


University Hospital of North Staffordshire
NHS Trust











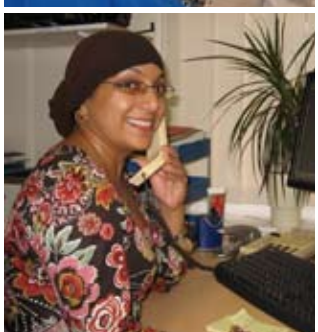

# ANNUAL REPORT
# 2009/2010

# Contents







# Foreword

**The chairman and chief executive reflect on another University Hospital year.**

University Hospital is a large and complex organisation and so, as usual, 2009/10 presented us with a lot to be proud of but also some issues that were very challenging.

Without doubt the highlight of our year has been the opening of our new maternity centre and cancer centre. These publicly funded projects opened on time and on budget. Staff who would be working in them were heavily involved in designing and equipping the new centres which now provide a world class setting for our excellent clinical services.

Because of the nature of the service, maternity staff had to move their entire operation from the old building to the new in just one weekend in April. The transfer went very smoothly and was mirrored just two months later by the move into the new cancer centre.

Our staff put in an enormous effort to manage the moves with minimum impact on our patients. We learned a great deal from the way they achieved it, which will help us enormously when we come to move into the main building in 2012.

Over the past two years the top priority for our Trust has been reducing the number of hospital acquired infections. Huge investment and an absolute focus on the issue means we have achieved low levels of infections this year that are well below the limit set for us by regulators.

There is, of course, no room for complacency when it comes to patient safety so there is still more to do to meet our aim of eradicating all avoidable hospital infections. Everyone at University Hospital is engaged in this project and it will remain a top priority in the hospital for the future.

Our emergency department (A&E) is one of the busiest in the country. Sometimes in the early part of the year, when many patients arrived within a short time frame, staff found it difficult to provide care to the standard we all expect. That is, of course, unacceptable and required urgent action.

To improve the experience for our patients and reduce the pressure on our staff we have brought in more doctors and nurses, introduced a system of rapid patient review by senior doctors, built ten more cubicles so that patients can be seen more quickly and introduced a new ward to which patients can be referred directly by their GP.

These changes were designed to enable us to cope with the record numbers of patients who came to the department during the most difficult winter for some years. However, the problems at the beginning of the year have meant that, overall, we missed the national 4 hour maximum wait target (98%) by just 0.2%. This is a great disappointment.

We have performed well again this year on other national targets, especially the maximum 18 week wait between GP referral and treatment and the maximum 2 week cancer target. Rapid access to chest pain services, heart attack services and diagnostic services have all been a feature of our improving hospital this year, where national standards have all been comfortably met.

Elsewhere in the hospital our innovators have been putting North Staffordshire on the national clinical map. Our stroke service is one of the best in the country, with exceptional recovery rates. New ways of treating stroke patients mean that more of them than ever are recovering well and returning home.

University Hospital is one of only five hospitals in the UK to offer intra-arterial thrombolysis, a treatment suitable for around 20 stroke patients a year who would otherwise not survive or would be severely disabled.

In clinical research, despite being a small centre, University Hospital is attracting some national attention and is winning bids for funding over bigger, more established institutions.

This year we have built on our previous work by listening to and working with patients and the public as we develop our services.

We held 10 'Big Conversations' at various locations around North Staffordshire during the year – open events which gave people an insight into some of our services, a chance to meet some of our frontline staff and the opportunity to challenge us.

This year we formed a Health Improvement Panel. These committed volunteers are working with us on an ongoing and more formal basis to give us insight into public wishes and expectations. They also offer advice about the development of our patient services.

It has been an exciting and rewarding twelve months at University Hospital. We wish to thank everyone who has contributed to our growing success and look forward to the challenges and opportunities that lie ahead.

Our ambition is to provide the people of North Staffordshire with world class hospital services. We can achieve that only with the support and involvement of staff, patients and public. Hence our motto:

*"Everyone Improving Quality"*

*Mike Brereton*
*Chairman*

*Julia Bridgewater*
*Chief Executive*

# University Hospital Vision

**Our vision is to be a first class provider of clinical services, education and research and development. Our STEPSS to success objectives are designed to help us achieve it:**

## Sound finances and getting the basics right

We will continue to develop our financial, governance and management systems to ensure that we continue to meet our statutory duties. We will continue to improve the clinical care our patients receive.

## Teaching hospital and learning organisation

We will work with partners to maximise the opportunities which teaching hospital status provides, as well as enhancing our education, training, research and development activities.

## Excellence in healthcare

We will achieve all Care Quality Commission core standards and establish and maintain a reputation for excellence in the delivery of clinical care. We will achieve all national service targets, including offering a maximum waiting time for referral to treatment of 18 weeks.

## Partnerships and social responsibility

We will work with primary care trusts, local authorities, voluntary groups and other partners to support joint work to improve the health of the local population. We will support and play our part in the regeneration of the local area, particularly through initiatives which support skills training and development for employment in the health sector.

## Specialised services

We will continue to develop our role as a provider of specialist services, where this makes sense clinically and financially and is supported by our commissioners.

## Service and workforce transformation

To deliver our new hospital and associated services in the community, we will need to change or transform our hospital services by 2012/2013.

Our strategic objectives are the basis upon which we agree our long and short-term business objectives. They are also linked to the performance framework which ensures the improvement of service standards across the Trust.

All papers and reports considered by both the Executive Committee and Trust Board include a clear indication of how they support the STEPSS.

# A little about us

## Who we are and what we do

University Hospital of North Staffordshire is a large acute teaching hospital on the border of Stoke-on-Trent and Newcastle-under-Lyme in Staffordshire.

We are one of the largest hospitals in the West Midlands and have one of the busiest emergency departments in the country.

We have good transport links, being close to the M6 and A50, and lie roughly centrally between Manchester and Birmingham to the north and south, and Derby and Shrewsbury to the east and west.

The hospital is based on three main sites. Most of our services and all our 1,300 inpatient beds are at the Royal Infirmary and City General sites which are half a mile apart. Our Central Outpatients Department and Central Pathology Laboratory lie between the two.

On average during the year we employed the equivalent of 6,359 full time staff.

## Our services

We provide a full range of general acute hospital services for approximately half a million people living in and around North Staffordshire and specialised services for a population of some three million in a wider area, including neighbouring counties and Wales.

Our specialised services include cancer diagnosis and treatment, cardiothoracic surgery, neurosurgery, renal and dialysis services, neonatal intensive care and paediatric intensive care.

We are also recognised for our particular expertise in respiratory conditions, spinal surgery, upper gastro-intestinal surgery, complex orthopaedic surgery, laparoscopic surgery and the management of liver conditions.

In 2009/2010 over 100,000 patients attended our Emergency Care Centre (A&E). Many emergency patients are brought to us from a wide area by both helicopter and land ambulance because of our skills in treating trauma cases.

