University College London Hospitals
NHS Trust

uclh

ANNUAL REVIEW 2002

8 hospitals • **1 vision**

University College Hospital (UCH)

UCH, Cecil Flemming House, Grafton Way, London WC1E 6DB

UCH provides local people, commuters and visitors to London with accident and emergency and medical services. It also houses the largest bone marrow transplant programme in the UK.

The Middlesex Hospital

The Middlesex Hospital, Mortimer Street, London W1T 3AA

The Middlesex houses medical, surgical, adolescent and paediatric services as well as a wide variety of diagnostic and therapeutic facilities. It also has a wide range of outpatient clinics for adults, adolescents and children.

Hospital for Tropical Diseases (HTD)

HTD, Mortimer Market, Capper Street, London WC1E 6JD

This hospital is a national centre for the diagnosis and treatment of tropical diseases. Inpatients are housed in a new infectious diseases unit at UCH, with outpatients, the travel clinic and parasitology located in the Mortimer Market Centre just off Tottenham Court Road.

National Hospital for Neurology and Neurosurgery (NHNN)

NHNN, Queen Square, London WC1N 3BG

The NHNN is a leading centre for the diagnosis, treatment and care of patients with a wide range of conditions such as epilepsy, MS, Alzheimer's, stroke and head injuries. With its neighbour, the Institute of Neurology, it is a major international centre for research and training.

Eastman Dental Hospital (EDH)

EDH, 256 Gray's Inn Road, London WC1X 8LD

EDH provides specialist treatment, research, postgraduate teaching and training in dentistry with the Eastman Dental Institute which shares the same site. Outpatient attendances at the Eastman account for nearly a quarter of all outpatient attendances within the trust.

The Royal London Homoeopathic Hospital (RLHH)

RLHH, Greenwell Street, London W1W 5BP

The Royal London Homoeopathic Hospital, which joined the trust in April 2002, is the largest NHS provider of complementary and alternative medicine in Europe. With its current site in Queen Square being re-developed, it is now located temporarily in Greenwell Street.

Elizabeth Garrett Anderson (EGA) & Obstetric Hospital

EGA & Obstetric Hospital, Huntley Street, London WC1E 6DH

The hospital houses the trust's gynaecology, maternity services and neonatal and fetal medicine services.

The Heart Hospital

The Heart Hospital, 16 – 18 Westmoreland Street, London W1G 8PH

Formerly a privately owned hospital, The Heart Hospital is a cardiac hospital with world class facilities for treating NHS patients in the centre of the capital.

Our mission

UCLH is committed to delivering top quality patient care, excellent education and world class research.

Our values

We will:

- Take pride in caring for our patients as individuals
- Provide equal access to all our patients
- Be open and approachable to all
- Deliver high quality outcomes in partnership with others
- Value the contribution and develop the potential of all our staff
- Be responsible and accountable for all we do

University College London Hospitals NHS Trust (UCLH) is one of the largest and busiest hospital groups in the country.

Its eight specialist teaching hospitals provide treatment for local people, commuters and visitors to London as well as highly specialised services for patients referred from all over the country. Its links with the Royal Free and University College Medical School, make it one of the UK's leading centres for medical education, training and research. By 2005, phase 1 of one of the largest building projects in the NHS will be complete, providing a multi-million pound super hospital on the Euston Road with world class facilities for patients, staff and visitors.

Chairman's foreword

As in previous years, this report celebrates some of our achievements during the year and also demonstrates a positive approach to the future.

The most noteworthy success was undoubtedly the acquisition of The Heart Hospital, and the subsequent leap forward in terms of our cardiac services which it enables us to achieve. While the difference it has made is described later in this report, it's important to remember that this addition of some 90-odd beds to our capacity was delivered through a ground-breaking transaction, representing a new and streamlined process for the NHS, which we hope will be copied elsewhere. A combination of strong backing from the centre, direct public funding and the admirable negotiating skills of our team produced a result that we can all be proud of, on a timetable that could not be matched either by PFI or by more traditional procurement methods.

In addition to The Heart Hospital, The Royal London Homoeopathic Hospital with its long and distinguished history chose to join us in April 2002. We welcome the staff of both institutions to our extended family and look forward to working with them in the future.

Starting to see the new hospital rise out of the excavations on Euston Road is exciting. The challenge for us is to create an organisation that is fit for purpose for our patients, our staff and for the community we serve. It is important that the new physical environment is matched by new ways of thinking and new ways of delivering services. With our attention clearly focused on the patient, we have a great deal to do and are determined that we shall be ready for all the challenges ahead.

We have already made great strides in delivering the NHS plan and have concentrated on a clear agenda of improving our services. Some of the results are featured in this annual report and I hope demonstrate our total commitment to excellence of patient care. None of this could be done without the dedication and hard work of all our staff. They make the achievements featured here actually happen and make my role as Chairman a real pleasure.

Peter Dixon

Chairman

Chief executive's introduction

2001/2002 has been an eventful time for UCLH. We're now a group of eight rather than six hospitals following the acquisition of The Heart Hospital and the Royal London Homoeopathic Hospital. We're also doing things differently - the restructure we initiated last April has devolved power and accountability to senior clinicians at every level of the trust.

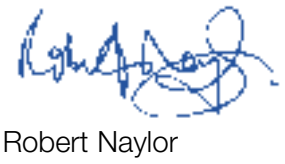
So change has been at the heart of what we did last year, and will be at the centre of what we must do in future. Changing the way we work is essential if we are to maximise the opportunities ahead, paticularly in preparation for the new hospital in 2005.

The publication of star ratings for NHS trusts last autumn marks the beginning of a new era of public scrutiny. In July 2002, we were delighted to achieve the top rating of three stars which gave us additional funding, new freedoms and the opportunity of considering foundation trust status. By focusing our energies on the things that matter most to patients (via our top 10 priorities), we have achieved many of the targets we set ourselves. But we want to, and can, improve on that.

With news of record funding for the NHS comes high expectations; we must build upon and sustain the improvements we made in the last year. Our revised top 10 priorities for 2002/3 are:

- Reduce inpatient waiting lists and times
- Eliminate double cancelled operations
- Reduce outpatient waiting times (implement booking systems)
- Reduce A&E waiting times
- Improve communications to staff and patients
- Improve staff recruitment and retention
- Develop clinical governance capacity
- Prepare for the new hospital
- Improve hospital cleanliness and environment
- Achieve financial balance

It's a challenging time for the NHS, but with additional funding, our new found freedoms and the prospect of the new hospital, it's a really exciting future for UCLH.



Robert Naylor

Chief executive

Contents

Our year
2001/02 highlights

Above **The authors of *"Living with Cancer"* sign copies of their book for patients featured in the series.**

2001:

Above **Emergency Services staff help co-ordinate the evacuation of the burning Rosenheim Building.**

APRIL
Staff evacuate over 80 patients from a burning Rosenheim Building in rapid time in the early hours of 5 April.

MAY
The first wave of Australian nurses arrives to join the trust as new overseas recruits. They were joined by 50 new recruits from the Philippines in August, and another 52 in January 2002.

JUNE
Official opening of the Elizabeth Garrett Anderson and Obstetric Hospital marked the merger of two famous hospitals for women after a £3.5m face-lift.

JULY
Street Football, a footie league for rough sleepers set up by an ex-UCLH doctor, held its final play off and hits the spot with an ITV documentary featuring the story.

