory and mandatory training policy
- manual handling policy
- the pre-employment and post -employment checks policy
- trust wide recruitment and selection procedure
- risk assessment procedure
- risk management purpose and strategy.

The Trust will publish a revised diversity, equality and human rights policy in 2011, taking account of recent legislative changes.

Equality and diversity report

The Trust's approach continues to be led by the Diversity & Equality Steering Group (DESG). The DESG is responsible for ensuring the aims and objectives set out in the Trust's SES are achieved. The DESG performance is monitored via progress reports to the board of directors as part of the Human Resources and Communications Committee report. The Patient Issues Committee also receives reports from the clinical board leads.

The 'Workforce Diversity & Equality Report' published in July 2010 captured the composition of the Trust's workforce by age, ethnicity and gender and provided a detailed analysis of the Trust's profile by clinical board, staff groups and pay bands. An ethnicity profile for new starters and leavers was also provided.

The profile has since been refreshed to include data for disability, religion and/or belief and sexual orientation. Additional information is provided (see appendix 3) to illustrate the staff profile characteristics as at February 2011 in comparison to 2009 and 2010. This data enables the Trust to understand trends, review policies, practices and implementation of any actions arising from the analysis. It also contributes towards our understanding of the impact of people management practices through the equality impact assessments and to fulfil our legal obligations under the various strands of equality legislation.

Whilst the Trust has made improvements in capturing data for the characteristics which fall under the Equality Act for all new employees, more work will be undertaken to improve the data on existing staff for monitoring and to inform decision making.

The available data demonstrates the following;

- The age group 26-40 has the largest proportion of staff, representing 46% of our workforce
- The age range 65+ represents the smallest proportion of staff employed within the

Trust accounting for just 1%: the Trust expects to see an increase in the number of staff working over the age of 65 with the Government's abolition of the default retirement age in 2011

- There has been a sharp increase in the number of new staff who have not disclosed their ethnicity
- For 2010, there has been an increase in the number of male staff in comparison to previous years
- In terms of staff religion/ cultural beliefs, 72% remain undefined whilst 14% declared their religion/ belief as Christianity. The undefined group consist of those staff who joined the Trust prior to 2010 (when this data began to be captured on ESR) and so these percentages are likely to change once this information is captured for all staff
- In terms of the Trust's profile for sexual orientation, the undefined group consist of those staff that joined prior to 2010 (when this data began to be captured on ESR) and so these percentages are likely to change once this information is captured for all staff.
- There were no significant changes to the composition of the workforce by Occupational Staff Group in 2010.

Age profile by occupational staff groups

The age profile as at February 2011 shows Nursing & Midwifery employs the largest single age ranges of 31-35 years at 20% (565) and 36-40 at 20% (555) of its workforce. In comparison to last year, 36-40 was the largest single age range, therefore the Nursing and Midwifery workforce shows a trend of being younger in age.

Gender profile by occupational staff groups

The gender profile shows for the Trust's gender composition is currently 71% women and 29% men. Nursing and midwifery has the largest number of women accounting for 25% (2,224) of the workforce and Medical and Dental continues to employ the largest number of men representing 35% (1,008) of employees.

Ethnicity profile by occupational staff groups

Again Nursing & Midwifery represents the largest occupational staff group. White ethnic groups are the largest represented group with (1,164) 42%, followed by 'other' (474) 17% and Black (463) 17%. Mixed represented the smallest represented group with (34) 1%.

The 'Diversity, Equality & Human Rights Policy' outlines the Trust's vision, priorities and objectives within UCLH. This is under review to ensure that it takes account of the recent changes under the Equality Act 2010.

With the introduction of the Equality Act 2010, some focused work has taken place throughout the year primarily to ensure the Trust's workforce is kept informed of changes in equality law, including the provision of training sessions for Trust staff. In addition the Trust continues to work through an internal action plan to ensure full compliance against the Equality Act 2010, tracking the Employee Relations caseload over the past 12 months where protected characteristics have been sited as follows, to ensure consistency:

Table 10: Employee Relations cases 2010/11

2010								2011		
Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1	1	0	2	1	0	1	2	0	0	0

Disability

The Trust began to capture disability status for Trust staff in 2010 on ESR. During this time 11% of staff indicated their disability status as 'none' and less than 1% have disclosed their disability status. A key priority for the next twelve months will be to work on capturing the data for existing staff in order to improve records and provide targeted support to our workforce.

Table 11: age and gender profile at 31 March 2011

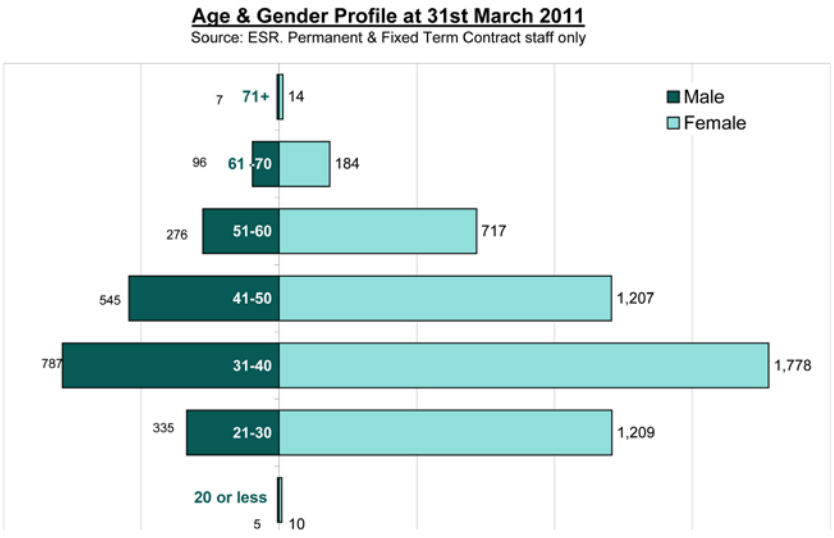


Table 12: ethnicity at 31 March 2011

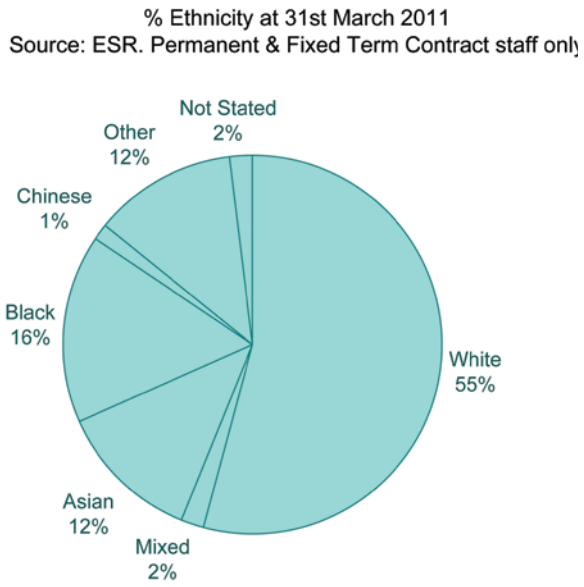


Table 13: disability at 31 March 2011

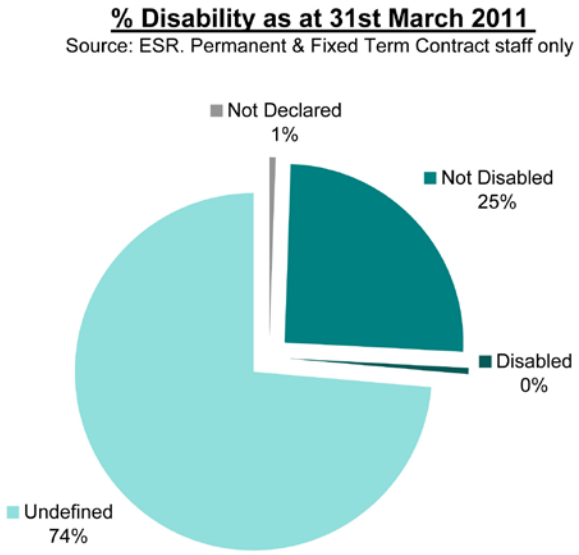
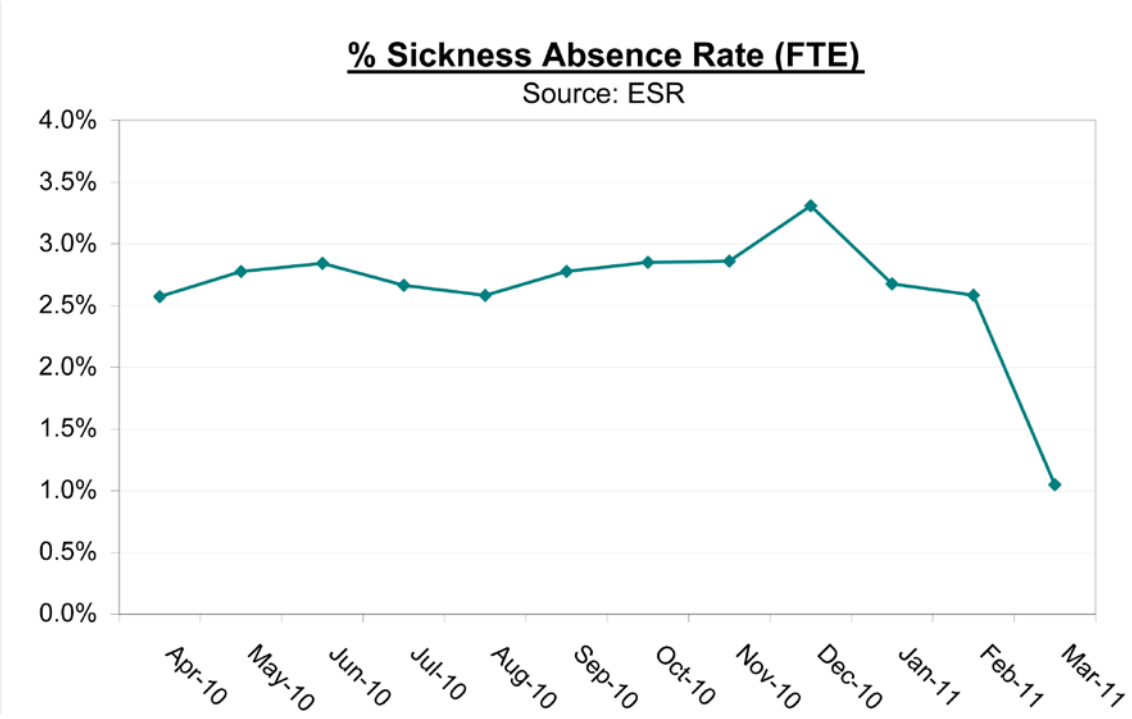


Table 14: sickness absence rate



NHS Constitution

The NHS Constitution became law in January 2010 and was designed to safeguard the NHS for generations to come. For the first time, it brought together in one place the NHS principles and values, and the rights and responsibilities of patients, the public and staff.

Our values are based on those of the NHS which are embedded in the NHS Constitution. It plays a core role in our governance and everyone who writes a Trust policy is required to consider the implications of the NHS Constitution. All staff are urged to understand its principles and values which shape the way we work and interact with patients. It is discussed as part of the mandatory induction programme for all new staff and background information is provided on our intranet.

Information about the NHS Constitution is provided for patients, carers and visitors through PALS and on our external website. This year the values, rights, pledges and responsibilities will be central to the development of the Trust's patient and public involvement strategy.

Working in partnership

The Trust works in partnership with primary care trusts, the North Central London Acute Commissioning Agency, practice based commissioners, GPs and referring hospitals to deliver high quality services to the patients referred to the Trust. UCLH also plays a central role in delivering healthcare to local people within networks of care, such as the North London Cancer Network.

As well as commissioners, the Trust works with a number of different partners including individuals, private healthcare providers (for example HCA International Limited) and other public and private sector organisations which support the Trust's day-to-day work. These include:

- volunteers
- temporary staff providers such as Pulse (who manage our Nurse Bank Service)
- University College London (UCL)
- Other local hospitals
- Facilities providers (including Interserve Facilities Management at UCH, Sodexho, catering at The Heart Hospital, Medirest catering at Queen Square and SRCL who manage our clinical waste disposal across the Trust)
- Logica CMG for IT support
- Azzuri for telecoms support
- Iron Mountain for data storage and retrieval including case notes
- Pathology - TDL pathology and UCLH working together to provide a joint service.
- Door 2 Door (D2D) for patient transport services.
- Supply partners such as Healthcare Purchasing Consortium (HPC), NHS Supply agency (DHL) and London Procurement Programme (LPP) to support the procurement of goods and services.

The Trust plays an active part in UCL Partners (UCLP) together with UCL, The Royal Free Hampstead NHS Trust, Great Ormond Street Hospital for Children NHS Trust and Moorfields Eye Hospital working to improve the quality of healthcare, research and education provided across the constituent organisations.

Building strong relationships with GPs

We aim to improve the quality of care we provide for patients and reduce costs by working with colleagues in primary care across the North Central London (NCL) sector to develop new, integrated care pathways.

Building strong relationships with GPs has been identified as

one of UCLH's top ten corporate objectives for 2011/12. This involves:

- Improving the patient pathway of five key conditions, as agreed with GPs
- Improving the timeliness and quality of discharge letters to GPs
- Making it easier for patients and GPs to contact hospital staff.

The development of integrated care pathways with primary care colleagues in the NCL sector offers excellent opportunities for focusing the healthcare resources where there are the biggest improvements for patients. This shift in how the NHS delivers care depends upon changes in how we manage patients at UCLH. It also depends upon changes in the primary care infrastructure, most notably ensuring that there is enough capacity in place to receive patients previously seen in hospital, and ensuring that standards of patient safety and quality will be met.

The aim of our integrated care work will be to reduce duplication in patient pathways, support self care and ensure that patients have rapid access to hospital services when they need it. We also implemented a post acute care re-enablement scheme in January 2011 that supported patients receiving the personalised care in their own home by our hospital staff following discharge. Post acute care enablement has been trialled nationally over the past year and has received very positive feedback from patients who are delighted with their continuity of care following discharge. We aim to expand the project this year to cover a much wider group of patients.

Our elderly care team has developed its model of care to provide greater input at the start of a patient's admission to the Trust. This model of working has meant that elderly patients who often have very complex care requirements following discharge are been assessed sooner. Communication with community teams is starting much earlier to develop plans for ongoing care and reduce any delays that may occur later in the patient pathway. We have also developed our model for chronic obstructive pulmonary disease (COPD) by enhancing the expert respiratory care for patients and linking with community teams.

Keeping in touch with GPs

UCLH is driving forward with a programme to significantly improve how we work with GPs. We have created a GP Partnership board, led by one of our medical directors to ensure the Trust is really focused on the issues which matter to GPs. Rising to this challenge will not only improve patient care but is of huge importance to the ongoing success of the Trust.

The Trust publishes GP Links, a GP newsletter which is sent out by post and email six times a year, with information about services and developments across our six hospitals. The Trust also surveys GPs each year to obtain feedback on our services so that we build on areas where GPs believe we perform well and so we can improve where they tell us we could do better.

Throughout the year the Trust holds evening educational seminars for primary care and subjects covered in 2010/11 included: early onset dementia, women's health and colorectal cancer.

In 2010/11 we redesigned the UCLH website with GPs' needs in mind. A dedicated GP section of the website lists each service and includes information on how to refer with contact details for staff and services.

GP Portal

We have continued to develop an online 'GP portal' to improve the quality and timeliness of the information we provide to GPs about their patients. It enables GPs to get up to date information about their patients' progress at our hospitals, including details of appointments and admissions, A&E attendances, clinical documents, results and discharge summaries.

The portal uses a secure NHS IT network and GPs can access only their patients' records.

The GP portal will provide more transparency to GPs on exactly where patients are on their sometimes complex pathways through our services. We aim to roll out the GP Portal to all GPs in Camden, Islington and Westminster by the end of June 2011, followed by our other key referring GPs by the end of September 2011.

During 2011/12 we will also be putting in place an e-messaging solution that will allow us to send electronic clinical documents directly into GP systems, fitting into current workflows and reducing the amount of paper GPs receive.

1,000
extra bank workers recruited

Discharge information for GPs

Our inpatient discharge letters are generated by our e-discharge electronic proforma, which includes key clinical information, results, medication and follow-up advice.

The 2010/11 Commissioning for Quality and Innovation (CQUIN) objective requested additional information to be included and for us to send an electronic discharge summary to a patient's GP within 24 hours of their discharge. We are currently faxing the discharge summary to the GP and the latest audit showed that 62% were being sent within the 24 hour timeframe, and where relevant, the additional information was included in the summary. We will continue to work with ward staff to resolve delays at an earlier stage to improve this timeframe. In autumn 2011 we will implement e-messaging for discharge summary information and expect to see significant improvement.

The 2011/12 CQUIN objective for inpatient discharge summaries will also include improving A&E summaries which can also be transmitted via e-messaging to those GP practices that are enabled.

GP Liaison Committee

We try hard to keep our GPs as up-to-date as possible with developments at the Trust. Our UCLH GP Liaison Committee (GPLC) is a long-established high level forum providing clinical leadership to oversee the co-ordination and management of clinical interface issues between primary and secondary care. The committee is made up of GPs and PCT representatives from Camden, Islington and Westminster, as well as a mix of senior clinicians and managers from UCLH. The group meets quarterly and discusses a range of issues. As a result of GPLC feedback, significant changes have been made to the way the Trust works. Some of the notable successes of 2010/11 have included:

- Supporting the roll-out of access to the UCLH GP Portal
- Discussing a series of improvements at the interface between Trust and GPs including: new processes for notifying GPs of a patient's admission and discharge from the Acute Medical Unit, and of a patient's death; gastroscopy access forms; patient information leaflets and communication of biopsy results; interim solution to problems of discharge letters to GPs about patients attending the Emergency Department
- GPs were kept updated on projects including: a COPD initiative to reduce admissions and length of stay; UCL Partners engagement with primary care; transforming the diagnostic pathway in prostate cancer and the new UCLH website.

For 2011/12 the committee will be:

- Supporting improved communication with GPs about a new pathway for vascular surgery patients
- Improving the process for GP referral to specialist teams for emergency assessment
- Sustaining improvement in discharge letters from the Emergency Department
- Reviewing the process for booking outpatient ultrasound scans.

7 Research and development

Our designation as one of the UK's five comprehensive biomedical research centres continues to create excellent opportunities in research and development.

Comprehensive Biomedical Research Centre

The UCLH/UCL National Institute for Health Research (NIHR) Comprehensive Biomedical Research Centre (CBRC) aims to translate pioneering scientific research into tangible treatments that will directly benefit patients. Work is divided into 15 research themes which build on the Trust's recognised expertise in areas such as cancer, cardiovascular disease, neurosciences, women's health, gastroenterology and technologies such as cellular and gene therapy. Key strands of work include:

- **Investing in new research projects:** Over £5m has been allocated towards new, high-quality research projects. The CBRC attracted over £60m from external sources for new projects.
- **Building research capacity:** The Centre for Neuromuscular Diseases is supported by the CBRC and is supporting clinical trials linked to specialist clinical services. Other developments include:
  - a new UCL Partners obesity programme
  - investment in a UCL-led biobank for disease risk assessment, screening and prediction
  - genetic profiling of the UCLH head and neck tissue bank
  - infrastructure development for a new Comprehensive Infection Research Centre for Investigation, Translation and Training (CIRCITT).
- **Supporting world-class research teams:** The CBRC has established new courses and student positions to promote future research leadership. Twenty-three CBRC staff have been awarded Senior Investigator status by the NIHR.

UCL Partners

The CBRC continues to be the driving force for research behind the health improvement objectives of UCL Partners (UCLP). The current list of UCLP programmes and their objectives are shown in table 15.

Table 15: UCLP programme and core objectives for population health gain

Programme	Core objectives for health improvement
Cancer	Develop a provider network to deliver integrated, patient focused, care pathways - brain cancer treatment to provide the first model
	Reduce mortality and morbidity by promoting early diagnosis
	Increase availability of clinical trials of innovative cancer treatments
Neurosciences	Reduce mortality and morbidity from stroke
	Improve outcomes for neurosurgical and neuro-oncology patients
	Improve outcomes for dementia and other central neural system degenerative conditions
Cardiovascular	Prevention of premature cardiovascular disease
	Congenital heart disease: prevention, integrated paediatric to adulthood care, suitably powered studies to inform and improve outcomes
	Improve outcomes for major cardiac events - acute coronary syndromes, heart failure, atrial fibrillation and cardiovascular surgery
Immunology and transplantation	Develop and implement new genetic tests for auto-immune diseases and immunodeficiency
	Develop and implement new treatments for immunodeficiency and opportunistic infections
	Improve outcomes for patients requiring transplantation
Infection	Reduce mortality and morbidity caused by imported infection
	Integrated model of care for HIV and large scale studies of new agents
Eyes and vision	Improved management and outcomes of chronic glaucoma in the community using innovative new technology and education
Child health	Tackling obesity in 0-19 year olds
	Improve care for juvenile diabetes
Women's health	Improve maternity care (outcomes for mother and baby, satisfaction and efficiency),
	Focus research and development on major determinants of prematurity and pre-eclampsia
	Improved STI screening and care of sexual health closer to home; reduce teenage pregnancy by switching to more effective methods, especially intrauterine devices

Other developments

In 2010/11 we developed funding mechanisms to improve the transparency of research income to the Trust and to increase accountability for research activity through formal acknowledgment in consultant job plans. This will help the Trust to be more rigorous in the control of research costs, more assertive in pursuit of new income and more explicit about the benefits that our research brings to patients.

Planning continues for the UK Centre for Medical Research and Innovation at St Pancras which will establish the country's largest concentration of biomedical scientists and will provide major collaborative opportunities for research at UCLH.

We continue to support a large portfolio of clinical trials and studies. The portfolio is one of the largest in the country (1,500 projects). The Trust is one of the largest recruiters of patients to NIHR studies.

We completed refurbishment of our clinical research facility and it is now fully operational. The new centre can conduct clinical trials and other studies in a purpose built environment, enabling research to be conducted rapidly, effectively and safely.

8 Improving our services

Our overall corporate strategy is framed by our commitment to clinical and research excellence. Driven by our strong research capability we are always striving to improve the quality and range of our services.

In February 2008 we identified seven areas of strategic focus, the first four of which were our immediate priorities:

- neurosciences
- cancer
- cardiac
- women's health
- dental
- paediatrics
- acute surgery and medicine.

We believe that these seven service areas remain the right core specialties for the Trust. We are however exploring broadening the existing strategic focus on dental services with the intention to create a mouth, ear, nose and throat centre of national excellence. We are hoping that the Royal National Throat, Nose and Ear Hospital (RNTNEH) will join the Trust during 2011/12.

Over the past year we have seen a number of service improvements resulting in improvements in patient care. Some examples are:

- Introduction of the Quality Improvement Framework (incorporating 'transforming care at the bedside' and 'productive ward' initiatives)
- Introduction of nurse-led discharge
- Development of 'enhanced recovery' initiative. The aim is to improve patients' experience and make best use of resources. This is achieved by:
  - empowering patients with active participation in their own recovery
  - reduced length of stay with discharge planning from the outset
  - increased number of patients being treated if there is a demand
  - reduced resources or use in different ways
  - better staff environment with multidisciplinary working and skill mixing.
- Launch of the new Institute for Sports, Exercise and Health working with the British Olympic Institute and English Institute of Sport
- Development of the aortic endovascular programme to deal with highly complex patients. Our service is one of very few in Europe.
- Progression to seven-day working for our MRI service and extended working hours on weekdays.
- Introduction of targeted intraoperative radiotherapy (TARGIT) to treat breast cancer
- Introduction of a robotic-assisted surgery programme using the DaVinci Si system
- New leading-edge technology has been introduced to the Nuclear Medicine department with two new cameras that combine CT and nuclear images to better locate disease; as well as the introduction of new techniques to assess sentinel lymph nodes
- Introduction of a nurse-delivered HIV testing service at the HTD
- New pathways for interferon gamma release assay to prevent TB reactivation in patients receiving anti-TNF therapies
- Introduction of intravenous artesunate for patients with severe malaria at the HTD
- In collaboration with the Bloomsbury clinic, introduced a Prevention of Admission to Hospital (PATH) clinic to provide ambulatory care for patients with advanced HIV

who might otherwise have required admission to hospital
- New radiotherapy and radiosurgery treatment with TrueBeam technology for cancer patients
- Development of Oesophageal Doppler Monitoring (ODM) helping patients recover quickly from surgery with fewer complications
- Opening of Paul's House – the first 'home from home' accommodation in London for paediatric and adolescent cancer patients and their families
- Patients across NCL sector are benefitting from the full opening of the HASU, as we have now doubled our rate of patients receiving blood clot treatments
- Introduction of excimer laser technology to treat blocked leg arteries with short bursts of laser energy, restoring natural blood flow without the need for complex bypass surgery
- Introduction of the 'butterfly scheme' which better identifies patients with dementia so they can receive more personalised care
- Development of fertility services with the introduction of IVF services
- Introduction of "one-stop" clinics in the Reproductive Medicine Unit
- Introduction of new antenatal and postnatal patient pathways for women patients with a body mass index over 30 and for women who have sustained significant birth injury
- Introduction of a new obesity service targeted at adolescent patients aged between 12 and 18 years
- New services for patients with COPD/asthma to improve the care they receive from respiratory nurses
- Establishment of the weight-loss, metabolic, bariatric and endocrine surgery centre
- Use of The Finometer® to detect fluctuations in blood pressure and cardiac output per heartbeat
- Introduction of deep brain stimulation to treat patients with cluster headaches
- Opening of the UK's first dedicated brain tumour unit
- Opening of the acute devices bed at the Heart Hospital for patients who are admitted with an abnormal heart rhythm
- Introduction of the neuro-oncology vocational rehabilitation service at the NHNN to support patients with brain and spinal tumours
- Introduction of same-day admission at the Heart Hospital for all cardiothoracic patients
- Opening of the hemianopia clinic at the NHNN
- Introduction of transcatheter aortic valve implantation for treatment of aortic stenosis without the need for open heart surgery
- Introduced photodynamic therapy treatment - a non-invasive therapy for skin cancer
- Set up Mohs micrographic surgery – a method that completely removes skin cancer in one treatment with less than a 1% chance of recurrence
- Introduced combined outpatient and transport booking service at UCH to ensure patients only have to ring one number to book both appointments.
- Introduced facility for UCLH clinicians to electronically review GP requested results to enhance patient clinical management and avoid duplication of test requests.
- Enhanced support to patient discharge by providing a 'pack & go' service to ensure patients can get home more speedily
- Enhanced haematology nursing care provision provided to infectious clinical haematology patients based on the infection ward
- Developed MRSA dashboard to highlight which patients require screening and those who have been screened
- Developed and implemented the glutamate dehydrogenase test for Clostridium difficile – a quick and cost effective test with high success rates (compared to current national standard test)
- Implemented daily microbiology ward rounds at the NHNN, to improve management of infections and infection prevention.

Patient and Public Involvement

The UCLH chief nurse is the executive lead for Patient and Public Involvement (PPI) and oversees the development of PPI at UCLH.

In 2010 a Trust-wide PPI consultation event was held for members of a diverse contingent of PPI groups that are established across the Trust. These groups include: disease support groups such as the Hypermobility

Syndrome Group and Dose Adjustment for Normal Eating (DAFNE) - a self-education group for diabetic patients; the RLHIM patient panel and various focus groups that discuss specific issues. The aim of the event was to meet and support valued patient representatives and provide an opportunity to share experiences that the Trust can learn from and to initiate consultation on a new PPI strategy. Our Local Involvement Network (LINks) representative in Camden also spoke about the upcoming PPI proposals for a new involvement body – Health Watch and its implications for PPI at foundation trusts. Patient governors and group representatives enjoyed the event and valued the opportunity to give their opinions.

Feedback from the event was used to draw up an action plan and enabled us to prioritise patient experience feedback. Improvements in communication in surgery via a bleep system now provides patients with continuous updates which means they are better able to manage their time. The initiative is now being introduced in surgical reception. Other priorities where improvements have been made were administrative efficiency to improve the patient pathway from their first point of contact with the Trust as well as a drive to improve staff attitude, compassion and empathy.

A new patient experience initiative will be launched in May 2011 with a patient involvement workshop to make significant and sustainable improvements in the patient experience 'putting the patient at the centre of everything we do'.

LINks members and also

UCLH governors have continued to participate in the Patient Environment Action Teams (PEAT) inspections. This year it was noted that there had been marked improvements in cleaning and environmental scores at NHNN and UCH.

Patients and the public have also been involved in successful projects across the Trust. For example, a former patient is launching a fundraising campaign to support UCH's neonatal services and a charity for those suffering pregnancy losses. She is an active patient representative of the Bereavement Services Working Group.

The Trust's Service Commitment initiative has continued to run its successful staff award ceremony at the Governing Body Annual General Meeting. In 2010 patients were given the opportunity to become more involved through nominating members of staff for the awards.

Inpatient survey

UCLH uses patient feedback to drive quality improvement. The Trust receives this feedback via local patient surveys and the national programme of patient surveys, in particular the inpatient survey. This work is led by the Trust Inpatient Steering Group, which examines in detail patient responses form both the national and local surveys and puts plans in place to make improvements. Some areas where improvements have been made in light of inpatient survey results are:

- An action plan was developed to ensure patients received clear information about the side-effects of the medication they are taking home
- Work was undertaken with anaesthetists and theatre staff across the Trust so that patients felt they received adequate information about what would happen when they were put to sleep and how their pain would be controlled
- The steering group worked with the security team and looked at existing policies to ensure that patients did not feel threatened by other patients or their families
- Work is being undertaken to address issues about the availability of information asking patients and visitors to wash their hands
- The increased availability of comment cards now means that patients feel they are able to give their views about the quality of their care
- The introduction of patient diaries has aided communication between patients and staff and means that patients now feel more involved in decisions about their care.