## Our estate

Building work for the new hospital on the City General site is on target. During 2009 the new maternity centre and cancer centre were completed and services moved into the new buildings on time and on budget. These two centres have been publicly funded at a cost of £70m and are around a quarter of the total size of the new hospital.

The main hospital building work is on track. A topping out ceremony was held in December and, now that the main construction is complete, work is concentrated on the interior. Services will move in to the new building over a six month period in 2012.

The main building is part of a circa £300m private finance initiative (PFI) and will house wards, theatres, the emergency department and outpatient services.

We are continuing to provide our full range of clinical and support services while building work is ongoing. A high level of off-site fabrication allows us to keep the number of construction staff on site low, which minimises disruption but gives us improved quality and health and safety considerations.

Inevitably we have had to move some services and departments to accommodate the work and, from time to time, we have to alter traffic routes through the site and car parking.

We are grateful to our patients, visitors and staff for their co-operation and tolerance of any disruption during this period.

We continue to liaise with our neighbours through the local residents associations to minimise the effect on them of the building work, traffic and car parking.

In addition to the new construction, some of the existing buildings on the City General site are being retained and will be refurbished from the Trust's capital programme rather than within the PFI. This includes the most recent clinical buildings (the surgical and paediatric block and the orthopaedic and surgical block) and the oldest, listed buildings which will generally be converted for administration use. This scheme gives us flexibility to respond to changes in clinical demand, either increasing or decreasing.

Whilst staff are excited about working in the new hospital we are conscious that many services, especially at the Royal Infirmary, are being provided in very old buildings that are not suited to 21st century healthcare. Although the site will start to be vacated as services move into the new hospital from 2012, we are continuing to invest in the Royal Infirmary to make the wards and public areas as suitable and pleasant as possible for the patients, visitors and staff still using its facilities.

When the new hospital and refurbishment work in the retained estate is complete, the Royal Infirmary, Central Outpatients and Central Pathology Laboratory will be vacated. There are no plans for the redundant buildings and sites to be used for health services, so it is intended that they will be disposed of at this time.

## Our plans for Foundation Trust status

During 2009/10 we have made good progress on our journey towards Foundation Trust status, with the main emphasis this year being on building our engagement with, and accountability to the local public.

At the end of the year we revised the timescale for when we aim to achieve all of the standards required, which we expect to be by the end of 2011.

The lessons from failures at other hospitals have rightly resulted in a change in the assessment process, with a much greater emphasis on the Trust's quality of services. This is our priority too.

# Sound finances and getting the basics right

## How we are organised

We currently have four clinical divisions – medicine, surgery, clinical support services and women and children. Each is led by an associate director who is supported by a professional head of nursing, human resources manager and finance manager. Within each division are a number of specialties, each headed up by a clinical director.

Our non-clinical staff support the work of the Trust's clinical teams. Some work within the clinical departments and others are organised into departments of central functions. These include our executive directors and their teams, human resources, finance, operations and performance. The corporate services division includes estates, facilities, catering, cleaning, portering and security.

From early in the new financial year we will rationalise our clinical divisions into three. Obstetrics and gynaecology will transfer into the surgical division and paediatrics will move into the medical division. Clinical support services, the division that provides diagnostic facilities including imaging and pathology, remains unchanged.

At the same time we will change our reporting lines to a service line management model. There will be 44 designated and agreed service lines. Each will be led by a clinician, nurse and manager who will take responsibility for specific clinical areas.

The aim of the reorganisation is to improve decision-making while moving responsibility and accountability closer to the patient.

An executive committee oversees the day to day planning and running of the hospital. 19 clinical directors (consultants) sit on this group that meets every fortnight.

Our Trust Board is led by a non-executive chairman. We have five non-executive directors who attend and vote at board meetings and who support specific areas of work according to their special interests.

Five of our executive directors have voting rights on the Board. They are the chief executive, medical director, chief nurse, chief operating officer and director of finance. Our non-voting directors cover human resources, corporate services, foundation trust development and strategy and planning.

## Being monitored and accountable to you

Ten Board meetings a year are held in public with a meeting beforehand for interested members of the public and media to discuss the papers with the chairman. The papers are published on the Trust's website a few days before each public meeting.

We are monitored by local, regional and national bodies so the public can be assured about our services and the way we operate our Trust.

## National monitoring

In April 2009 the Care Quality Commission was established to replace the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission. The new body, established under the Health and Social Care Act 2008, brought together regulation of all aspects of health and social care. The aim of the Care Quality Commission is to make sure better care is provided for everyone, whether that is in hospital, in care homes, in people's own homes, or elsewhere.

The annual health check is the mechanism by which the Care Quality Commission can measure compliance with national standards and provide assurance to the public on how we are performing.

In October 2009 the Care Quality Commission published the results of the annual health check for 2008/09 and we received a rating of **Fair** for both Quality of Services and Use of Resources.

We are working on improvements to our services to deliver the best possible care for our patients and so improve our rating.

The annual health check results for 2009/10 will be published in October 2010.

From 1st April 2010 all NHS trusts are required to be registered with the Care Quality Commission. To do so, trusts must show they are meeting new essential standards of quality and safety across all of the regulated activities they provide.

The new system will make sure that people can expect services to meet essential standards of quality and safety that respect their dignity and protect their rights. The new system is focused on outcomes, rather than systems and processes, and places the views and experience of people who use services at the centre.

Our Trust was registered without conditions in March 2010.

## Regional and local monitoring

NHS West Midlands is responsible for the strategic development of non-foundation trust NHS organisations within the West Midlands region and aims to ensure patients have faster access to the highest quality services possible. They have close contact with all the NHS organisations in the area, providing leadership and support to meet essential standards and to provide high performing local services.

Closer to home, each of our four local authorities has a Health Overview and Scrutiny Committee through which elected councillors monitor our performance on behalf of their constituents. We work closely with each committee, attending meetings to respond to particular concerns or to keep councillors updated on new activities and proposed changes to services.

The new Stoke-on-Trent Local Involvement Network (LINk) has a role to play in monitoring our services on behalf of the public and we are working closely with them to help them become as effective as possible in the role.

## The annual PEAT inspection

Patient Environment Action Team (PEAT) annual assessments were established in 2000, to look at how trusts are performing in key areas including food, cleanliness, infection control and the patient environment.

The City General and Royal Infirmary sites are scored separately for environment, food and privacy and dignity. In 2009 the scores were all 'good' with the exception of the Royal Infirmary which achieved a food score of 'excellent'.

The National Patient Safety Agency sets the requirements for the assessment process. Our assessing team in 2009 included staff from various parts of the Trust and Sodexo, patient representatives and an external verifier. The teams visited a minimum of 25% of the wards and advance warning of the date and time of the inspection was known only to those taking part in the inspection process.

The findings for 2010 have still to be verified by the National Patient Safety Agency but we believe the assessments show we have at least maintained our position from last year. The assessments also highlighted some areas of good practice to be considered for use in other parts of the Trust, such as the use of labels to show that equipment is clean and ready for use.