AUGUST
UCLH is the first NHS trust to buy a private hospital to treat NHS patients. The Heart Hospital, a five-star facility in the centre of London, was purchased for £27.5m from the private sector, to help cut waiting times and increase the number of heart operations.

Left **We welcome the first wave of Australian recruits to the trust.**

SEPTEMBER
Staff housing gets a boost as the Genesis Housing Group announces a £10m investment programme to improve residential accommodation.

OCTOBER
Living with Cancer, a six-part documentary series, filmed at the trust is screened on BBC1, netting over two million viewers. Critically acclaimed, the series went on to win the Royal Television Society's prestigious award for best documentary series.

NOVEMBER
The Department of Health awards the trust two stars for performance in the first ever public rating of hospitals.

DECEMBER
One of the country's first Patient Advice and Liaision Service (PALS) is opened at UCLH.

2002:

JANUARY
The Hospital for Tropical Diseases becomes host to the national centre for travel health.

FEBRUARY
Staff collect their prizes at the trust's very own *Positively PR Awards* ceremony to mark their contribution to improving communications. On the right, they're shown in the magazine *Hospital Doctor* enjoying their spoils.

MARCH
The trust comes second out of 268 hospitals in the Dr Foster "Good Hospital Guide".

Countdown to improvement...

Meeting targets is part of everyday life in the NHS. Our top 10 priorities for 2001/2, agreed by the board in April 2001, set out a framework for improving our services. We've made some real improvements, but it's staff who've made it happen, so this year's annual report tells some of their stories.


Emma Costin, patient booking team leader

Reducing outpatient waiting times

The waiting game

The government's pledge that all patients should wait less than 26 weeks for their first outpatient appointment by 31 March 2002 was always a tall order. But Emma Costin - who leads the new patient booking team at the National Hospital for Neurology and Neurosurgery - explains how waiting lists have been slashed in some of the hospital's highly specialist clinics.

"We've reduced waiting times for new patients across 30 clinics at the hospital, but it hasn't been a case of "one size fits all". We've used some tried and tested approaches, such as opening more clinics and validating our waiting lists, but the most innovative method we've used is to implement partial booking in selected clinics.

Before, patients were issued with an outpatient appointment often months in advance. Inevitably, appointments got forgotten, or weren't convenient so needed to be changed, usually at the last minute, which meant wasted appointment slots, and longer waiting times for everyone. Partial booking puts the ball in the patient's court. When we get a referral, we write to patients to let them know they're on our list. Between four to six weeks before their appointment is due, we write to patients asking them to contact us to arrange an appointment. This way, they have to be pro-active about making the appointment, and they're able to choose convenient times and dates, so they're more likely to attend. If we don't hear from them, we write again and advise them that if we don't hear from them by a specified date, we'll contact their GP or hospital to let them know they're no longer on our waiting list. There's a four-week window for the process which leaves plenty of time. It's giving patients choice, but also responsibility.

Partial booking definitely works – in our headache clinic, we've practically halved waiting times (from 40 weeks to 26 weeks) but the added bonus is that patients really appreciate having a 'voice on the end of the phone'. Patients often have questions relating to, say, transport or accommodation – and because we may speak to any one patient on a number of occasions, we develop relationships with them."

In 2001/2 83% of our 391,793 outpatients were seen within 30 minutes of their appointment, compared to 82% last year.

Reducing inpatient waiting times

By the end of March 2002, 5,308 patients were waiting for elective surgery, compared to 5,366 at the same time last year.

By January 2002, no patients were waiting more than 15 months for elective surgery, the target set out in the NHS Plan.

A patient's eye view

"Rather than just issue an appointment, the patient booking team leader did her very best to arrange an appointment that was convenient at a date and time for me, that fitted in with my commitments and made allowances for my disability. She was the most helpful and the most thoughtful person I've come across in my 33 years in attending the NHNN, or indeed any other hospital."

Nicky King, ward sister at the Heart Hospital

Increase cardiac surgery

At the heart care…

In August 2001, in the first deal of its kind, a private hospital, The Heart Hospital, was brought back into the NHS fold to become part of UCLH trust. Thanks to this extra capacity, the trust has been able to make significant progress in increasing the number of patients treated and reducing waiting times for heart surgery. Nicky King is a ward sister at The Heart Hospital and explains what a difference it has made.

"Before the move to The Heart Hospital, cardiac services were based at the Middlesex Hospital. The most obvious difference working here is the improvement in the physical environment. As a former private hospital, we're lucky to have five star facilities. Good food, cleanliness and high standards of housekeeping really add to the overall patient experience.

Working in a clean, comfortable, well-maintained environment has had a positive impact on staff morale. It's easier to get things done, and it's certainly easier to recruit new staff – we recently recruited 30 nurses across all grades - a real achievement when you consider the nationwide problems with nurse recruitment.

The physical environment is very nice, but it's essentially the icing on the cake - the real benefit has been the opportunity to improve and develop our services. 30 additional beds means we can do more surgery (we now do six cardiac surgery cases per day, where previously we did four) and shorten waiting times. We're working differently too – our new acute coronary ward cares for patients who would previously have been in ITU/HDU beds, freeing up capacity and making cancellations less likely.

The move was initially unsettling for staff working at both sites – but the pros far outweigh the cons. Now we're here, I don't think I'm alone in saying that I wouldn't go back."

Reducing cancer waiting times

The NHS Plan stated that there should be a maximum two week wait for an outpatient appointment for patients referred urgently with suspected cancers.

In 2001/2, 94% of suspected cancer patients were seen within the 14-day limit. This compares to 69% in the same period last year.

Eliminating double cancelled operations

Cancelling out

Cancelled operations are bad news for everyone- distressing and inconvenient for patients, costly for the NHS (an estimated £100 million per year) and bad for staff morale. But why does it happen? There are a number of reasons but Deborah Jamieson, an advanced practitioner, thinks she many have some answers…

"My role involves identifying allergies and minor infections, as well as more serious conditions which may require medical attention before surgery can go ahead. We can also identify those patients who no longer require surgery, or who have made alternative arrangements. These patients can then be removed from our waiting lists which in turn can allow other patients to have their operations brought forward. Our role in confirming admission dates with patients helps address the issue of non-attendance. It also acts as a reminder so that patients do not miss their planned surgery date.

Successful pre-assessment helps address many problems which occur in the current admission system. For example, early identification of patient's physical and social needs enables effective post operative and discharge planning, which benefits the patient and improves bed availability, helping to reduce waiting times.

Feedback from patients has been really positive – it's been proven that patients who've been pre-assessed feel less anxious, require less sedation and return to normal activities more quickly. Ultimately, improving the patient experience is what all the targets and priorities are about."

In 2001/2, of 31,182 elective admissions, 593 (1.9%) were cancelled for non-clinical reasons, compared with 842 last year.

Deborah Jamieson, advanced practitioner

Debra Glastonbury,
A&E manager/modern matron

Improving A&E waiting times

Emergency measures

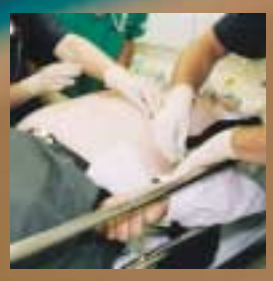
The national target states that 75% of patients attending A&E should wait a maximum of four hours from arrival to admission, transfer or discharge. To meet the deadline of March 31 2002, our A&E department has had its work cut out. But Debra Glastonbury, A&E manager/modern matron, explains how we've responded to this challenging target.