Significant improvements across a range of questions were seen in the 2010 inpatient survey.

Managing complaints

The Trust encourages feedback from patients and their representatives and uses complaints as an opportunity to examine areas where improvements can be made.

During 2010/11 we continued to work closely with complainants and in discussion with them agree how they would like their complaint to be dealt with for example, with a meeting, a formal in-depth investigation, a written response, further clinical review such as an outpatient appointment or conciliation, and to agree a timescale. All efforts are made to achieve local resolution, if a complainant is not happy with our initial response further attempts to achieve local resolution are made.

In September 2010 the Ombudsman published her annual report which showed that relatively fewer UCLH complaints had been referred to the Ombudsman (compared to other London trusts of a similar size) and of those referred, no cases required intervention by the Ombudsman, and no cases were accepted for more in depth investigation or were upheld.

During the year the Trust has piloted a new approach to complaints which involves greater direct clinical staff involvement. Benefits derived from the pilot are to be tested in other parts of the Trust during 2011/12.

The Trust aims to respond to complaints within 25 working days unless otherwise agreed with the complainant. In 2010/11 the Trust received 671 formal complaints against a backdrop of increased activity.

Improvements in patient and carer information

In 2010/11 the Patient Information Library grew to approximately 200 leaflets giving patients and carers information about conditions, treatments or UCLH services. To ensure this information is of top quality, a new Trust-wide patient information approval form has also been introduced which can only be signed off if all the required standards are met – for example, patient leaflets must give the risks, benefits and alternatives to any treatment.

A much improved second edition of the UCH inpatient guide went into print in March giving patients even more helpful information than before, and also featuring some specially commissioned photographs. The guide is now being distributed to patients through the pre-assessment clinics or on the wards.

Among the Trust-wide leaflets to have been produced is a new VTE leaflet which has important information for patients about the prevention of blood clots while they are in hospital.

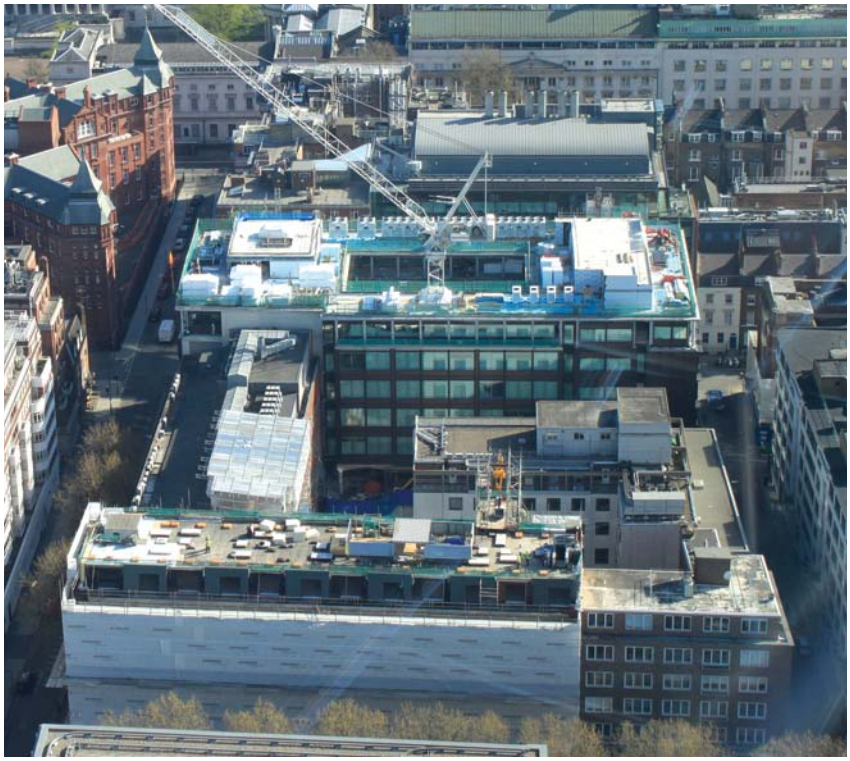
Over the last six months we have also been developing a set of 'easy read' leaflets to help patients with learning disabilities understand what they can expect when they come to hospital – often a particularly anxious time for these patients. The leaflets have been approved via the Camden Learning Disabilities Group, and are available on the Trust website.

The annual audit of Trust patient information showed standards have increased slightly over the previous year.

Social and community issues

UCLH is an active member of the local community and has a community liaison group. This is a platform for local residents and community groups to raise questions or concerns that they may have regarding operational procedures, proposed development, planning and issues relating to the Trust and its aspirations to be a good and considerate neighbour. The group meets quarterly. As part of the community involvement in ongoing development and 'under construction' projects, the Trust has put in place a monthly meeting with Skanska, the Cancer Centre construction company, and community representatives to discuss building issues. Regular monthly update newsletters are sent to our neighbours by email or by post. Skanska has a considerate builder policy with respect to noise, dust, disruption and site noise.

This year the Trust launched a project that addresses the needs of homeless patients. The project identifies the appropriate healthcare required when the patient is in hospital and then working with other agencies, such as social services, housing departments, outreach teams, and drug and alcohol workers coordinates efforts so that once the patient is discharged they have community support.



Strategic priorities

Our strategic priorities this year included:

Commissioning the University College Hospital Macmillan Cancer Centre

In 2009/10 the Board approved the business case to build the innovative Cancer Centre in Huntley Street, directly opposite the UCL Cancer Institute, on the site of the old Elizabeth Garrett Anderson and Obstetric Hospital. The Cancer Centre will be phase three of our strategic development plan and will open in 2012. The building itself will be completed in January 2012 and will open to patients by April 2012. To support services in the new environment we have invested in the first PET-MR scanner in the UK which will be installed in autumn 2011.

The Cancer Centre will provide a world-class patient environment for outpatient and day case cancer services at UCLH and the innovative design will provide a welcoming and supportive environment and range of services for patients living with cancer. Working with our partner Macmillan, we will improve patient experience through

- bringing different specialists treating cancer together to provide a better service
- reviewing patient pathways so that we diagnose and treat patients faster
- new appointments systems so that patients receive one pathway, not separate appointments with different departments

- communication with patients and GPs via the telephone, the website and using patient information and new IT systems.

Macmillan are also supporting us to establish a new Patient Experience Board to give patients a real voice in how we design and deliver services, and to make sure that we deliver our commitments to patients.

Securing Proton Beam Therapy

We are working to become the first centre in the UK to provide Proton Beam Therapy (PBT). PBT is an advanced form of radiotherapy which can target tumours far more precisely than conventional methods. This new technology is only available in a handful of centres worldwide and is beneficial for child, brain and eye cancer cases. We have formed a partnership with other hospitals in our national bid to be one of two national centres which are planned to be established in the UK by 2014. UCL Partners is supporting the development.

The Department of Health wrote to us in September 2010 confirming that it was proceeding with the evaluation of two options for provision of PBT facilities:

- A two site solution comprising UCLH and the Christie
- A three site solution comprising UCLH, the Christie and University Hospitals Birmingham.

A decision on next steps is expected in 2011/12. The PBT facility will be part of phase four of our development programme.

Developing a Mouth, Ear, Nose and Throat national centre of excellence

As described previously the proposed transfer of the Royal National Throat, Nose and Ear Hospital (RNTNEH) to UCLH will provide the platform to develop a national centre of excellence for mouth, ear, nose and throat services. Ear, nose and throat (ENT) services are already one of the priority research themes for UCL partners. This development will bring together ENT with the head and neck services at the Trust, dental services at the Eastman Dental Hospital and ENT cancer services. A state-of-the-art new facility for mouth, ear, nose and throat services is part of our plans for phase four of the Trust's development.

Developments in other priority areas

Our hyper-acute stroke unit (HASU) opened in summer 2010. It is based at the UCH site and is led by neurologists from Queen Square. A highly skilled multi-disciplinary team provides rapid assessment, treatment and continuous monitoring to patients within the first 72 hours following a stroke. This maximises acute management and rehabilitation of stroke patients in the most appropriate setting. We are delivering the service in close partnership with stroke units at the Royal Free Hampstead NHS Trust, Barnet and Chase Farm Hospitals NHS Trust and North Middlesex University Hospital NHS Trust, with patients sent to these partners once they have had all necessary specialist input at UCLH.

During 2011/12 we will continue to work with partners in North Central London and beyond to develop our cardiac services and cardiac facility strategy in light of the recent London review of cardiovascular services.

Our clinical support services are fundamental to the successful operation of the Trust but also provide world-class services in their own right. In order to maximise the opportunity to not only reduce costs but provide the benefit of our expertise to the wider London market and beyond, each of our clinical support services is developing plans this year to build critical mass through partnership with other trusts from UCL Partners or through joint venture initiatives with the private sector.

We will continue to develop our partnership working with Great Ormond Street Hospital for Children NHS Trust (GOSH) as part of the development of our paediatric services. We already have a number of joint appointments in both surgery and medical specialties that have helped patients move from paediatric care at GOSH to adolescent care at UCLH. We are a recognised joint centre for Children and Young People's Cancer and in 2009/10 changed surgical rotas so that the full urology team are based across the two sites.

9 Our organisational structure

Governance arrangements

The Trust was authorised in July 2004 to operate as a public benefit corporation. It is led by a board of directors responsible for all aspects of the Trust's performance and for meeting high standards of clinical and corporate governance. The board is accountable to the governing body (the name the Trust gives to its board of governors). The governing body members are either elected or appointed to represent the interests of the Trust's membership and partner organisations.

The responsibilities of the board of directors and the governing body are set out in the Trust's constitution and in approved standing orders and a scheme of delegation which sets out the powers reserved to the board. One of the powers the board has reserved for itself is responsibility to approve amendments to the constitution having first consulted with the governing body. During the year the board considered a revision to its constitution.

Statement of compliance with Monitor's code of governance

The Trust is committed to high standards of corporate governance as set out in the NHS Foundation Trust Code of Governance. The Trust meets all the main principles of the code especially those relating to the development and management of patient services, information provision and accountability for the use of public resources.

There are four areas where the board is divergent with

the code and has agreed it should declare non-compliance:

- **A.3.1** - The board should identify each non-executive director it considers to be independent.
  Declaration - The board considers that all its non-executive directors (NEDs) are independent in character and judgement including the nominee of UCL. The test of independence for NEDs is made both at interview and again annually at performance review. The UCL nominee brings a breadth of expertise to the board; he is independent of the executive and is able to provide an objective and balanced opinion on matters relating to the Trust's business.

- **A.3.2** – At least half the board of directors, excluding the chairman, should comprise non-executive directors determined by the board to be independent.
  Declaration - The board, which has a greater number of executives than non-executives, has a voting structure, authorised by Monitor, such that the non-executive directors, including the chairman with a casting vote, have majority control.

- **A.3.3** – The board of directors should appoint one of the independent non-executive directors to be the senior independent director.
  Declaration - The board has not appointed a senior independent director (SID). It considers it has effective processes in place to raise issues of concern. The Trust has an elected lead governor as an independent contact for governors. It takes the view that a SID would discourage governors and directors from building relationships with the non-executive directors.

- **C.1.3** – The chairman or an independent non-executive director should chair the nomination committee(s).
  Declaration – An elected governor chairs the nomination and remuneration committee. This provides an appropriate level of independent evaluation.

Our governing body

The governing body under the leadership of the Trust chairman, Richard Murley, is a valued and effective body dealing with issues of importance to patients and other service users.

The governing body comprises 23 elected governors and ten appointed stakeholder and partner governors as shown in table 16. The skills and experience governors bring to the governing body help the Trust shape strategy and make sure the views of the people it serves are taken into account.

The governing body represents the interests of its members and partner organisations in the wider health community acting as a link between the membership and the board of directors. It has a number of statutory responsibilities described in the Trust's constitution including appointing or removing non-executive directors, deciding the remuneration for non-executive directors, appointing or removing the Trust's auditors and receiving the Trust's annual report, accounts and auditors report. The governing body also provides comment on the Trust's forward plans and governors feed back to the people they represent information about the Trust's plans and performance.

Governing body governance

The governing body met five times during 2010/11. Four meetings were held in public including an annual public meeting held in September. Papers for meetings are published on the Trust website. In addition the governing body and board of directors held its annual joint meeting and there were seven seminars including four on the Trust's forward plan. The opinion of governors is sought when preparing the agendas for these meetings which cover a wide range of subjects including clinical and financial performance, service strategy and patient experience. A record of attendance at governing body meetings is available from the membership office on request.

The governing body also considers reports from a formal sub-committee, a nomination and remuneration committee from a governors group on high quality patient care (HQPCG); from governors who sit on Trust committees for example the patient issues committee which outlines how governors contribute to the patient experience agenda; and an annual report from the chair of the audit committee. These reports also inform directors about governor and member concerns.

Understanding the views of governors and members

Board directors routinely attend governing body meetings and non-executive directors are invited to governor seminars and members meetings. These provide opportunities for board members and governors to contribute their specific expertise and knowledge or a different perspective to support the function of the governing body and enable directors to keep in touch with governor and member opinion.

The Trust also works with governors and members to engage them more effectively in its work:

- Governors provided their views on the Trust's forward plans and input to the development of the Trust's 2011/12 objectives
- Governors participated in the non-executive directors' induction programme
- The HQPCG focused on patient care projects; through this work governors made sure they fed back views and opinions about Trust services to the board
- Governors sit on a number of Trust committees, for example, the nursing and midwifery advisory board. Through these committees governors influence practice in the Trust particularly in the area of patient experience
- Governors have access to a facility, shared with non-executive directors, which they can use when they visit the Trust
- A Governor has been appointed as membership champion and with a small group of members and other governors, following training, is active in the recruitment of new members
- Members were invited through a survey to rank the priorities the Trust should focus on in order of importance to them and decided the programme of health related 'MembersMeet' seminars for 2011/12
- Members provided feed back to the Trust on its 2011/12 plan at a MembersMeet held in February 2011
- Members were provided with opportunities to give their views to governors at the annual election event, Trust open event and the MembersMeet seminars
- Members and the public who attend governing body

meetings are invited to complete a question/comment form - if they raise a question it is answered by the chairman
- Governors and members participated in projects and groups e.g. PPI focus group, PEAT inspections and Chief Nursing Officer (CNO) benchmarking.

Elected and appointed governors normally hold office for periods of three years unless stated otherwise. They are eligible for re-election or re-appointment at the end of their first term. Governors may not hold office for more than seven consecutive years.

In August 2010 elections using the 'single transferable vote' system were held in 11 seats; overseen by the Electoral Reform Services the elections cost £17,665.

Table 16: Elected governors, terms of office and key areas of work

Governor	Constituency	Term of office	Areas of work
Wendy de Silva	Public	1 September 2008	Arts committee Older people's strategic steering group
Amanda Gibbon	Public	1 September 2009 for 2 years	Audit tender panel HQPCG Patient issues committee Nomination and remuneration committee, chair Trust organ donation committee, chair
Patricia Orwell	Public	1 September 2010	HQPCG Patient information group Patient issues committee
Peter Brayshaw	Patient, local	1 September 2010	Audit tender panel Nomination and remuneration committee Transport review group
Bonnie Wallace	Patient, local	1 September 2009	HQPCG Patient information group
Christine Mackenzie	Patient, local	1 September 2008	HQPCG Nursing and midwifery advisory board
Diane Wales *replaced Patricia Pank*	Patient, local	1 September 2010 *1 September 2007*	Membership recruitment *Editor, UCLH News* *HQPCG*
Dee Carter	Patient, local	1 September 2009	HQPCG Nursing and midwifery advisory board Membership recruitment Older people's strategic steering group

Governor	Constituency	Term of office	Areas of work
Veronica Beechey	Patient, regional	1 September 2009 for 2 years	HQPCG, chair Lead governor Quality and safety committee Transport review group
Fiona McKenzie	Patient, regional	1 September 2010	HQPCG Learning disabilities champion Membership champion Quality and safety committee
John Green *replaced Mary Shelley*	Patient, regional	1 September 2010 *1 September 2007*	Nomination and remuneration committee *Food and nutrition group* *Membership recruitment* *Nomination and remuneration committee*
Anthony Baylord	Patient, regional	1 September 2009	Food and nutrition group HQPCG
Alison Forbes *replaced Marcus Carr*	Patient, regional	1 September 2010 for 2 years *1 September 2008 – resigned August 2010*	HQPCG Patient issues committee
Joan Bell	Patient, national	1 September 2009 for 3 years	Cancer Centre steering group Editor, UCLH News HQPCG
Stuart Shurlock *replaced Kevin Ryan*	Patient, national	1 September 2010 *1 September 2007*	HQPCG Membership recruitment Transport review group HQPCG
Maureen-Rose Brown	Patient, national	1 September 2008	
Carol Hart	Patient carer	1 September 2008	HQPCG Nomination and remuneration committee Trust FTGA representative
Marcia Persaud	Staff, nursing and midwifery	1 September 2009	HQPCG
Caroline Dux	Staff, nursing and midwifery	1 September 2010	HQPCG

16,398
members

Governor	Constituency	Term of office	Areas of work
Fion Bremner *replaced Mark Gaze*	Staff, medical and dental	1 September 2010 *1 September 2007*	 *Nomination and remuneration committee, chair, until August 2010*
Malcolm Barnicoat *replaced Raj Davé*	Staff, allied health professionals	1 September 2010 *1 September 2007*	
Tom Hughes *replaced Janet Clarke*	Staff, administrative and clerical	1 September 2010 *1 September 2007*	HQPCG *HQPCG*
Maureen Holas (reserve candidate) *replaced Lorraine Beirne*	Staff, administrative and clerical	1 August 2010 for 2 years *1 September 2009 resigned July 2010*	HQPCG Nomination and remuneration committee

Table 17: Appointed governors and terms of office

Governor	Representing	Term of office
David Taylor	Camden PCT	1 October 2009
Andrew Whitley	Westminster PCT	1 April 2008
Andy Watts	Islington PCT	1 February 2010
Adam Harrison *replaced Roger Freeman*	Camden Council	1 July 2010 *1 February 2007*
Kate Groucott *replaced Janet Burgess*	Islington Council	7 October 2010 for 1 year *14 May 2010 for 1 year - resigned*
Daniel Hochhauser	UCLH research group	5 March 2010
Sheela Bonarjee *replaced Eileen West*	Trust league of friends	1 September 2010 *1 September 2007*
Graham Faulkner	Trust's charity committee	1 September 2007
Judith Ellis	London South Bank University	1 July 2010
Lord Ajay Kakkar	University College London	23 March 2011

Governing body nomination and remuneration committee

Chaired by a governor, the Trust has a nomination and remuneration committee comprised solely of governors. It purpose is to oversee the arrangements for appraisal, remuneration and appointment of non-executive directors (including the chairman) and make recommendations to the governing body. This also includes the appointment of the UCL representative to the board whose position does not go through a formal recruitment process.

To determine non-executive remuneration the committee uses benchmark data surveyed confidentially amongst a foundation trust peer group. This committee will also ensure that a review of the composition of the non-executive director component of the board is carried out at least every three years.

The committee met on five occasions. On remuneration its recommendation that the chairman's and non-executive directors' remuneration should remain the same as in 2009/10 was ratified by the governing body. Peter Dixon, the Trust's previous chairman joined the committee to consider the re-appointment of one non-executive director. The committee recommended to the governing body that Nick Monck should be re-appointed to the board.

Table 18: Members of the governing body nomination remuneration committee

Member	Position	Meetings attended
Amanda Gibbon	Committee chair and public governor from November 2010	4 of 5
Veronica Beechey	Patient governor	4 of 5
Peter Brayshaw	Patient governor	3 of 5
Judith Ellis	Partnership governor	1 of 2
Graham Faulkner	Partnership governor	3 of 5
John Green	Patient governor from November 2010	2 of 2
Carol Hart	Patient governor	4 of 5
Daniel Hochhauser	Partnership governor from November 2010	1 of 2
Maureen Holas	Staff governor	2 of 2
Mark Gaze	Committee chair and staff governor *until 31 July 2010*	3 of 3
Mary Shelley	Patient governor until 31 July 2010	3 of 3
Eileen West	Partnership governor until 31 July 2010	3 of 3
Richard Murley	Trust chairman from 1 July 2010	1 of 1
Peter Dixon	Trust chairman until 30 June 2010	1 of 1
Nick Monck	Non-executive director	1 of 1

Non-executive appointment panel

Appointments for non-executive directors (including the chairman) are made for a three year term following a process of open competition. Subject to satisfactory performance and the specific needs of the Trust there is an option to re-appoint for a further three year and one year term respectively.

Following an agreed process the nomination and remuneration committee established an appointment panel comprising the Trust chairman, three governors and two non-executive directors to appoint a replacement for Richard Murley. Members of the panel were Peter Dixon (out-going chairman); governors, Peter Brayshaw, Amanda Gibbon and David Taylor; and non executive directors, Nick Monck and Richard Murley. It was considered appropriate that Richard Murley as chairman elect should be a member of the panel.

The panel met on three occasions including one in 2009/10. It developed a candidate brief and advertised the position in open competition. The panel was supported by an external advisor. The panel recommended one candidate to the governing body; Richard Delbridge was appointed as non-executive director.

Governors selected to sit on a non-executive director or chairman appointment panel are required to attend recruitment and selection training, this includes diversity and equality training.

Our board of directors

The board of directors, led by the chairman, sets the overall Trust strategy. It determines the Trust's corporate objectives and regularly monitors performance against those objectives; it decides on matters of risk and assurance and is responsible for ensuring the delivery of a high quality and safe service. It has delegated decision making for the operational running of the Trust to the executive board which is responsible for the day-to-day running of the Trust and delivery of Trust strategy.

The board comprises executive and non-executive directors chosen for their knowledge, skills and experience. The board has 14 directors including the chairman and chief executive.

The division of responsibilities between the chairman, and the chief executive is set out in writing in governance documents, and has been approved by the board. In overall terms it is:

- The chairman leads the board of directors and is responsible for ensuring its effectiveness.
- The chief executive is accountable to the board for the operational management and performance of the Trust and for the delivery of strategy.

There have been a number of changes to the board in this year. Sir Peter Dixon completed his tenure as chairman at the end of June and was succeeded by Richard Murley. The resulting non-executive director vacancy was filled by Richard Delbridge who took up post on 1 July. Louise Boden, chief nurse, retired on 30 November and was replaced by Katherine Fenton who joined the Trust on 1 January 2011.

Names of the board members, together with appointment terms for non-executive directors and declarations of their relevant interests for the period are detailed on the pages that follow.

Directors' attendance at the board and governing body meetings are available on request from the Trust secretary directors@uclh.nhs.uk

Non-executive directors

Richard Murley – chairman (from 1 July)

Joined the board in November 2008. In July 2010 he was appointed chairman for three years. Richard chairs the remuneration committee and is also a member of the quality and safety committee and a director of UCL Partners.

Richard Murley qualified as a solicitor after leaving university. He has worked in the City for more than 30 years and is vice chairman of Rothschild where he has worked since 2006. Between 2003 and 2005 he was director general of the Panel on Takeovers and Mergers, regulating the conduct of takeovers of public companies in the UK.

- Vice-Chairman, NM Rothschild & Sons (Corporate Finance) Limited
- Member of the Financial Reporting Council's Financial Reporting Review Panel
- Member of the organising committee of Crisis Urban Investors
- Director of UCL Partners
- Wife, Dr Penelope Wiseman is a consultant in medicine for the elderly at Barnet & Chase Farm NHS Trust

Dr Sue Atkinson CBE

Joined the board in April 2007; she was re-appointed for three years in 2010. Sue is chair of the human resources and communications committee and is a member of the audit and remuneration committees; she has a special interest in the elderly and in the sustainability agenda.

Sue is a public health doctor. She was director of public health and then chief executive at south east London health authority (1988-1993) and regional director of public health at south western and south Thames regional offices (1994-1999). In 1999 Sue was appointed regional director of public health for London and health advisor to the Mayor of London and Greater London Authority, a position she held until 2006.

- Board Member, Food Standards Agency
- Chair, Public Health Action Support Team, A Social Enterprise Community Interest Company
- Co-chair, Climate and Health Council
- Member, Public Health Interventions Advisory Committee, NICE
- Honorary Visiting Professor, Dept of Epidemiology & Public Health, UCL
- Trustee, UCLH Charity

Richard Delbridge

Joined the board in July 2010. A chartered accountant, he has worked in finance and banking for more than 40 years, holding senior positions including managing director and general manager of JP Morgan UK, group finance director HSBC plc, and director and group chief financial officer of National Westminster Bank plc from October 1996 until 2000.

Since 2000 Richard has held a number of non-executive director positions and was treasurer of the Open University for eight years until 2009. He has also served on the Financial Reporting Council's Financial Reporting Review Panel, Committee for Guidance on Audit Committees and the Audit Governance Working Group. Richard chairs the investment committee and is a member of the remuneration committee.

- Non-executive director, Standard Chartered plc
- Member, Finance Committee, London School of Economics

Sir Nicholas Monck

Joined the board in February 2005; he was re-appointed for a final one year term in 2011. In September 2010 he was appointed vice chairman of the board. He is chair of the audit committee and is a member of the investment committee, the finance and contracting committee and the remuneration committee.

Nick had a distinguished career as a senior civil servant. During his time, he served as second permanent secretary at the treasury and as permanent secretary of the employment department group.

- Chairman, Oxford Policy Institute
- Member, Advisory Council, Transparency International (UK)
- Trustee, Better Government Initiative
- Member, Council of Management of the National Institute of Economic & Social Research

Jane Ramsey

Joined the board in January 2007; she was re-appointed for three years in 2010. Jane is chair of the finance and contracting committee and a member of the human resources and communications committee and the remuneration committee.

Jane was chair of Lambeth PCT for five years prior to joining UCLH. Since then she has undertaken a range of non-executive roles including as a lay member of the Royal Pharmaceutical Society of Great Britain and chair of a local housing association. Before that she was vice-chair of Lambeth, Southwark & Lewisham Health Authority and a senior lawyer in local government in London, latterly as Director of Law and Public Services at Islington Council.

- Non-executive member, Department of Health Audit Committee
- Associate member of the Board, NHS London
- Chair, Croydon Care Solutions Ltd

Professor Sir John Tooke

Joined the board in February 2010 for a three year term. He is chair of the quality and safety committee and a member of the audit and remuneration committees.

John is vice provost (health) at University College London (UCL) and is head of the UCL school of life & medical sciences and head of the UCL medical school. He joined UCL in 2009 from the Peninsula College of Medicine and Dentistry, which he led from inception. He was a Wellcome Trust senior lecturer in medicine and physiology and Honorary Consultant Physician at Charing Cross and Westminster Medical School. John is the immediate past chair of the medical schools council and chairs the UK healthcare education advisory committee.

- Non-executive director and Chair of the Medical Advisory Panel, BUPA
- Non-executive board member, UCL Business plc
- Non-executive board member, UK Centre for Medical Research & Innovation
- Member, Medical Schools Council Executive Committee
- Member, National Institute of Health Research Advisory Committee
- Member, Health Education National Strategic Exchange
- Chair, UK Health Education Advisory Committee

Sir Peter Dixon – chairman (until June 2010)

Sir Peter was first appointed to the chair of UCLH in 2001 and was re-appointed for a final two year term in June 2008. He chaired the board of directors, governing body and the remuneration committee, was a member of the finance and contracting committee, the NED lead for security and a director of UCL Partners.

Peter was appointed chairman of the Housing Corporation, the government's national affordable housing agency, in October 2003 and chaired the board until December 2008 when it transferred its function to two successor agencies. He was awarded a knighthood 'for services to the housing sector' by Her Majesty The Queen in the New Year Honours List 2009.

- Director, Quintain Estates & Development PLC
- Director and shareholder, Sedgevale Ltd
- Chair, the Office for Public Management Ltd.
- Interim Chairman, Colchester Hospital NHS Foundation Trust (December 2009 to July 2010)
- Wife, Judith Dixon, is GP Medical Director for Camden Primary Care Trust

Executive directors

Sir Robert Naylor – chief executive

Sir Robert has been chief executive since November 2000, having previously spent 15 years as the chief executive of a teaching hospital in Birmingham. Robert led the development of the largest single building project in the NHS to create the new world-class University College Hospital which was handed over to the Trust in two phases in 2005 and 2008.

Robert was awarded a Knighthood 'for services to healthcare' by Her Majesty The Queen in the New Year Honours List 2008. He has been a chairman of a number of national and regional committees and is a senior associate fellow at the University of Warwick, institute of governance and public management. He was awarded an honorary doctorate by Greenwich University in 2009.

- Board Member, Foundation Trust Network
- Chairman, Radiology Reporting Online
- Director, UCL Partners

Richard Alexander - finance director

Richard joined the board in April 2007 from Oracle Corporation, one of the world's largest software companies. His 15 year career at Oracle included three years in India establishing a global financial information centre in Bangalore, over two years in the Netherlands as country finance director and ending up as a vice president. Richard began his career at Mars Confectionery before joining Zenith Data Systems and then Oracle in 1991. Richard has a mathematics degree from Oxford University and is a chartered management accountant.

- No relevant interests declared

Dr Geoff Bellingan - medical director for surgery and cancer

Geoff trained as a chest physician and then in intensive care and has been a consultant in intensive care at UCLH since 1997. He was an MRC clinician scientist and obtained his PhD in inflammatory cell biology at the University of Edinburgh. He is a Reader in intensive care medicine at UCL and is lead for the critical care and anaesthesia theme in the comprehensive biomedical research centre UCLH. He has a strong interest in medical leadership and was clinical director of critical care 2002, theatres and anaesthesia 2006 and of emergency services 2008.

- UK Council member for European Society of Intensive Care Medicine
- Member, Critical Care Committee for the Royal College of Physicians
- Member, Research Committee for the Intensive Care Society
- Member, Radiology Reporting Online
- Co-director, London Intensive Care Ltd
- Co-director, CPX Ltd

Katherine Fenton – chief nurse

Katherine was appointed as chief nurse from January 2011. Previously she was Director of Clinical Standards and Workforce/ Chief Nurse at South Central Strategic Health Authority.