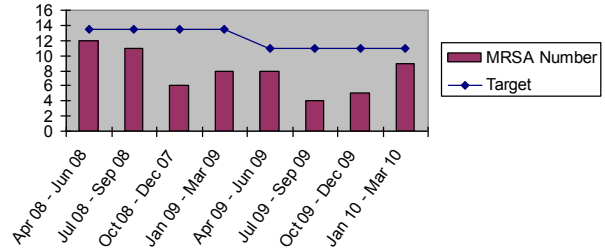
## Infection rates continue to fall

Over the past twelve months we have built on our success in reducing the number of healthcare associated infections. We have continued with daily monitoring of our infection rates at executive level and monthly discussion at the public Trust Board meetings.

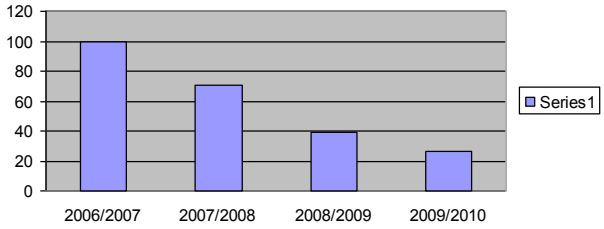
Each case of MRSA bacteraemia and Clostridium *Difficile* (C *Diff*) infection is investigated by those involved in the patient's care through root cause analysis. The doctor concerned is held accountable to the chief executive and preventable causes are shared in clinical areas to try to prevent a repetition.

We had 26 cases of MRSA bacteraemias against a limit set at 44 and 276 cases of C diff against a limit of 348.

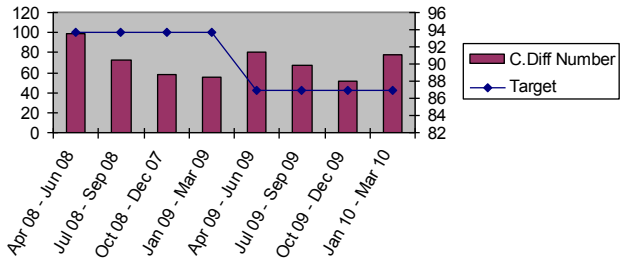
**MRSA Quarterly Totals**



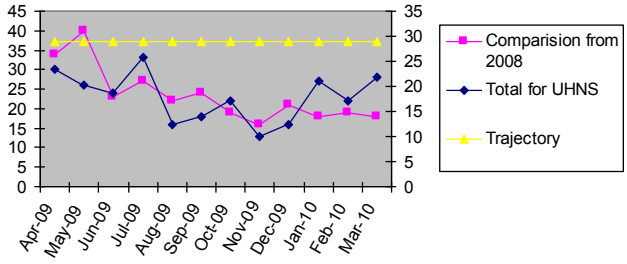

**MRSA bacteraemia performance, year on year comparison**




**C.diff Quarterly Totals**




**C.diff performance April 2009 to March 2010**



This year there has been a focus on infection control at the front door. Our second year of screening for MRSA in all emergency admissions has achieved 95% compliance. During 2009, in line with national guidance, we extended our screening programme and now screen all emergency and elective patients in the hospital.

A twelve month programme of infection control education was introduced in the emergency department. Each month we focussed on a different topic and used a number of different educational strategies. The aim was to improve staff knowledge, improve practice and enhance public and patient awareness of the risks of infection. A poster summarising the initiative was accepted at one international and two national medical and nursing conferences during 2009.

To give staff access to timely information the infection control team has developed an information dashboard. This electronic database enables ward staff to record hand hygiene audit scores, cleaning scores and rates of infection so they can track their progress. The information is shared with the staff on the ward so good practice can be recognised and areas highlighted where there is a need to improve practice and monitor progress.

We are pleased with the reductions we have achieved but there is more to do to meet our aim of no avoidable hospital acquired infections by the time we move into our new hospital in 2012. Work on the next stage has begun.

## Treating people equally and fairly

The Care Quality Commission measures us against standards for equality and diversity each year. Following significant and sustained progress we have declared full compliance with those standards in 2009/10.

We have an equality and diversity policy and a dignity at work policy which promote compliance with the standards. Our recruitment and selection policy ensures we comply with employment equalities and human rights legislation. We provide a range of opportunities for learning and development without discrimination.

We hold Positive About Disability status, awarded by the Jobcentre Plus service, and have met the Racial Equality Means Quality standard, assessed by the Racial Equality Council.

## University Hospital scoops national awards

Finding ways of reducing waste in all its forms is currently high on the NHS agenda, but University Hospital staff are among the country's leaders and are ahead of the game.

Staff all around the hospital are looking closely at the way they work and are changing what they do in order to avoid unnecessary or duplicated processes. The results have been remarkable and, because the changes are made by the staff involved, they are sustained and become simply the way people now work.

University Hospital's achievements were recognised at the Lean Healthcare Academy Awards in November 2009 where we won Organisation of the Year, Lean Champion of the Year and the Productive Series awards.

Heidi Poole, Lean Champion of the Year, is passionate about reducing waste and encourages others in the quest through her training sessions and monthly newsletters.


*The ultimate accolade, Lean Organisation of the Year. Heidi Poole, our Lean champion is pictured second right.*

*Photographs courtesy of Lean Healthcare Academy.*

*The productive ward team collect their accolade.*

# Our Headline Finances

## Our Finances

A summary of the principal financial statements is included in the Annual Report at pages 30 to 33. A full copy of our annual accounts can be found on our website (www.uhns.nhs.uk) or you may request a copy from the Director of Finance via telephone 01782 555022 or email chris.calkin@nhs.net or by writing to the Director of Finance at the Royal Infirmary.

**The headline figures are:**

**STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31st March**

| | 2009/10 £'000 | 2009/10 % | 2008/09 £'000 | 2008/09 % |
|---|---|---|---|---|
| **Income from activities** | **355,968** | **87.05%** | **321,104** | **86.47%** |
| **Other operating income** | **52,970** | **12.95%** | **50,238** | **13.53%** |
| **TOTAL INCOME** | **408,938** | **100.00%** | **371,342** | **100.00%** |
| **Operating expenses** | **(463,216)** | **(113.27%)** | **(371,706)** | **(100.10%)** |
| **OPERATING SURPLUS/(DEFICIT)** | **(54,278)** | **(13.27%)** | **(364)** | **(0.10%)** |
| Profit/(loss) on disposal of property, plant and equipment | **(126)** | **(0.03%)** | **(168)** | **(0.05%)** |
| **SURPLUS/(DEFICIT) BEFORE INTEREST** | **(54,404)** | **(13.30%)** | **(532)** | **(0.15%)** |
| Investment Revenue | **70** | **0.02%** | **679** | **0.20%** |
| Finance Costs | **(621)** | **(0.16%)** | **(394)** | **(0.11%)** |
| **SURPLUS/(DEFICIT) FOR THE FINANCIAL YEAR** | **(54,955)** | **(13.44%)** | **(247)** | **(0.06%)** |
| Public dividend capital dividends payable | **(7,515)** | **(1.84%)** | **(7,597)** | **(2.05%)** |
| **RETAINED SURPLUS/(DEFICIT) FOR THE YEAR UNDER IFRS** | **(62,470)** | **(15.28%)** | **(7,844)** | **(2.11%)** |