"Why do patients in A&E end up waiting? The answer is not straightforward. As A&E straddles specialty and organisational boundaries, there are several obvious factors - such as bed management, relationships with other healthcare providers and patients' inappropriate use of the service. But by putting ourselves in the shoes of our patients we were able to pinpoint what we were doing to add to the delays.

As a result we identified several things - the triage system, where patients are seen by an assessment nurse, then a second triage nurse before being seen by an A&E doctor - was contributing to longer waiting times, particularly for those with minor injuries. Once categorised as a 'minor', patients would go to the back of the queue behind more urgent cases with inevitable delays.

Based on these findings, we've run pilot sessions for minors using a process known as 'streaming'. After being seen by a nurse who determines whether the patient has a 'minor' or a 'major' injury, 'minors' are seen almost immediately by an emergency nurse practitioner and a consultant or registrar. More often than not, a specially trained nurse can then treat and discharge the patient, leaving the doctor to treat the patient next in line. It's good for patients, whose waiting times are reduced and good for nursing staff who develop additional skills and have a more active role in treating patients.

The increased focus on A&E has been accompanied by additional resources but it's not just extra money that makes a difference, it's changing our practice. The patient mapping process exemplifies that, and shows that simple changes in the system can make a huge difference."



In 2001/2, 9,411 patients were admitted to A&E: 75% were seen in under two hours (compared to 58% last year), 97% were seen in less than four hours (compared with 83% last year) and only 3% waited over four hours.

"SIMPLE CHANGES IN THE SYSTEM CAN MAKE A HUGE DIFFERENCE."

DEBRA GLASTONBURY

Improve hospital cleanliness and environment

Patient Environment Action Team (PEAT) inspections were introduced in Autumn 2000 to assess the cleanliness of patient areas such as wards, outpatient departments and common areas like entrances and public toilets. The trust's hospital sites have now been inspected on four separate occasions and these, after extra funding of £300,000, have shown a steady improvement in cleanliness with each inspection ranging from - a poor rating for the Middlesex and UCH in 2000 - to a top rating for all sites by March 2002.

Achieve financial balance

Balancing the books

UCLH achieved an operational break-even position and a further surplus creating a cumulative break-even position over the last five years. A full breakdown of our accounts in shown in detail on page 13 and 14 of this report.

Improving internal and external communications

In the loop

UCLH has one of the busiest press offices in the NHS, and an enviable external profile, consolidated in 2001/2 by regular appearances in the national media and an award-winning television series "Living with Cancer". But the way we communicate with our staff has been the focus of the last year so we've designed a range of tools to ensure that our staff are kept in the loop wherever they work, whatever they do.

Our revamped trust newsletter "Inside Story" is now attached to monthly payslips and we've introduced a system of team briefing to ensure that all our staff get the same key messages, at the same time. We've also developed *uclhweb*, our new intranet, bringing trust news and information to desktops across the trust.

But communication is a two-way process - bottom up as well as top down. Staff can hear and put their questions to our chief executive at road-shows which take place at five different sites, every six months. And in a new initiative, our chief executive has been joined by our chairman and chief nurse on a series of "walkabouts" to meet staff in every area across the trust. Staff are also encouraged to feedback their views via the annual staff attitude survey, the results of which inform the work of the "Improving Working Lives" (IWL) group, a cross section of staff from across the trust. The joint staff consultative committee also continues to meet on a monthly basis.

Information to patients

During 2001/2002 we began a review of all general patient information. This has resulted in a newly produced map guide to all our hospital sites. 40,000 copies have been distributed across the trust and these are now being sent to all new outpatients and patients having diagnostic procedures and they are available in reception areas. The outpatient and inpatient information booklets are now being reviewed with a view to improving the information provided to patients about our services.

Single sex accommodation

We are still working towards the provision of single sex accommodation on our wards. We're unable to fully implement the requirement of single sex accommodation because of the constraints of our facilities at the UCH and Middlesex Hospitals. These facilities are to be replaced when we move to our new hospital in 2005, which will enable us to meet this requirement.

The way ahead: our new top 10

There are three new areas in the top 10 for 2002/3: developing clinical governance capacity, preparing for the new hospital and improving staff recruitment and retention.

Developing clinical governance

Focus on developing clinical governance capacity.

In March, we appointed a new director of clinical governance to help improve and develop our clinical governance systems and processes. But areas of good practice are already in existence as Anthea Blake, senior nurse, and Mark Sellwood, consultant at the neonatal unit at the Elizabeth Garrett Anderson and Obstetric Hospital, testify.

Anthea Blake, senior nurse, and Mark Sellwood, consultant NNU

"Clinical governance in itself isn't new - the various components of it, which include measuring effectiveness, audit and risk management, have been the basis of good clinical practice for some time. What is new is bringing together these components under one 'umbrella' and managing them in a more systematic way. It's also about encouraging all staff to contribute to a culture of openness and accountability.

Neonatal medicine is a complex, highly unpredictable specialty, so there's always been a need for us to look at what we do and share what we learn with our colleagues. Our monthly clinical governance committee, open to everyone working here, provides a forum for discussing what has gone right, what has gone wrong, and what we can do to improve, in a supportive, non-judgmental atmosphere. We discuss a wide range of issues – from training needs to health and safety issues and include parents' views. We hope that it is more than 'just another meeting' - everyone can have a voice and flag up problems and issues, and be part of the solutions too. It's a long way from naming and blaming and promotes a "can do" attitude amongst staff.

Our local group is linked via our directorate "umbrella" group to the trust's clinical governance committee. Information can flow both up and down the network, encouraging sharing of ideas, problems and solutions.

For us, developing clinical governance capacity has been about having systems which encourage constant review and improvement, aiming to achieve the best possible care for the babies and their families."

Recruiting and retaining staff

Investing in and valuing staff is now recognised as vital to NHS reform. *Improving Working Lives* (IWL) is a national initiative, which aims to provide a better deal for everyone working in the NHS. We are committed to the IWL standard as a major tool for tackling vacancy rates and enabling us to recruit and retain staff. Improving the situation of our staff at work will enable us to raise morale and improve performance.

Preparing for the new hospital

Peter Marsden, head of radiation physics and protection

As the new hospital rises from its foundations, 2005 doesn't seem too far away. But it's not just a case of packing our bags and moving in, we've got a lot of preparation to do. Peter Marsden, head of radiation physics and protection is involved in making sure that our new building is radiation safe…..

"Although ionising radiation is used to good effect in everyday clinical practice, it can cause damage to tissue and should therefore be used with extreme caution. It's our job to ensure that our buildings and equipment safeguard our patients, staff, the public and the environment. For example, the construction of lead walls in rooms where radiation is being used, needs to be factored into the master building plan sooner rather than later. The challenge is that although we know where X-ray rooms are going to be, any transmission into adjacent rooms needs to be taken into account. Quite often we don't know what's going to be in those rooms, so we have to plan for the unknown. It's my job to be aware of any changes so I can keep radiation safety on the agenda.

At the end of the day, it's my job to ensure that we can make use of radiation in our new hospital safely – from day one. The worst case scenario would be that we would be unable to make use of our new building because it wouldn't be safe to do so, so it's well worth thinking – and planning ahead."