Katherine's nursing and midwifery career spans 30 years and has included posts at St. James University Hospital in Leeds, University Hospital Birmingham and the Airedale Hospital NHS Trust, Director of Nursing and Patient Services at Southampton University Hospitals NHS Trust and at Barts and The London NHS trust.

Katherine sits on a number of national groups and has a special interest in increasing the contribution of the professions to improving care pathways and a strong expertise in improving patient safety.

- No relevant interests declared

Michael Foster – deputy chief executive

Michael joined UCLH in 2003 as finance director and was appointed as deputy chief executive in April 2007. His career has been developed in NHS financial management, initially working in the south west of England before moving to London in 1994. In London Mike has held the position of finance director in five NHS organisations. He has an interest in organisational development, performance improvement systems, management information and IT strategy. Immediately prior to joining the Trust Mike was director of finance and investment for the North Central London Strategic Health Authority.

- No relevant interests declared

Dr Gill Gaskin – medical director, specialist hospitals

Gill was appointed medical director in January 2010. She trained in renal and general medicine at Hammersmith Hospital, undertaking an MRC Fellowship and completing a PhD on the biology of systemic vasculitis at the royal postgraduate medical school. Appointed as consultant there in 1995, she gained wide experience in clinical research, education and medical leadership, as senior lecturer, director of postgraduate medical education, clinical director for medicine, and most recently director of the medicine clinical programme group at Imperial College Healthcare Trust. Gill was north London training programme director in renal medicine for four years and an active member of the North West London clinical reference group.

- Member, London Workforce Advisory Forum
- Honorary Consultant, Imperial College Healthcare NHS Trust

Dr Paul Glynne – medical director, medicine

Paul was appointed medical director in July 2009. He is a consultant general and critical care physician, and has held a number of medical leadership positions at UCLH including divisional clinical director of emergency services. Paul studied medicine at University College London and trained in general medicine, nephrology and critical care at The Hammersmith and University College Hospitals. He was previously Wellcome Trust Research Fellow at Imperial College London, and awarded a PhD for his work on the pathogenesis of acute renal failure in sepsis. His key interests are in acute care, general internal medicine, peri-operative medicine, and medical leadership in the NHS.

- Member, Acute and General Medicine Committee, Royal College of Physicians
- Member, Workforce Review Team, Royal College of Physicians
- Member, Payment by Results Committee, Royal College of Physicians
- Director, London Acute Care Ltd
- Director, The Glynne Medical Practice Ltd

Professor Tony Mundy – medical director, corporate

Tony has been a medical director since 2001. Since November 2006 he has been the corporate medical director with Trust-wide responsibility for quality and safety, research and development and training and education. He was previously clinical director of urology and nephrology and medical director for medicine and surgery. Tony is a professor of urology at the University of London and was director of the Institute of Urology from 1996 to 2008.

- Past President of the British Association of Urological Surgeons
- Member, Council of the Royal College of Surgeons of England

Louise Boden OBE – chief nurse (until November 2010)

Louise joined the Trust as director of nursing in 1993. She first began working in the NHS in 1969, training as a nurse at the United Sheffield Hospitals. She also trained as a midwife and a specialist oncology nurse and worked as a surgical ward sister before moving into nursing management. Louise was awarded an OBE for 'services to nursing' in the New Year's Honours in 2003.

- Governor, Chalfont Centre for Epilepsy
- Honorary Visiting Professor, Department of Applied Social Sciences, City University
- Honorary Visiting Professor of Nursing Leadership and Cancer Care, Faculty of Health & Social Care, London South Bank University
- Nursing Advisor, NHS Employers

Board evaluation

On appointment all directors receive a formal induction. Throughout their appointment directors are updated on changes to the governance framework within which the Trust operates.

All directors undergo an annual performance review. The chief executive evaluates the performance of each executive director and following discussion with the non-executive directors the chairman appraises the chief executive. The chairman evaluates the performance of the non-executive directors, providing a report to the nomination and remuneration committee. The chair of the nomination and remuneration committee leads to the appraisal of the chairman. Appraisals for board directors have been completed this year. An evaluation of the performance of the board overall will commence in April 2011.

The board believes its directors possess the appropriate range of skills, experience and expertise to ensure the board has the appropriate balance in its composition to deliver its business. A balance and completeness review in 2009/10 led to the appointment of a non-executive director with significant business skills. A further review will be undertaken in 2011/12.

Board meetings

The board met on 12 occasions during the year of which 11 meetings were held in public. The board may also hold a confidential meeting each month if required. Board papers are published on the Trust website. Governors receive copies of the agenda and minutes of the public meetings.

The board receives reports from the audit committee, finance and contracting committee, investment committee, human resource and communication committee and quality and safety committee. All committees are chaired by non-executive directors. In addition the board receives a report from the executive board, chaired by the chief executive, and regular reports on performance and risk. These reports ensure that directors can reach informed and considered decisions and ensure the Trust meets its objectives.

Audit committee

The audit committee met regularly throughout the year. Chaired by Nick Monck the committee comprises three non-executive directors (including the committee chair) considered by the Trust to be independent. The chair has relevant financial expertise. Committee meetings are regularly attended by the internal and external auditors, the finance director, deputy chief executive and director of corporate services. Other executive directors attend by invitation. The committee met on eight occasions.

Table 19: Attendance at audit committee meetings

Name	Position	Meetings attended
Sir Nicholas Monck	Chair	8 of 8
Dr Sue Atkinson	Member	7 of 8
Professor Sir John Tooke	Member	3 of 8
Richard Alexander	Attendee	7 of 8
Michael Foster	Attendee	4 of 8
Tonia Ramsden	Attendee	7 of 8
Robert Naylor	Attendee	1 of 1
Richard Murley	Attendee	1 of 1
Louise Boden	Attendee	1 of 1
Professor Tony Mundy	Attendee	2 of 2

The audit committee provides assurance to the board through its monitoring of work commissioned from the Trust's internal auditors. It oversees the Trust's systems of internal control including the maintenance of an effective system of integrated governance and risk management across the whole of the Trust's activities. The committee is well placed to do this since its membership includes the chairs of the quality and safety committee and the human resources and communications committee and a member of the finance and contracting committee. This broad coverage of knowledge and skills strengthens the effectiveness of the committee.

It fulfils its oversight responsibilities with regard to the monitoring of the integrity of financial statements and the annual accounts, including the annual statement of internal control before submission to the board.

The committee is responsible for the relationship with the external and internal auditors. It approves the annual internal audit strategy and considers the major findings of internal audit investigations and management's response.

The committee undertakes an assessment of the auditors' independence each year including a review of non-audit services. There is a policy in place to safeguard the auditors' objectivity and independence. During the year PricewaterhouseCoopers LLP (PwC) were not engaged for any non-audit work.

Meetings are also held between the non-executive directors and the internal and external auditors in private.

In this year the committee has reviewed and discussed the risk register and quarterly assurance framework documents which covers risk to the delivery of the Trust's objectives. It has evaluated its own performance and considered reports from internal and external audit focusing on those giving 'limited assurance' and the implementation of agreed recommendations. It also received reports on counter fraud work at the Trust including the annual report of the Local Counter Fraud Service.

The Trust's external auditors are appointed by the governing body and report to them through the audit committee. The Trust's external audit service provided by PwC comes to an end in 2010/11. Following an agreed tender process the Trust established an audit tender panel comprising two governors, Peter Brayshaw and Amanda Gibbon, Sue Atkinson, non-executive director and member of the audit committee and the Trust's finance director. The governing body supported a recommendation to appoint Deloitte for an initial period of three years commencing in 2011/12.

Remuneration committee

The remuneration committee which deals with executive arrangements sets and implements policy for the remuneration of executive directors (and other senior designated staff) and considers the performance of the executive directors. It is chaired by the Trust chairman and comprises all other non-executive directors. The chief executive attends by invitation. The committee met on two occasions in 2010/11.

The first on 9 June was to consider a recommendation on remuneration. The committee sets remuneration with due regard to the appropriate market rates for comparative senior posts within the NHS sector.

The second meeting on 10 November was to consider the

appointment of a new nursing director. Executive directors are appointed on permanent contracts.

Details of salary and pension entitlements for the directors of the Trust are set out in section 10 - Remuneration report, and in appendix 4.

Registers of interests

The Trust holds two registers of interests; one for board directors and one for the governing body. Directors and governors are asked to declare any interests that are relevant and material on appointment or after election and should a conflict arise during the course of their term. The registers of interests which are updated and published annually are maintained by the Trust secretary and available to the public on our website www.uclh.nhs.uk. A copy can be obtained from the Trust or viewed by appointment.

Our membership

Membership recruitment, engagement and involvement are key strands of the Trust's membership strategy agreed by both the governing body and board in 2009 and were the focus of work during the year.

Membership Recruitment

We plan to steadily build a strong informed, engaged and involved patient and public membership. Our programme of recruitment campaigns across our hospital sites is supported by a governor membership champion assisted by members who following appropriate training will help recruit patient members and answer questions about membership. Further recruitment has taken place at local GP surgeries and plans are underway to visit more surgeries. A membership letter from our new chairman to patients is proving to be successful as is a local residents mail shot campaign.

Membership of the Trust continues to grow and we currently have 16,469 members including staff. We set targets this year to increase our membership by 10% public and 5% patient respectively and both have been exceeded.

Table 20: membership figures by constituency

Constituency	Last year	This year
Public	1,494	1,663
Patients	7,599	7,983
Staff	6,233	6,752
	15,326	16,398

The Trust has three membership constituencies and all members are eligible to vote for or stand as governors.

Public members

Individuals who are aged 14 or over or live in the following areas of London: Camden, Islington, Westminster (the wards of Regents Park, Marylebone High St, West End or St James) and the City of London (the wards of Farringdon Without, Farringdon Within, Aldersgate, Cripplegate, Bassishaw, Cheap, Cordwainer, Walbrook, Vintry, Queenhithe, Castle Baynard, Bread Street, Coleman Street, Dowgate).

90%
venous thrombolysis risk assessments for all admitted patients

Patient members

A patient or unpaid carer of a patient who lives anywhere in the country and who has attended the hospital within the last three years. Patients must be aged 14 or over but carers e.g. a parent of a younger patient can become a member.

Public and patient membership is an opt-in scheme. Individuals eligible to be public or patient members must not be eligible for the staff constituency.

Staff members

All staff who have a contract to work with the Trust for at least twelve months; employees of UCL, paid volunteers or contractors who provide services to the Trust are automatically members. Staff can opt-out if they wish. This right is explained on appointment and on the staff intranet. Only ten staff have chosen to do so, all of whom opted out in 2004.

Membership engagement and involvement

Engagement with local communities included a successful event at Full of life in Camden; a diabetes seminar at the Bengali Workers Association (BWA); a stall at an event held by Camden Volunteer; and meetings with Somers Town Youth Centre and the Islington Bangladeshi community. We will return to Islington in the summer to participate in a health awareness event. The programme for next year will be linked more closely with the Trust's PPI work (see section 8 – Improving our services) and will include engagement with disability groups and Camden youth groups.

Our series of MembersMeet seminars continue to be well attended attracting a good balance of new and longstanding members. They provide a regular mechanism for involvement in particular our meeting on the Cancer Centre led to many members joining patient wellbeing project groups. The MembersMeets are supported by governors and Trust staff. The governors talk about their role and answer questions about how they meet their responsibilities; the staff talk about Trust services and health issues. This work has resulted in an increase in members from the local Asian community.

Engagement with members has increased. Analysis of a members' survey to which 823 members responded indicated that up to 50 members were interested in standing for governor. With the introduction of new technology we have improved our website; we now post invitations to our MembersMeet seminars on both the website and the new UCLH twitter page and in the Camden LINks calendar. We are also inviting members to contribute to UCLH News, the membership magazine.

A staff intranet forum is being established in the Trust to make staff governors more visible – the objective is to improve the interface between staff governors and their members so that staff understand what their governors do and why it matters.

Members are getting involved in service improvement projects. A member has been linked to each of the nursing benchmark programmes and members have been involved in outpatient focus groups, website development, participated in surveys and been actively involved in our recruitment campaigns.

Members who wish to contact governors can do this via the membership office at foundation.trust@uclh.nhs.uk this will ensure the enquiry is directed to the appropriate governor. This information is published in UCLH News, on the Trust website and in all other information sent to members.

For those wishing to contact the governing body or the board of directors, this email address foundation.trust@uclh.nhs.uk as well as telephone and postal address details which are displayed on the Trust's website www.uclh.nhs.uk

10 Remuneration report

The salary and pension entitlements for senior managers and directors for the financial year are shown in appendix 4. This includes the real increase of pensions during the reporting year, the value of accrued pension at the end of the reporting year and related pension lump sum at age 60, the value of 'Cash Equivalent Transfer Value' (CETV) and the real increase of CETV during the financial year.

The remuneration and expenses for the Trust chairman and non-executive directors are determined by the governing body, taking account of the guidance issued by organisations such as the NHS Confederation and the NHS Appointments Commission.

Remuneration for the Trust's most senior managers (executive directors who are members of the board of directors, and other directors) is determined by the Trust's remuneration sub-committee, which consists of the chairman and the non-executive directors.

The only non-cash element of senior managers' remuneration packages are pension related benefits accrued under the NHS Pensions Scheme. Contributions are made by both the employer and employee in accordance with the rules of the national scheme which applies to all NHS staff in the scheme.

Pay levels are informed by executive salary surveys conducted by independent management consultants and by the salary levels in the wider market place. Affordability, determined by corporate performance and individual performance, are also taken into account. Terms and conditions are consistent with the new NHS pay arrangements.

The Trust's strategy and business planning process set key business objectives which in turn inform individual objectives for senior managers. Performance is closely monitored and discussed through both an annual and ongoing appraisal process. All senior managers' remuneration is subject to performance.

Senior managers, other than directors, have pay progression in line with the nationally implemented Agenda for Change system.

Senior managers are employed on contracts of employment and are substantive employees of the Trust.

The Trust's disciplinary policies apply to senior managers, including the sanction of dismissal for gross misconduct. The Trust's redundancy policy is consistent with NHS redundancy terms for all staff.

Details of the remuneration committees which determine the remuneration of board members, and details of the appointments committees, can be found in section 9 – Our organisational structure.

No compensation for early termination was paid during this financial year. No early terminations are expected and no provisions are required accordingly. No awards have been made to any past senior managers or directors.

There were no benefits in kind or non-cash elements of remuneration paid to directors in the year.

The salaries and pension entitlements of the directors for 2010/11 and 2009/10 are shown in appendix 4.

Sir Robert Naylor
Chief Executive
University College London Hospitals NHS Foundation Trust
1 June 2011

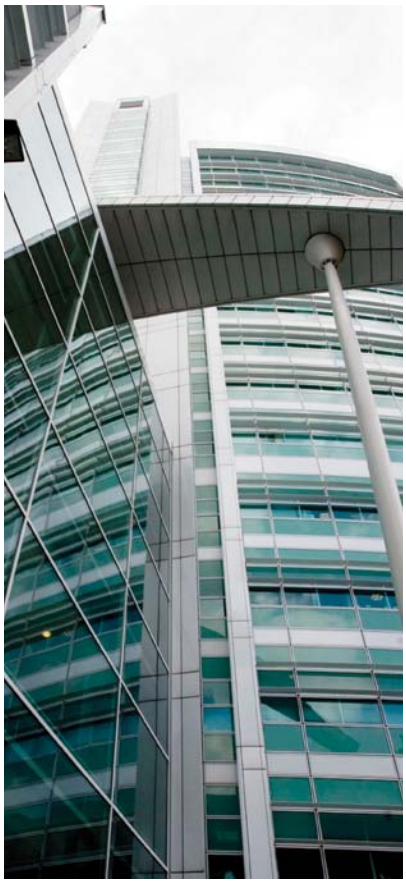
Appendix 1

Quality report 2010|2011

Contents

1 Chief executive statement

Our commitment to outstanding quality of care for our patients and placing patient safety and experience at the heart of all we do continues to be our central mission at University College London Hospitals NHS Foundation Trust.



Translating this into meaningful and continuous improvements for patients depends on the individual acts of all our staff and on our commitment, at board level, to provide the environment in which all our aspirations for improving the quality of our services can be delivered. This Quality Account reflects how we are going about this and the progress we are making.

During 2010/11 we have continued to build on our very strong foundations. Once again we achieved one of the lowest hospital standardised mortality ratios nationally, delivered one of the best A&E waiting times in London and continued our strong performance in the national inpatient survey. We worked with our Academic Health Science Centre partners (UCLP) to find new, more effective ways to provide support services as well as working with partner Trusts to develop clinical improvement projects in areas of common interest.

Despite the many successes during the year, there have been disappointments in some areas. Our performance in reducing MRSA was significant but despite a 40% reduction from 22 to 13 cases we failed to achieve our target. Our performance in the national cancer patient survey was also below what we had hoped for.

During 2010/11 we have, however, worked hard to find new and better ways to involve frontline clinical staff in improving services for patients. This Quality Account describes just some of these successes.

I am pleased therefore in this third year of quality reporting, to have the opportunity to present our Quality Account for 2010/11 which I believe to be a fair and accurate report of our quality and standards of care.

Sir Robert Naylor
Chief Executive

Quality Account requirements

All providers of NHS services are required to produce an annual Quality Account as set out in the National Health Service (Quality Account) Regulations 2010. This requirement took effect in April 2010 although UCLH also took part in a Quality Report pilot in 2009.

This is therefore the third year that we have published a Quality Report and the second year of publication of the mandatory Quality Account.

The regulations specify the requirements for all Quality Accounts and certain elements are mandatory. We have used the Department of Health Quality Accounts toolkit as the basic template for our Quality Account as well as the published guidance from Monitor the Foundation Trust regulator.

The report provides information about our progress through last year and our priorities and ambitions for the year ahead. We believe it will be of interest and value to patients and the public as well as to those who commission our services.

Quality narrative

1.1 Our current view of the Trust's position and status on quality

During 2010/11 we continued to build on the quality improvements previously reported as well as starting new programmes. Some of these have been initiated at corporate level and others by local clinical teams, reflecting a Trust-wide culture that supports quality improvement.

We continued to refine our quality measurement framework. We want important information to reach clinical teams more quickly and more often: on patient experience, on safety indicators such as infections and falls and on clinical outcomes such as stroke care, mortality rates and readmissions.

During the year we extended our leadership programme for clinicians and managers to include a Quality Improvement Network – helping to build the skills needed to lead and manage quality projects. We have also developed a new Staff College in collaboration with a military training academy and are in discussion with the Department of Health about a wider NHS rollout.

To help put quality improvement ideas into practice, we piloted and refined a UCLH Quality Improvement Framework. In 2011/12 this will be implemented on all wards throughout the Trust.

Last, but by no means least, we continued to use hand-held computers to collect 'real time' feedback from patients in wards. We will be extending these surveys to other areas such as outpatients and A&E.

The following describes some of our quality highlights and challenges from the year:

Stroke care

The UCLH Hyper Acute Stroke Unit (HASU) opened at full capacity in July 2010. It serves the population of North Central London (NCL) and expects an annual caseload of 1,800 patients. Its capacity may be exceeded by 10%. The service is based around 18 beds and requires efficient turnaround. Good communication is crucial to enable efficient transfer to local stroke units or discharge home. The unit provides consultant led services, seven days a week, and uses the expertise of all NCL stroke neurologists and physicians, fostering cooperation between them. The results so far are excellent. The rate of thrombolysis (also known as 'clot busting') has doubled across the sector (currently to 18%). The in hospital mortality for patients treated through HASU has been exceptionally low at 6%, compared to the national average of 27%. The HASU has achieved excellence in all the performance standards intended of it in the London Stroke Strategy.

Enhanced recovery

We extended our enhanced recovery programme which helps patients to speed up their recovery after surgery. The programme helps patients to prepare mentally and physically for surgery and helps mobilise them afterwards, supporting early recovery and discharge. There is already national evidence that the programme improves outcomes and at UCLH we have seen positive results in bariatrics and colorectal patients.

We have extended the programme to trauma, orthopaedic and cardiac patients. In the coming year we plan to apply it to all surgical patients with particular emphasis on urology, gynaecology and some aspects of neurosurgery.

Quality Improvement Framework

We introduced the UCLH Quality Improvement Framework which provides a straightforward and consistent approach to quality improvement that can be used throughout the Trust. The framework draws on established international experience as well as our own experience of improving ward care. It also links well with national initiatives including the National Energising for Excellence programme and the High Impact Actions for Nursing and Midwifery.

The framework has five themes:

- transformational leadership
- safe and reliable care
- staff vitality and teamwork
- patient centred care
- value added care processes (for example, increasing nurses' time at the bedside).

The framework aims to:

- reduce harm from pressure ulcers, falls and urinary infections resulting from catheters
- simplify processes, for example, patient discharge
- improve patients' experience
- improve the use of resources.

In 2011/12 we will introduce five tried and tested interventions that will improve patient care and the effectiveness of ward teams:

- intentional rounding (regular checking of patient status on things such as pain and position at specific intervals through the day)
- patient status boards
- standard communication tool

for patient handover (SBAR)
- lean process management techniques to improve the ward environment
- care bundles to help tackle key patient safety issues such as falls.

The UCLH Quality Improvement Framework will focus initially on wards but over time we expect all clinical areas and departments to follow.

Models of integrated care

The Trust recognises that we must constantly adapt to meet the changing needs of patients and the local community. More complex health care is now undertaken within the community following improvements in technology and medicine has created new opportunities to help patients manage their conditions and maintain their quality of life. UCLH piloted the Post Acute Re-enablement Project in January 2010. The project identifies patients who can be discharged with a personalised home care package during the first seven to 14 days. The pilot started in medical patients and has the potential to extend to surgical patients over the coming year. We will work with local services to broaden the range of home care projects that support patients in their homes.

We will respond to the growth of long-term conditions by working closely with local GPs on four or five pathways that have most impact on the long-term health of patients. We have successfully redeveloped services for chronic obstructive pulmonary disease (COPD) and aim to significantly improve the overall health of local residents by working with local GPs to create integrated care pathways. This work will be led by one of our medical directors and the GP Partnership board.

Improving discharge

In 2010/11, we focused on improving discharge following concerns from patients about delayed discharge. We improved advice to patients on medication and the process of preparing patients on the day of discharge, We ensured regular communication with community teams about patients with complex needs from the moment they arrive at our hospital. We improved our turn around time for giving patients their medication. Our discharge lounge services now help patients to pack and serve hot food in the morning.

We discharge more patients earlier in the day – when more services in the community are available to enable people to adjust more easily to their return home.

Safer Patient Network (SPN) innovation project

We submitted a successful project application to the Safer Patients' Network (led by the Health Foundation and the Institute for Healthcare Improvement) which develops and tests innovations in patient care. The project assesses the effectiveness of a technique called 'teach back' which tests each patient's understanding of the instructions they receive about what they need to do after leaving our care. Each patient explains their understanding of the instructions. The conversation continues until staff are confident the patient fully understands.

Use of 'teach back' has been shown to deliver significant patient safety improvements, but the work around preventing readmissions is less well understood. We are very pleased to be leading this work in the UK. We will be trialling the scheme on our care of the elderly ward until August 2011.

Energise for Excellence

UCLH has been participating in the national Energise for Excellence (E4E) programme, which embraces a number of key programmes that nurses and midwives can use to drive quality improvement. The programme provides a clear link between delivery of care, patient experience, measurement of care, staff experience and getting the staffing right. Core to E4E are the High Impact Actions (HIAs) for nurses and midwives which focuses on the improving the quality of the essentials of care.

In 2011 we intend to fully implement eight High Impact Actions for nurses & midwives as follows
- reduce hospital acquired pressure ulcers
- prevent falls
- improve nutrition and hydration
- promote normal birth
- provide choice of where patients die
- reduce urinary catheter related infections
- reduction in staff sickness.

Care of patients with learning disabilities

During 2010/11 we focused on improving the care of patients with learning disabilities. We developed an action plan with help from community service providers, users and carer representatives.

We continue to exchange best practice with other hospitals and community services in North Central London.

We adopted the use of a butterfly symbol at the bedside of patients with Alzheimer's disease to help raise awareness among staff and visitors of the patient's difficulties remembering events, places and faces.

Over the coming year we will continue to improve services for patients with learning disabilities and their carers. We aim to train learning disability champions in each clinical area and increase the availability of patient information that's easy to read.

Healthcare associated infection

In 2010/11 we have continued to focus on minimising the number of healthcare acquired infections within the Trust. As a result of improvements in a number of areas there were 62 Trust Attributable cases of Clostridium difficile, an improvement of 30% on the previous year and well within our threshold of 119 cases. We reduced Trust attributable cases of MRSA by 40% in 2010/11 as a result of our work on hand hygiene, care bundles and detailed analysis of the causes of MRSA cases. We were disappointed, however, that we did not stay within our threshold of eight cases & recorded 13 cases for the year. We are redoubling our efforts in the coming year starting with the launch of a new zero tolerance campaign in April 2011.

Waiting times

We have continued to deliver very strong performance against the A&E four hour waiting time target. In 2010/11 we delivered the best results for any acute trust in London. Our annual performance against the national four hour standard was 98.5%, one of only three trusts in London to keep its performance above the old national standard of 98%. We have also met all our referral to treatment waiting time targets, and have improved waiting times in some specialties that have previously struggled to meet the national standards.

We delivered against most of the cancer waiting time targets, although we have struggled to deliver against the 62 day standards for treatment following referral from GPs and screening centres. Part of the challenge that we face on these two targets is due to the particular kinds of cancer that we treat that are not as appropriate to treat in the same fast-track way that other cancers are rightly managed. Our performance is also significantly affected by the management of early stages of the pathways that are controlled by other healthcare providers. There are of course parts of these pathways that we could speed up, and as a result we have taken action in access to diagnostic imaging and surgical facilities during the course of the year. We will continue to identify areas for improvement that are within our control, and we will treat this as one of our key objectives for 2011/12.

Discharge summaries

During 2010/11 GPs have expressed their concerns about the timeliness and quality of discharge summaries we send about patients who have attended A&E. We have implemented ssome solutions and some improvements have been reported to us by GPs but this remains an issue that we need to focus on further. We have commited to a CQUIN sceme for the coming year to drive delivery of quicker, higher quality discharge information to GPs

2 Priorities and Statement of Assurance

2.1 Report on Priorities for 2010/11

Last year we identified four Quality Priorities and the following report describes our achievements against these priorities all of which continue to be relevant to our quality improvement strategy and are carried forward into this year. These were:

Priority 1: Improve overall patient satisfaction

Priority 2: Reduce avoidable harm (SSI, CVC, VTE)

Priority 3: Improve recognition and response to deterioration in hospital patients

Priority 4: Reduce adverse clinical outcomes (GTT trigger tool)

Priority 1: Improve overall patient satisfaction

2010/11 was the second year of this priority the success of which is measured by the national inpatient survey which is an independent survey conducted every year for all acute and specialist trusts. During the year we have continued to support ward teams with real time patient feedback from ongoing surveys. We have targeted poorer performing areas from the previous years' survey especially information given about anaesthetic and information given in A&E. Local teams have developed plans specific for their area and have used the ongoing survey to monitor the overall patient experience.

Our 2010 national survey results show that the specific areas we targeted have improved and our performance was strong compared to our peers in London. The survey showed that patients continue to rate their care highly and 97% of patients said they would recommend the hospital to family and friends.

Survey question	2009	2010
Did the anaesthetist explain how you would be put to sleep	88%	93%
How much information about your condition did you get in A&E	76%	87%
Overall rating of care	84%	83%

Improving overall patient satisfaction will continue as a priority for 2010/11

Priority 2: Reducing Avoidable Harm (SSI, CVC, VTE)

This priority targeted three areas of known avoidable harm by the implementation of safety interventions called care bundles, which are known to reduce harm from infections and thrombosis.

During 2010/11 we set ourselves the task of establishing care bundles to prevent surgical site infection (SSI) and central line infections (CVC).

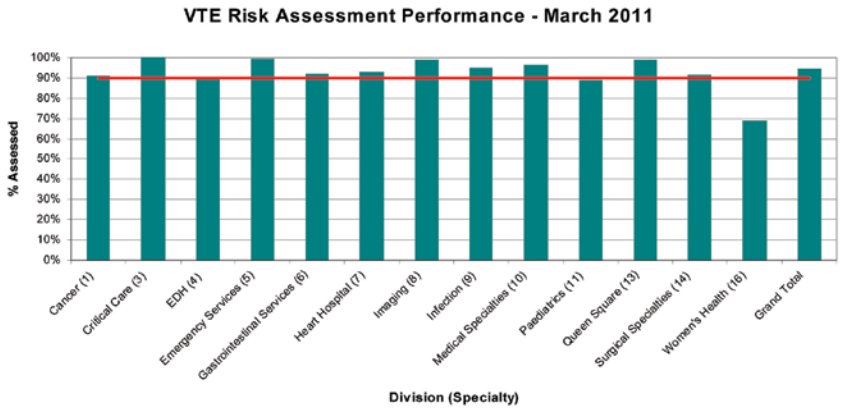
The planned initiatives were to establish:

- baseline data for SSI and CVC
- clinical leads and implementation methodology
- ongoing monitoring using a care bundle audit mechanism.
- a reporting mechanism leading to root cause analysis of all wound and line infections.

This infrastructure is now in place and we will begin reporting SSI and CVC infections on our monthly quality and safety scorecard with effect from April 2011 enabling us to set targets for reduction and report progress in our Quality Account next year.

The care bundle for venous thrombolysis (VTE) is aimed at preventing thrombosis (blood clots) and begins with the implementation of VTE risk assessments for all admitted patients.