**PERFORMANCE AGAINST BREAKEVEN DUTY**

| | | |
|---|---|---|
| Retained surplus / (deficit) under IFRS | **(62,470)** | **(7,844)** |
| Add back impairments of IFRS assets | **3,780** | **7,234** |
| Add back other impairments | **61,227** | **-** |
| Add back other impact of IFRS | **2,775** | **3,618** |
| **Performance against statutory break even duty** | **5,312** | **3,008** |

2009/10 is complicated by the change to the accounting rules that requires all NHS bodies to report their accounts under International Financial Reporting Standards (IFRS). This is to ensure that whoever and wherever somebody is in the world, all the accounts of countries that have adopted IFRS are able to interpret and read the accounts, knowing that they have been prepared on the same basis. To ensure that comparisons between years may be drawn, we have also been required to restate the 2008/09 accounts under the IFRS conventions. This has made our financial position look very different from that reported previously. There has been no change to our underlying financial performance. Treatment of the Trust's PFI scheme is very different under IFRS, with higher levels of interest being charged to the Statement of Comprehensive Income (SOCI), the IFRS equivalent of the Income and Expenditure Account, in the earlier years of a PFI contract. This is very similar to how our own personal mortgages work.

The good news is that, whilst we report under IFRS, we continue to be performance managed under the previous accounting regime, hence the second element of Table 1 converts the IFRS Accounts to performance against the statutory break even duty. In 2009/10 there is a very large difference between the retained deficit for the year under IFRS of £62.5m and the Trust's performance against the statutory break even duty (a surplus of £5.3m) because

• The value of the Trust's land and buildings has been reduced significantly as the result of a professional valuation. This reduction is attributable to a general fall in land and building values and the Trust's plans to move out of its old buildings into the maternity and cancer building and other new buildings currently being built as part of the PFI scheme

• The treatment of the PFI scheme in the accounts under IFRS is very different from the treatment in previous years

The Trust did not achieve the "control total" target of £7.8m set for it by the Strategic Health Authority and the Department of Health in 2009/10. The actual break even performance was £5.3m, creating a shortfall of £2.5m against the 2009/10 target. This is a problem for the Trust as we were required to achieve cumulative surplus of £15m by the end of 2009/10 to recover the £15m loss incurred in 2005/06. The cumulative target was underachieved by £2.3m. The reason for the shortfall was the outcome of the dispute with the local PCTs, requiring a write off of £2.5m of income the Trust had expected to receive. This has resulted in our External Auditor having to issue a Section 19 letter to the Secretary of State, informing the Department of Health that the Trust has failed to achieve its statutory duty to break even over the agreed five year period.

However, the cash generated by the £5.3m surplus remains in the Trust. Unlike previous years when this surplus was used immediately for investment, in 2010/11 this cash will be held back for committed investments in the retained estate programme in future years.

The surplus achieved this year was largely achieved by non recurrent funding. The level of recurrent costs of the Trust exceeds the recurrent income received by approximately £3m, so the £5.3m surplus delivered was achieved on a non recurrent basis with the support of £8.3m non recurrent income. This is still a considerable improvement on the previous year's performance when recurrent costs exceeded recurrent income by approximately £7m and it shows the Trust slowly moving back to financial health. There remains much further work to secure the recurrent financial position of the Trust and the future stability and viability of the Trust.

## Staff Awards 2009

University Hospital celebrated its Staff Awards 2009 with a special ceremony at Keele Hall. Eight awards were given out to individuals or teams that had gone the extra mile to improve the care of our patients.

Volunteers play an enormously important role in supporting both patients and staff.

John Guy, who volunteers in pressure therapy, won the volunteer of the year award.

Bob Eccles, the Trust's bereavement officer, scooped the employee of the year award for his outstanding commitment to his job. The breast cancer team won the patient experience award, the productive ward facilitation team won the improving working life/ environment award, the maternity theatre team won the service improvement/transformation award, the clinical coding team won the non-clinical award and the colorectal and respiratory same day next day service teams shared the clinical innovation award.

*The respiratory team show off the clinical innovation award for their same day next day service.*

In summary, the changes to the Trust's income and expenditure position as shown in the Statement of Comprehensive Income are:

| | 2009/10 £'000 | 2008/09 £'000 | % Change |
|---|---|---|---|
| **Income from Clinical activities** | **356.0** | **321.1** | **10.9%** |
| **Other Income** | | | |
| Medical School (SIFT) | 13.0 | 12.6 | 3.2% |
| Junior Doctor Training (MADEL) | 11.3 | 11.4 | (0.9%) |
| Other Training (NMET) | 1.8 | 1.2 | 50.0% |
| Research & Development | 2.1 | 0.9 | 133.3% |
| Non Patient Care Services to Other NHS Bodies | 14.5 | 14.0 | 3.6% |
| PFI Transitional Relief | 5.1 | 5.1 | 0.0% |
| Other Income | 5.2 | 5.0 | 4.0% |
| **Total Other Income** | **53.0** | **50.2** | **5.6%** |
| Total Income | 408.9 | 371.3 | 10.1% |
| Expenditure Changes | | | |
| Staff Costs | 260.2 | 242.4 | 7.3% |
| Clinical Supplies | 65.1 | 59.9 | 8.7% |
| Depreciation | 18.4 | 16.7 | 10.2% |
| PFI Operating costs | 12.5 | 7.0 | 78.6% |
| Premises costs | 11.1 | 10.8 | 2.8% |
| Clinical Negligence | 6.1 | 3.4 | 79.4% |
| General Supplies | 4.3 | 4.5 | (4.4%) |
| Other | 20.5 | 19.8 | 3.5% |
| Total operating expenses before impairments | 398.2 | 364.5 | 9.2% |
| Impairments | 65.0 | 7.2 | 802.8% |
| Total operating expenses | 463.2 | 371.7 | 24.6% |

Significant changes to Income and Expenditure are explained below:

# Income

## Clinical income

There has been substantial growth in clinical income in 2009/10, increasing by 10%. This is after discounting for activity for which the Trust was not paid and the outcome from the dispute process, amounting to £9m. These levels of growth cannot be sustained in the future. The Trust, working with PCTs, will need to manage activity to levels that are affordable within the health economy.