Valuing our staff

Improving working lives

We have adopted achieving the Improving Working Lives (IWL) standard by April 2003 as the vehicle for progressing equalities and employment issues. To meet the standard we must be able to demonstrate progress towards the following:

- modern employment practices and policies to enable staff to achieve a balance between their working and non-working lives
- accessible training and development opportunities for all staff
- valuing, respecting and supporting all staff

IWL is about involving and asking staff for their views and suggestions for improvements - then working with them to put them into practice.

The findings of the 2001 staff attitude survey have been used to draw up a list of priority areas for the coming year. These are:

- Cleaner working conditions/improved hygiene
- Improved workplace facilities
- More staff
- Improved communications/meetings
- Senior management development
- Better hours
- Better pay
- Development opportunities
- Equipment – better – up-to-date, safe and more efficient.

Significant progress has already been made in terms of a flexible working policy and improving access to training and development.

As well as direct input from staff, we will continue to work with stakeholders, including trade unions, to ensure that there are effective mechanisms to ensure that staff are continually part of the IWL process.

Equality

Our equalities forum meets every quarter to oversee the trust's progress on equal opportunities. Our work reflects a number of the requirements outlined in The Vital Connection and the IWL initiative. The forum has also overseen the development of the Race Equality Scheme which sets out an action plan to eliminate racial discrimination and promote good race relations.

Positive about disability

We conform to the DfEE's two ticks standard in respect of employment of people with disabilities.

Looking after our patients

Patient power

Our patients are the real experts on what we're doing right. As well as gathering feedback through support groups, satisfaction surveys and comment cards, we've sought patients' views through two new channels:

PALS

The Patient Advice and Liaison Service (PALS) is a source of help, advice and information and can also initiate service improvements and developments as a result of concerns expressed by patients. We were one of the first trusts to set up a PALS service and by mid 2002, it had assisted over 600 patients.

The NHS National Inpatients Survey

850 recently discharged patients (to the end of November 2001) were sent a postal questionnaire asking their views of the services and care they had received whilst in our hospitals. 501 questionnaires were returned. We scored above average compared to other trusts in dealing with patients' physical and emotional needs and providing information about treatment and care. Overall, 95% would recommend our hospitals to family and friends. The survey also highlighted other notable performance including A&E, cleanliness and sympathetic staff as well as areas for concern such as admission, privacy and delayed discharge.

Complaints

We positively welcome complaints, as they are an important source of information about our services. Examples of how complaints have been used to improve our services in 2001/2 include:

- the introduction of snacks and drinks for patients at the Highgate Dialysis unit
- a review of secretarial services at the NHNN and an increase in administrative staff to speed up communication with GPs
- new practices to ensure patient privacy and dignity in ophthalmology outpatients

Every formal complaint is investigated by a local manager who produces a report which is sent to the complainant with a letter from our chief executive. If complainants aren't satisfied, it is re-investigated by the relevant clinical director or alternatively, complainants can request an independent review. During 2001/2 we received 270 complaints, 62% of which were responded to within the national target of 20 days. This compares to 204 received last year, 64% of which were responded to within 20 days. The complexity and size of the trust is the main reason we have difficulty in reaching the target.

Independent review panel requests

In 2001/2, five requests for independent review were made. The convenor has referred four of the five requests back to local resolution and advised that there is no need for further action in the fifth case. During 2001/2 the Health Service Ombudsman suggested some ways in which we could have improved our managment of a patient complaint. We have acted on this advice.

Research and development activity

We are one of the UK's largest providers of research and development, spending £32 million per year, giving us the second largest research budget in the NHS. This translates into over 1000 ongoing projects. The foundations of our research activity lie in close collaborative links with the Royal Free and University College Medical School, with which we share staff and a large centrally-located campus. Our strong research base provides our patients with access to early and more effective treatments, as well as contributing to the teaching and training of the next generation of doctors.

In 2001/2 we attracted major funding from external funding bodies, including:

- £7m from the Wellcome Trust to support brain imaging research at the NHNN, leading to improvements in the management of long-term chronic illnesses, such as Alzheimer's disease.
- £4m from the British Heart Foundation to support ongoing work in cardiovascular disease
- £5m from the Medical Research Council to support research in several areas including juvenile arthritis, epilepsy and rehabilitation.

In the next year, research will focus on government priority areas, such as cancer, ageing and heart disease.

Clinical governance

Clinical governance requires us to focus on delivering high quality, effective care to our patients. Arrangements for clinical governance (which conform to the national guidance described in HSC/1999/065) are as follows:

- **The clinical governance committee (and its risk management, clinical standards and patient quality subcommittees) reports to the board.**
- **Leadership for clinical governance at a local level is provided by each of the four medical directors.**
- **Our director of clinical governance oversees all aspects of clinical governance strategy.**

Further details are provided in the clinical governance annual report available in October 2002 on our website, *www.uclh.org*

Financial Review and Summary Financial Statements

Introduction

The accounts for the year ended 31 March 2002 have been prepared by the Trust under section 98 (2) of the National Health Service Act 1977 (as amended by section 24 (2), schedule 2 of the National Health Service and Community Care Act 1990) in the form which the Secretary of State has, with the approval of Treasury, directed. They are audited by District Audit, who are appointed by the Audit Commission as our External Auditors.

Summary Financial Statements are merely a summary of the information contained in the full accounts, which are available on demand. The full Annual Accounts may be obtained on application to: **Chief Accountant, University College London Hospitals NHS Trust,140 Hampstead Road, London, NW1 2BX**

Operating And Financial Review

A number of significant structural changes were proposed to the way the NHS is organised and the associated flow of funding during the year under review. Against this changing and uncertain environment the Trust ended the year with a planned surplus of £6.7m.

During the year the Trust concluded a number of details from its financial recovery plan. Underlying recurrent balance was achieved for the next financial year. Income support of £6.7m from the NHS Executive London Regional Office was secured, resulting in the Trust's achievement of its cumulative break-even duty over a five year period. However, £700k of this total will be repaid by the Trust over two years. As part of its commitment to the recovery process the Trust must maintain long term financial stability. The final issue to be resolved is the Trust's long term cash deficit, which is currently mitigated by short-term government borrowing.

Changes to Accounting Policies

A major change in accounting policy occurred during 2001/02, where responsibility for accounting for clinical negligence claims against the Trust was transferred to the NHS Litigation Authority (NHSLA). The transfer to the NHSLA had the following impact on the Trust's financial statements:

- an exceptional gain of £3,143k and exceptional loss of £3,143k;
- NHS debtors and provisions were reduced by £3,143k.

Therefore there was no overall effect on the financial out-turn or total assets and liabilities of the Trust.