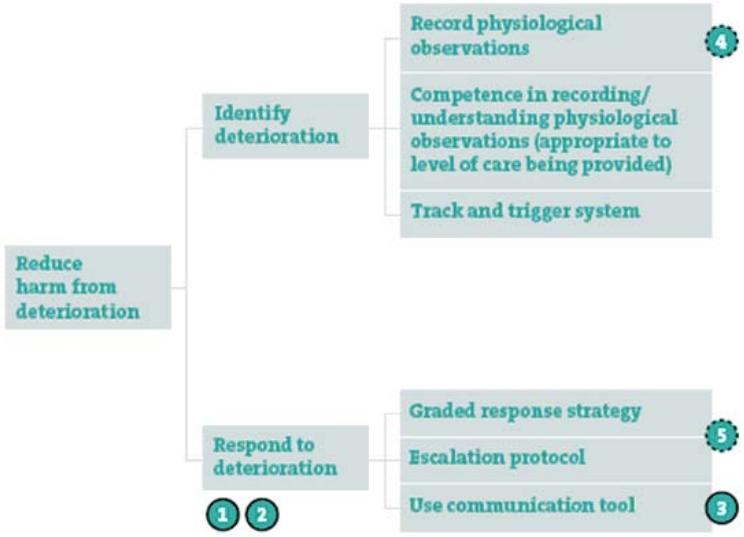
The 2010/11 target was to achieve 90% risk assessments for all admitted patients by March 2011. During the year we have developed and introduced the means for on line recording of VTE risk assessments, providing a monitoring mechanism and a prompt for clinicians. A robust system of reports is now in place which clinical teams can access on a daily basis to see any patient's risk assessment status. As a result of these initiatives we are pleased to report we have achieved the 90% target.



Prevention of VTE will continue to be a quality priority for 2010/11 as we shift our focus to other aspects of the care bundle, particularly to 'appropriate prophylaxis'. This means that, once risk assessed, those patients who have a risk of VTE will be given appropriate treatment to prevent it occurring.

Priority 3: Improve recognition and response to deterioration in hospital patients

This priority focuses on the implementation of a care bundle that recognises when patients are deteriorating and enables swift action to take place to prevent complication and ultimately cardiac arrest from occurring. The care bundle includes regular recording of vital signs (pulse, blood pressure, temperature etc.); using triggers to alert staff to potential deterioration and using a validated communication tool (SBAR – see box 1) so that staff can escalate their concerns effectively.



During the year we focused on improving the consistency and competence of our performance in recording and responding to vital signs as the first level alert system for preventing deterioration. We are pleased to report that monthly audits have demonstrated a significant improvement in performance

	April	May	June	July
All UCH (& Maternity Care U)	46%	37%	62%	76%

When vital signs are outside of normal parameters, the SBAR communication tool is a crucial next step. It ensures that information is transferred quickly and accurately to medical staff and the Trust Patient Emergency Response Team. We have begun using SBAR in all areas of the Trust

We will carry out monthly audits of compliance with vital signs recording throughout the coming year and we will monitor the proportion of referrals to the Patient Emergency Response Team (PERT) that use SBAR.

Improving recognition and response will continue to be a quality priority in 2011/12 – helping to further reduce our Hospital Standardised Mortality Ratio. In the coming year we expect to introduce a new early warning system that has been developed by the Royal College of Physicians.

Box 1: SBAR communication tool explained

SBAR:

Situation – Where you are and why you are calling, what you are concerned about
Background – relevant patient history, why they are in hospital what has happened to them so far
Assessment – what their condition is now; vital signs, urine output, mental state etc.
Recommendation – what you want to happen; e.g. "I would like you to come and see the patient straight away"

Priority 4: Implementation of Global Trigger Tool to detect and reduce adverse clinical outcomes

The Global Trigger Tool, used extensively across the world, was devised for the purpose of identifying the types and scale of adverse events. It is much more sophisticated than the routine system of clinical incident reporting and identifies potential as well as actual harm. Organisations that are using the global trigger tool can be very focused in their action to reduce harm and are seen to be at the forefront of the drive to improve patient safety.

It involves patient case note review using the Global Trigger Tool (GTT) which identifies adverse events which may lead on to complications of care and adverse outcomes. Working via a manual review of patient records this method uses a checklist of over 50 trigger events. Specially trained doctors and nurses examine patient records to see if any of these triggers are present and if so, did they lead on to an adverse clinical outcome. Unplanned clinical outcomes such as return to theatre, nausea for a prolonged period and pressure ulcer are just some of the triggers that may indicate a complication of treatment.

The target was to implement fortnightly case note review and build a baseline of data from which recurring themes could be identified. We have now fully implemented the Global Trigger Tool both for fortnightly review and also carry out twice yearly mortality reviews.

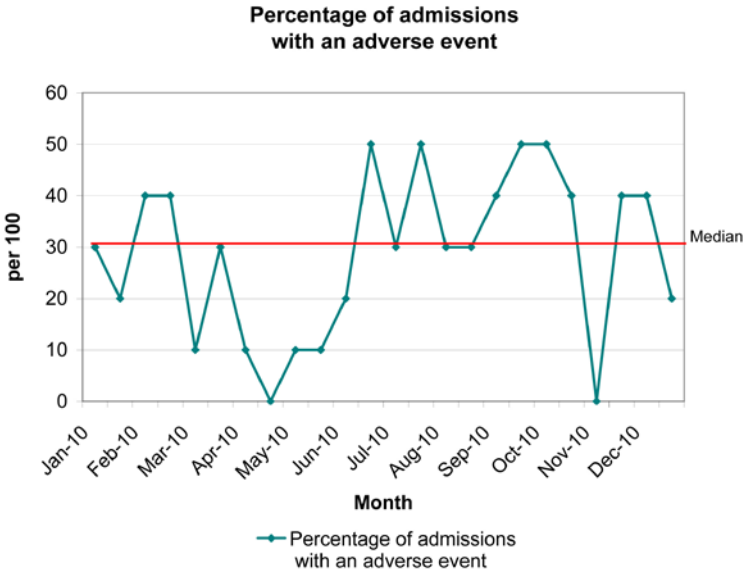
The next step is to examine the types of adverse events to determine whether they could be anticipated or prevented and to put actions in place accordingly.

Our aim was to reduce the percentage of admissions with an adverse event by 5% from the baseline of 37% (2009/10) to 32% and our latest analysis shows we have reduced this to 31%.

A high identification of adverse events with a corresponding reduction in serious incidents is known to be a good thing – this is the case in UCLH.

The accepted way of displaying this information is by use of run charts and the chart below

shows run chart data for the percentage of admissions with an adverse event throughout 2010.



NB: International average for percentage of admissions with an adverse event is 30 – 35%

Implementing GTT effectively will continue to be a priority in 2011/12 as part of our ongoing commitment to reduce our Hospital Standardised Mortality Ratio.

2.1 Priorities for 2011/12

How we prioritised our quality improvement areas for the coming year

Our starting point for choosing the quality priorities for the coming year was to review last year's priorities and ask which if any of them should be carried forward. In the course of the review we used a range of information, including performance against our quality and safety measures, information from national survey reports and clinical audits, risk reports and issues raised by staff during executive safety walk rounds. We consulted with Trust staff and governors through face to face discussions, surveys and presentations. We consulted with local PCTs and commissioners through our Clinical Quality Review Group. We also involved our local LINk before making a final choice.

The conclusion of these discussions is that our priorities for 2010/11 should continue as our overarching aims in 2011/12. We have set new or more ambitious objectives within each area. We will combine two of the priorities from last year into a single priority of improving our Hospital Standardised Mortality Ratio. We expect to achieve this through early recognition and response to deterioration and by applying lessons from the findings of global trigger tool reviews. There will be a new fourth priority to reduce readmissions.

Our priorities for 2011/12 which have been agreed by the board will therefore be:

Priority 1: Improve patient Experience

Priority 2: Reduce avoidable harm (SSI, CVC, VTE preventing falls & pressure ulcers)

Priority 3: Improve hospital standardised mortality ratio (incorporating rapid response to deterioration & GTT reviews)

Priority 4: Reduce hospital readmissions

Priority 1: Improve patient satisfaction as measured by national patient surveys

Rationale

Treating the clinical condition of patients is the fundamental purpose of any hospital; however excellent healthcare is about more than that. The experience of our patients during their hospital journey is of equal importance to their health outcomes and is central to our mission of providing outstanding quality of care.

Improving patient satisfaction as measured by the national in patient survey has been a quality priority for the past two years. In 2011/12 we will add a new dimension to this priority by including out patient experience and improving the experience of our cancer patients. This priority continues to have the full and specific support of our staff, governors and commissioners.

Current status

Inpatient Survey

The 2010 national in patient survey result showed that our good performance in 2009 was maintained in 2010.

We were particularly pleased that our 2010 performance was in the top 20% for all hospitals nationally for providing patients with information and feedback on their operation or procedure. We also retained our top 20% performance in the 'overall views and experiences' section of the survey. Both these sections are green rated by the Care Quality Commission.

In the individual questions the Trust was in the top performing 20% nationally for a total of 27 out of 64 questions

The full results of the UCLH 2010 inpatient survey is available on the CQC website

In the coming year we will focus on some specific areas which include those identified in the national CQUIN for patient experience. These are shown in the table below together with other areas where the 2010 survey shows there is most room for improvement.

CQUIN focus	2010	Issues arising from 2010 survey	2010
Involvement in care decisions	75%	Storage for personal belongings	67%
Privacy when discussing treatments	82%	Dr's and nurses working well together	79%
Discharge medication side effects	53%	Trust and confidence in nurses	84%
Knowing who to contact after discharge	73%	Availability of alcohol hand rub	95%
Finding someone to discuss worries and fears	60%		

Cancer survey

In 2010 the Department of Health commissioned the National Cancer Patient Experience Survey. All acute hospitals providing cancer services took part. It was the first national survey of its kind and included results for all tumour groups as well as the overall trust performance.

The overall results for the Trust were very disappointing and although the experience of our patients did vary between tumour groups we hope to make a significant and sustained improvement in the experience of all cancer patients.

In particular in 2011 we are targeting improvements in the following areas and we will commission another cancer survey to track our progress:

- providing clear and understandable explanations and information
- providing choice of treatments and involvement in decisions
- providing support from a clinical nurse specialist.

Survey Question	2010 Results	2011 Target
Patient felt they were told sensitively that they had cancer	77%	83%
Patient completely understood explanation of what was wrong	64%	73%
Patient definitely involved in decisions about which treatment	66%	69%
Last time seen, time spent with CNS about right	90%	94%
Patient had trust & confidence in all doctors treating them	80%	82%
Patient had trust and confidence in all ward nurses	55%	63%

Outpatient survey

For many patients the majority of their experience within the Trust takes place in an outpatient setting and we are keen to make improvements to that experience. In 2011 there will be a national outpatient survey - last conducted in 2009 – in which we aim to improve our overall performance as measured by responses to the following questions:

Survey Question	2009	2011 Target
Overall were you treated with respect and dignity	90%	93%
Overall how would you rate the care you received	81%	83%

How will we do it?

We reported last year that we had introduced a system of real-time patient feedback on wards. In 2011/12 we will extend the real-time survey programme to include outpatient areas and we will include specific surveys for cancer patients to cover all settings where cancer diagnosis and treatment takes place. We will explore new ways of gathering patient feedback throughout the year.

We will also use the following:

- We will analyse the national surveys and prioritise areas for improvement
- We will provide weekly/monthly real-time survey results to wards and clinical teams so that they can monitor their performance
- We will provide analysed information showing trends over time in order to measure progress
- We will develop action plans at Trust and specialty level
- We will monitor & report progress at the Trust Quality & Safety Committee.

Measuring progress:

- Monthly review of real-time surveys within wards and divisions
- Monthly reporting via Trust performance scorecard at Quality and Safety Committee and Executive Board
- Annual national surveys

Priority 2: Reduce avoidable harm in identified areas

Rationale

Keeping patients safe is a fundamental and long standing expectation of both healthcare providers and patients. The concept of avoidable harm however is a more contemporary notion. Over recent years more attention has been focused on the complications which sometimes occur on a patient journey which result in harm which could be avoided if certain steps are taken. Healthcare associated infection and thrombosis are two such areas which were identified in last years Quality Account. This year we add falls in hospital and hospital acquired pressure ulcers both of which have the specific support of governors, the board and commissioners.

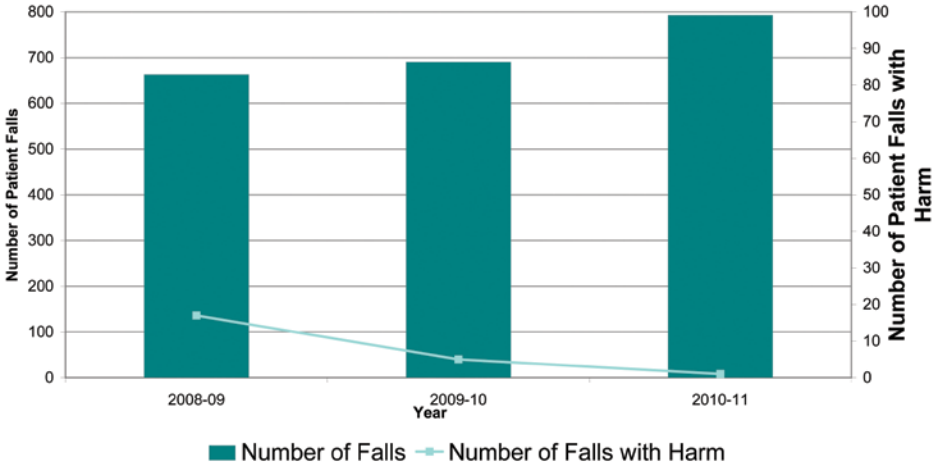
Current status

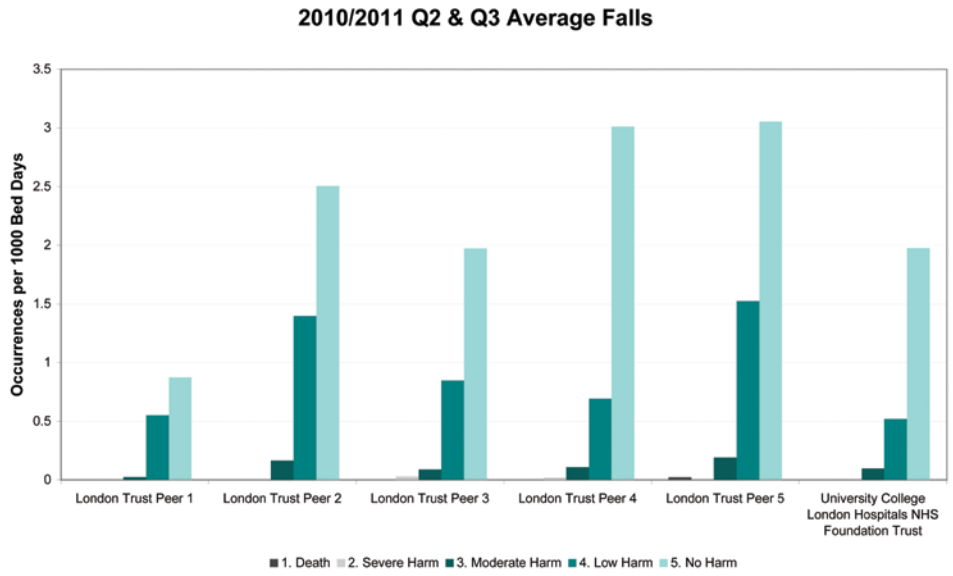
Falls

Reducing patient falls will be a key focus in 2011/12. As the graphs below and overleaf show, we have succeeded in reducing the number of falls which result in harm over the last three years. UCLH's falls rate (2.5/1000 days) is less than half the national average and lower than most of its London peers. However, despite introducing a number of new interventions in the last year, the overall fall rate remains higher than we would like and we want to reduce it considerably. Even when there is no injury associated with a fall, we recognise that a fall is an unpleasant experience for patients and we need to do all we can to prevent them taking place whilst preserving patients' independence. In order to achieve this we will be introducing a falls care bundle in addition to the measures we are already taking.

This year a national CQUIN has been introduced which requires trusts to introduce measures that help reduce falls. UCLH has already introduced the majority of these but will consolidate them in 2011/12 as well as introducing additional measures of our own.

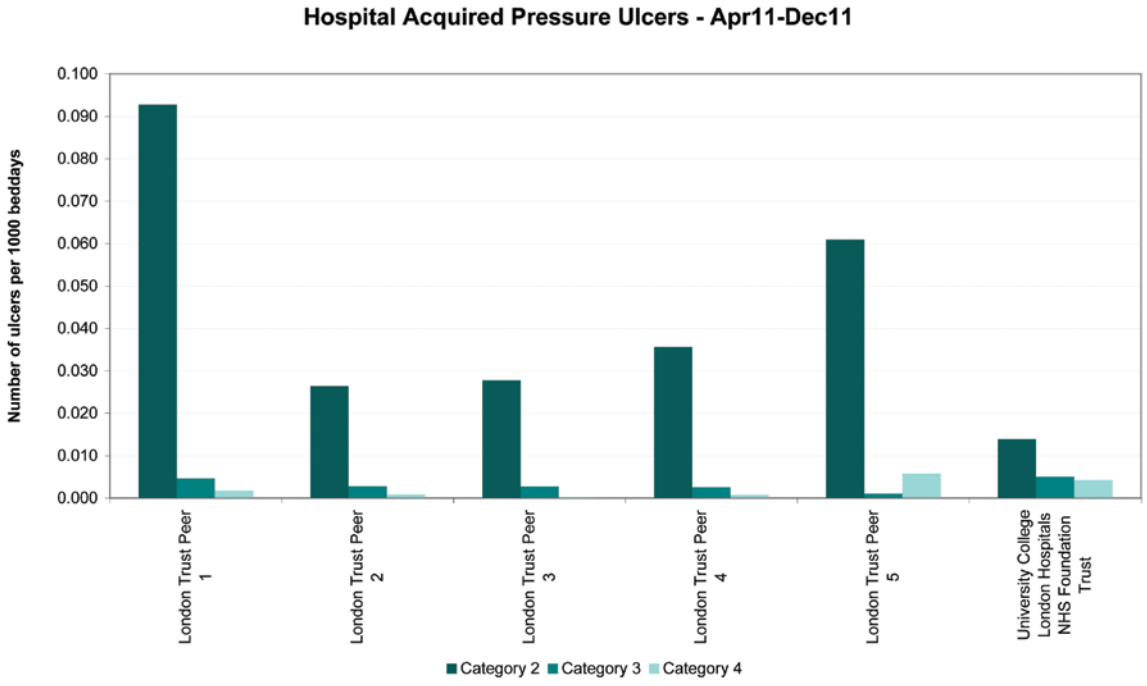
Number of Patient Falls from 1st April 2008 to 31st March 2011





Hospital acquired pressure ulcers

Reducing and preventing hospital acquired pressure ulcers (HAPU) is another key national imperative and UCLH is committed to driving down both their number and severity. Whilst raising awareness has led to better reporting of HAPU, we are concerned that we still have too many. Compared to other London trusts, we have a lower overall rate of HAPU but the proportion of category 3 and 4 HAPU – the more serious cases – seems to be higher. This requires further exploration and action and, as with falls, we are introducing a HAPU care bundle.



How will we do it?

We will continue our implementation and monitoring of care bundles, described in last years report, for the prevention of surgical site infection, line infection and venous thrombosis. In addition this year we will add care bundles for the prevention of falls and pressure ulcers. Care bundles bring together a number of proven interventions and then apply them in rigorous and consistent manner across the whole organisation. Some of the key actions to prevent falls and pressure ulcers are shown below in boxes 2 and 3.

Box 2: Preventing falls

Falls care bundle: the SAFE bundle

Safe environment – keep the ward free of hazards, have the right equipment and use it correctly
Assessment of risk and care planning – all patients to have accurate falls risk assessment and individualised care plans if deemed to be at risk
Footwear – eliminate falls from slips by use of appropriate footwear
Education and reassurance – ensure patients and relatives know about the risk of falling and how they can reduce it. Ensure that patients call for help when they need it and that their needs are proactively met through the use of intentional rounding.

Target:
- Further reduce number of falls with harm by 25%
- Reduce overall falls rate to 1.5/1000 bed days or less

Measuring progress

In 2011/12 we will measure our progress using monthly audits to monitor falls and HAPU including:

- monthly audits of care bundles
- monthly measurement of incidence of falls and pressure ulcers
- monthly performance monitoring within divisional, nursing and Quality and Safety Committees
- monthly reporting of falls incidence and levels of harm and pressure ulcer incidence and severity to divisional meetings, nursing and midwifery board and Quality and Safety Committee

Box 3: Preventing pressure sores

HAPU care bundle: the SKIN Bundle

Surface – ensure the patient is on the right mattress, keeping wrinkles out of sheets, daily HAPU risk assessment
Keep moving – regular change of position and skin inspection, early mobilisation
Incontinence – help with toileting, keeping skin clean and dry
Nutrition – regular nutritional risk assessment, maintaining optimal diet, keeping hydrated

Target:
- Reduce category 2 and 3 HAPU by 80%
- Eliminate category 4 HAPU

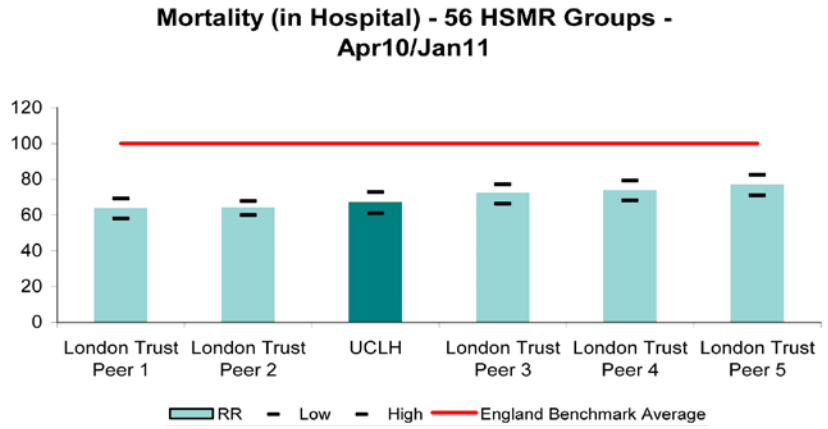
Priority 3: Reducing Hospital Standardised Mortality Ratio (HSMR) to best performing hospital in the country

Rationale:

Hospital Standardised Mortality Ratio (HSMR) compares a trust's actual number of deaths with their expected number of deaths. The prediction calculation takes into account factors such as age, sex, diagnosis, whether the admission was planned or emergency and length of stay. An HSMR of 100 indicates the expected number of deaths. Lower than 100 means fewer than expected.

Current status

Our current HSMR is 67 which means there are significantly fewer deaths than average for the country – one of the lowest rates nationally – but we wish to reduce that still further and regain our position as lowest HSMR nationally.



How will we do it?

A number of our quality improvement programmes contribute to achieving our low HSMR and will help us to drive it lower still.
In particular, our work on early detection of deterioration in hospital patients means that by recognising and responding to signs of deterioration at an early stage we are able to quickly deploy our Patient Emergency Response Team to treat and manage acutely ill patients and thereby avoid further deterioration.
Similarly we will continue our programme of mortality reviews to examine and understand when and where untoward deaths take place with a view to identifying if we can do anything differently and thereby avert the outcome.

Measuring progress

- monthly audit and review of cardiac arrest calls
- monthly audit and review of vital signs recording
- monthly Global Trigger Tool review

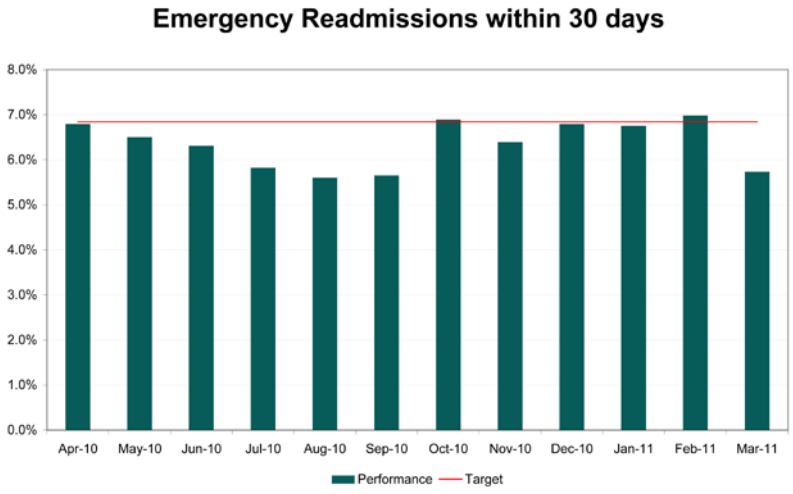
- twice yearly mortality review
- measurement and analysis of trends over time to enable action plans to be formulated
- reporting of audits and GTT reviews and mortality ratios to Quality and Safety Committee

Priority 4: Reducing readmissions to hospital within 30 days by 30%

Rationale

Across the country there are many patients who are discharged from hospital only to be readmitted very shortly after discharge. In some instances the readmission is unrelated to the previous admission but there are a number of instances where the readmission is for the same condition. The reasons behind readmissions is highly complex and what is clear is there is no single cause but a combination of factors including availability of community services, changes in clinical practice and coordination between services. Avoidable readmissions are not in the interests of patients or the hospital and therefore the Trust will make this a priority this year and has the full and specific support of the Trust executive and our commissioners. Nationally 8.3% of all admissions are readmissions within 30 days. At UCLH that rate is below the national average and using our own internal measurements we set a target of 6.8% for 2010/11. This year we aim to significantly reduce this and in conjunction with partners in primary and community care we are examining the causes and conditions which result in patients needing to be readmitted and aim to reduce the incidence of readmission by 30%

Current status



The readmissions graph for 2010/11 (above) shows that whilst there was some monthly variation there was no sustained reduction. In 2011/12 we will introduce new pathways and preventative measures and we will track the impact of these on readmissions.

How will we do it?

We will use the following methods to help reduce readmissions:

- establish a Readmissions Strategy Group (RSG) with overarching responsibility for setting priorities and overseeing work streams
- review the main types and causes of readmission by specialty
- Identify the most common conditions which result in readmission and audit what leads to it
- redesign pathways for chronic conditions to provide more effective community support
- outreach support from the hospital to support care at home
- more effective patient discharge information and teaching
- set targets for reduction in readmissions for specific workstreams.

Measuring progress

- monthly reports of readmission rates and categories to clinical teams, boards and RSG
- monthly validation of readmission data and audit of causes by divisional clinical lead
- monthly reporting and monitoring of readmission rates by Readmissions Strategy Group and Quality and Safety Committee
- measure progress against targets by RSG and report to Quality and Safety Committee

2.3 Statements of assurance from the board

During 2010/11 UCLH NHS Foundation Trust continued to provide NHS services within 60 specialties delivered through 15 divisions which are grouped into three clinical boards.
Through the following processes the Board reviews all the data available on the quality of all the NHS services provided as part of our internal and external management and assurance processes.

The Trust board receives a monthly corporate performance report which includes progress against national indicators such as infection and prompt access for patients to our services. The report includes a range of quality indicators across the three domains of patient safety, experience and clinical effectiveness. In addition the board receives quarterly reports in areas such as serious incidents; child safeguarding and complaints and annual reports in areas such as clinical audit. Our processes have been reviewed by internal audit and have been externally assessed by the National Health Service Litigation Authority (NHSLA) using national Risk Management Standards. The Trust achieved NHSLA level two and is now working towards achieving level three (the highest available level).

The income generated by the NHS services represents 100% of the total income generated from the provision of NHS services by UCLH NHS Foundation Trust for 2010/11.

Clinical Audit

Clinical audit is an evaluation of the quality of care provided against agreed standards and is a key component of quality improvement. Its aim is to provide assurance and to identify improvement opportunities. UCLH NHS Foundation Trust has a yearly programme of clinical audits which includes three types of audit:

1. National audit where specialties are asked to become involved. These are listed below
2. Corporate audit where we set a list of clinical audits that all specialties should carry out based on Trust priorities
3. Local audit which clinical teams and specialties determine and which reflect their local priorities and interests.

National Clinical Audit

During 2010/11, 46 National Clinical Audits (NCA) and seven National Confidential Enquiries (NCE) covered NHS services that UCLH provides.

During that period, UCLH participated in 41 (89%) NCAs and seven (100%) NCEs of those for which it was eligible. UCLH eligibility and participation in national clinical audits and national confidential enquiries during 2010/11 are detailed below, alongside the number of cases submitted, or the percentage of the number of registered cases required by the terms of that audit.