## Other income

The Trust receives funding for three separate streams of training. These are:

**1.** Medical School to provide education and training for doctors in years 3 to 5 of their training. This has increased in recent years as the number of students at Keele increases to reach the planned number. This growth to the planned number will level off from 2010/11 and there will be reductions in future years.Changes to the allocation of medical students are reflected in the funding we receive. The number of students in training at the University will remain the same; it is the number of students coming to the Trust that will fall. There will also be reductions in the level of payment the Trust receives per student in 2011/12 and we anticipate further reductions until 2013/14.

**2.** Junior Doctor Training - this provides funding for the basic salary of junior doctors. Depending on the grade of doctor this can be 100%. The Trust remains responsible for any unreimbursed salary and additional out of hours payments. The amount we receive fluctuates as it depends on the number and skill mix of doctors allocated to the Trust by the West Midlands Deanery

**3.** Non Medical Education and Training - provides funding for a range of staff including Professions Allied to Medicine eg therapists.

Research and Development will present an increasing opportunity for the Trust to attract research funding and projects to North Staffordshire.

# Expenditure

In 2009/10 and in the 2008/09 restated comparatives, the Trust's position was again complicated by impairment issues. In 2009/10 this followed a full valuation of the Trust's land and buildings. Impairments are where we reduce the value of the old hospital assets as a result of changes in estimated building costs and lives. These changes take into account the building of the new hospital and the plans to demolish many of the old buildings.

Total operating costs, excluding impairments, grew by 9%, which compares to the 10% growth in income.

## Staff costs

Increases reflect three main factors:

1] General increase in pay rates for 2009/10 of 2% and an incremental payment of approximately 3% for the majority of staff.
2] Increase in the average numbers employed of 257, an increase of 4.2% over the average numbers employed in 2008/09.
3] An increase in agency and non NHS staff relating to senior medical staff to provide additional support for A&E and finance functions.

## Clinical supplies

The growth is in line with the expected increase in costs given the increase in activity and income.

## Depreciation

Depreciation is the amount charged to the Statement of Comprehensive Income to reflect the value of capital assets consumed in delivery of the activity. This year the Trust has had to accelerate depreciation charges to reflect the lives of some of the assets. Part of the increase is also attributable to new PFI buildings which the Trust occupied for the first time in the middle of 2008/09 and new radiotherapy equipment that has been installed in the new oncology building.

## PFI operating costs

The increase reflects the increase in services provided by the Trust's PFI partner in 2009/10. Cost elsewhere will reduce as services are transferred. For example, salary costs will go down as more staff, who remain as "retained employees", transfer to the PFI partner, but the charge from the PFI partner will increase as they take on responsibility for paying these staff. This process will continue until 2015/16. The main PFI scheme payments are expected to increase as follows:

| Year | Unitary Payment £m |
|---|---|
| 2009/10 | 7.0 |
| 2010/11 | 11.2 |
| 2011/12 | 18.8 |
| 2012/13 | 43.9 |
| 2013/14 | 46.1 |
| 2014/15 | 47.3 |
| 2015/16 | 48.5 |

## Clinical negligence

Clinical negligence premiums have increased significantly for all NHS acute hospitals, particularly where maternity units are located. The increase of £2.7m in 2009/10 represents a national revaluation of potential clinical liabilities. It reflects the awards made by courts. These have been increasing in recent years so the NHS Litigation Authority, which acts as the "insurer" for NHS trusts, has reassessed the potential liability for claims currently in progress. It does not represent an increase in risk to the Trust.

## Purple power is sweeping wards

A new uniform has been launched at University Hospital. Patients can now identify the matrons and senior nursing staff by their purple uniform.

As part of the Back to the Floor programme the 'purple team' talk to patients about the standard of their care as well as working a shift alongside their colleagues.

To ensure what they learn is shared throughout the hospital, the team comes together each Thursday for a de-brief. Ward sisters join in and training sessions are organised around 'hot topics'.

Everyone agrees the new colour is much nicer than the old grey and they can certainly see the modern matrons coming.

*Julia Bridgewater, centre, is pictured with some of her senior nurses who are now highly visible on the wards.*

### Key financial performance indicators (metrics)

| Performance Indicator | | Plan | Outturn | Explanation/Note |
|---|---|---|---|---|
| Surplus | | £7.812m | £5.312m | £2.5m shortfall, see previous comment |
| Capital Absorption Rate | | 3.5%+/-½% | 3.5% | Due to changes in the way the DoH calculate the Public Dividend, as long as we make a surplus we will meet this metric. |
| External Finance Limit | | £0 | £0.5m Undershoot | Technicalities with the accounting treatment of the PFI scheme required the Trust to have a buffer on its EFL performance. |
| Capital Resource Limit | | £0 | £1.8m Undershoot | The Trust was planning an undershoot, however slippage on key schemes resulted in the undershoot being larger than planned. Undershoots are allowed. The cash remains within the Trust to complete the schemes next year |
| Invoices Paid | | | | |
| Non NHS | number | 95% | 93% | Changes in year to the way in which our internal control systems operate caused performance to fall across all headings. Performance has now returned to the required levels. |
| | value | 95% | 91% | |
| NHS | number | 95% | 85% | |
| | value | 95% | 92% | |
| Monitor Risk Rating (1 poor, 5 good) | 3 | 3 | In line with plan | |

# Key financial challenges for 2009/10

## Cost improvement plan

The Trust was required to generate £18.5m of cost savings. The principal change for 2009/10 was the establishment of a Programme Management Office to monitor and manage the Trust's delivery of the cost improvement programme. This year we adhered strictly to the principles of not counting additional income or savings achieved only on a non recurrent basis. By the end of the year the Trust had identified saving schemes with a recurrent full year effect of £16.8m. This was our most successful year in delivering recurrent savings. The balance of unachieved savings target has been added to the 2010/11 target.

## Over performance

The Trust delivered significantly more activity (i.e. treated more patients) than has been planned in the agreed "contracts" with primary care trusts (PCTs). This over performance, covering all the PCTs that we provide services to, amounted to £27.6m. This was subject to a SHA dispute process which resulted in the Trust having to credit £8.9m back to PCTs. It is clear as we move forward that the level of activity delivered by the Trust in 2009/10 cannot be afforded by PCTs. The Trust and PCTs have put in place a range of measures to ensure that we deliver, from quarter 2 of 2010/11, activity in line with the agreed "contract". Any over activity will be agreed on a rolling basis to avoid the need to invoke the dispute process in 2010/11.