Main changes in Trust Income & Expenditure

	2001/02	2000/01	Change	
	£000s	£000s	£000s	%
NHS Patient Care income	196,355	201,899	(5,544)	(2.7)
Non-NHS Patient Care Income	14,706	12,998	1,708	13.1
Education, Training & Research	66,215	99,920	(33,705)	(33.7)
Other income	35,150	27,093	8,057	29.7
Total income	312,426	341,910	(29,484)	(8.6)
Staff costs	175,708	161,307	14,401	8.9
Clinical Supplies and Services	64,464	57,345	7,119	12.4
General Supplies & Services	12,792	3,857	8,935	231.7
Hospital Running Costs	28,086	26,149	1,937	7.4
Depreciation & Impairments	4,096	40,856	(36,760)	(90.0)
Non-Medical Education & Training	0	34,356	(34,356)	(100.0)
Other	8,638	8,113	525	6.5
Total Expenditure	293,784	331,983	(38,199)	(11.5)

Total Trust income decreased from £341,910k to £312,426k, a decrease of 8.6%:

- NHS Patient Care Income reduced by £5.5m (2.7%). Overall contract income increased in line with the agreed uplift, and the £6.7m Regional Office support for the cumulative deficit (see breakeven note below). The decrease is the result £32m of impairment income (following FRS11 - Impairment of Fixed Assets and Goodwill) required in 2000/01, but not in 2001/02.
- Non-NHS Patient Care Income rose by £1.7m (13.1%) following a £2m rise in private patient income.
- Education, Training and Research Income reduced by £33.7m (33.7%). This reflects the transfer of responsibility for Non-Medical Education and Training from the Trust (acting as lead body for CELEC) to the North Central London Consortium (NCLC) from 1st April 2001. Non-Medical Education and Training expenditure of £34.4m also transferred.
- Other Income increased by £8.1m (29.7%). This is due mainly to an increase in drug sales, and other income from the Heart Hospital being included for the first time.

Total Trust expenditure decreased from £331,983k to £293,794k a decrease of 11.5%:

- Staff Costs increased by £14.4m (8.9%). The main increases were in clinical areas, following a rise of 200 in the number of doctors and nurses employed by the Trust. Increases in agency staff costs and the increase in employer's National Insurance costs added to this overall increase.
- Clinical Supplies and Services increased by £7.1m (12.4%), mainly resulting from increased expenditure on drugs.
- General Supplies and services increased by £8.9m (231.7%). This reflects the transfer of hotel services staff formerly employed by the Trust to the Trust's PFI partner.
- Depreciation and impairment reduced by £36.8m (90.0%). As highlighted above the £32m for impairment/accelerated depreciation was not required in 2001/02 and there was actually a net impairment reversal of £4m.

Breakeven performance

	1997/98	1998/99	1999/00	2000/01	2001/02
	£000	£000	£000	£000	£000
Turnover	213,198	255,369	272,851	341,910	312,426
retained (deficit)/surplus for the year	(649)	(3,846)	(4,992)	3	6,762
2000/01 Prior period adjustment relating to 97/98, 98/99 and 99/00	0	0	1,419	0	0
Break-even in-year position	(649)	(3,846)	(3,573)	3	6,762
Break-even cumulative position	(649)	(4,495)	(8,068)	(8,065)	(1,303)
Materiality test:					
Break-even in-year position	-0.3%	-1.5%	-1.3%	0.0%	2.2%
Break-even cumulative position	-0.3%	-1.8%	-3.0%	-2.4%	-0.4%

As at 31st March 2002, the Trust has an accumulated deficit (as measured by HSC 1999/146) of £1,303k. This represents -0.42% of turnover which is within the 0.5% materiality level for the achievement of the break-even duty. The break-even position has been achieved following the receipt of £6.7m support in 2001/02 from the Department of Health and Social Care, London as part of an agreed financial recovery plan concerning the accumulated deficit.

Capital cost absorption rate

The trust is required to absorb the cost of capital at a rate of 6% of average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital, totalling £12,580k, bears to the average relevant net assets of £233,390k, that is 5.4% (2000/01 6.4%).

The variance from 6% arises due to two major acquisitions during 2001/02, namely the Heart Hospital (£30.1m) and the Royal London Homoeopathic Hospital (£7.3m).

If these transactions were excluded from the calculation, the capital cost absorption rate would be 5.9%.

External Financing Limit

The Trust is given an EFL by the NHS Executive (+£15.830m) which it is permitted to undershoot. The closing EFL position of the Trust was +£15.577m which resulted in a permissible undershoot of £253k.

Capital Resource Limit

The trust is given a CRL (+£28.545m) which it is not permitted to overspend. The final charge against the CRL was +£28.165m, which resulted in a permissible underspend of £380k.

Compliance statement on NHS Managers Pay/Management Costs

The Trust was required, within the overall cash envelope for management costs, to take all practical steps to ensure that the cost of individual pay rises for Board and Senior Managers within the organisation was limited to a maximum of 3.7% in year effect for 2001/02.

The Trust complied with this requirement, with an in-year effect of 3.7%, for Senior Manager pay awards.

Management Costs:

		2000/01
	£000	£000
Management Costs	11,654	11,495
Income	276,687	274,890

Better Payment Practice Code

The NHS Executive requires that Trusts pay their non-NHS trade creditors in accordance with the Confederation of British Industries (CBI) prompt payment code and Government accounting rules. This aims to pay all non-NHS trade creditors within 30 days of the receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

Measure of Compliance

			2000/01
	Number	£000	Number
Total bills paid in the year	158,824	202,555	117,879
Total bills paid within target	101,290	125,753	65,356
Percentage of bills paid within target	63.8%	62.1%	55.4%

Related Party Transactions

During the year none of the Board Members or members of key management staff or parties related to them has undertaken any material transactions with University College London Hospitals NHS Trust, except for:

- Professor D. Fish (Medical Director) - Director of Q.S. Enterprises Ltd (unpaid).
- Mr G. Petty (Finance Manager) - Director of Q.S. Enterprises Ltd (unpaid).
- Mr P. Burroughs (Development Director) - Secretary/Treasurer to University College London Hospitals Charity.

Capital Programme

The Trust spent a total of £47.6m on its capital expenditure, of which £3m was funded by donations. The major schemes were:

- The Heart Hospital £30.8m
- Royal London Homoeopathic Hospital £7.3m
- CT Scanner £545k

During the year the Trust disposed of residential accommodation to the Paddington Churches Housing Association (now Sutherland Housing Association) for £16.6m, resulting in a profit on disposal of £628k. A major programme of refurbishment has started following the transfer.

New Hospital Development

Construction of the New Hospital is ongoing, and phase one is still planned to open in April 2005. There were no material transactions in the accounts this year resulting from this project, as the whole scheme is deemed off balance sheet. Lease payments will start in 2005, and from 2008, following the completion of phase 2, will total £22.6m. In 2041 the ownership of the building will revert back to the Trust.

The Trust is now undertaking a £60m procurement of an Electronic Patient Record system and managed Information Management and Technology service to support new working practices in the New Hospital. The proposal was part of the original £422m business case, and the system will be implemented throughout the Trust in line with the opening of phase 1.

Other Future Developments

Following the transfer of cardiac work from the Middlesex Hospital to the Heart Hospital, the Trust was able to use the freed space to operate the first Diagnostic and Treatment Centre (DTC) in the NHS. Building work is currently ongoing to move the DTC work into a specially designed space within the Middlesex Hospital campus, and is currently due for completion in October 2002. The DTC will provide fast-track access to services for routine procedures, thereby reducing waiting times in these areas.

At the end of the year, the Trust also acquired the Royal London Homoeopathic Hospital, on Great Ormond Street. This whole hospital is now being redeveloped, incorporating education, conferencing, library and research facilities. The Hospital will also house the Treatment and Diagnostic Centre, and physical therapy and orthotics services of the Royal National Orthopaedic Hospital.