Audit	UCLH eligible	UCLH participated	Cases submitted
National Neonatal Audit Programme	Y	Y	100%
Paediatric pneumonia	Y	N	N/A
Paediatric asthma	Y	N	N/A
Paediatric fever (College of Emergency Medicine)	Y	Y	100%
Paediatric congenital heart disease	Y	Y	100%
Paediatric Diabetes (RCPH National Paediatric Diabetes Audit)	Y	Y	100%
Emergency use of oxygen (British Thoracic Society)	Y	Y	100%
Adult community acquired pneumonia (British Thoracic Society)	Y	Y	N/A: study not yet completed
Non invasive ventilation (NIV) in adults (British Thoracic Society)	Y	Y	N/A: study not yet started
Pleural procedures (British Thoracic Society)	Y	Y	Pilot completed. To take part in full audit in 2011
Cardiac arrest (National Cardiac Arrest Audit)	Y	Y	100%
Vital signs in majors (College of Emergency Medicine)	Y	Y	100%
Adult critical care (Case Mix Programme)	Y	Y	100%

Audit	UCLH eligible	UCLH participated	Cases submitted
Potential donor audit (NHS Blood & Transplant)	Y	Y	100%
Diabetes (National Adult Diabetes Audit)	Y	N	N/A
Heavy menstrual bleeding (RCOG National Audit of HMB)	Y	Y	N/A: study not yet started
Chronic pain (National Pain Audit)	Y	Y	Pilot completed. To take part in full audit in 2011
Ulcerative colitis & Crohn's disease (National IBD Audit)	Y	Y	4 patients to date: study not yet completed
National colonoscopy audit	Y	Y	Starts March 2011
Parkinson's Disease (National Parkinson's Audit)	Y	N	N/A
COPD (British Thoracic Society / European Audit)	Y	N	N/A
Adult asthma (British Thoracic Society)	Y	Y	17 cases in 2009
Bronchiectasis (British Thoracic Society)	Y	Y	N/A: study not yet completed
Hip, knee and ankle replacements (National Joint Registry)	Y	Y	62%
Elective surgery (National PROMs Programme)	Y	Y	Orthopaedics: 79%
	Y	Y	Vascular: 73%
Coronary angioplasty (NICOR Adult cardiac interventions audit)	Y	Y	100%
Carotid interventions (Carotid Intervention Audit)	Y	Y	64%
CABG and valvular surgery (Adult cardiac surgery audit)	Y	Y	100%
Familial hypercholesterolaemia National Clinical Audit	Y	Y	100%
Acute Myocardial Infarction & other ACS (MINAP)	Y	Y	100%
Heart failure (Heart Failure Audit)	Y	Y	100%
Pulmonary hypertension (Pulmonary Hypertension Audit)	Y	Y	9 cases submitted towards The Hammersmith Hospital returns
Acute stroke (SINAP)	Y	Y	100%
Stroke care (National Sentinel Stroke Audit)	Y	Y	100%

Audit	UCLH eligible	UCLH participated	Cases submitted
Renal colic (College of Emergency Medicine)	Y	Y	100%
Lung cancer (National Lung Cancer Audit)	Y	Y	118 cases submitted
Bowel cancer (National Bowel Cancer Audit Programme)	Y	Y	126 cases submitted
Head & neck cancer (DAHNO)	Y	Y	68 cases submitted
Hip fracture (National Hip Fracture Database)	Y	Y	Insufficient data
Severe trauma (Trauma Audit & Research Network)	Y	Y	100%
Falls and non-hip fractures (National Falls & Bone Health Audit)	Y	Y	47%
O neg blood use (National Comparative Audit of Blood Transfusion)	Y	Y	100%
Platelet use (National Comparative Audit of Blood Transfusion)	Y	Y	N/A: study not yet completed

NCE	UCLH eligible	UCLH participated	Cases submitted
NCEPOD Cardiac Arrest	Y	Y	8
NCEPOD Peri-operative Care	Y	Y	155
NCEPOD Surgery in Children	Y	Y	1
CMACE Perinatal mortality	Y	Y	56
CMACE Maternal Death	Y	Y	1
CMACE Obesity in pregnancy	Y	Y	25
CMACE Head Injury in children	Y	Y	16

In the event of uncompleted or non-participation in national audit we have assessed the reasons and where appropriate we have put actions in place to assure our full participation in future years

The reports of 34 national clinical audits, all NCEPOD reports and 233 local audits have been reviewed by the Trust Clinical Audit Committee along with analysis of the proposed actions following audit findings.

Within the year a comprehensive review of clinical audit has been undertaken and reported to the Trust Audit Committee and executive board as part of the Trust quality assurance process. This has confirmed that all clinical teams are actively engaged in national audits and confidential enquiries thereby enabling the Trust to benchmark its performance against others nationally. The review also confirmed that clinical audit is being undertaken in areas which support the Trust quality and safety priorities.

As a result of clinical audit the following is a sample of the actions the Trust intends to take:

National audits:

Cancer Services

Metastatic Spinal Cord Compression (MSCC) audit

- Liaison with Queen Square Division to employ a coordinator
- A patient information leaflet has been written and is awaiting approval by the Radiotherapy Governance group.

Trauma & Orthopaedics

National Joint Registry (NJR)

- Recruit an arthroplasty care practitioner

National Patient Related Outcomes Measures (PROMs) Programme

UCLH exceeds the national target of 80% for hip and knee surgery. Local demographics and patient reluctance to participate impacted full recent data capture for hernia and varicose vien surgery. Further patient education may improve participation and we intend to explore ways of facilitating this.

National Hip Fracture database

Specialist trauma sister appointed with responsibility for coordination of the database. We aim to fully participate by April 2011.

Acute Medical Unit (AMU)

Adult asthma

- Increase Respiratory team input: review role of respiratory nurse involvement on AMU
- Protocol for asthma discharge
- New service instituted
- Present findings to AMU Pharmacy team to improve documentation of inhaler technique checks
- Re-audit.

Pathology

Paediatric blood use

- Neonatal Blood Product Administration Guidelines reviewed and approved April 2010
- Audit compliance with new UCLH guidelines. Guidelines to be updated to include revised guidance on blood sampling frequency and volume in line with national audit recommendations
- Review neonatal blood wastage following implementation of new guideline; action completed. Reduction in wastage observed.

Cardiac Services

Coronary angioplasty (NICOR adult cardiac interventions audit)

- Monthly catheter lab user meetings have commenced
- Improve documentation to enhance management of diabetes and renal impairment
- Audit of unsuccessful angioplasty commenced.

Corporate and local clinical audits

Prevention of venous thromboembolism (VTE)

- Review of current maternity VTE guideline to ensure consistency with new RCOG thromboprophylaxis guideline
- Trust clinical lead to present trust and maternity VTE guidelines at governance/audit meetings
- Laminated sheet of VTE risk factors to be developed (end of all beds and drug chart folders)
- Junior doctor-led weekly audits followed by circulation of results
- Introduction of new drug charts incorporating VTE risk assessment
- Specific coverage on local induction programmes
- e-VTE risk assessment reported via Clinical Data Repository (CDR)
- Continued local monitoring in addition to participation in Trust-wide audit.

Compliance with World Health Organisation safe surgery checklist

Continued local monitoring and review of findings in addition to Trust-wide audit

Change WHO sign out to include indication for caesarean section and future recommended mode of delivery

Process to ensure that original WHO safe surgery checklist forms are always available in labour ward

Cascade to all obstetricians and anaesthetists regarding responsibilities for completion of WHO safe surgery check list.

Women's Health

Audit of Maternal & Fetal assessment Unit (MFAU)

- Medical cover planned for MFAU between 5 - 8pm
- Receptionist for MFAU
- Put in place processes to ensure all women attending MFAU see midwife within 15 minutes

and leave within four hours

Cardiac Services

Pre-admission clinic (PAC) audit for Cardiac Surgery
All pre-operative tests will be completed at the time of the patient's original outpatient appointment in order that PAC is a 'stepping stone', to surgery rather than somewhere where new problems are identified.

- Improve pathology processing and reporting
- Re-audit in six months.

Trauma & Orthopaedics

Audit of heparin-induced thrombocytopoenia (HIT)

- Raise awareness of HIT monitoring when constructing an operation note and writing a discharge summary
- Ensure monitoring continues in the community following discharge
- The findings have been relayed to the clinical directors of haematology and orthopaedics for continued discussions.

Pathology

Blood and blood product traceability: rolling audit

- Now being monitored within the Trust key performance indicators framework in addition to weekly non-compliance reports being sent to relevant wards / departments
- Ongoing action – weekly traceability non compliance reports to ward / department sister and charge nurses
- Ongoing action: competency assessed within framework of blood transfusion competency assessments
- Ongoing action: traceability requirements covered within mandatory and local teaching sessions
- Ongoing action: Trust-wide compliance monitored by Hospital Transfusion Team/ Committee and Patient Safety and Risk Steering Group.

Queen Square division

Infection control audits

- Continue to monitor compliance with local policy for management of intravenous cannulae
- Hand hygiene: actions include poster campaigns and awareness raising. Continue to closely monitor compliance locally and divisionally.

Medical Specialities

Incomplete excision rate audit in dermatological surgery

- Altered techniques
- Training
- Appointment of an additional consultant.

Infection / Hospital for Tropical Diseases (HTD)

IV line care

- Tower eight ward junior doctors to perform a weekly snap-shot audit of line care and report back at the Friday ward round. Now extended to Acute Admissions Unit. Implement safety checklist in the long term.
- A box on indication for IV line to be included in the next draft of the VIP score sheet
- Ward safety checklist should support sustained improvement – training in progress and current focus of business rounds

Tower eight ward readmissions

- Facilitate early outpatient follow-up for high risk patients
- Engagement with elderly care teams
- Create a discharge plan information leaflet for patients.

Acute Medical Unit (AMU)

AMU readmission audit

- Plan for re-audit over longer time period at a different time of year
- Improve detail on CDR discharge summaries
- Therapies team to keep an electronic record of discharges
- Establish GP telephone service.

Emergency Department

Paediatric double sign-off

- Training within the Paediatric and Emergency Department Teams.

Eastman Dental Hospital

An audit of the restorative - orthodontic interflow for hypodontia patients

- Put in place a method to automatically recall all patients with hypodontia for review between 12 and 24 months post-treatment.

Critical Care

ETT cuff pressure audit

- Innovation team reviewing usage of low pressure

cuffs and sub-glottic secretion management.

Cancer

Rolling audit continuing from the 2006 NCEPOD report into patients who die within 30 days of receiving chemotherapy

- Further analysis and breakdown of patient data for consultant teams
- Clear algorithms for treatment
- Clear process for morbidity and mortality reviews within each clinical team, particularly for poor performance status patients and those having 4th and 5th line chemotherapy
- Review of sepsis management.

Gastrointestinal (GI) oncology endoscopy request audit for urgent inpatient referrals

- Upper GI cancer clinical nurse specialist (CNS) to act as formal coordinator between GI oncology, gastroenterology and endoscopy
- All endoscopy requests to be submitted via CNS
- All patients on whom endoscopy requested to have gastroenterology review within 24 hours.

Pharmacy

Drug dose omissions

- Convene dose omission project group (action complete)
- Cascade findings to relevant governance and management groups
- Reinforce importance of documentation via the clinical pharmacists
- Identify problem areas and develop local solutions
- Monitor dose omissions on a monthly basis via the dose omission project group.

Research

Clinical research looks to improve the clinical treatments available to patients and to discover new ways of managing conditions. UCLH NHS Foundation Trust works at the forefront of research and actively works to bring effective solutions promptly to the bedside so that patients can have confidence that all that could be done is being done.

The number of patients receiving NHS services provided by UCLH NHS Foundation Trust that were recruited during 2010/11 to participate in research approved by the research ethics committee and adopted on the the NIHR CRN portfolio of research was 6,688. NIHR CRN portfolio accounts for 30% of studies in progress at UCLH. It is estimated that the remainder contribute in excess of 20,000 participants or controls.

The Trust's commitment to clinical research is further evidenced by the fact it is part of UCL Partners one of five Academic Health Science Partnerships. UCLP itself has a director of quality committed to sharing best practice across the partnership and promoting links to other centres of excellence in clinical research.

CQUIN

Commissioning for Quality and Innovation (CQUIN) is a payment framework which allows commissioners to agree payments to hospitals based on agreed improvement work. Through discussions with our commissioners we agreed a number of improvement goals for 2010/11 which reflect areas of improvement interest nationally, within London and locally.

The amount of income in 2010/11 agreed between the Trust and NCL Agency based on quality improvement and innovation goals was £7,500,000.

A high level summary of the CQUIN measures for 2010/11 is shown in the following table;

Performance Indicators	financial value	Performance Indicators	financial value
VTE Assessment	£750,000	Implementation of Dementia Pathway	£450,000
Improving Patient Experience	£750,000	Improving care for Long Term Conditions patients (diavetes, COPD and Heart failure) by reducing	£900,000
Implement IHI Global Trigger Tool	£375,000	Ensuring Hospital Standardised Mortality Index remain below 100	£600,000
Implement Enhanced Recovery Programme in at least 2 recognised	£375,000	Reducing deaths in low mortality procedures	£600,000
Improving inpatient discharge information to GP's – content and	£300,000	Surgical site recording and improvement	£650,000
Improving timeliness of discharge – increased percentage of weekend	£100,000	Implementation of nutritional assessment and support	£650,000

Performance Indicators	financial value	Performance Indicators	financial value
Improving timeliness of discharge – increased percentage of patients	£100,000	Choose & Book – 99% of appropriate services available	£500,000
Improving timeliness of discharge increasing the proportion of patients discharged in line with predicted	£100,000	Choose & Book – 98% slot availability	
Improving outpatient information to GP's – timeliness and content	£300,000	Choose & Book – Directory of service rating of either 0 or 1	

Further details of the agreed goals for 2010/11 and for the following 12 month period are available on request from:

Greg Stevens, head of performance.
Email greg.stevens@uclh.nhs.uk
Tel: 08451555000 ext 3920.
Address: Performance Department, Level 2, Maple House, 149 Tottenham Court Road, London, W1T 7NF

Care Quality Commission

The Care Quality Commission (CQC) is the organisation which regulates and inspects health and social care services in England. All NHS hospitals are required to be registered with CQC in order to provide services and are required to maintain specified 'essential standards' in order to retain their registration.

As part of its role the CQC is required to monitor the quality of services provided across the NHS and to take action where standards fall short of the essential standards. Their assessment of quality is based on a range of diverse sources of external information about each Trust which is regularly updated and reviewed. This is in addition to their own observations during periodic, planned and unannounced inspections. If an issue raises concern during the data review process or from other sources of information CQC may undertake an unplanned, responsive inspection.

UCLH NHS Foundation Trust is fully registered with CQC across all locations without conditions.

No enforcement action has been taken against the Trust during 2010/11 and the Trust has not been subject to responsive inspection.

In March 2011 the Trust was randomly selected by CQC for an unannounced inspection of standards relating to dignity and nutrition for older people. This programme of inspections followed on from the Health Service Ombudsman report on NHS care of older people and looked at whether older people are treated with respect (outcome 1) and if they get help with food and drink when needed (outcome 5). Care was observed on three wards on the University College Hospital site and inspectors talked to patients, carers and staff. The subsequent CQC inspections debrief noted the commitment of all staff towards older people and noted that they had observed many examples of good practice.

The CQC report received in May 2011 noted that University College

Hospital was found to be meeting both Standard 1 and Standard 5. No concerns were noted and we were not required to take any actions.

Data Quality

Clinicians and managers need ready access to accurate and comprehensive data to support the delivery of high quality care. Improving the quality and reliability of information is therefore a fundamental component of quality improvement.

At UCLH NHS Foundation Trust we monitor the accuracy of data in a number of ways including a monthly data quality review group

The Trust has improvement groups including coding improvement and medical records improvement and we monitor our performance through data quality metrics across a broad range of information.

NHS Number and General Medical Practice Code Validity

UCLH NHS Foundation Trust provides submissions to the Secondary Uses System (SUS)

This is a single source of comprehensive data which enables a range of reporting and analysis in the UK and is run by the NHS Information Centre.

The Trust submitted records during 2010/11 to the SUS service for inclusion in the hospital episode statistics. The percentage of records in the published data:

- which included the patients valid NHS number was:
  - 94.5% for admitted patient care
  - 95.8% for outpatient care
  - 71.6% for accident and emergency care
- which included the patient's valid General Medical Practice Code was:
  - 92.5% for admitted care
  - 94.5% for out patient care
  - 76.3% for accident and emergency care

Information Governance Toolkit attainment levels

The Information Governance Toolkit provides an overall measure of the quality of data systems, standards and processes. The score a trust achieves is therefore indicative of how well they have followed guidance and good practice.

The Information Governance Toolkit for 2010/11 (V8) has changed significantly in scope and methodology and although the Trust has continued to prioritise work in this area the score for 2010/11 was 66% (compared with 81% using V7 in 2009/10)

Clinical coding error rate

Clinical coding is the process by which patient diagnosis and treatment is translated into standard, recognised codes which reflect the activity that happens to patients. The accuracy of this coding is a fundamental indicator of the accuracy of patient records.

UCLH was not subject to the Payment by Results clinical coding audit by the Audit Commission during 2010/11 due to its aggregated performance over the past three years that demonstrated high quality coding in line with the national standard. Through the Audit Commission's risk based approach to audit within 2010/11 focus was directed upon those trusts that manifested significant scope for improvement in the accuracy of their coding.

An annual Information Governance audit has been undertaken in 2010/11 however and illustrated the Trust's ongoing delivery of high quality coding. This year the error rates in the latest published audit is 8% a notable improvement on 2009/10 Information Governance audit resulting in the Trust securing a high Information Governance Toolkit level 2 position in this area.

The services reviewed in the audit were:

- Maternity
- General Surgery
- Infectious and Tropical Diseases.

The audit showed the following error rates:

- Primary diagnoses incorrect 9.5%
- Secondary diagnoses incorrect 11%
- Primary procedures incorrect 5.6%
- Secondary procedures incorrect 5.3%.

The clinical coding results should not be extrapolated further than the actual sample size and services audited.

3. Quality Overview

In selecting our quality metrics for the quality overview we have chosen measures from the Trust Quality and Safety scorecard which forms part of our continuous Trust review and reporting. These measures cover patient safety, experience and clinical outcomes and are metrics which are nationally known to be important indicators in their respective areas, as well as those which reflect our quality priorities. Where possible we have included historical performance and where available we have included national benchmarks. This year we have also provided a new column which specifies what an individual measure means.

We have chosen to measure our performance against the following metrics: Safety measures reported	2009/10	2010/11	2010/11 Benchmark (where available)	What this means
1 Patients with MRSA infection/10,000 bed days †	0.76	0.45	0.13 Using uplifted 2009/10 bedday figures from HES	Lower scores are better
2 Patients with C.difficile infection/10,000 bed days †	3.04	2.14	2.02 Using uplifted 2009/10 bedday figures from HES	Lower scores are better
3 Percentage of all admissions screened for MRSA +	123%	137%	The DH mandates at least 100%	Higher percentage is better - means that more tests have been done than patients admitted
4 Medication incidents +	672	*970	There were 87800 medication incidents in Acute and General Hospitals reported to the NPSA from July 09 to June 10	Higher scores indicate a more open reporting culture
5 Incidence of falls per annum +	673	*897		Higher scores indicate a more open reporting culture
6 CVC line care		74.9%		This is the compliance with CVC care protocol, higher scores are better
7 Adverse events using Global Trigger Tool +	37%	31%		
8 Safe surgery intervention (time out using who safety checklist)	N/A	69%		
9 Harm from deterioration (vital signs audit)	N/A	76%		
10 Surgical site infections +		4.27%		This is the number of infections recorded subsequent to surgery in a defined basket of procedures. Lower scores are better.
Clinical outcome measures reported				
11 Hospital Standardised Mortality Ratio + (Observed events / Expected events) * 100 (Within 56 HSMR Diagnoses basket)	72.0 (revised figure since last publication) (95% CI 66.4 – 77.9) (Apr 09 - Mar 10)	66.9 (95% CI 62.5 – 71.6) (Apr 10 - Mar 11)	100.0	This is the observed number of deaths divided by the expected number of deaths. Lower scores are better.
12 Stroke mortality rates (Based on diagnoses I61x, I64x, P101, P524)	15.0% (95% CI 12.0% – 18.0%)	11.0% (95% CI 9.5% – 12.5%) (Apr10 – Feb11)		
13 Deaths in hospital +	784	802 (Apr10 – Mar11)		The actual number of deaths recorded throughout the year. Lower numbers are better.

We have chosen to measure our performance against the following metrics: Safety measures reported	2009/10	2010/11	2010/11 Benchmark (where available)	What this means
14 Deaths in low risk diagnoses - rate per 1000 spells +	0.78	0.43 (Jan10 – Jan11)		Lower numbers are better.
15 Cancelled operations +	1.2%	0.9% (Apr10 – Mar11)	England average is 0.8% from Apr 10 to Dec 10	Proportion of patients cancelled shortly before their procedure. Lower scores are better.
16 30 day Emergency Readmission rate †† +	6.4%	6.3% (Apr10 – Mar11)		Lower numbers are better.
17 Complication following surgery	118	75 (Apr10 – Mar11)		Numbers of patients returning to theatre within 48 hours. Lower numbers are better.
18 PROMS +	Available from May	77%		Higher numbers are better.
Patient experience measures reported				
19 Overall satisfaction rating +	83%	83%		Higher numbers are better.
20 Nurses and Doctors working together +	81%	79%		Higher numbers are better.
21 Privacy and dignity +	90%	91%		Higher numbers are better.
22 Involvement in decisions +	76%	75%		Higher numbers are better.
23 Worries and fears +	63%	60%		Higher numbers are better.
24 Patient would recommend hospital to family/friends +	87%	89.8%		Higher numbers are better.
Staff experience measures reported				
25 Staff job satisfaction+	3.43***	3.46		Higher numbers are better
26 Appraisal & re-validation rates+	70%	74%		Higher numbers are better
27 Care of patients is my Trust's top priority	72%	N/A		
28 Staff would recommend the Trust as a place to work+	64% (3,82)			Higher numbers are better
29 If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust+	80%	3.88****		Higher numbers are better

† Trust Attributable infection cases only; beddays excludes daycases

** Incident reporting across all categories of incidents has seen a significant increase in 2010/11 due to the introduction of on line reporting making it quicker/easier to report.*

*** Since the publication of the previous Quality account, the definition of the stroke mortality indicator has been revised following advice from relevant clinicians. The numbers of deaths for this indicator are relatively few and so we have also provided confidence limits for this indicator. This shows that we can be 95% confident that the Trust's actual performance lies within these upper and lower limits.*

**** Since publication of the previous Quality Account, measurement of this question has been revised to a score out of 5.*

†† This indicator was previously based upon a definition for 28 day readmissions used by the Healthcare Commission in 2005. This year we have amended this so that we use the recently published Payment by Results guidance to define the indicator.

+ These indicators use nationally agreed definitions in their construction. Otherwise indicators are necessarily locally defined.

***** 28&29 combine to a single question in 2010 survey using a score out of 5. The 2009/10 score out of 5 is given in brackets as a comparator*

3.2 National targets and regulatory requirements

	Threshold 2010/11	2009/10	2010/11
• Care Quality Commission Targets estimated Performance :+			
Existing Commitments		26	N/A
National Targets		37	N/A
Core Standards		Full Met	N/A
• Clostridium difficile year on year reduction † +	119	88	62
• MRSA – maintaining the annual number of MRSA bloodstream infections at less than half the 2003/04 level † +	8	22	13
• 18-week maximum wait from point of referral to treatment (admitted patients) +	90%	93.9%	94.6%
• 18-week maximum wait from point of referral to treatment (non-admitted patients) +	95%	96.9%	97.3%
• Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge +	95%	99.2%	98.5%
• People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack)	Service is not provided in this trust	Service is not provided in this trust	Service is not provided in this trust
62-day wait for first treatment from urgent GP referral to treatment: all cancers +	85%	82.5%	83.7%(1) 85.6%(2)
62-day wait for first treatment from consultant screening service referral: all cancers +	90%	67.6%^	71.4%
31-day wait for second or subsequent treatment: surgery +	94%	96.7%	98.3%
31-day wait for second or subsequent treatment: anti cancer drug treatments +	98%	100%	100%
31-day wait for second or subsequent treatment: radiotherapy +	94%	91.2%	98.6%*
31-day wait from diagnosis to first treatment: all cancers +	96%	97.3%	98.2%
Two week wait from referral to date first seen: all cancers +	93%	93.1%	94.0%
Two week wait from referral to date first seen: breast symptoms +	93%	95.1%#	94.6%

Measurement of indicator by Monitor introduced in Q4 2009/10
* Measurement of indicator by Monitor introduced in Q1 2010/11
^ Performance not tracked externally due to low numbers
† Trust Attributable cases only
+ These indicators use nationally agreed definitions in their construction. Otherwise indicators are necessarily locally defined.
(1) Our reported performance is exclusive of the effect of shared breaches that UCLH has requested from other providers in 2010/11
(2) Performance if all breach reallocation forms sent out to other providers in Q1 to Q4 are signed and returned to UCLH

Statement from our Local Involvement Network (LINks) – Camden LINks

As we can see, overall care is excellent, especially surgical procedures, and nursing. However, from talking to many post treatment patients, three issues are pointed out again and again.

1. There are still problems with Appointment Systems. We know there are always too many DNAs, and the Trust presumably has its own procedures for trying to reduce them. But it would be helpful if the Trust could try to streamline the systems within each of their hospitals. Sometimes appointments arrive by post too late, sometimes patients get reminders by telephone or by text - the latter is helpful, but it's erratic and unreliable, according to different patients' experiences.
2. The gap between leaving hospital after surgery/treatment, and then what? Some patients find that GPs seem uninvolved in their at-home after care, there are often problems with different and repeat medication, none of this helps recovery. The LINk would like to see more 'joined up' care between the hospital doctors, and the GPs, which used to exist before PCTs were in place, and then stopped.
3. There is an increasing need for a more sensitive approach from many senior clinicians to patients. It is accepted that with the huge throughput of patients with serious illnesses, these doctors are understandably concerned with treatment rather than interpersonal relations. However a kinder, gentler one-to-one approach can lift spirits immeasurably, often helping a patient cope much better with their illness. It sometimes seems that senior doctors forget how fearful and diminished people feel about illness, and being in hospital. They have to put their trust in the teams who look after them, so senior clinicians have the power to put them more at ease, but they do sometimes fail to put in the vital ingredient of humanity. As has often been said – why shouldn't doctors treat NHS patients with the same deference that they show to private patients?

UCLH response:

We are currently reviewing the appointment system and will feed these comments into that review.

We have several joint forums and joint projects in place between UCLH, GPs and community services specifically to look at how we can provide more effective and joined up support. We will report on the progress.

The Trust had very good patient survey results in 2010 especially in the questions about doctors, however, we do want to re-emphasis that care and compassion underpin the patient experience and to this end have commenced a major programme for this year.

Statement from commissioning PCT

The North Central London Commissioning Agency has reviewed this document and is pleased to assure this Quality Account for UCLH.

We have taken particular account of the identified priorities for improvement and the work plan to ensure delivery which we are confident will deliver real improvements in the care of patients. We have also taken account of the views of the main PCTs whose local residents access services from the Trust.

We are particularly pleased to see the reference to the cancer survey and waiting times and how the Trust intends to make improvements. We asked that the improvement in A&E discharge summaries be included and are pleased to see that UCLH has commited to improving this important area .

We look forward to continuing our partnership with the Trust.

Statement of Directors' Responsibilities

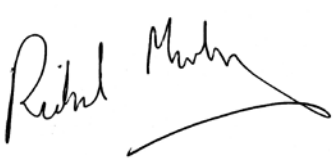
The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Trust Boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality in preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation trust Annual Reporting Manual 2010-11
- the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2010 to June 2011
  - Papers relating to quality reported to the Board over the period April 2010 to June 2011
  - Feedback from the commissioners dated May 2011
  - Feedback from governors between October 2010 and April 2011
  - Feedback from LINKs dated May 2011
  - The trust's annual complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulation 2009 dated July 2010 and quarterly reports during the year
  - The national patient survey report 2010
  - The national staff survey report 2010
  - The Head of Internal Audit's annual opinion over the trust's control environment dated May 2011
  - CQC quality and risk profiles dated April 2011
- the Quality Report presents a balanced picture of the 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 those controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance 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



Chairman
Date: 11 May 2011

Chief Executive
Date: 11 May 2011

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

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

Scope and subject matter

We read the Quality Report and considered whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual*, and consider the implications for our report if we become aware of any material omissions.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual 2010/11* issued by the Independent Regulator of NHS Foundation Trusts ('Monitor').

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that the content of the Quality Report is not in accordance with the *NHS Foundation Trust Annual Reporting Manual* or is inconsistent with the documents.

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

- Board minutes for the period April 2010 to May 2011;
- Papers relating to quality reported to the Board over the period April 2010 to May 2011, specifically the Performance Reports and the Quality and Safety Committee Reports;
- Feedback from the commissioners dated May 2011;
- Feedback from governors provided through the High Quality Patient Care group in May 2011;
- Feedback from LINKS dated May 2011;
- The Trust's Annual Report on Complaints Management 2009/10 published under regulation 18 of the Local Authority Social Services and NHS Compliance Regulations 2009, and the Complaints Quarterly Update October to December 2010 report;
- The Picker Inpatient Survey 2010 and the Care Quality Commission (CQC) Patient Survey Report 2010;
- The CQC 2010 National NHS Staff Survey 2010;
- The 2010/11 draft Head of Internal Audit's annual opinion over the Trust's controls environment reported to the April 2011 Audit Committee; and
- The CQC Quality and Risk Profile April 2011.