## Capital

The Trust continues to make significant investments in capital as it prepares for the Fit for the Future changes to healthcare provision in North Staffordshire. In 2009/10 the Trust invested a further £16.9m (£40.5m in 08/09) in capital. The reduction from the previous year is due to the completion of the new maternity and cancer centres on the City General site during 08/09. The underlying level of investment remains the same in 2009/10. The main areas of investments were:

| Scheme Description | £'000 |
|---|---|
| Guy Hilton Research Centre | 191 |
| Maternity and Oncology Equipment | 699 |
| Pharmacy Robot | 693 |
| Neurointerventional Bi Plane | 1,079 |
| Critical Care | 1,029 |
| 4th Linac and Simulator | 568 |
| Paediatric Flexible Bronchoscopes | 101 |
| Echo Machines | 180 |
| Wireless Network Upgrade | 715 |
| Business Intelligence System | 200 |
| PC Replacements | 1,012 |
| Server Replacements | 234 |
| Monitoring System ICU | 363 |
| Mass Spectrometer | 175 |
| Blood Tracking Machines | 101 |
| Haemodialysis Machines | 490 |
| Digital Mammography | 239 |
| Clinical Skills Laboratory | 180 |
| FftF Enabling Works | 1,560 |
| Estates and General Works | 1,600 |
| Estates Rationalisation | 1,248 |
| Retained Estates Work | 1,351 |
| 9's Block Refurbishment | 379 |
| Flexible Endoscope | 466 |
| Privacy and Dignity | 132 |
| Radiotherapy equipment (PFI) | 5,933 |
| X ray equipment (PFI) | 282 |
| Other Schemes | 2,878 |
| Total Capital Spend | 24,078 |

In 2009/10 capital continued to be funded by a combination of internally generated funds (surplus from previous years and depreciation) and charitable donations.

## Financial challenges for 2010/11 and beyond

It seems that each year presents new and more difficult challenges. 2010/11 is no different. The Trust will have to achieve a significant cost reduction programme (£22m) as well as taking capacity out of the system (£12.6m). As important as achieving these target savings is the change in culture required to make it happen. The NHS has seen unprecedented growth over the last 10 years, but we are moving into a less certain financial era. Managing in a period of sustained growth is very different from managing in a period of reduced or flat funding, even if some sources of funding are protected. Every healthcare professional has a responsibility to ensure that we maximise the value to patients of every pound of tax payers' money we receive.

We also have a responsibility to ensure that we continue to drive up quality. The requirement to reduce costs and increase quality are not mutually exclusive objectives, indeed quality reduces costs.

For 2010/11 the Trust has restricted the level of capital spending to ensure that we retain sufficient cash resources. It is also in recognition that we have a major capital investment plan to complete the hospital once the main hospital construction is complete.

It is unlikely that we will see for a generation the levels of investment in the NHS that we have seen for the previous ten years. We still have a massive amount of resources. The task is to ensure that we deliver for the population of North Staffordshire even more services at higher quality in the future.

## Quarter of a million reasons to remember Guy

The parents of a 12-year-old who died from asthma in 2002 have raised £250,000 for research at University Hospital. John and Ro Hilton's fundraising is the highest single contribution from private individuals the Trust has ever received. The Trust named its research centre after Guy Hilton when it opened in 2006.

The research centre works closely with patients and its success is a fitting tribute to Guy. It is very important that, as a university hospital, the Trust is at the forefront of research in the region. Success breeds success and University Hospital, together with Keele University, is doing everything it can to improve the health of future generations.


*Mr and Mrs Hilton are pictured on a visit to the research centre named after their son with (left) Professor Andy Garner, Professor Warren Lenney and (right) Professor Gordon Ferns.*

# Teaching hospital and learning organisation

## Learning from experience

The vast majority of the 680,000 visits to our hospital this year resulted in very positive experiences for our patients. We want to give all our patients and their relatives the best possible service but we do recognise that there are times when not everything goes right and patients become so dissatisfied they raise complaints with us.

The mark of a learning organisation, which we strive to be, is that it listens when things go wrong and makes changes to avoid the same situations being repeated.

Whilst complaints can be uncomfortable for our staff, we know patients and relatives can feel more uncomfortable. They can sometimes worry that they will be in some way penalised if they complain whilst in hospital, which is certainly not the case.

Whilst we aim to give no cause for complaint, we want our patients to be confident that they can raise issues with us at the time. We encourage them to first talk over the problem informally with the ward sister or matron, who may well be able to resolve it so the remainder of the patient's stay is more positive. Our PALS (patient advice and liaison) team can provide extra help if needed.

If the issues cannot be resolved at this early stage a formal complaints process, common to all NHS organisations, is available to help us try to reach a satisfactory conclusion.

University Hospital is signed up to the 'Principles for Remedy' published by the Health Service Ombudsman. Our complaints processes include a commitment to getting it right, being patient focussed, being open and accountable, acting fairly and proportionately, putting things right and seeking continuous improvement.

Where someone makes a formal complaint we agree a timescale to allow us to investigate thoroughly and then share what we find. Some of the recommendations that come from looking into complaints are specific to the particular area and sometimes we change our practice more widely in the hospital.

Learning from things that occasionally go wrong in our own hospital is very important, but we also keep abreast of reports into problems at other hospitals and assess ourselves against the recommendations.

The issues highlighted in the recent independent inquiry into care provided by Mid Staffordshire Foundation Trust have been considered carefully by our Board, senior clinicians and senior managers. The findings of the inquiry will continue to feature strongly in our discussions and decisions to ensure we act in line with its recommendations.

## Sharing good practice

Our clinical governance department is the central point for assessing and monitoring the quality of service provision to help us achieve consistent good practice throughout the hospital. A major role for the department is to disseminate information from outside agencies and from investigations into adverse incidents to make sure our clinicians are aware of the most up to date practice to keep our patients safe and to provide the best possible care.

Our clinical guidelines staff keep abreast of research and published evidence on clinical practice. They produce comprehensive guidelines each year for doctors and nurses to promote consistent, safe care.

As members of the Bedside Clinical Guidelines Partnership, clinicians and patients in twenty-four trusts around the country benefit from the guidelines which are produced by University Hospital of North Staffordshire.

## Doctors of tomorrow

Our undergraduate medical school, which operates in partnership with Keele University, continues to be very popular with students who rated it in the top ten in a recent national survey.

The latest assessment of the medical school by the GMC in November 2009 supported the widely held high opinion and cited areas of particularly good practice.

Each year applications are oversubscribed, allowing us to take very high calibre students. This is reflected in the pass rate which is one of the highest in the country.

In addition to producing excellent doctors of the future, the medical school is a major draw when we are recruiting new consultants. The opportunity to teach on a successful and prestigious course is an attraction to high-achieving senior doctors who would normally be inclined towards working in major cities.

## Best research for best health

The government has recently changed the way it funds research in the NHS. The new system is designed to enable the best research and researchers to win grants for their work, regardless of where they are located. Previously, money was allocated on historic levels of funding, so smaller research units like ours often found it difficult to attract major grants.

The change has brought both challenges and opportunities for our research, much of which is based at the Guy Hilton Research Centre. Although overall funding levels are lower, we are able to compete with more established research centres by playing to our research strengths and aligning them with national initiatives, local priorities and clinical need.

We are members of clinical research networks covering stroke, cancer and medicine for children, all of which are particularly relevant to our local population. We are also members of the West Midlands North Comprehensive Local Research Network.