Income & Expenditure account for the year ended 31 March 2002

		2000/01
	£000	£000
Income from activities:		
Continuing operations	211,061	214,897
Other operating income	101,365	127,013
Operating expenses:		
Continuing operations	(293,794)	(331,983)
OPERATING SURPLUS (DEFICIT)		
Continuing operations	18,632	9,927
Exceptional gain:		
on write-out of clinical negligence provisions	3,143	0
Exceptional loss:		
on write-out of clinical negligence debtors	(3,143)	0
Cost of fundamental reorganisation/restructuring	0	0
Profit (loss) on disposal of fixed assets	628	4,948
SURPLUS (DEFICIT) BEFORE INTEREST	19,260	14,875
Interest receivable	571	297
Interest payable	(427)	(427)
Other finance costs	(62)	(80)
SURPLUS (DEFICIT) FOR THE FINANCIAL YEAR	19,342	14,665
Public Dividend Capital dividends payable	(12,580)	(14,662)
RETAINED SURPLUS (DEFICIT) FOR THE YEAR	6,762	3

Balance Sheet as at 31 March 2002

		31 March 2001
	£000	£000
TANGIBLE FIXED ASSETS	347,404	298,982
CURRENT ASSETS		
Stocks and work in progress	7,283	6,052
Debtors	63,226	75,343
Cash at bank and in hand	9,024	3
	79,533	81,398
CREDITORS : Amounts falling due within one year	(75,286)	(107,596)
NET CURRENT ASSETS (LIABILITIES)	4,247	(26,198)
TOTAL ASSETS LESS CURRENT LIABILITIES	351,651	272,784
CREDITORS: Amounts falling due after more than one year	(9,385)	(6,870)
PROVISIONS FOR LIABILITIES AND CHARGES	(2,025)	(5,818)
TOTAL ASSETS EMPLOYED	340,241	260,096
FINANCED BY:		
CAPITAL AND RESERVES		
Public dividend capital	182,573	130,285
Revaluation reserve	133,456	114,929
Donated Asset reserve	19,365	17,587
Government grant reserve	0	0
Other reserves	4,073	4,073
Income and expenditure reserve	774	(6,778)
TOTAL CAPITAL AND RESERVES	340,241	260,096

Statement of Total Recognised Gains and Losses for the year ended 31 March 2002

		2000/01
	£000	£000
Surplus for the financial year before dividend payments	19,342	14,665
Fixed asset impairment losses	0	0
Unrealised surplus on fixed asset revaluations/indexation	18,703	5,105
Increases in the donated asset and government grant reserve due to receipt of donated and government grant financed assets	3,363	3,275
Reductions in the donated asset and government grant reserve due to the depreciation, impairment and disposal of donated and government grant financed assets	(971)	(1,765)
Total recognised gains and losses for the financial year	40,437	21,280
Prior period adjustment	0	(4,708)
Total gains and losses recognised in the financial year	40,437	16,572

Cash Flow Statement for the year ended 31 March 2002

			2000/01
	£000	£000	£000
OPERATING ACTIVITIES			
Net cash inflow from operating activities		26,887	36,183
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:			
Interest received	571		298
Interest paid	(62)		(80)
Interest element of finance leases	(427)		(427)
Net cash inflow/(outflow) from returns on investments and servicing of finance		82	(209)
CAPITAL EXPENDITURE			
Payments to acquire tangible fixed assets	(48,766)		(46,229)
Receipts from sale of tangible fixed assets	15,719		11,388
(Payments to acquire)/receipts from sale of intangible assets	0		0
Net cash inflow (outflow) from capital expenditure		(33,047)	(34,841)
DIVIDENDS PAID		(12,580)	(14,662)
Net cash inflow/(outflow) before management of liquid resources and financing		(18,658)	(13,529)
MANAGEMENT OF LIQUID RESOURCES			
Net cash inflow (outflow) from management of liquid resources		0	0
Net cash inflow (outflow) before financing		(18,658)	(13,529)
FINANCING			
Public dividend capital received	92,485		57,315
Public dividend capital repaid (not previously accrued)	(44,500)		(46,800)
Public dividend capital repaid (accrued in prior period)	(32,155)		0
Loans received	0		0
Loans repaid	0		0
Other capital receipts	3,081		3,275
Capital element of finance lease rental payments	(256)		(258)
Cash transferred from/to other NHS bodies	0		0
Net cash inflow (outflow) from financing		18,655	13,532
Increase (decrease) in cash		(3)	3

Directors' Remuneration

Name	Title	Salary	Other Remuneration	Golden hello/ compensation for loss of office	Benefits in kind
		£000	£000	£000	£000
P Dixon	Chairman	20	0	0	0
R Naylor	Chief Executive	150	0	0	0
Professor D. Fish	Medical Director	25	58	0	0
Dr A Webb	Medical Director	25	102	0	0
Professor S. Spiro	Medical Director	25	105	0	0
Professor T Mundy	Medical Director	25	102	0	0
ML Boden	Chief Nurse	88	0	0	0
PH Burroughs	Development Director	110	0	0	0
HA Chalmers	Finance Director	110	0	0	0
P Brading	Non-Executive Director	5	0	0	0
A Page	Non-Executive Director	5	0	0	0
M Cosin	Non-Executive Director	5	0	0	0
L Chung	Non-Executive Director	5	0	0	0
Professor Souhami	Non-Executive Director	3	0	0	0
Professor Levinsky	Non-Executive Director	2	0	0	0

During 2001/02 Professor Souhami resigned as at 30 September 2001 and Professor Levinsky was appointed as from 1 October 2001.

Greenbury requirements are that the Trust should disclose the name, age, remuneration and pension liability of all senior employees. 'Senior employees' is deemed to cover the voting Executive and Non-Executive directors of the trust. The directors have determined that they will not disclose age and pension liability. The age of any employee has no determination on their remuneration, and is considered to be contrary to the spirit of current discrimination legislation.

The NHS pension entitlement of all directors is determined by the rules of the NHS pension scheme. No entitlement is due to any senior employee under the terms of the pension arrangements available to staff who transferred with the Heart Hospital. The trust has not exercised the option under AVCs to enhance any pension benefits. An individual's NHS entitlement is determined solely by length of service, current salary, and personal choice in making additional voluntary contributions at no additional expense to the trust.

All senior employees have the right to refuse to disclose the above information (except remuneration to the Chairman and Non-Executive Directors as appointees under the Commissioner for Public Appointment's Code of Practice) on the basis of the Data Protection Act 1998.

Statement of Directors' Responsibility in Respect of Internal Control

The Board is accountable for internal control. As Accountable Officer, and Chief Executive Officer of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's objectives, and for reviewing its effectiveness. The system of internal control is designed to manage rather than eliminate the risk of failure to achieve these objectives; it can therefore only to provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing risk management process designed to identify the principal risks to the achievement of the organisation's objectives; to evaluate the nature and extent of those risks; and to manage them efficiently, effectively and economically. The system of internal control is underpinned by compliance with the requirements of the core Controls Assurance standards:

- Governance
- Financial Management
- Risk Management [Risk Management System standard for 2001/2002]

I plan to have the necessary procedures in place by the beginning of the financial year 2003/04 necessary to meet the Treasury guidance. This takes into account the time needed to fully embed the processes that the Board has agreed should be implemented.