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

This report, including the conclusion, has been prepared solely for the Board of Governors of the Trust as a body, to assist the Board of Governors in reporting the Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the board of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Governors as a body and the Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

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

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

Limitations

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

Conclusion

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

PricewaterhouseCoopers LLP
Chartered Accountants
London
2 June 2011

Appendix 2
Staff survey results

	2009/10		2010/11		Trust Improvement/ Deterioration
Top 4 Ranking Scores	Trust	National Average	Trust	National Average	
Staff recommendation of the Trust as a place to work or receive treatment	3.82	3.50	3.88	3.52	+6%
Percentage of staff reporting good communication between senior management and staff	30%	26%	36%	26%	+6%
Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell	22%	26%	21%	26%	+1%
Work pressure felt by staff	3.00	3.08	2.97	3.11	+1%

	2009/10		2010/11		Trust Improvement/ Deterioration
Bottom 4 Ranking Scores	Trust	National Average	Trust	National Average	
Staff feeling valued by their work colleagues	70%	77%	71%	76%	+1%
Percentage of staff working extra hours	76%	65%	71%	66%	+5%
Percentage of staff receiving health and safety training in last 12 months	59%	65%	69%	80%	+10%
Percentage of staff believing the trust provides equal opportunities for career progression or promotion	82%	90%	84%	90%	+2%

Appendix 3
Staff profile statistics

Tables of statistics demonstrating the Trust profile comparisons for 2008, 2009 and 2010

Ethnicity Profile

	Head Count	% Head Count	Head Count	% Head Count	Head Count	% Head Count
	2008/9		2009/10		2010/11	
White	3596	56.3%	3699	54.8%	3889	54.2%
Mixed	110	1.7%	125	1.9%	147	2.0%
Asian	710	11.1%	761	11.3%	873	12.2%
Black	1037	16.2%	1118	16.5%	1156	16.1%
Other	765	12.0%	798	11.8%	837	11.7%
Unspecified	169	2.6%	255	3.8%	273	3.8%
Total	6387	100.0%	6756	100.0%	7175	100.0%

Age Profile

	Head Count	% Head Count	Head Count	% Head Count	Head Count	% Head Count
	2008/9		2009/10		2010/11	
Under 16	1	0.0%	1	0.0%	0	0.0%
16 - 20	27	0.4%	15	0.2%	16	0.2%
21 - 25	410	6.4%	417	6.2%	455	6.3%
26 - 30	1014	15.9%	1,051	15.6%	1,094	15.2%
31 - 35	1214	19.0%	1,263	18.7%	1,352	18.8%
36 - 40	1092	17.1%	1,162	17.2%	1,211	16.9%
41 - 45	825	12.9%	887	13.1%	984	13.7%
46 - 50	653	10.2%	724	10.7%	769	10.7%
51 - 55	520	8.1%	558	8.3%	596	8.3%
56 - 60	370	5.8%	386	5.7%	397	5.5%
61 - 65	194	3.0%	210	3.1%	223	3.1%
66 - 70	50	0.8%	62	0.9%	57	0.8%

	Head Count	% Head Count	Head Count	% Head Count	Head Count	% Head Count
	2008/9		2009/10		2010/11	
71 & above	17	0.3%	20	0.3%	21	0.3%
Total	6,387	100.0%	6,756	100.0%	7,175	100.0%

Gender Profile

	Head Count	% Head Count	Head Count	% Head Count	Head Count	% Head Count
	2008/9		2009/10		2010/11	
Male	1840	28.8%	1,954	28.9%	2,051	28.6%
Female	4547	71.2%	4802	71.1%	5,124	71.4%
Total	6387	100.0%	6756	100.0%	7,175	100.0%

Religion and Cultural Belief Profile

	Head Count	% Head Count	Head Count	% Head Count	Head Count	% Head Count
	2008/9		2009/10		2010/11	
Atheism	28	0.4%	155	2.3%	290	4.0%
Buddhism	1	0.0%	16	0.2%	23	0.3%
Christianity	207	3.2%	742	11.0%	1276	17.8%
Hinduism	19	0.3%	93	1.4%	171	2.4%
Undisclosed	80	1.3%	266	3.9%	342	4.8%
Islam	33	0.5%	115	1.7%	213	3.0%
Jainism	0	0.0%	0	0.0%	5	0.1%
Judaism	0	0.0%	16	0.2%	28	0.4%
Other	28	0.4%	98	1.5%	186	2.6%
Sikhism	4	0.1%	14	0.2%	26	0.4%
Undefined	5987	93.7%	5241	77.6%	4615	64.3%
Total	6387	100.0%	6756	100.0%	7175	100.0%

Sexual Orientation Profile

	Head Count	% Head Count	Head Count	% Head Count	Head Count	% Head Count
	2008/9		2009/10		2010/11	
Bisexual	4	0.1%	10	0.1%	17	0.2%
Gay	10	0.2%	19	0.3%	36	0.5%
Heterosexual	305	4.8%	1,193	17.7%	2,129	29.7%
Undisclosed	85	1.3%	290	4.3%	368	5.1%
Lesbian	0	0.0%	3	0.0%	10	0.1%
Undefined	5983	93.7%	5,241	77.6%	4,615	64.3%
Total	6387	100.0%	6756	100.0%	7,175	100.0%

Appendix 4
Remuneration tables

University College London Hospitals NHS Foundation Trust - Accounts for the Period ended 31 March 2011

Salary and Pension entitlements of senior managers (Director's Costs)

A. Remuneration

	Year ended 31 March 2011		Year ended 31 March 2010	
Name and title	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000
Sir P Dixon Chairman to 30 June 2010	15 to 20	0	60 to 65	0
R Murley Chairman from 1 July 2010	60 to 65	0	15 to 20	0
S Atkinson Non-Executive Director	10 to 15	0	10 to 15	0
R Delbridge Non-Executive Director	5 to 10	0	0	0
Sir N Monck Non-Executive Director	15 to 20	0	15 to 20	0
J Ramsey Non-Executive Director	10 to 15	0	10 to 15	0
Sir J Tooke Non-Executive Director	10 to 15	0	0 to 5	0
Sir R Naylor Chief Executive	260 to 265	0	260 to 265	0
R Alexander Finance Director	180 to 185	0	180 to 185	0
G Bellingan Medical Director	25 to 30	210 to 215	10 to 15	85 to 90

	Year ended 31 March 2011		Year ended 31 March 2010	
Name and title	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000
ML Boden Chief Nurse to 6 Dec 2010	80 to 85	0	115 to 120	0
K Fenton Chief Nurse from 01 January 2011	35 to 40	0	0	0
MP Foster Deputy Chief Executive	180 to 185	0	180 to 185	0
G Gaskin Medical Director	25 to 30	170 to 175	5 to 10	35 to 40
P A Glynne Medical Director	25 to 30	130 to 135	25 to 30	130 to 135
A Mundy Medical Director	25 to 30	175 to 180	25 to 30	210 to 215

A Mundy was employed on a part time basis during the month of January 2011.

B. Pension Benefits

Name and title	Real increase/ (decrease) in pension and related lump sum at age 60 (bands of £2500) £000	Total accrued lump sum at age 60 at 31 March 2011 (bands of £2500) £000	Cash equivalent transfer value at 31 March 2010 £000	Real increase/ (decrease) in cash equivalent value £000	Cash equivalent transfer value at 31 March 2011 £000
Sir R Naylor Chief Executive	(5 to 2.5)	390 to 392.5	0	0	0
R Alexander Finance Director	0 to 2.5	25 to 27.5	105 to 106	20 to 21	126 to 127
G Bellingan Medical Director	2.5 to 5	182.5 to 185	793 to 794	146 to 147	939 to 940
ML Boden Chief Nurse	(2.5 to 0)	187.5 to 190	0	0	0

Name and title	Real increase/ (decrease) in pension and related lump sum at age 60 (bands of £2500) £000	Total accrued lump sum at age 60 at 31 March 2011 (bands of £2500) £000	Cash equivalent transfer value at 31 March 2010 £000	Real increase/ (decrease) in cash equivalent value £000	Cash equivalent transfer value at 31 March 2011 £000
K Fenton Chief Nurse	5 to 7.5	190 to 192.5	1,229 to 1,230	27 to 28	1,257 to 1,258
MP Foster Deputy Chief Executive	0 to 2.5	257.5 to 260	1,905 to 1,906	(156 to 155)	1,749 to 1,750
G Gaskin Medical Director	0 to 2.5	32.5 to 35	197 to 198	1 to 2	198 to 199
P A Glynne Medical Director	0 to 2.5	90 to 92.5	417 to 418	(60 to 59)	357 to 358
A Mundy Medical Director	0 to 2.5	305 to 307.5	0	0	0

The above information is based on that provided by the NHS Pension Agency.

Appendix 5

Annual Accounts 2010|2011

Statement of the chief executive's responsibilities as the accounting officer of University College London Hospitals 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 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 the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed the University College London Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of University College London Hospitals NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; 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 Monitor's NHS Foundation Trust Accounting Officer Memorandum.

Signed ……..

Sir Robert Naylor
Chief Executive
Date: 1 June 2011

Statement on internal control 2010/11

1. Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's 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 NHS foundation 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.

The Board of Directors (Board) is accountable for internal control. I have overall accountability for risk management in the Trust. The control of risk is embedded into the management roles of the Executive Directors, particularly the Corporate Medical Director who leads on Clinical Risk and Medical Directors of the Medicine, Surgery & Cancer, and Specialist Hospitals Boards, given their prime responsibility for the delivery of operational services. Levels of accountability and responsibility are detailed in the Trust Risk Management Strategy and Purpose. The risk register and risk process is overseen by the Risk Co-ordination Board (RCB), an executive sub committee chaired by the Deputy Chief Executive, reporting to the Executive Board.

In order to ensure that risk management is not seen only as an issue that needs to be addressed within the organisation alone there are arrangements in place for working with stakeholders and partner organisations, including close working with Camden and Islington Primary Care Trusts (PCTs) and University College London. These cover both operational and strategic issues such as service planning and commissioning, performance management, research, education and clinical governance. Issues arising from such work are fed into the Trust's risk capture process and are subject to risk action plans if the risk is graded sufficiently highly on the risk grading matrix.

The Trust continues to build upon the Board Assurance Framework (BAF). The central purpose is to set out the objectives of the Trust for the year, identify principal risks against them, the controls and any gaps in control, the assurances and gaps in assurances, and the action plans to remedy such gaps. The assurance framework is subject to an Executive Director led peer review process which is considered quarterly by the Executive Board and the Board.

Processes for auditing and monitoring clinical activity are in place in all the clinical divisions. Clinical processes are updated when national guidance is published or in response to adverse events and national safety notices via the Central Alerting System (CAS), which is monitored closely via the Patient Safety and Risk Steering Group with no overdue alerts during the year. Sub committees of the Quality and Safety Committee (QSC) monitor implementation. Standard clinical data sets have now been established and are assessed on a monthly basis by the QSC to provide assurance on clinical outcomes and to identify any emerging risks for further investigation and action. The Corporate Medical Director receives ongoing notification of unexpected complications and all deaths and issues are escalated if appropriate to the QSC or Executive Board for action. Developments are taking place to implement practical solutions to known high risk clinical activities such as wrong site surgery and other national "Never Events". Progress with implementation is being audited as part of the mandated corporate clinical audit programme. Clinical Audit has recently been reviewed and improved.

The Audit Committee terms of reference require it to review all risk and control related disclosure statements prior to endorsement by the Board, and the effectiveness of the management of principal risks including risk review procedures and reports.

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 University College London Hospitals (UCLH) NHS Foundation 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 UCLH NHS Foundation Trust for the year ended 31 March 2011 and up to the date of approval of the annual report and accounts.

The system of internal control is founded upon having

a number of individual controls in place; policies and procedures covering important business activities, how staff are appointed and managed, the Standing Orders, Standing Financial Instructions and Scheme of Delegation, the checks and balances inherent in internal and external audit reviews, Executive Board and Board of Director oversight.

Capacity to handle risk

The Executive Board brings together the corporate, financial, workforce, clinical, information and research governance risk agendas. The Board Assurance Framework ensures that there is clarity over the risks that may impact the Trust's ability to deliver its strategic objectives together with any gaps in control or assurance.

Clinical and non clinical risks which are assessed by the Trust Risk Manager to be significant enough to be categorised as a Serious Incident (SI) are forwarded to the Corporate Medical Director and the Director of Quality and Safety for confirmation and declaration. Once declared SI's are reported to Camden PCT as the coordinating commissioner (Host PCT). The QSC oversees the investigation, learning lessons and management actions. A quarterly report on SI's is provided to the Trust Board.

The operational responsibility for the Trust's risk management agenda is overseen within the RCB which enables clinical risk management and corporate risk issues to be brought together and reported as a whole. Cross reporting takes place between RCB and QSC to enable the full risk profile to be considered. The process of identification, assessment, analysis and management of risks and incidents is the responsibility of all staff across the Trust and particularly of all managers. The process for the identification, assessment, reporting, action planning, review, and monitoring of risks is detailed in the Trust Risk Management Policy and Procedure reporting to the Executive Board, has been central to the improvements made in this important area of our work during the year.

The Trust has improved the processes to bring together comprehensive risk registers across the Trust. Board members receive training in risk management and an overview of the risk systems. Staff receive training in identification and reporting of risk. Training at induction covers the wider aspects of Governance. The emphasis of our approach is increasingly on the proactive management of risk and ensuring that risk management plans are in place for all key risks.

An annual exercise is undertaken to assess the Trust's compliance with the Care Quality Standards. The Executive Board considers the results, and best practice resulting from this process is highlighted and shared across divisions via the Quality and Safety Committee and the Divisional Clinical Boards.

The Trust Maternity Services were assessed by the National Health Service Litigation Authority (NHSLA) against Level 3 of their risk management standards in January 2010, and were awarded a pass at this level.

The Care Quality Commission (CQC) published Essential standards of quality and safety in March 2010. The standards consist of 28 regulations and associated outcomes that are set out in two pieces of legislation, the Health and Social Care Act (2008) and the Care Quality Commission Regulations 2009. In line with the national system the Trust has registered eight locations and eight registerable activities. An improved system for monitoring compliance with the regulations and outcomes was agreed by the Executive Board in June 2010 and implemented throughout the remainder of the year. The system is based on the CQC's own system for assessing Trusts and involves the completion of Provider Compliance Assessments, evidence collation, risk assessment and challenge. The outcome of the monitoring showed significant compliance with the regulations though some areas of weakness were identified which have been addressed by mitigating actions and forward plans.

The risk and control framework

The Trust has a comprehensive Risk Management Purpose and Strategy which was updated in the year and approved by the Board and is available to all staff on the Trust's intranet site. A key improvement was the introduction of the incident reporting upgrade to DatixWeb in April 2010 which increased incident reporting within the Trust by making reporting more accessible to staff and managers.

Risks and risk management plans are captured by Divisions and agreed by the Clinical Boards and there is increasing focus on the forward projection of risks with each risk graded with an original grading, current grading, and a target grading projected risk profile. DatixWeb has been upgraded to include online risk registers more easily accessible to staff and managers.

This means that risks are captured from within the organisation and are supplemented with a quarterly assessment of risks by the Chief Executive and the Non-Executive Directors. The Trust is becoming more risk aware, for example the Strategic Programme

Board embeds risk into its ongoing work programme and the reports from the ICT Strategy Board routinely incorporate a section on risk based on achievement against the Information Governance Toolkit standards.

The Trust fully reviews risk registers and risk management plans every three months. The Trust Risk Manager collates the risk register submissions from Divisions, and submits these to the Risk Review Group who review the severity of Trust-wide risks. A report is submitted to the RCB who ensure that appropriate risk assessments and resulting action plans are in place. The RCB report is reported to the Executive Board for further monitoring of the action plan progress, and this is monitored by the Audit Committee. The Executive Board report is reported to the Board for further review and assessment with key risks being collated into strategic themes and those reported to the Board Assurance Framework for review by the Board.

The Audit Committee oversees and monitors the performance of the risk management system, Internal Audit (RSM Tenon) and External Audit (PricewaterhouseCoopers) work closely with this committee. They undertake reviews and provide assurances on the systems of control operating within the Trust. An audit of assurances in relation to the BAF was carried out by RSM Tenon during January and February 2011, and a positive report received stating 'The developments put in place have been positively received and overall the Trust has a strong assurance framework in place'

Internal Audit and Counter Fraud activities

The results of Internal Audit reviews are reported to the Audit Committee which takes a close interest in ensuring system weaknesses are addressed. Improved procedures are in place to monitor the implementation of control improvements and to undertake follow up reviews where systems were deemed less than adequate. An internal audit action recommendation tracking system is in place which records progress closing down the recommendations by management. Management's progress in implementing corrective action following Internal Audit recommendations is reported to the Audit Committee and the Executive Board also receives regular reports on outstanding high and medium issues. The counter fraud programme is monitored by the Audit Committee.

Information Governance

The Trust has an Information Governance Group (IGG) which is chaired by the Caldicott Guardian. This Group reports to the ICT Strategy Board (ICT SB). The ICT SB has a direct reporting line to the Executive Board and is chaired by the Deputy Chief Executive who is the Senior Information Risk Officer (SIRO) for the Trust. The IGG and ICT SB oversee the Trust's Information Governance Toolkit annual assessment and action plan. Through this governance structure the Trust's Information Governance Statement of Compliance (IGSoC) is assessed on an ongoing and annual basis to ensure connection to the NHS National Network (N3) and the use of the NHS Care Records Service applications. The controls exercised by the Trust are compliant with the IGSoC control requirements.

The toolkit includes a requirement to undertake an annual "data mapping" exercise to assess all routine data flows within the Trust and between the Trust and any third party. The output of this exercise was fed into the Trust's Risk Management Framework. The Trust is making good progress in determining its IG Toolkit attainment levels and collating the relevant documentation and evidence to support its attainment levels. Version 8 of the Toolkit introduced significant new requirements and required a more detailed set of evidence to support assessment scores. Although standards were improved or maintained, the IG Toolkit overall assessment score fell from 81% in version 7 in 2009/10 to 67% in version 8 in 2010/11 due to changes in the methodology of the assessment.

Data security risks are managed via an Information Governance Framework, which comprises an Information Governance Policy, related policies and guidance and the Information Governance Group (IGG). In particular, the Information Risk Policy sets out a structured approach to information risk management which is integrated with the Trust's broader risk management arrangements. This includes the appointment of Senior Information Risk Officer (SIRO), Information Asset Owners (IAOs) and Information Asset Administrators (IAAs).

Information risk identification is supported by the maintenance of an Information Asset Register and regular information mapping exercises. Any significant risks identified from these processes are included in the Trust's Risk Register and will therefore be subject to the formal management attention commensurate with the assessed risk.

The Trust completes the Information Governance Assurance Tool (IGT) to demonstrate adequate practice

and provide assurance that all aspects of information risk management are appropriately managed. The IGT assessment is externally reviewed by the Trust's Internal Auditors. The SIRO and IGG monitor progress and compliance with the IGT on an ongoing basis. The SIRO and Caldicott Guardian report to Executive Board and Board of Directors on a six monthly basis.

An in year risk has been identified in relation to interruption to services due to ageing IT infrastructure. Capital allocations have been approved to improve the ICT infrastructure and a project has been established oversee these improvement works. Following completion of the project, ICT infrastructure will be risk assessed to ensure appropriate levels of risk reduction have been achieved.

The unintentional disclosure of patient identifiable data continues to be an in year risk. One data loss incident in 2010/11 was reported to the Information Commissioner's Office (ICO) who required that an undertaking be signed by the Trust. An action plan to improve awareness and further reduce this risk has been developed.

The Trust operates in a complex environment and exchanges data with a number of organisations. The Trust therefore continues to prioritise activities to reduce the risk of data loss or accidental disclosure of personal data. Information Governance Policy and guidance is continually reviewed and training and awareness raising programmes target all Trust staff. In addition, a project to implement further technical controls to manage sensitive data is underway. Information Governance Training includes an assessment of understanding of key aspects of policy and assessment scores will indicate the success of awareness raising activities. Strengthened technical controls will result in a reduction of risk of specific types of data loss, for example preventing the use of unencrypted memory sticks.

Stakeholder involvement in risk management

Stakeholders attend meetings and are involved with the Trust which gives them opportunities to raise issues relating to risks which impact upon them. These stakeholders include for example:

Patients and the public

- The Patient Advice and Liaison Service and specific patient representative groups.
- The work of the local Overview and Scrutiny Committees.
- Annual public meeting of the Board.
- The National Patient Survey Programme.
- Local Involvement Networks (LINKs).
- Patient Issues Committee.
- High Quality Patient Care Group.

Staff

- The annual staff survey.
- Staff road shows with the Chief Executive.

Health partners

- Regular discussion of key issues and performance management arrangements with PCTs and GPs.
- Stakeholder membership of Trust working groups, for example voluntary sector.
- Joint strategic planning meetings with healthcare partners.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Equality Impact Assessments are carried out when reviewing policies and service changes.

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 deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Risk assessments are undertaken and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Quality Report

There are a number of controls in place to ensure the quality of the Quality Report, the key controls are:

- Corporate objectives for data quality are defined
- Data quality priorities are monitored
- Comprehensive guidance on data quality in the data capture policy
- Data quality reports are provided to divisions
- Performance is monitored at Executive Board and QSC

- Clinical Boards monitor and manage performance
- Clinical and quality data is reported to the Board and scrutinised and challenged at Board sub committees

External assurance statements on the Quality Report are provided by our local commissioners and our local links as required by Quality Account Regulations.

External audit is undertaken by PwC as required by Monitor and their report and findings on the 2009/10 Quality Report have been considered by the Board. The PwC report identified a number of strengths in the arrangements in place in 2009/10 and noted that further arrangements were planned which would enhance the overall arrangements. The recommendations included in the report have subsequently been actioned and have been reassessed internally for their effective implementation.

Internal audit and PwC have been commissioned to conduct audit of the data quality and specific quality indicators as part of the production of the Quality Report for 2010/11.

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

Review of economy, efficiency and effectiveness of the use of resources

Monthly finance and performance reports are presented to the Finance and Contracting Committee, Executive Board and to the Board. The Trust has exceeded the target for EBITDA and generation of surplus.

PricewaterhouseCoopers are required as part of their annual audit to satisfy themselves the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and report by exception if in their opinion the Trust has not.

3. 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 and the executive managers within the NHS Foundation 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 and risk co ordination board and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review of the effectiveness of the system of internal control is informed by Executives and managers within the organisation, who have responsibility for the development and maintenance of the system of internal control and the Assurance Framework. The responsibility for compliance with the Care Quality Commission Essential standards is allocated to lead Executive Directors who are responsible for maintaining evidence of compliance. The assessment of compliance and the work of Internal Audit through the year, including advice and support on the development of the Board Assurance Framework have been of great assistance. The results of External Audit's work on the Trust's annual accounts are a key assurance together with patient and staff surveys and NHSLA Level 2 Risk Management Standards assessment, which is likely to be upgraded to Level 3. I have been advised on the implications of the results of my review of the effectiveness of the system of internal control by the QSC, Medical Director Corporate and the Audit Committee, and plans to address weaknesses and ensure continuous improvement of the system are in place.

The Trust did not stay within its MRSA threshold for 2010/11. At a national level the methodology for setting the thresholds for MRSA was changed resulting in a very demanding threshold and the Trust declared to Monitor as part of its annual plan submission it expected to breach the threshold. Extensive improvement work in 2010/11 drove a 40% improvement in performance over 2009/10.

The Trust missed the threshold of 85% compliance against the national cancer target for urgent GP referrals to be treated within 62 days from referral for quarters 2 and 3. The threshold was missed narrowly in Q2 because of changes in the application of rules relating to referrals which are received late from other hospitals. We have now agreed with other Trusts that responsibility for 6 of these delayed cases could have been reallocated to those referring Trusts, which would have enabled us to meet the threshold for Q2. There were breaches during Q2 and Q3 on

the prostate cancer pathway, and the Trust developed and implemented by January 2011 an improvement plan to improve patient flow on this pathway. New arrangements were also put in place for all relevant divisions to monitor compliance with this target prospectively on a weekly basis and the Clinical Boards are follow up any breaches. Subsequently the trust has been compliant with this national target, and is expected to maintain quarterly compliance in 2011/12.

The Trust missed the 90% threshold for patients being treated within 62 days of a referral from the screening programme during quarters 2, 3 and 4. The number of breaches of this target across the year was low (nine cases) and were principally due to issues outside of the Trust's direct control: patients appropriately deciding to delay diagnostic tests to match their personal circumstances and commitments, and administrative errors on the part of the bowel screening hub which led to an unexpected surge in referrals to UCLH from the screening centre. No patient was adversely affected by these delays. Given the low number of patients covered by this target we have asked Monitor to consider amending the de minimus target so that single breaches of the target in a quarter do not drive a non-compliant position.

On 22nd February the Trust suffered a significant failure in the IT network, following which a review was undertaken and plans put in place to prevent a recurrence.

There were three Serious Incidents reported to Camden PCT relating to the loss of patient information.

It is not anticipated that the Trust will be considered in breach of its terms of authorisation by Monitor following publication of the 2010/11 annual accounts. This view is shared by the Trust's external auditors, PwC, who do not intend to issue a qualified audit certificate in respect of the Trust's use of resources for the financial year.

The Board has played a key role in reviewing risks to the delivery of the Trust's performance objectives through monthly monitoring and discussion of the performance dashboard which reports performance in the key areas of finance, activity, national targets, patient safety and quality and workforce. This enables the Executive Board and the Board to focus on key issues as they arise and address them.

At an overall Trust level we continued to show improvements in our management against budgets and our ability to forecast. The Trust recognises the difficult financial constraints to be faced in the following financial years and has commenced detailed planning under our Quality Efficiency and Productivity project aiming to achieve savings of £45.0m in 2011/12.

The Head of Internal Audit Opinion has given a significant assurance there is a generally sound system of internal control but has drawn attention to one Red rated report, relating to Appraisals of non medical staff. Where a Red rating is given the control weaknesses are reported to the Executive Board and the management actions to address them are agreed and monitored both by the Executive Board and the Audit Committee. A new appraisals system is being introduced early in 2011/12 in order to improve the appraisals and performance management.

Internal Audit grade the assurance level the Trust may take from their audits as green, amber green, amber red and red. The main financial systems are audited annually and 2010/11 saw further improvements in the levels of assurance reported.

The Audit Committee has overseen the effectiveness of the Trust's risk management arrangements and the Statement on Internal Control and has reviewed and acted upon a report on its own role and effectiveness.

Conclusion

No significant internal control issues other than those mentioned above were identified in the year.

Sir Robert Naylor
Chief Executive
Date: 1 June 2011

Accounts for the year ended to 31 March 2011

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

Chief Executive
Sir Robert Naylor

Date: 1 June 2011

Foreword to the accounts

These accounts, for the year ended 31 March 2011, have been prepared by the University College London Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

Chief Executive
Sir Robert Naylor

Date: 1 June 2011

Independent Auditors' Report to the Board Of Governors of University College London Hospitals NHS Foundation Trust

We have audited the financial statements of University College London Hospitals NHS Foundation Trust for the year ended 31 March 2011 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity and the related notes. The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Respective responsibilities of directors and auditors

As explained more fully in the Statement of chief executive's responsibilities as the accounting officer on page 111 the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with the NHS Act 2006, the Audit Code for NHS Foundation Trusts issued by Monitor and International Standards on Auditing (ISAs) (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the Board of Governors of University College London Hospitals NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view, in accordance with the NHS Foundation Trust Annual Reporting Manual, of the state of the NHS Foundation Trust's affairs as at 31 March 2011 and of its income and expenditure and cash flows for the year then ended; and
- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual.

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

In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual; and
- the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

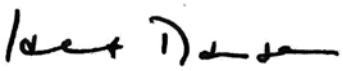
Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if:

- in our opinion the Statement on Internal Control does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual or is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Accounting Officer's Statement on Internal Control addresses all risks and controls or that risks are satisfactorily addressed by internal controls;
- we have not been able to satisfy ourselves that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- we have qualified our report on any aspects of the Quality Report.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.



Janet Dawson (Senior Statutory Auditor)
For and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
7 More London Riverside, London, SE1 2RT
Date: 2 June 2011

Statement of comprehensive income for the year ended 31 March 2011

	NOTE	2010/11 31 March £000	2009/10 31 March £000
Revenue			
Operating Income from continuing operations	3	**745,081**	700,086
Operating Expenses of continuing operations	4	**(692,843)**	(678,051)
Operating surplus		**52,238**	22,036
Finance costs:			
Investment revenue	9	**229**	220
Other gains	10	**0**	21
Finance costs	11	**(27,378)**	(25,099)
Public dividend capital dividends payable		**(8,523)**	(8,150)
Surplus/(Deficit) for the financial year		**16,566**	(10,972)
Other comprehensive income			
Impairments and reversals	14	**(11,040)**	(25,268)
Gains on revaluations		**17,770**	12,191
Receipt of donated assets		**2,041**	4,243
Reclassification adjustments:			
- Transfers from donation reserves		**(3,317)**	(3,221)
Total comprehensive income for the year		**22,020**	(23,028)

The notes on pages 127 to 166 form part of these accounts.