In November 2009 Professor Gordon Ferns joined the Trust as Director of Research and Development, a joint post with Keele University where he is Director of the Institute of Science and Technology in Medicine. He will be driving forward our research and development strategy, which has been formally signed off by the Trust Board, and forging closer links with the university.

Professor Ferns also has a clinical role at the Trust where he is professor in metabolic medicine and a consultant in clinical biochemistry.

This year University Hospital was named as one of only eight hyperacute stroke research centres. The award, worth £375,000 over three years, will allow us to put in place the infrastructure needed to conduct research in patients coming to hospital within the first nine hours of their stroke, the most critical period of their illness.

During 2009 we have had a number of research grant successes from the National Institute of Health Research, including support for the development of a novel saliva-based point of care biosensor and for the investigation of the root causes of excessive replicate pathology testing.

In partnership with Keele University we have secured £1.5m of research grant income during 2009/2010. This partnership delivers a 'bench to bedside' approach to research so that the results of research feed through to daily clinical practice in clinics and on the wards.

## Listening to our staff

When it comes to improving the way we do things in the organisation the best people to advise us are often our own staff. In 2009 we introduced a programme called Listening into Action. This aims to put our staff at the centre of change and to harness their knowledge and creativity in tackling issues that can sometimes get in the way of them providing the best possible care for our patients.

The programme was launched with a series of 'staff conversations' which were attended by over 400 members of staff from all parts of the Trust. During the sessions staff identified a number of issues they wanted to explore.

Work on twelve early adopter projects began in October, with a further 20 due to start in April.

In addition to the formal projects, staff identified a number of quick wins they would like to see in place. Among these are the staff ideas boxes which have been placed around the hospital so staff can put forward suggestions.

We aim to use the programme's approach in all areas of the Trust so that our staff are empowered to make changes and improvements, making us as efficient as possible while providing the safest and highest quality care for our patients.

## Cancer Centre's brush with art

Cancer patients at University Hospital are now surrounded by soothing and uplifting art during their treatment. The new Cancer Centre, which opened in summer 2009, has installed work from local artists to improve the feel of the corridors and waiting areas. Patients love the paintings and have told staff just how much they help them cope with such a traumatic time.

All of the artists feel privileged to have their work on show at the hospital. The aim is to allow the art to be uplifting but calming at the same time. Their belief is that the power of art can help the healing process.

The new centre has rightly been described as one of the best in the country and the artwork will only add to how people cope with their illness.

*The healing power of art at work in the new cancer centre.*

## Clean hands make safe hands

University Hospital called on two Port Vale Football Club goalkeepers to get the ball rolling for 2009's Infection Control Week. Chris Martin and Daniel Lloyd-Weston met children and parents on Cheethams to test out the hospital's hand hygiene training. Chris and Dan used special hand gel and ultra violet light to show how they need to clean their hands in the future.

Hospital staff were delighted the players supported the initiative to highlight the importance of hand hygiene in hospitals under the slogan "Clean Hands make Safe Hands". Chris even joked that, as a goalkeeper, it's vital to look after your hands, but even more so for those people visiting the hospital.

*Port Vale goalkeeper and Stoke City fan Izaak James find something to agree on with the Clean Hands Make Safe Hands campaign.*

# Excellence in healthcare

## How we performed

All NHS hospitals are monitored to make sure they are providing safe care of good quality. Information is collected on a wide range of measurements and targets and is used by regulators to monitor individual hospital performance and to compare hospital performances across the country. This shows where standards need to be raised and where good practice can be passed on to others.

Our own key performance indicators are monitored every month by our Trust Board so we can assure ourselves that we are meeting the standards set for us. Where we are not, the consistent monitoring enables us to address and resolve issues during the year.

Below are some of the key standards and how we performed over the last two years. The number of patients treated in every category (shown in the top part of the table) has increased in 2009/10 from the previous year.

| | 2009/10 | 2008/09 |
|---|---|---|
| **Number of inpatients and day cases treated (in spells)** | | |
| Elective inpatients | 13,294 | 12,815 |
| Elective day cases | 53,762 | 53,449 |
| Emergency inpatients | 68,657 | 61,215 |
| **Number of outpatients seen** | | |
| New appointments | 147,298 | 137,785 |
| Follow up appointments | 297,125 | 269,080 |
| **Number of emergency attendances** | | |
| A&E Department | 100,855 | 99,110 |
| **Waiting lists** | | |
| Total number on inpatient waiting list | 4,948 | 4,159 |
| Total number on outpatient waiting list | 8,599 | 7,336 |
| **Progress towards 18 week referral-treatment target** | | |
| Inpatients waiting longer than 26 weeks | 0 | 0 |
| Outpatients waiting longer than 13 weeks | 0 | 0 |
| Referral to Treatment (RTT): | | |
| 95% for non admitted | 96.91% | 95.95% |
| 90% for admitted patients | 91.34% | 91.69% |
| **A&E four-hour wait (target 98%)** | 97.80% | 96.62% |
| **Cancer waiting targets (percentage of patients within target time)** | | |
| 2 week wait referral to first outpatient appointment – all cancers | 94.4% | 99.78% |
| 31 day wait diagnosis to treatment – overall | 98.6% | 99.37% |
| 62 day wait referral to treatment – overall | 82.9% | 94.53% |
| **Infection Control** | | |
| MRSA total bacteraemia (limit 44) | 26 | 39 |
| C Difficile (limit 348) | 276 | 282 |
| **Access to genito-urinary medicine (GUM) clinics** | 99% | 100% |
| **Operations cancelled at short notice** | 893 (1.33%) | 884 (1.33)% |
| **Not re-arranged within the target time of 28 days** | 76 | 66 |
| **Complaints** | | |
| Total number of formal complaints received | 566 | 513 |
| Total number of complaints received by PALS | *1,258 | - |
| Percentage resolved within target time | 92% | 58% |

**The total figure is not comparable with last year as it now includes complaints received by the Patient Advice and Liaison Service (PALS). These are now considered to be formal complaints. The comparable figure is 566.*

In 2007 the Government set a target that, by December 2008, all hospitals had to ensure that 90% of patients requiring a planned admission waited no longer than 18 weeks and that 95% of patients not requiring admission were also seen within 18 weeks. We achieved that target and have sustained it through 2009/10. This means patients are being seen more quickly and getting the treatment they need sooner.

An additional requirement introduced in 2009 was the delivery of the 18 week target across all specialties. We are pleased to report that we have achieved this in 14 out of 15 specialties, the exception being orthopaedics where there is a national shortage of capacity. We will continue to work with national expert teams to ensure that we can meet this target in all specialties in the future.

We had broadly the same number of operations cancelled at short notice as last year. Avoiding cancellations remains a high priority for us because we know how distressing it can be for patients. What we consider routine in clinical terms is not routine for the patient concerned. If we have to cancel an operation at short notice we try to re-schedule it within 28 days. This year there were slightly more cases where we were not able to achieve this.