The actions taken so far include

- The Trust has undertaken a self-assessment exercise against the core Controls Assurance standards (Governance, Financial Management and Risk Management) and an action plan has been developed and implemented to meet any gaps.
- The Trust has in place arrangements to monitor as part of its risk identification and management processes compliance with other key standards, including relevant controls assurance standards covering areas of potential significant organisational risk.

In addition to the key actions outlined above, in the coming year it is planned to:

- Develop the Trust-wide risk register so that it represents all known risks.
- Ensure that all risks are systematically identified, recorded, assessed, monitored and reviewed.
- Ensure there is an effective and documented system of internal control following the introduction of new financial management systems.
- Provide all employees, including managers and the Board, with further information, instruction and training on the Trust's Standing Orders, Standing Financial Instructions, and financial management.

As Accountable Officer I also have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control has taken account of the work of the executive management team within the organisation who have responsibility for the development and maintenance of the internal control framework, and of the internal auditors. I have also taken account of comments made by external auditors and other review bodies in their reports.

Chief Executive (on behalf of the board)

Finance Director

Date: 7th August 2002

Independent Auditors' Report to the Directors of the Board Of University College London Hospitals NHS Trust on the Summary Financial Statements

We have examined the summary financial statements.

Respective responsibilities of directors and auditors

The directors are responsible for preparing the Annual Report. Our responsibility is to report to you our opinion on the consistency of the summary financial statements with the statutory financial statements. We also read the other information contained in the Annual Report and consider the implications for our report if we become aware of any misstatements or material inconsistencies with the summary financial statements.

Basis of opinion

We conducted our work in accordance with Bulletin 1999/6 'The auditor's statement on the summary financial statements' issued by the Auditing Practices Board for use in the United Kingdom.

Opinion

In our opinion the summary financial statements are consistent with the statutory financial statements of the Trust for the year ended 31 March 2002 on which we have issued an unqualified opinion.

Date: 7th August 2002
Geoffrey Banister, Audit Manager,
District Audit, 4th Floor, Millbank Tower, Millbank, London, SW1 4QP

Our board

Our board oversees the running and direction of the trust. It is led by a chairman who ensures that the trust fulfils all its responsibilities. The chairman and the five non-executive directors are appointed by the Secretary of State for Health.

The names of our trust board members are detailed below, together with a declaration of their relevant interests.

Key:
AC Member of the audit committee
RC Member of the remuneration committee
CRC Chair, remuneration committee

Non-executive directors

Peter Dixon: Chairman
RC CRC

Peter Dixon was appointed to the chair of UCLH in 2001. Peter was previously chair of Enfield and Haringey Health Authority, a post he held from 1998. He has lived locally and been active in community affairs in north London for over 30 years. He has a long-standing commitment to social housing, and sits on the boards of two large housing associations. He works as a non-executive director and business consultant. His interest in health stems from his work in social housing and his marriage to a local GP.

Board member, chairman, North Thames Region, London & Quadrant Housing Trust
Wife, Judith Dixon, is a GP principal in Islington and chairs the C&I MAAG
Director and shareholder, Sedgevale Ltd
Chairman, The Manifest Voting Agency Ltd
Board member, Anglia Housing Group
Chairman, Health Policy and Partnerships Committee, NHS Confederation

Philip Brading RC

Philip Brading is deputy chair of the trust board and chairs the finance and contracting committee. He spent over 20 years in the City, where he was involved in most forms of corporate and public sector finance: he spent ten years as a director of Hill Samuel Bank. He now runs a specialist panel products manufacturing business. He was a member of Haringey Health Authority for a decade.

Chair, Neat Concepts Ltd

Professor Roland Levinsky
RC

Professor Roland Levinsky is currently the Hugh Greenwood Professor of Immunology and honorary consultant at Great Ormond Street Hospital for Children NHS Trust. Since October 1999, he has been Vice-Provost for Biomedicine and head of the graduate school at University College London. Prior to that he was Dean and Director of Research at the Institute of Child Health for nine years.

Director, Freemedic plc
Director, UCL Cruciform Ltd.
Director, Multilyte Ltd.
Director Bloomsbury Bioseed Fund Ltd.
Director, Bloomsbury Dental Practices Ltd.
Trustee, Child Health Appeal Trust, Institute of Child Health
Trustee, General Charitable Trust, Institute of Child Health

Maggie Cosin RC AC

Maggie Cosin is a councillor and was deputy leader of Camden Council. She chairs a partnership in the Highgate Ward of Camden Council. She is a political researcher for a minister and a magistrate on the South Westminster Bench. She is also a member of the Labour Party's national policy forum.

Chair, Highgate Newtown Partnership

Anne Page RC AC

Anne Page is chief executive of the London Research Centre – a major provider of data, information, research and analysis about urban affairs and local government in general, and London in particular.

Founder-chair of Urbandata, a European network of urban research centres.
Chair, London Awards Committee of the National Lottery Charities Board.
Member, Statistics Users' Council
Director, Court of Governors of the London School of Economics.
Member, Council, London School of Economics
Chair, London Awards Committee
Chair, UCLH Audit Committee

Linda Chung RC AC

Linda Chung has a career spanning business and industry and was a director and personnel consultant for ISIS Offshore for over 20 years. She was a member of the medical and dental disciplinary committees at Camden and Islington Health Authority, where until 1999, she chaired the consumer information group. Her past appointments include membership of the Family Health Services Authority, governor of the Adult Education Institute, and ILEA Youth Standing Committee. She is a member of the employment tribunals and chaired the national Council for Employment Tribunal Members' Associations. Linda is closely involved in Chinese community affairs and was a founder member of the Chinese in Britain forum.

Partner, Fulton Chung Associates
Member, Camden and Islington Health Authority Disciplinary Panel
Member, Employment Tribunals
Chair, CETMA (to June 2001)
Director/Treasurer, Chinese in Britain Forum
Director, Camden Chinese Community Centre

Executive directors

Robert Naylor AC

Robert Naylor has been chief executive since November 2000, having spent 15 years as chief executive at Birmingham Heartlands and Solihull NHS Trust. In his first year at UCLH, he negotiated the purchase of the Heart Hospital and the successful transfer of the Royal London Homoeopathic Hospital to the UCLH group. Robert has been a member of numerous advisory groups nationally and locally within the NHS.

Non-executive director, Ministerial Advisory Board on Procurement
Member, National Performance Management Working Group (NHS Plan)

Andrew Webb

Dr Andrew Webb is the medical director for clinical services (including critical care, imaging, medical physics, nuclear medicine, pathology and pharmacology). He has been a consultant at UCLH's intensive care unit since 1990, and was clinical director from 1992 – 2001. He has built up an internationally respected intensive care department which admits critically ill patients from all over the south of England. In the last year, he has concentrated on developing clinical services to meet the needs of patients and user departments.

Honorary Treasurer – Intensive Care Society

Tony Mundy

Professor Tony Mundy is medical director for surgery. Tony is a professor of urology and was clinical director for urology and nephrology. He joined St Peter's Hospitals in 1986, moving to The Middlesex in 1992. He has been professor of urology at the University of London since 1991 and director of the Institute of Urology and Nephrology since 1996.

Stephen Spiro

Professor Stephen Spiro is medical director for medicine. A consultant in general and thoracic medicine at UCH and The Middlesex since 1977, Stephen has been clinical director for medicine since 1994. He was formerly a physician at the Royal Brompton Hospital and UCH between 1977 and 1994.