Note to Statement of Comprehensive Income

			£000	£000
Total comprehensive income as above			**22,020**	(23,028)
less impairments, revaluations, donated assets and transfers from donation reserve.		a	**(5,454)**	12,056
less exceptional items included in surplus/ (deficit) above		b	**(5,134)**	22,485
Net Surplus excluding exceptional items	2		**11,432**	**11,513**

This is the primary view which is used by the Board of Directors to monitor the Trust's financial performance. It is used by the Foundation Trust Regulator as a component of its measure of the Trust's financial performance.
a This is the total of the four items shown above in Other Comprehensive Income
b This is the total of impairments and impairments reversals charged to expenditure or credited to income as Note 14

Statement of financial position as at 31 March 2011

	NOTE	31 March 2011 £000	31 March 2010 £000
Non-current assets			
Property, plant and equipment	12	**611,914**	565,320
Intangible assets	13	**98**	108
Trade and other receivables	18	**17,364**	13,226
Total non-current assets		**629,375**	578,654
Current assets			
Inventories	17	**16,726**	14,265
Trade and other receivables	18	**45,529**	57,308
Cash and cash equivalents	19	**107,166**	91,956
		169,421	163,529
Non-current assets held for sale	20	**0**	5,430
Total current assets		**169,421**	168,959
Total assets		**798,796**	747,613
Current liabilities			
Trade and other payables	21	(95,007)	(92,950)
Borrowings	22	(3,290)	(3,085)
Provisions	27	(3,603)	(3,440)
Other liabilities	23	(6,630)	(5,650)
Net current assets/(liabilities)		**60,892**	63,834
Total assets less current liabilities		**690,267**	642,488
Non-current liabilities			
Trade and other payables	21	(1,478)	(278)
Borrowings	22	(286,048)	(269,337)
Provisions	27	(2,255)	(4,304)
Other liabilities	23	(1,009)	(1,177)
Total assets employed		**399,477**	367,392
Financed by taxpayers' equity:			
Public dividend capital	SOCITE	**195,366**	185,301
Retained earnings	SOCITE	**49,674**	19,380
Revaluation reserve	SOCITE	**110,406**	115,268
Donated asset reserve	SOCITE	**39,958**	43,370
Other reserves	SOCITE	**4,073**	4,073
Total Taxpayers' Equity		**399,477**	367,392

The financial statements on pages 122 to 126 and the accompanying notes to the financial statements were approved by the Board on 25th May 2011 and signed on its behalf by:

Signed: ..... Finance Director Date: 1 June 2011

Signed: ..... Chief Executive Date: 1 June 2011

Statement of changes in taxpayers' equity

	Public dividend capital (PDC)	Revaluation reserve	Donated asset reserve	Other reserves	Retained earnings	Total
	£000	£000	£000	£000	£000	£000
Balance at 1 April 2010	185,301	115,268	43,370	4,073	19,380	367,392
Changes in taxpayers' equity for 2010/11						
Surplus for the year				0	16,566	16,566
Impairments		(8,297)	(2,743)	0	0	(11,040)
Revaluations		17,163	607	0		17,770
Receipt of donated assets			2,041	0		2,041
Asset disposals		(13,729)	0	0	13,729	0
Public Dividend Capital received	10,065					10,065
Public Dividend Capital repaid	0					0
Public Dividend Capital written off	0					0
Other reserve movements	0	0	(3,317)	0	(0)	(3,317)
Balance at 31 March 2011	**195,366**	**110,406**	**39,958**	**4,073**	**49,674**	**399,477**

Prior year

	Public dividend capital (PDC)	Revaluation reserve	Donated asset reserve	Other reserves	Retained earnings	Total
	£000	£000	£000	£000	£000	£000
Balance at 1 April 2009	180,419	126,144	45,522	4,073	29,381	385,539
Changes in taxpayers' equity for 2009/10						
Deficit for the year				0	(10,972)	(10,972)
Impairments		(22,095)	(3,173)	0	0	(25,268)
Revaluations		12,191	0	0		12,191
Receipt of donated assets			4,243	0		4,243
Asset disposals		0	0	0	0	0
Public Dividend Capital received	4,882					4,882
Public Dividend Capital repaid	0					0
Public Dividend Capital written off	0					0
Other reserve movements	0	(971)	(3,221)	0	971	(3,222)
Balance at 31 March 2010	**185,301**	**115,268**	**43,370**	**4,073**	**19,380**	**367,392**

Statement of cash flows for the year ended 31 March 2011

	NOTE	2010/11 31 March £000	2009/10 31 March £000
Cash flows from operating activities			
Operating surplus from continuing operations		**52,238**	22,036
Operating surplus of discontinued operations		**0**	21
Operating surplus		**52,238**	**22,057**
Non-cash income and expenses:			
Depreciation and amortisation		**20,103**	18,765
Impairments		**2,169**	22,506
Reversals of impairments		**(7,303)**	0
Transfer from the donated asset reserve		**(3,317)**	(3,221)
(Increase)/Decrease in Trade and Other Receivables	18	**7,642**	(21,169)
(Increase) in Inventories	17	**(2,461)**	(84)
Increase in Trade and Other Payables	21	**2,585**	6,761
Increase/(Decrease) in Other Liabilities	23	**812**	(627)
Increase/(Decrease) in Provisions	27	**(1,886)**	1,803
NET CASH GENERATED FROM OPERATIONS		**70,581**	**46,791**
Cash flows from investing activities			
Interest received		**229**	220
Purchase of Property, Plant and Equipment		**(67,274)**	(32,194)
Sales of Property, Plant and Equipment		**20,250**	810
Net cash (used in) investing activities		**(46,795)**	(31,164)
Cash flows from financing activities			
Public dividend capital received		**10,065**	4,882
Public dividend capital repaid		**0**	0
Loans received		**20,000**	0
Loans repaid		**0**	0
Capital element of finance lease rental payments		**0**	0
Capital element of Private Finance Initiative Obligations		**(3,085)**	(2,895)
Interest paid		**(44)**	(50)
Interest element of finance lease		**0**	0
Interest element of Private Finance Initiative obligations		**(27,334)**	(25,049)
PDC Dividend paid		**(8,179)**	(8,150)
Cash flows from (used in) other financing activities		**0**	0
Net cash (used in) financing activities		**(8,576)**	(31,262)
Increase/(decrease) in cash and cash equivalents		**15,210**	(15,636)
Cash and Cash equivalents at 1 April		**91,956**	107,592
Cash and Cash equivalents at 31 March		**107,166**	**91,956**

Notes to the accounts

1. Accounting Policies and other information

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2010/11 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

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.

1.2 Consolidation

Subsidiaries

Subsidiary entities are those over which the Trust has the power to exercise control or a dominant influence so as to gain economic or other benefits. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year except where a subsidiary's financial year end is before 1 January or after 1 July in which case the actual amounts for each month of the Trust's financial year are obtained from the subsidiary and consolidated.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK GAAP) then amounts are adjusted during consolidation where the differences are material. Subsidiaries which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'.

For 2010/11 NHS charitable funds considered to be subsidiaries are excluded from consolidation in accordance with the accounting direction issued by Monitor.

Associates

Associate entities are those over which the Trust has the power to exercise a significant influence. Associate entities are recognised in the Trust's financial statement using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the Trust's share of the entity's profit or loss or other gains and losses (e.g. revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution e.g. share dividends are received by the Trust from the associate. However, where the Trust's proportion of an associates cumulative profits or losses at year end are less than £50,000, no adjustment is made to the cost of the investment on the basis of immateriality.

Associates which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'.

Joint Ventures

Joint ventures are separate entities over which the Trust has joint control with one or more other parties. The meaning of control is the same as that for subsidiaries.

Joint ventures are accounted for by consolidating the Trust's share of the transactions, assets, liabilities, equity and reserves of the entity.

Joint ventures which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'.

Joint operations

Joint operations are activities which are carried on with one or more other parties but which are not performed through a separate entity. The Trust includes within its financial statements its share of the activities, assets and liabilities.

1.3 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of healthcare

services. Revenue relating to patient care spells which are part-completed at the year end is apportioned across the financial years on the basis of 50% of the expected spell price.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

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 sum due under the sale contract net of costs of sale.

1.4 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 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 employees are permitted to carry-forward leave into the following period.

Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the UCLH NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.5 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.

1.6 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Valuation

All property, plant and equipment are measured 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.

All assets are measured subsequently at fair value. Fair value is defined in IAS16 as 'the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction'. The valuation of each property is therefore on the basis of market value, on the assumption that the property is sold as part of the continuing enterprise in operation.

Specialised assets are valued using the Modern Equivalent Asset (MEA) approach. Both physical and functional obsolescence is applied to buildings, to reflect their actual characteristics and value.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Assets are revalued and depreciation commences when they are brought into

use. Borrowing costs are not capitalised.

Non-specialised assets are held at fair value which is measured on an existing use basis. Surplus land and buildings are valued on the basis of fair value, taking into account alternative uses.

Subsequent expenditure

Expenditure incurred after items of property, plant and equipment have been put into operation, such as repairs and maintenance, is normally charged to the income statement in the period in which it is incurred. In situations where it can be clearly demonstrated that the expenditure has resulted in an increase in the future economic benefits expected to be obtained from the use of an item of property, plant and equipment, and where the cost of the item can be measured reliably, the expenditure is capitalised as an additional cost of that asset or as a replacement.

Depreciation

Items of property, plant and equipment are depreciated on a straight line basis over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated. Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'

Impairments

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.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

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 in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale' ; and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

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 and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated assets

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the

asset is released from the donated asset reserve to the income and expenditure account. Similarly, any impairment on donated assets charged to the income and expenditure account is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value of the donated asset is transferred from the donated asset reserve to the income and expenditure reserve.

1.7 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. The underlying assets are recognised as property, plant and equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 17.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The finance cost is calculated using the implicit interest rate for the scheme.

The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

Lifecycle replacement

An amount is set aside from the unitary payment each year into a Lifecycle Replacement Prepayment to reflect the fact that the Trust is effectively pre-funding some elements of future lifecycle replacement by the operator.

When the operator replaces a capital asset, the fair value of this replacement item is recognised as property, plant and equipment.

Where the item was planned for replacement and therefore its value is being funded through the unitary payment, the lifecycle prepayment is reduced by the amount of the fair value.

The prepayment is reviewed annually to ensure that its carrying amount will be realised through future lifecycle components to be provided by the operator. Any unrecoverable balance is written out of the prepayment and charged to operating expenses.

Where the lifecycle item was not planned for replacement during the contract it is effectively being provided free of charge to the Trust. A deferred income balance is therefore recognised instead and this is released to operating income over the remaining life of the contract.

Assets contributed by the Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Other assets contributed by the Trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.
Expenditure on research is not capitalised.
Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources

are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments 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 in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Government grants

Government grants are grants from Government bodies other than income from primary care trusts or NHS trusts for the provision of services. Grants from the Department of Health, including those for achieving three star status, are accounted for as Government grants as are grants from the Big Lottery Fund. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

Where the grant is used to fund capital expenditure the grant is held as deferred income and released to operating income over the life of the asset in a manner consistent with the depreciation charge for that asset.

1.10 Inventories

Inventories are valued at the lower of cost and net realisable value.

Pharmacy inventories are valued on a weighted average cost basis recalculated monthly.

1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

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.

1.12 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for 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, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

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 for leases described below.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the

obligation is discharged, cancelled or expires.

Classification and Measurement

Financial assets are classified into the following categories: financial assets at fair value through Statement of Comprehensive Income (SoCI); held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial liabilities are classified as 'fair value through income and expenditure' or as 'other financial liabilities'. Otherwise, financial liabilities are initially recognised at fair value.

Financial assets and financial liabilities at 'Fair Value through SoCI'

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise: cash and cash equivalents, NHS debtors, accrued income and 'other debtors'

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

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. When items classified as 'available-for-sale' are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in 'Finance Costs' in the Statement of Comprehensive Income.

Other financial liabilities

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

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on

the estimated future cashflows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

1.13 Leases

The Trust as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

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

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

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.

1.14 Provisions

University College London Hospitals NHS Foundation Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arsing from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual

contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at Note 27.

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.

1.15 Contingencies

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 28 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 28, 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 of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.16 Public dividend capital

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

A charge, reflecting the cost of capital utilised by the 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 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 and (ii) net cash held with the Government Banking Service and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as 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.

1.17 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 fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.18 Corporation Tax

NHS Foundation Trusts can be subject to corporation tax in respect of certain commercial non-core health care activities they undertake in relation to the Finance Act 2004 amended S519A Income and Corporation Taxes Act 1988.

Recent guidance issued by HMRC states that the earliest date corporation taxation will be applicable to Foundation Trusts is 1 April 2011.

1.19 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.20 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual. Details of third party assets are given in Note 32 to the accounts.

1.21 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 that individual cases are 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 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.

1.22 Critical accounting judgements and key sources of estimation uncertainty

In the application of the foundation 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.

2. Operating segments

The NHS foundation trust operates solely in the UK. Patients who do not live in the UK are treated via reciprocal arrangements or are required to pay for their own treatment. £1,935k (£948k in 2009/10) came from overseas patients without reciprocal arrangements.

The Trust's activity is organised into three clinical boards, each of which provide healthcare services, and one corporate segment.

The board of directors receive financial reports that analyse the financial performance of the Trust in several ways. However, expenditure is reported against budget for each of three clinical boards, research and development, education and corporate segments.

These segments are run on a day to day basis by a separate clinical or executive board. The clinical segments are Medicine, Surgery & Cancer and Specialist Hospitals. The latter encompasses the Eastman Dental Hospital, paediatrics and adolescents, womens' health, The National Hospital for Neurology and Neurosurgery, the Heart Hospital (cardiology and cardiothoracic surgery), and the Royal Hospital for Integrated Medicine.

Income for the clinical boards is received via the contracts with PCTs. The contracts follow the requirements of the DH's payment by results and services are paid for on the basis of a national tariff for each treatment. The number of treatments is agreed with our main commissioning PCTs.

The Chief Operating Decision Maker (CODM) of this Trust is the Trust board. It has been determined that this is the CODM as under our scheme of delegation the Board is required to approve the budget and all major operational decisions.

The monthly performance report to the CODM reports financial summary information in the format of the table below.

This financial information is the information which was reported to the May board meeting for the period ended 31 March 2011.

	Medicine		Specialist Hospitals		Surgery & Cancer		Research & Development		Education		Corporate		**TOTAL**	
	10-11 £m	09-10 £m	10-11 £m	09-10 £m	10-11 £m	09-10 £m	10-11 £m	09-10 £m	10-11 £m	09-10 £m	10-11 £m	09-10 £m	**10-11 £m**	**09-10 £m**
Direct Income	134	133	314	281	179	166	33	40	46	46	21	20	727	686
Direct Costs	(108)	(107)	(245)	(225)	(149)	(128)	(24)	(33)	(48)	(50)	2	0	(572)	(542)
Indirect Costs	(17)	(18)	(41)	(44)	(24)	(28)	(9)	(7)	-	-	4	16	(87)	(81)
EBITDA	9	8	28	13	6	10	0	0	(2)	(4)	27	36	68	63
IDTA (excl. exceptional items	-	-	-	-	-	-	-	-	-	-	(56)	(52)	(56)	(52)
Net Surplus/(Deficit)	9	8	28	13	6	10	0	0	(2)	(4)	(29)	(16)	12	11
Exceptional Items	-	-	-		-		-	-	-	-	5	(22)	5	(22)
Net Surplus/ (Deficit)	**9**	**8**	**28**	**13**	**6**	**10**	**0**	**0**	**(2)**	**(4)**	**(24)**	**(38)**	**17**	**(11)**

In the above table, IDTA is the total of interest, taxation, depreciation and amortisation. EBITDA is earnings before interest, taxation, depreciation and amortisation.

The exceptional item of £5.1m shown above consisted of a negative impairments of £7.3m shown in these Accounts as income, partially offset by £2.1m of impairments shown in these Accounts as expenditure. The exceptional item of £22.5m in 2009-10 related to impairments arising from a decrease in asset values.

Total assets are not reported to the CODM by reportable segment.

£528.6m (£488.3m in 2009/10) of our income is received from PCTs. Our main commissioning PCT is Camden PCT and £119m of our income came from contracts with that PCT.

3. Operating Income

	2010/11 31 March £000	2009/10 31 March £000
Income From Activities		
NHS Foundation Trusts	**2**	96
NHS Trusts	**0**	330
Strategic Health Authorities	**21,911**	16,275
Primary Care Trusts	**528,643**	488,254
Non NHS: Private patients	**7,567**	8,028
Non-NHS: Overseas patients (non-reciprocal)	**1,935**	948
NHS injury scheme (formerly RTA)	**383**	537
Non NHS: Other	**2,973**	3,593
Total Income From Activities	**563,413**	**518,061**
Other Operating Income		
Research and development	**35,436**	38,022
Education and training	**49,074**	49,527
Charitable and other contributions to expenditure	**1,447**	2,052
Transfer from donated asset reserve	**3,317**	3,221
Non-patient care services to other bodies	**29,400**	27,515
Reversal of impairments of property, plant and equipment	**7,303**	0
Other *	**55,689**	61,689
Total Other Operating Income	**181,667**	182,025
Total Operating Income	**745,081**	700,086

** The main component of Other income is pharmacy trading income*

	2010/11 31 March	2009/10 31 March
	£000	£000
Private Patient Income		
Private patient income (including overseas patients)	**9,502**	**8,976**
Total patient related income	**563,413**	**518,061**
Proportion as a percentage	**1.7%**	**1.7%**
Terms of Authorisation Private Charges Cap	**6.6%**	**5.9%**

Section 44 of the NHS 2006 Act requires that the proportion of Private Patient income to the total patient related income of the NHS Foundation Trust should not exceed its proportion whilst the body was an NHS Trust in 2002/3. Monitor has redefined activities to be included as private patient income and following a submission by the Trust in March 2010 has increased the private patient cap to 6.6%.

4. Operating Expenses

	2010/11 31 March £000	2009/10 31 March £000
Services from NHS Foundation Trusts	**0**	1,834
Services from NHS Trusts	**5,032**	2,822
Services from other NHS bodies	**5,868**	5,565
Purchase of healthcare from non NHS bodies	**4,752**	4,173
Employee Expenses - Executive directors	**2,138**	2,129
Employee Expenses - Non-executive directors	**75**	84
Employee Expenses - Staff	**375,139**	356,184
Drug costs	**99,360**	94,492
Supplies and services - clinical (excluding drug costs)	**72,837**	64,420
Supplies and services - general	**6,787**	6,172
Establishment	**6,694**	5,249
Research and development	**2,676**	6,312
Transport	**5,171**	5,377
Premises	**67,010**	66,837
Depreciation on property, plant and equipment	**20,081**	18,752
Amortisation on intangible assets	**21**	13
Impairments of property, plant and equipment	**2,169**	22,506
Reversal of impairments of property, plant and equipment	**0**	0
Audit fees- statutory audit *	**215**	210
Audit fees - regulatory reporting	**0**	0
Other auditors remuneration - further assurance services **	**50**	0
Other auditors remuneration - other services	**0**	44
Clinical negligence	**6,461**	5,569
Legal fees	**844**	340
Consultancy costs	**5,967**	6,218
Training, courses and conferences	**1,551**	1,262
Other services, eg external payroll	**298**	479
Losses, ex gratia & special payments	**19**	150
Other	**1,628**	858
	692,843	678,051

* The audit fee for the 2010-11 statutory audit was £164,000 (exclusive of vat), comprising £147,000 Regulatory reporting fee (2009/10: £128,000) and £17,000 Quality Assurance reporting fee.

** Fees for other auditors remuneration include £30,000 (exclusive of vat) in respect of the 2009/10 quality report, reported in the 2010/11 figure.

5. Operating leases

5.1 As lessee

The Trust has a number of property leases for both clinical and administrative buildings. These leases are of varying length of term between one and 77 years, with the average being 10 years. In addition, the trust has a portfolio of equipment leases, typically with lease terms of between five to seven years.

The Trust's operating lease contracts do not allow for the renewal of leases for a secondary period at substantially lower than market rates nor do they allow for the Trust to exercise beneficial purchase clauses allowing the Trust to acquire assets at other than market value.

Contingent rentals

The majority of the Trust rentals are fixed for any particular accounting period. Some of these leases include clauses that allow for an uplift of future rentals, typically on a five year basis, to prevailing market rates. Given the uncertainty of future rent reviews the Trust does not estimate such future uplifts. Accordingly lease payments under operating leases exclude contingent rental amounts. Equipment leases are fixed for the period of the concession and accordingly contain no contingent rents.

All of the above leases have been assessed in accordance with IAS 17 and deemed to be classified as operating leases.	**2010/11 31 March**	2009/10 31 March
	£000	£000
Minimum lease payments	**19,162**	18,382
Contingent rents	0	0
Less: Sub-lease payments received	0	0
Minimum lease payments	**19,162**	18,382

The aggregate future minimum lease payments under non-cancellable operating leases are as follows :

	2010/11 31 March	2009/10 31 March
	£000	£000
Not later than 1 year	**12,534**	13,758
Later than 1 year and no later than 5 years	30,502	28,018
Later than 5 years	35,436	38,714
Total	**78,472**	80,490

5.2 As lessor

The Trust is the lessor in an arrangement with HCA. This is an operating lease from which the Trust receives an annual rent of £1.6m.

6. Employee costs and numbers

6.1 Employee costs

	2010/11 31 March £000	2009/10 31 March £000
Salaries and wages	**307,986**	281,907
Social Security Costs	24,073	22,188
Employer contributions to NHS Pension scheme	31,730	29,282
Pension Cost - other contributions	**4**	7
Termination benefits	**229**	145
Total excluding Agency/Contract staff	**364,022**	333,529
Agency/Contract staff	**13,256**	24,784
Employee benefits expense	**377,277**	358,313

6.2 Average number of people employed

	Average in year ended 31st March 2011 Headcount	Average in year ended 31st March 2010 Headcount
Medical and dental	1,085	1,041
Administration and estates	1,410	1,360
Healthcare assistants and other support staff	497	492
Nursing, midwifery and health visiting staff	2,044	1,953
Scientific, therapeutic and technical staff	1,200	1,147
Social care staff	3	2
Bank and agency staff	**654**	622
Total	6,893	6,617

6.3 Staff Exit Packages

During the year the Trust agreed compulsory redundancies and other exit packages within the cost bands shown below:

- Under £10,000 – No. of compulsory redundancies: Nil (2010: Nil); No.of other agreed packages 8 (2010: 1)
- £10,000-£25,000 – No. of compulsory redundancies: Nil (2010: Nil); No.of other agreed packages 5 (2010: 1)
- £25,001-£50,000 – No. of compulsory redundancies: Nil (2010: Nil); No.of other agreed packages 2 (2010: Nil)
- £50,001-£100,000 – No. of compulsory redundancies: Nil (2010: Nil); No.of other agreed packages 1 (2010: 2)

Total number of compulsory redundancies Nil (2010 Nil) and other agreed packages 16 (2010: 4)
Total cost of packages £229,066 (2010:£144,619)

7. Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

a) Full actuarial (funding) valuation

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

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

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

b) Accounting valuation

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

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

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

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

In 2008-09 the NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

Annual Pensions

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

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

Pensions Indexation

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971. Up to and including 2009/10, that increase was based

on retail price index, subsequently it is based on the consumer price index.

Lump Sum Allowance

A lump sum is payable on retirement which is normally three times the annual pension payment.

Ill-Health Retirement

Early payment of a pension, with enhancement in certain circumstances, is available to members of the Scheme who are permanently incapable of fulfilling their duties or regular employment effectively through illness or infirmity.

Death Benefits

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

Additional Voluntary Contributions (AVCs)

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

Transfer between Funds

Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

Preserved Benefits

Where a scheme member ceases NHS employment with more than two years service they can preserve their accrued NHS pension for payment when they reach retirement age.

Compensation for Early Retirement

Where a member of the Scheme is made redundant they may be entitled to early receipt of their pension plus enhancement, at the employer's cost.

8. Retirements due to ill-health

This note discloses the number and additional pension costs for individuals who retired early on ill-health grounds during the year.

During 2010/11 there was one retirement (2009/10: five), at an additional cost of £40,567 (2009/10: £526,959). This information has been supplied by NHS Pensions.

9. Investment revenue

	2010/11 31 March	2009/10 31 March
	£000	£000
Rental revenue:		
PFI finance lease revenue:		
planned	0	0
contingent	**0**	0
Other finance lease revenue	**0**	0
Interest revenue:		
Bank accounts	**229**	220
Other loans and receivables	**0**	0
Impaired financial assets	**0**	0
Other financial assets	**0**	0
Total	**229**	220

10. Other gains and losses

	2010/11 31 March	2009/10 31 March
	£000	£000
Gain/(loss) on disposal of property, plant and equipment	**0**	21
Total	**0**	21

11. Finance Costs

	2010/11 31 March	2009/10 31 March
	£000	£000
Interest on loans	**24**	0
Interest on obligations under finance leases	**0**	0
Interest on obligations under PFI contracts:	**0**	0
- main finance cost	**27,309**	25,049
- contingent finance cost	**0**	0
Interest on late payment of commercial debt	**0**	0
Unwinding of discount on provisions	**0**	0
Other finance costs	**45**	50
Total	**27,378**	**25,099**

12. Property, plant and equipment

2010/11:	Land	Buildings excluding dwellings	Dwellings	Assets under construct and poa	Plant and machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2010	107,182	350,318	0	38,390	93,092	13,268	24,495	626,745
Additions purchased	7,000	479	0	60,124	0	0	0	67,603
Additions donated	0	0	0	2,041	0	0	0	2,041
Acquisition through business combination	0	0	0	0	0	0	0	0
Impairments charged to revaluation/donated asset reserves	(2,319)	(8,721)	0	0	0	0	0	(11,040)
Impairments recognised in operating income and expenses	1,677	4,726	0	(606)	(663)	0	0	5,134
Reclassifications	(0)	15,322	0	(23,801)	4,569	1,732	2,167	(12)
Transferred from assets held for sale	18,180							18,180
Revaluation surpluses	6,747	11,023	0	0	0	0	0	17,770
Transferred to disposal group as asset held for sale	(15,911)	(15,275)	0	(1,105)	(689)	0	(20)	(33,000)
Disposals	0	0	0	0	0	0	0	0
At 31 March 2011	**122,556**	**357,872**	**0**	**75,043**	**96,308**	**15,000**	**26,642**	**693,421**
Depreciation at 1 April 2010	0	66	0	0	51,000	5,907	4,452	61,425
Provided during the year	0	10,567	0	0	5,832	1,150	2,532	20,081
Revaluation surpluses	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0
Depreciation at 31 March 2011	**0**	**10,633**	**0**	**0**	**56,832**	**7,057**	**6,984**	**81,506**
Net book value at 31 March 2011								
Owned	122,557	96,131	0	74,256	28,699	7,275	17,497	346,415
PFI	0	225,542	0	0	0	0	0	225,542
Donated	0	25,567	0	787	10,776	667	2,160	39,957
Total at 31 March 2011	**122,557**	**347,240**	**0**	**75,043**	**39,475**	**7,942**	**19,657**	**611,914**
Analysis of property, plant and equipment								
Protected Property	**87,475**	**325,408**	**0**	**0**	**0**	**0**	**0**	**412,883**
Unprotected Property	**35,082**	**21,832**	**0**	**75,043**	**39,475**	**7,942**	**19,657**	**199,031**
Total at 31 March 2011	**122,557**	**347,240**	**0**	**75,043**	**39,475**	**7,942**	**19,657**	**611,914**

Reclassifications in the year represent Plant, Property, Equipment and Intangible assets where construction has been completed and the asset brought into use. Completed assets are re-categorised from Asset Under Construction to the asset category appropriate for the type asset. The total on the 'Reclassifications' line is normally zero as the amount moved transferred from Assets Under Construction are matched by an equivalent amount classified over the other PPE categories. However, the residual negative balance of £11,655 relates to reclassifications made to Intangible Assets. A corresponding £11,655 (positive figure) appears on the Reclassification line in the Intangible Asset note 13.

Prior year:

2009/10:	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construct and poa £000	Plant and machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2009	110,063	396,036	62	24,159	81,913	8,489	20,362	641,084
Additions purchased	0	290	0	32,952	0	0	0	33,242
Additions donated	0	0	0	4,243	0	0	0	4,243
Impairments charged to revaluation reserve	0	(25,206)	(62)	0	0	0	0	(25,268)
Impairments recognised in operating expenses	0	(22,506)	0	0	0	0	0	(22,506)
Reclassifications	0	2,825	0	(22,964)	11,179	4,779	4,133	(48)
Revaluation surpluses	794	634	0	0	0	0	0	1,428
Transferred to disposal group as asset held for sale	(3,675)	(1,755)	0	0	0	0	0	(5,430)
Disposals	0	0	0	0	0	0	0	0
At 31 March 2010	**107,182**	**350,318**	**0**	**38,390**	**93,092**	**13,268**	**24,495**	**626,745**
Depreciation at 1 April 2009	0	144	0	0	45,414	5,196	2,677	53,431
Provided during the year	0	10,680	0	0	5,586	711	1,775	18,752
Acquisition through business combination	0	0	0	0	0	0	0	0
Depreciation reinstated to revaluation reserve		(9,764)	0	0	0	0	0	(9,764)
Reversal of impairments	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0
Revaluation surpluses	0	(994)	(4)	0	0	0	0	(998)
Transferred to disposal group as asset held for sale	0	0	0	0	0	0	0	0
Disposals	0	0	4	0	0	0	0	4
Depreciation at 31 March 2010	**0**	**66**	**0**	**0**	**51,000**	**5,907**	**4,452**	**61,425**
Net book value at 31 March 2010								
Owned	107,182	100,961	0	36,678	30,499	6,644	16,713	298,677
PFI	0	223,273	0	0	0	0	0	223,273
Finance Lease	0	0	0	0	0	0	0	0
Donated	0	26,018	0	1,712	11,593	717	3,330	43,370
Total at 31 March 2010	**107,182**	**350,252**	**0**	**38,390**	**42,092**	**7,361**	**20,043**	**565,320**
Analysis of property, plant and equipment								
Protected Property	94,746	349,079	0	0	0	0	0	443,825
Unprotected Property	12,436	1,173	0	38,390	42,092	7,361	20,043	121,495
Total at 31 March 2010	**107,182**	**350,252**	**0**	**38,390**	**42,092**	**7,361**	**20,043**	**565,320**

During the year assets to the value of £2,041k were donated to the Trust by the following:

- The National Brain Appeal (formally National Hospital Development Foundation) provided the Brain Tumour Unit £1,300k contribution to building costs.
- UCLH Charity donated equipment and contributions to building enhancement £741k.

End of Year Valuation

In the year ending 31 March 2011 a valuation exercise was carried out on the Trust's properties by the District Valuers (DV). The purpose of this exercise was to determine a fair value for Trust land and buildings as at 31st March 2011. The exercise was carried out in February and March 2011 with the prospective valuation date of 31st March 2011, an agreed departure from the RICS Valuation Standards.

A detailed physical inspection was not carried out for this year's valuation on the working assumption that there have been no changes to either the properties or the immediate locality since the last physical inspection in March 2009 that would have a material effect upon the valuation.

The valuations were undertaken having regard to International Financial Reporting Standards (IFRS) as applied to the United Kingdom public sector and in accordance with HM Treasury guidance, International Valuation Standards and the requirements of the Royal Institution of Chartered Surveyors (RICS) Valuation Standards 6th Edition.

Basis of Valuation

The valuation was conducted in accordance with the terms of the Royal Institution of Chartered Surveyors' Valuation Standards, 6th Edition, in so far as these terms are consistent with the requirements of HM Treasury, the National Health Service and the Department of Health.

Fair value is defined as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. The fair value of land and buildings is usually determined from market-based evidence by appraisal undertaken by professionally qualified valuers.

The valuation of each property is on the basis of Market Value. The Market Value used in arriving at fair value for the Trust's operational assets is subject to the assumption that the property is sold as part of the continuing enterprise in occupation.

In the case of non-specialised operational assets, this equates in practice to Existing Use Value (EUV).

In the case of specialised operational assets, if there is no market-based evidence of fair value because of the specialised nature of the property and the item is rarely sold, except as part of a continuing business, fair value is estimated using a depreciated replacement cost approach subject to the assumption of continuing use.

Where depreciated replacement cost (DRC) has been used, it is confirmed that the valuer has had regard to the RICS Valuation Information Paper No. 10 *The Depreciated Replacement Cost (DRC) Method of Valuation for Financial Reporting, as supplemented by Treasury guidance.*

Non-operational assets, including surplus land, are valued on the basis of Market Value, on the assumption that the property is no longer required for existing operations, which have ceased.

There is an assumption that properties valued will continue to be in the occupation of the NHS for the foreseeable future having regard to the prospect and viability of the continuance of that occupation.

a) Depreciated Replacement Cost (DRC)

The basis used for the valuation of specialised operational property for financial accounting purposes is Depreciated Replacement Cost (DRC) The RICS Standards at Appendix 4.1, restating International Valuation Application 1 (IVA 1) provides the following definition:

"The current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all relevant forms of obsolesence and optimisation."

Those buildings which qualify as specialised operational assets, and therefore fall to be assessed using the Depreciated Replacement Cost approach, have been valued on a modern equivalent asset basis.

b) Existing Use Value (EUV)

The basis used for the valuation of non-specialised operational owner-occupied property for financial accounting purposes under IAS 16 is fair value, which is the market value subject to the assumption that the property is sold as part of the continuing enterprise in occupation. This can be equated with EUV, which is defined in the RICS Standards at UK PS1.3 as:

"The estimated amount for which a property should exchange on the date of valuation between a willing buyer and a willing seller in an arm's-length transaction, after proper marketing wherein the parties had acted knowledgeably, prudently and

without compulsion, assuming that the buyer is granted vacant possession of all parts of the property required by the business and disregarding potential alternative uses and any other characteristics of the property that would cause its Market Value to differ from that needed to replace the remaining service potential at least cost."

c) Market Value (MV)

Market Value is the basis of valuation adopted for the reporting of non-operational properties, including surplus land, for financial accounting purposes. The RICS Standards at PS3.2 define MV as:

"*The estimated amount for which a property should exchange on the date of valuation between a willing buyer and a willing seller in an arm's-length transaction after proper marketing wherein the parties had each acted knowledgeably, prudently and without compulsion."*

Variations to RICS Valuation Standards

In order to meet the underlying objectives established by HM Treasury and the Department of Health for capital accounting and the capital charges system, the following variations from the RICS Valuation Standards were required and agreed between the Trust and the DV.

For assets valued using depreciated replacement cost, the replacement cost figures include VAT and professional fees but exclude finance charges, with an 'instant building' being assumed.

The valuation figures reflect physical obsolescence and have been reduced to reflect functional obsolescence.

Assets in the course of construction at the valuation date are included at the cost incurred to the valuation date in accordance with current capital charging arrangements. When stating the certified cost of work carried out (as at the valuation date), no deduction has been made for the risk of failure to complete the project.

As regards alternative use values, it is confirmed that unless otherwise indicated operational assets have been valued to Fair Value on the assumption that their market value reflects the property being sold as part of the continuing enterprise in occupation. The value ascribed to the operational assets does not reflect any potential alternative use value, which could be higher or lower than the stated Fair Value.

Assumptions Arising from Use of a Prospective Valuation Date

The following assumptions were made in respect of giving a prospective valuation as at 31 March 2011, on valuations carried out in February and March 2011:

The age and remaining lives of buildings and their elements have been assessed as at the valuation date. The assumption is that building elements will continue to be maintained normally over the period from the date of inspection to the valuation date and that there will be no untoward changes.

With respect to non-specialised operational property valued to fair value assuming the continuance of occupation for the existing use, non-operational properties valued to Market Value and the land element of DRC properties, their valuations have been prepared having regard both to the market evidence available at the date of the report and to likely and foreseeable local and national market trends between the date of carrying out the valuation and the valuation date. The values were subsequently reviewed in March 2010, within two weeks of the valuation date, and are therefore considered valid for the purposes of the valuation exercise.

Interaction with Private Finance Initiative (PFI) Contracts

The Trust PFI asset (the new hospital building) has been valued to fair value on the market value, subject to the assumption of continuance of the existing use, with the DRC approach being adopted where the asset is specialised.

13. Intangible assets

	Computer software - purchased	Total
2010/11:	**£000**	**£000**
Gross cost at 1 April 2010	158	158
Additions purchased	0	0
Additions internally generated	0	0
Additions donated	0	0
Additions government granted	0	0
Reclassifications	12	12
Reclassified as held for sale	0	0
Disposals other than by sale	0	0
Revaluation	0	0
Impairments	0	0
Reversals of impairments	0	0
Gross cost at 31 March 2011	**169**	**169**
Amortisation at 1 April 2010	50	50
Provided during the year	21	21
Impairments recognised in operating expenses	0	0
Reversal of impairments recognised in operating expenses	0	0
Reclassifications	0	0
Revaluation surpluses	0	0
Transferred to disposal group as asset held for sale	0	0
Disposals	0	0
Amortisation at 31 March 2011	**71**	**71**
Net book value at 31 March 2011		
Purchased	98	98
Donated	0	0
Government granted	0	0
Total at 31 March 2011	**98**	**98**

Prior year:

2009/10:	Computer software - purchased £000	Total £000
Gross cost at 1 April 2009	110	110
Additions purchased	0	0
Additions internally generated	0	0
Additions donated	0	0
Additions government granted	0	0
Reclassifications	48	48
Reclassified as held for sale	0	0
Disposals other than by sale	0	0
Revaluation	0	0
Impairments	0	0
Reversals of impairments	0	0
Gross cost at 31 March 2010	**158**	**158**
Amortisation at 1 April 2009	37	37
Provided during the year	13	13
Impairments recognised in operating expenses	0	0
Reversal of impairments recognised in operating expenses	0	0
Reclassifications	0	0
Revaluation surpluses	0	0
Transferred to disposal group as asset held for sale	0	0
Disposals	0	0
Amortisation at 31 March 2010	**50**	**50**
Net book value at 31 March 2010		
Purchased	108	108
Donated	0	0
Government granted	0	0
Total at 31 March 2010	**108**	**108**

Intangible fixed assets represents application software identified in IT projects.

14. Impairments

In March 2011 a revaluation exercise was performed.

There was a net increase to the carrying value of the Trust's property, plant and equipment at 31st March 2011.

Where land and buildings increasing in value had been subject to prior impairment charged to operating expenses, these were reversed to other operating income as follows:

	£000	£000
Main Hospital; Phase 1	3,615	
Main Hospital; Phase 2 EGA	1,312	
Ear Hospital	1,170	
Heart Hospital W	513	
RLHIM	319	
Rosenheim Building	200	
Arthur Stanley House	130	
Warwickshire House	44	
Total		**7,303**

Impairments relating to consumption of economic benefits or downward price movements were charged to operating expenses as follows:

	£000	£000
Land	(900)	
Assets under construction	(606)	
Plant and Equipment	(663)	
Total		**(2,169)**

Summary of 2010-11 impairments:	Income and expenditure	Reserves	**Total**
	£000	£000	**£000**
Credited to operating income as above	7,303		**7,303**
Charged to operating expenses as above	(2,169)		**(2,169)**
Charged to revaluation reserve		(8,297)	**(8,297)**
Charged to donated asset reserve		(2,743)	**(2,743)**
Total impairments as shown in Note 12	**5,134**	**(11,040)**	**(5,906)**

15. Property, Plant & Equipment Economic Lives

Property, plant and equipment is depreciated on current valuation over estimated useful life as follows:

	Minimum	*Maximum*
Buildings excluding dwellings		50
Plant & Machinery	5	15
Information Technology	5	8
Furniture & Fittings	5	10

16. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	2010/11 31 March	2009/10 31 March
	£000	£000
Property, plant and equipment*	**28,630**	62,720
Intangible assets	**0**	0
Total	**28,630**	**62,720**

** £27m in 2010/11 relates to a new Cancer Centre. £60m of the 2009/10 capital commitment related to the new Cancer Centre.*

17. Inventories

	2010/11 31 March	2009/10 31 March
	£000	£000
Drugs	**6,296**	6,504
Consumables	**10,251**	7,475
Energy	**179**	286
Total	**16,726**	**14,265**

18. Trade and other receivables

18.1 Trade and other receivables

	Current		Non-current	
	2010/11 31 March	2009/10 31 March	**2010/11 31 March**	2009/10 31 March
	£000	£000		
NHS receivables	**43,943**	42,457	**0**	0
VAT	**0**	0	**0**	0
Non-NHS Accrued income	**4,585**	2,184	**0**	0
Provision for the impairment of receivables	**(29,489)**	(12,884)	**0**	0
Prepayments - PFI lifecycle replacements	**0**	0	**15,962**	13,226
Prepayments other	**3,381**	7,653	**1,401**	0
PDC Receivable	**500**	844		
Other receivables	**22,610**	17,054	**0**	0
Total	**45,529**	**57,308**	**17,364**	**13,226**

The great majority of trade is with Primary Care Trusts, as commissioners for NHS patient care services. As Primary Care Trusts are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

18.2 Analysis of impaired receivables

Ageing of impaired receivables,

	2010/11 31 March	2009/10 31 March
	£000	£000
By up to three months	**4,426**	**717**
By three to six months	**4,845**	**2,970**
By more than six months	**20,218**	**9,197**
Total	**29,489**	**12,884**

The above analyses the 'Provision for impairment of receivables' by reference to the age of the underlying debt.

All receivables over three months old are impaired. Accordingly, an aging analysis of receivables not impaired is not provided.

18.3 Provision for impairment of receivables

	2010/11 31 March £000	2009/10 31 March £000
Balance at 1 April	**12,884**	6,145
Increase in provision	**17,614**	8,493
Amounts utilised	**(1,009)**	(1,754)
Balance at 31 March	**29,489**	12,884

The Trust has impaired receivable based on age and any specific details known.

The increase in the credit note provision from the 31 March 2010 balance is due to:

a) reflecting in the accounts a number of agreed credit notes (not raised by the end of the year) relating to an agreed position with commissioners for the Trust to reimburse for a number of technical billing issues.

b) reflecting the very significant changes in both the approach and financial strength of commissioners. The volume and quality of challenges to our billing received and as yet unresolved has increased dramatically and the move to stronger commissioning at sector level has increased the impact of the financial deficits within some local PCTs upon the ability and willingness of debtors to settle.

19. Cash and cash equivalents

	2010/11 31 March £000	2009/10 31 March £000
Balance at 1 April	**91,956**	107,592
Net change in year	**15,210**	(15,636)
Balance at 31 March	**107,166**	91,956
Made up of		
Cash with the Government Banking Service	**105,345**	91,197
Commercial banks and cash in hand	**1,821**	759
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**107,166**	91,956
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**107,166**	91,956

The principal factor behind the increase in cash is the £20m of the Trust's agreed Foundation Trust Financing Facility loan which was drawn down in March. This is being used to fund part of the new £100m UCH Macmillan Cancer Centre, due to open in April 2012

20. Non-current assets held for sale

	2010/11 31 March	2009/10 31 March
	£000	£000
Balance brought forward 1st April	5,430	730
Plus assets classified as held for sale in the year	33,000	5,430
Less assets sold in year	(20,250)	0
Revaluation Gains on assets classified as held for sale	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	(18,180)	(730)
Balance carried forward at 31 March 2011	0	5,430

The former Ear Hospital in Capper St was classified as an asset held for sale in 2009-10. However, the sale did not materialise, and the Trust is no longer marketing the site.

The former Middlesex Outpatient Annex was classified as an asset held for sale during the 2010-11 financial year. However, during the last quarter of the year the building attained listed status. As a result, the site was reclassified from "held for sale" to non-current assets , as sale is not now likely to occur within 12 months.

The reclassification of these two assets from "held for sale" to non-current asset status does not affect the financial performance of the Trust in the 2010-11 financial year.

21. Trade and other payables

	Current		Non-current	
	2010/11 31 March	2009/10 31 March	**2010/11 31 March**	2009/10 31 March
	£000	£000	**£000**	£000
Receipts in advance	**0**	0	**0**	0
NHS payables	**8,601**	15,799	**0**	0
Amounts due to other related parties	**0**	0	**0**	0
Trade payables - capital	**10,173**	6,104	**1,478**	278
Other trade payables	**0**	0	**0**	0
Taxes payable	**11,847**	11,175	**0**	0
Other payables	**45,358**	35,742	**0**	0
Accruals	**19,028**	24,130	**0**	0
PDC payable	**0**	0	**0**	0
Reclassified to liabilities held in disposal groups in year	**0**	0	**0**	0
Total	**95,007**	92,950	**1,478**	278

22. Borrowings

	Current		Non-current	
	2010/11 31 March	2009/10 31 March	**2010/11 31 March**	2009/10 31 March
	£000	£000	**£000**	£000
Bank overdrafts	**0**	0	**0**	0
Drawdown in committed facility	**0**	0	**0**	0
Loans from Foundation Trust Financing Facility	**0**	0	**20,000**	0
Other Loans	**0**	0	**0**	0
Obligations under finance leases	**0**	0	**0**	0
Obligations under Private Finance Initiative contracts	**3,290**	3,085	**266,048**	269,337
Total	**3,290**	3,085	**286,048**	269,337

In March 2011 the Trust drew down £20m of its agreed Foundation Trust Financing Facility loan. The total loan facility is £65m and is being used to fund part of the new £100m UCH Macmillan Cancer Centre, due to open in April 2012

23. Other liabilities

	Current		Non-current	
	2010/11 31 March	2009/10 31 March	**2010/11 31 March**	2009/10 31 March
	£000	£000	**£000**	£000
Deferred Income	**6,630**	5,650	**1,009**	1,177
Total	**6,630**	5,650	**1,009**	1,177

24. Finance lease receivables (i.e. as lessor)

The Trust has an arrangement with PHCA, an organisation which rents four Trust properties. This arrangement falls under a finance lease arrangement, however the Trust receives no rent for these properties.

25. Finance lease commitments

The Trust has no finance lease commitments other than those included as Private Finance Initiative contracts (2010: £nil).

26. Private Finance Initiative contracts

26.1 PFI schemes off-statement of financial position

Integrated Care Record Service

In September 2003, UCLH NHS FT signed a 10 year contract with IDX Systems UK Limited for the provision of an Integrated Care Record Service (ICRS), including delivery of a Managed Service, along with the implementation of a network infrastructure to the new hospital. The total value of the contract is £87m (including Value Added Tax) and has been funded through the Private Finance Initiative.

During 2006/07 UCLH NHS FT was approached by the ICRS partner who wished to transfer their obligations under the 10 year PFI contract. A resultant agreement was reached whereby the main contractual aspects of the ICRS PFI contract were novated to Logica CMG, previously the main subcontractor under the original PFI contract.

In totality, the scheme was proposed to consume assets over its 10 year life of £17.4m. This contract has been assessed under IFRIC 4 to identify identify whether the arrangement contains a lease. Due to complexities with implementing the solution and the transfer of the contract in 2006/07 it has not been possible to accurately identify and estimate the capital value of any sole use assets. Accordingly, the Trust has not recognised any capital assets in the trust Statement of Financial Position.

In order to facilitate the implementation of an improved data centre facility the Trust signed a variation to the ICRS agreement during the year to extend the contract by 30 months. The contract will now end on March 2016. To provide the data centre the Trust made a one off enabling payment of £2.8m in 2009/10 of which £1.9m is recorded in prepayment at the year end (2010: £2.3m)

26.2 PFI schemes on-statement of financial position

University College Hospital – Private Finance Initiative

A contract for the development of the hospital was signed on 12 July 2000. The scheme is to build and run the hospital. The scheme is in conjunction with Health Management (UCLH) Plc (HMU), a consortium entity. The HMU consortium now consists of:
Land Securities Trillium Ltd, Balfour Beatty Infrastructure Investments Ltd and Interserve PFI Holdings Ltd.

The scheme is contracted to end on 1 June 2040, at which time the building will revert to the ownership of UCLH NHS FT.

The St Martin site, upon which the hospital was constructed, was purchased in 2000/01 to provide the site for the hospital. A 40 year lease has been granted to the PFI partners, who contracted to build the hospital.

The new building was handed over in two phases, phase 1 on 19 April 2005 and phase 2 on 5 August 2008. Over the period, we, and our partners HMU Plc, will have invested £422m in building and equipping the new hospital. A number of existing UCLH NHS FT properties have been and will be sold and most of the income invested in the scheme.

UCLH NHS FT is committed to pay quarterly PFI unitary charge payments in advance which commenced with the opening of phase 1 of the development in 2005. This was initially at a reduced rate until phase 2 opened in 2008. As phase 2 has now been handed over to the Trust, UCLH NHS FT will be committed to annual unitary charge building availability payments of £31.2m to the end of the contract in 2040 (subject to change in the Retail Price Index).

The PFI agreement has been assessed under IFRIC 12 and the asset is deemed to be on Statement of Financial Position. The substance of the contract is that the trust has a finance lease and payments comprise three elements – imputed finance lease charges, lifecycle fund and service charge.

£16.0m is included in non current trade and other receivables (2010 - £13.2m) which relates to lifecycle

replacement fund. These costs will be transferred to property, plant and equipment as and when the operator undertakes lifecycle modifications to the asset.
Total obligations for on-statement of financial position PFI contracts due:

	2010/11 31 March £000	2009/10 31 March £000
Not later than one year	**20,295**	20,280
Later than one year, not later than five years	**81,186**	81,120
Later than five years	**487,114**	507,490
Gross PFI liabilities	**588,595**	608,890
Less: interest element	**(319,258)**	(336,468)
Net PFI obligation	**269,338**	272,422
- not later than one year;	**3,290**	3,085
- later than one year and not later than five;	**15,486**	14,524
- later than five years;	**250,562**	254,813
	269,338	272,422

Service commitments

	2010/11 31 March £000	2009/10 31 March £000
Within one year	**16,384**	14,949
2nd to 5th years (inclusive)	**65,536**	59,796
Later than five years	**395,946**	376,216
Total	**477,866**	450,961

26.3 Charges to expenditure

The total charged in the year to expenditure in respect of off-statement of financial position PFI contracts and the service element of on-statement of financial position PFI contracts was £28.2m (prior year £27.5m).

The Trust is committed to the following annual charges

	2010/11 31 March £000	2009/10 31 March £000
PFI scheme expiry date:		
Not later than one year	**0**	0
Later than one year, not later than five years	**5,536**	0
Later than five years	**51,188**	53,436
Total	**56,724**	53,436

27. Provisions

	Current		Non-current	
	2010/11 31 March	2009/10 31 March	**2010/11 31 March**	2009/10 31 March
	£000	£000	**£000**	£000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	285	280	2,030	2,041
Other Legal claims	176	180	81	108
Agenda for change	1,959	496	0	0
Other	1,327	2,484	192	2,155
Total	**3,747**	3,440	**2,111**	4,304

	Pensions relating to other staff	**Legal claims**	**Agenda for change**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
At 1 April 2010	**2,321**	**288**	**496**	**4,639**	**7,744**
Change in the discount rate	0	0	0	0	**0**
Arising during the year	238	4	1,959	1,067	**3,268**
Utilised during the year	(285)	(38)	(10)	(4,379)	**(4,712)**
Reclassified to liabilities held in disposal groups in year	0	0	0	0	0
Reversed unused	0	0	(486)	(0)	(486)
Unwinding of discount	41	3	0	0	44
At 31 March 2011	**2,315**	**257**	**1,959**	**1,327**	**5,858**
Expected timing of cash flows:					
- not later than one year;	285	169	1,959	1,327	**3,747**
- later than one year and not later than five years;	1139	88	0	192	**1,220**
- later than five years.	891	0	0	0	**891**
Total	**2,315**	**257**	**1,959**	**1,327**	**5,858**

Staff pensions are calculated using a formula supplied by the NHS Pensions Agency. These pensions are the costs of early retirement of staff resulting from reorganisation.

Legal claims are estimates from the Trust legal advisors on employer and public liability claims. The risks are limited to the excess of the policy excesses with the NHS Litigation Authority.

Other provisions include provisions for Employment Appeal Tribunal claims (£629k).

Agenda for Change provision is in respect of ongoing claims.

£27.6m is included in the provisions of the NHS Litigation Authority at 31/3/2011 in respect of clinical negligence liabilities of the trust (2010 £29.4m).

28. Contingencies

Obligations under Section 106 of the Town and Country Planning Act 1990.

In order to obtain planning permission for the new hospital, UCLH NHS FT was contractually bound to deliver several obligations under the Town and Country Planning Act 1990 to provide the following categories of facilities for the London Borough of Camden

2. Affordable housing
3. A centre for independent living
4. A mental health resource centre
5. Additional car parking and vehicle holding areas
6. A community centre

UCLH NHS FT continues to work with the London Borough of Camden to satisfy all of its Section 106 obligations . The Trust spent £1.37m in 2010/11 meeting these changes and believes the future capital liability may be in the order of £4.3m. Until these solutions are agreed with London Borough of Camden it is not possible to accurately estimate a final financial provision for the cost of all the obligations.

UCLH NHS FT has made no financial provision in the Income & Expenditure account 2010/11 relating to the Section 106 obligations.

29. Financial Instruments

29.1 Financial assets

	At fair value through profit and loss	Loans and receivables	Available for sale	Total
	£000	£000	£000	£000
Embedded derivatives	0	0	0	0
Receivables	0	29,573	0	29,573
Cash at bank and in hand	0	91,956	0	91,956
Non-current assets held for sale			5,430	5,430
Other financial assets	0	32,464	0	32,464
Total at 31 March 2010	0	153,993	5,430	159,423
Embedded derivatives	**0**	**0**	**0**	**0**
Receivables	**0**	**14,454**	**0**	**14,454**
Cash at bank and in hand	**0**	**107,166**	**0**	**107,166**
Non-current assets held for sale			**0**	**0**
Other financial assets	**0**	**43,157**	**0**	**43,157**
Total at 31 March 2011	**0**	**164,777**	**0**	**164,777**

29.2 Financial liabilities

	At fair value through profit and loss	Other	Total
	£000	£000	£000
Embedded derivatives	0	0	0
Payables	0	15,799	15,799
PFI and finance lease obligations	0	272,422	272,422
Other borrowings	0	0	0
Other financial liabilities	0	35,742	35,742
Total at 31 March 2010	0	323,963	323,963
Embedded derivatives	**0**	**0**	**0**
Payables	**0**	**8,601**	**8,601**

	At fair value through profit and loss	Other	Total
	£000	£000	£000
PFI and finance lease obligations	0	269,338	269,338
Other borrowings	0	20,000	20,000
Other financial liabilities	0	45,358	45,358
Total at 31 March 2011	0	343,296	343,296

The fair value of financial assets and financial liabilities does not differ from carrying amount.

29.3 Financial risk management

The Trust's financial risk management operations are carried out by a Trust Treasury function, within parameters defined formally within the policies and procedures manual agreed by the board of directors. Trust Treasury's activity is routinely reported and is subject to review by internal and external auditors. Trust Treasury has the ability to propose the use of financial instruments to raise finance and to manage financial risk arising from the Trust's operations in accordance with its terms of authority.

The Trust's financial instruments, other than those used for treasury risk management purposes, comprise cash and liquid resources, borrowings and various items such as trade debtors and creditors that arise directly from its operations. The Trust does not undertake speculative treasury transactions.

Currency risk and interest rate risk

The Trust is principally a domestic organisation with the majority of transactions, assets and liabilities being in the UK and sterling based. As such, the Trust does not undertake transactions in currencies other than sterling and is therefore not exposed to movements in exchange rates over time. The Trust has no significant overseas operations.

Market price risk of financial assets

The Trust has no investments in overseas banks. Surplus cash is invested in the Office of the Paymaster General.

Credit risk

Due to the fact that the majority of the Trust's income comes from legally binding contracts with other government departments and other NHS Bodies the trust is not exposed to major concentrations of credit risk. The Trust investments in money market funds and money market deposits does expose the Trust to credit risk. This is managed by Treasury Policies limiting the investments to highly rated institutions and spreading the investments to restrict exposure .

Liquidity risk

The Trust is subject to limits on its borrowings imposed by way of its Prudential Borrowing Limit. The Trust has only utilised external borrowings in year associated with its PFI investment.
The Trust currently has substantial cash balances and is not currently exposed to any liquidity risk associated with inability to pay creditors.

30. Financial performance targets

The Trust is required to comply and to remain within a prudential borrowing limit.

This is made up of two elements:

- the maximum cumulative amount of long term borrowing. This is set by reference to the five ratio tests set out in Monitor's *Prudential Borrowing Code*. The financial risk rating set under Monitor's *Compliance Framework* determines one of the ratios and can therefore impact upon the long term borrowing limit.

- the amount of any working capital facility approved by Monitor.

Further information on the *NHS Foundation Trust Prudential Borrowing Code* and *Compliance Framework* can be found on the website of Monitor, the Independent Regulator of Foundation Trusts
The UCLH NHS FT Prudential Borrowing Limit ('PBL') for the year of 2010/11 is the sum of the following:

1. Maximum cumulative long term borrowing: £337.4 million (2010: £340m), and
2. Approved working capital facility: not to exceed £45.0 million (2010: £45.0m)

UCLH NHS FT did not use the working capital facility during the 2010/11 or 2009/10 financial year.

Financial Ratios

	Actual Ratios 2011	Approved PBL Ratios 2011	Actual Ratios 2010	Approved PBL Ratios 2010
Minimum dividend cover	4.70	-	4.72	-
Minimum interest cover	2.47	-	2.53	-
Minimum debt service cover	2.22	-	-	-
Maximum debt capital cover	42.26%	-	-	-
Maximum debt service to revenue	4.12%	-	-	-

31. Related party transactions

University College London Hospitals NHS Foundation Trust is a body corporate established by the Secretary of State. The Independent Regulator of NHS Foundation Trusts ("Monitor") and other Foundation Trusts are considered related parties.

The Department of Health is regarded as a related party as it exerts influence over the number of transaction and operating policies of the Trust. During the year ended 31 March 2011 the Trust had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department of those entities.
During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the Trust.

The Trust had material transactions with the following entities:

	2010/11			
Organisation	Income £000	Expenditure £000	Receivables £000	Payables £000
Barnet Primary Care Trust	29,000		3,000	
Brent Teaching Primary Care Trust	9,000			
Camden & Islington NHS Foundation Trust	1,000	2,000		
Camden Primary Care Trust	124,000	2,000	22,000	1,000
Department of Health	29,000			
East & North Hertfordshire Primary Care Trust	9,000			
Enfield Primary Care Trust	23,000		3,000	
Great Ormond Street Hospital for Children Nhs Trust			2,000	
Hampshire Primary Care Trust	18,000		1,000	
Haringey Teaching Primary Care Trust	30,000		5,000	
Harrow Primary Care Trust	7,000			
Islington Primary Care Trust	75,000		2,000	
London SHA	51,000			
London Specialised Commisioning Group	12,000		3,000	
NHS Blood and Transplant		5,000		
NHS Business Services Authority				2,000
Redbridge Primary Care Trust	6,000			
Royal Free Hampstead NHS Trust		1,000	1,000	2,000
South East Essex Primary Care Trust	35,000			
Surrey Primary Care Trust	11,000			
Tower Hamlets Primary Care Trust	25,000			
Waltham Forest Primary Care Trust	9,000			
West Hertfordshire Primary Care Trust	8,000			
Westminster Primary Care Trust	26,000			

Organisation	2019/10 Income £000	Expenditure £000	Receivables £000	Payables £000
Barnet Primary Care Trust	27,000		2,000	
Brent Teaching Primary Trust	9,000			
Camden & Islington NHS Foundation Trust	2,000	2,000		1,000
Camden Primary Care Trust	127,000		19,000	5,000
City & Hackney Primary Care Trust	17,000		3,000	
Department of Health	31,000			
East & North Hertfordshire Primary Care Trust	11,000			
Enfield Primary Care Trust	19,000			
Hampshire Primary Care Trust	15,000		3,000	
Haringey Teaching Primary Care Trust	37,000			
Islington Primary Care Trust	69,000		2,000	
London SHA	66,000			
South East Essex Primary Care Trust	31,000			
Surrey Primary Care Trust	11,000			
West Kent Primary Care Trust	12,000			
Westminster Primary Care Trust	23,000			

The Trust holds a 20% interest in UCL Partners Limited (a company limited by guarantee) acquired by a guarantee of £1. The company's costs are funded by its partners who contribute to its running costs on an annual basis. During the year the trust made a payment to UCLP of £115k (2010 £70k) which was expensed to operating expenses.

32. Third Party Assets

The Trust held £4,152 cash and cash equivalents at 31 March 2011 (£1,490 at 31 March 2010) which relates to monies held on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

33. Losses and Special Payments

NHS Foundation Trusts are required to report to the Department of Health any losses or special payments, as the Department still retains responsibility for reporting on these to Parliament.

By their very nature such payments ideally should not arise, and they are therefore subject to special control procedures compared to payments made in the normal course of business.

The total value [and number] of cases in the 12 months to 31 March 2011 was: £361,000 [185 cases] (2010: £276,000 [149 cases]).

There were no cases in any category exceeding £100,000.

Losses and special payments are reported on an accruals basis, and exclude provisions for future losses.

34. Post Balance Sheet Event

On 22 December 2010, the Trust entered into a arrangement with Imaging Partners Online Limited to operate a joint venture delivering imaging reporting services. As at the 31 March 2011 certain Conditions Precedent to the main contract had not been met and accordingly the contractual agreement had not become effective. After the end of the reporting period the final conditions precedent were met on 11 April 2011 and the agreement accordingly become effective. In accordance with the agreement the Trust will be required to invest circa £750k into the joint venture which will initially be recorded as a non-current investment in the Statement of Financial position.