David Fish

Professor David Fish is medical director for specialist hospitals. David is a consultant in neurology and clinical neurophysiology, based at the National Hospital for Neurology and Neurosurgery, where he has been since 1986 (apart from a year-long gap as visiting assistant professor in neurology in Canada). He was clinical director for clinical neurosciences and professor of clinical neurophysiology and epilepsy. His main clinical activity involves patients with epilepsy. He works closely with the National Society for Epilepsy, Epilepsy Bereaved and other related groups. He recently co-authored a NICE sponsored national audit on epilepsy related deaths in the UK. His academic work has focused on improving education, brain imaging and treatments for patients with epilepsy.

Director of QS Enterprises Ltd (unpaid)

Helen Chalmers AC

Helen Chalmers joined the trust as finance director in 1999. She qualified as a chartered accountant with Ernst and Young in Australia. Helen has experience of a wide range of NHS organisations, having worked at Islington Health Authority, North West Thames Regional Health Authority and Sussex Ambulance Service. Prior to joining UCLH she was Director of Finance and Business Planning at the London Ambulance Trust.

Member of Healthcare Financial Management Association (HFMA) Council & Chairman's Advisory Group
Chair, HFMA Audit & Corporate Governance Committee
Vice Chair, London branch, HFMA
Member of National Health Service Litigation Authority Policy Advisory Group (to Jan 02)
Chair, NHS Confederation Committee on Specialised Commissioning
Reviewer, Commission for Health Improvement.

Louise Boden AC

Louise Boden is the trust's chief nurse. She joined the NHS in 1969, training as a nurse at the United Sheffield Hospitals. After midwifery, Louise undertook specialist oncology training, then worked as a surgical ward sister before moving into nursing management. She joined University College and The Middlesex Hospital as director of nursing in April 1993 and was appointed as the trust's chief nurse & director of quality in 1994.

Governor, National Society for Epilepsy
Honorary Visiting Professor, Health Care Education Unit, City University
Member of Performance Improvement Team of the Modernisation Agency

Peter Burroughs

Peter Burroughs became the development director for the trust in 1998, with responsibility for all major developments, and in particular the new hospital. He has worked in the NHS for over 40 years, 17 of these as a finance director in three major London teaching hospitals. He came to University College / Middlesex Hospitals in 1992, as director of finance, and has overseen the new hospital development from its inception in 1993. He is also financial advisor to UCL Hospitals Charities, which provides substantial benefits to patients and staff.

Secretary/Treasurer, University College London Hospitals Charities

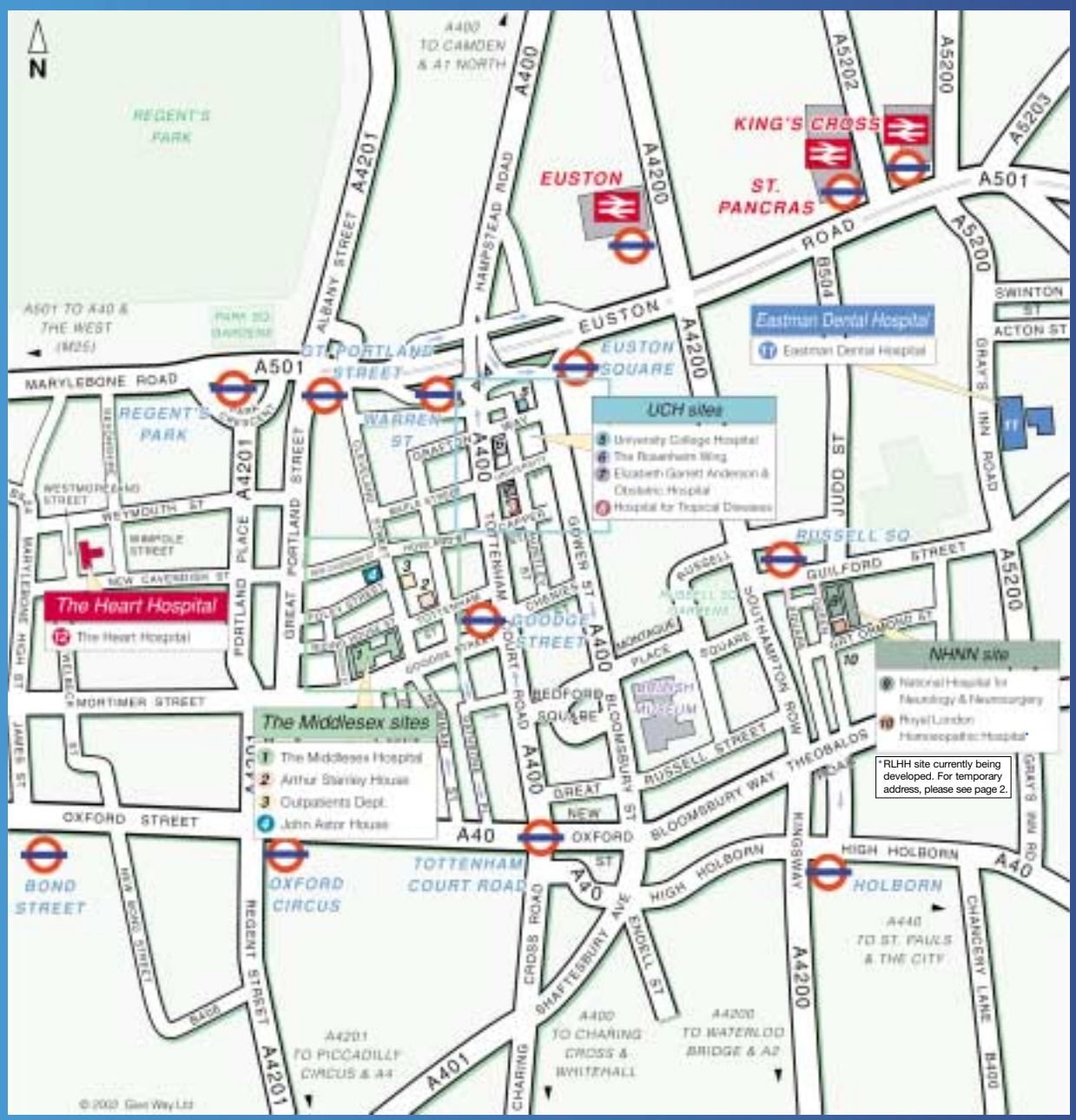
Former board members

Professor Robert Souhami

Professor Souhami was a non-executive director until September 2001. He was the principal of the Royal Free and University College Medical School and was the Kathleen Ferrier professor of cancer medicine at University College London Medical School until April 1997. Before that he was a consultant physician at UCH and senior lecturer in medical oncology.

The chief executive was appointed following national advertisement in summer 2000: he took up post in November 2000. His post is a permanent appointment, with terms and conditions determined by the remuneration committee. The committee sets remuneration with due regard to the appropriate market rates for comparative senior posts within the sector. These arrangements apply to all executive board member posts.

Where to find us



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NHS

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This report is also available on the UCL Hospitals' web site: **www.uclh.org**
Give us your feedback on this report by e-mailing us at **feedback@uclh.org**

University College London Hospitals NHS
NHS Trust

Produced by the Press & PR Unit at UCL Hospitals, September 2002.