During this year we have continued to be extremely busy with 100,855 accident and emergency attendances, a slight rise from the previous year. We have seen an increase from last year to 97.80% of patients seen and admitted or discharged within four hours. Unfortunately this is just short of the 98% national target which we have worked very hard to meet because we know how important it is to our patients.

We have been badly affected this year by norovirus which started in the community unseasonably early and resulted in a significant number of wards being closed to new admissions over a long period. This meant there were periods when empty beds were not available to patients.

We are continuing to work with our primary care trusts to avoid unnecessary admissions and to secure timely discharges which are key to ensuring that patients receive the most appropriate care in the most appropriate place.

There have been significant increases in the number of outpatients seen, with over 9,000 more first appointments and 28,000 more follow up appointments in the year.

We have continued to see a reduction in our infection rates, demonstrating our continued commitment to tackling hospital acquired infections.

## Recognising the work of our staff

In September 2009 we re-launched our annual staff awards to recognise individual and team excellence within our workforce.
Seven awards recognised excellence in the patient experience, service improvement, non-clinical work, clinical innovation, improving working life and the environment and volunteer services. The final award winner, our employee of the year, was chosen from the star performers of the year's employee of the month awards which has continued through 2009/10.

## Innovations in practice

Whilst we try to improve the quality of care we provide on a day to day basis, our staff invest a good deal of time and money in making major leaps forward.

This year has seen many examples of new developments in our services.

Faecal incontinence can destroy a person's quality of life and can cause them to feel isolated and alone. Consultant surgeon, Mr Martin Farmer, has pioneered the use of sacral nerve stimulation implants in North Staffordshire. The electronic device gives people back control of their bowel and confidence in their daily lives.

University Hospital, which is already one of the country's leaders in the treatment of stroke, has become one of only five centres in the UK to offer intra-arterial thrombolysis.

The treatment involves inserting a tube through the arteries from the groin to the brain in order to deliver the drug direct to the clot in order to disperse it.

The treatment is suitable for around 20 of the 900 stroke patients we see each year but, without it, those patients would not survive or would be left severely disabled.

In a further development in the care of stroke patients, occupational therapists have introduced a Nintendo Wii to help patients improve their mobility. It encourages arm movements and helps the patients' balance and gait. As an added bonus it helps lighten patients' mood and relieves boredom.

Benefit to patients does not come solely from developments in clinical treatments. It takes a huge team with different skills to support the clinical work and they need to move forward at the same pace.

The hospital pharmacy has recently invested nearly £700,000 in a new drug dispensing unit which selects prescribed drugs from stock and packages them for use on the wards. It will cut down the processing time from around an hour to just a few minutes. Besides reducing the potential for error and improving stock rotation, the new unit will allow pharmacists to spend more time on the wards working with clinical staff on prescribing the most effective medication for their patients.

# Partnership and social responsibility

To be most effective University Hospital must work in partnership with related organisations and the people it serves. Staff in the Trust work closely with other NHS bodies, particularly the two local primary care trusts NHS Stoke and NHS North Staffordshire, local GPs, Keele University and the local authorities.

As one of the biggest employers in the area we also have a responsibility to the local economy and for our impact on the environment.

## 10 Big Conversations and more

To help give local people a voice in the way we run our services we held our 10 Big Conversations this year.

Looking at topics ranging from cancer to children's services and emergencies to finance, we invited the public to half day sessions in community centres throughout the area. The format of each session was a short presentation on the topic of the day, followed by group work looking at specific questions on the issues involved. Experts were on hand at each table to answer questions.

A few sessions attracted quite small numbers but most were attended by around 20 to 30 people. All the comment and feedback has been invaluable in telling us how the people who use our services feel about them and what we need to take into account when changing how we work.

We have promised to report to the people involved in each session to tell them what we have changed because of what they told us or, where we have not made changes, why not.

We have also met with community groups such as the disabled user group, a local Sikh group and a Muslim women's group, all of whom have been able to give us an insight into the particular difficulties they face and what we might be able to do to make things easier for them.

We have recently formed a Health Improvement Panel made up of volunteers who are interested in working with us on a more formal basis as a 'critical friend'. Working in sub-groups of special interest, they will look in more depth at issues raised by users to give us an external insight into how we can improve.

The panel, which has around 25 members, will act as ambassadors for the Trust where appropriate, as they will have detailed knowledge of our services and plans.

Our clinical governance committee has been joined by a public representative who is able to offer an external view and challenge.

## Linked to LINks

Stoke-on-Trent Local Involvement Network (LINk) aims to listen to local people about their thoughts and views on local health and social care services. The LINk is not about taking individual complaints, but is about empowering local people to identify how local services can be improved within their communities.

We are working closely with our local LINk because we believe that, with their contacts throughout the City, they will be able to add to the wealth of information and feedback from the people using our services.

The LINk has a monitoring role and we welcome the feedback they are able to give us. As their membership grows they will become an organisation through which we can demonstrate our accountability and responsiveness to our local population.

## Encouraging the workforce of the future

The NHS locally and nationally will continue to be a major employer requiring a vast range of skills and knowledge.

Our Healthcare Careers and Skills Academy has an established place in encouraging the workforce of the future through its partnerships with local agencies and schools.

The academy runs a range of programmes aimed at different groups. The Young Persons Learning Support Project aims to provide healthcare careers advice and information to young people aged 14-19, raising aspirations and encouraging them to explore careers in the NHS that meet their abilities and interests.

The Aspiring Health Careers Project aims to support young people making career choices at key stages such as GCSE, A Level and Degree.

The academy is lead partner for the National Young Apprenticeship in Health and Social Care Programme for 14 to 16 year olds.

32 students graduated in May 2009, nine with distinction. In the biggest partnership to date, 35 students from seven schools across the county started the programme in September 2009.

It is a tribute to the success of the academy's programme that Skills for Health have commissioned a further intake of 35 students in 2010.

## Our carbon footprint

The impact of carbon production on the climate and acidification of the seas is now widely accepted by the scientific community and the government has set challenging and mandatory targets for carbon reduction by 2015 and 2050.

The public sector in general and the NHS in particular are among the biggest generators of carbon, which led to the 'Saving Carbon, Improving Health' targets introduced in January 2009.

University Hospital approved a plan to meet these targets in May 2009 and joined the Carbon Trust's carbon reduction programme in August of the same year.

We are in an unusual position in having a major construction in part completion. This gives us opportunities for carbon reduction when we move into the new building, but the transition period will mean an inevitable increase in energy consumption and carbon production through construction, double running and commissioning.

Aside from the benefits we can achieve in the new hospital, however, we have identified a number of projects that will start to reduce our energy requirement. They include a comprehensive awareness campaign to encourage staff involvement, re-commissioning of the combined heat and power plant on the City General site and various engineering projects

In parallel with this work we will be exploring procurement carbon savings and opportunities to develop sustainable energy sources on site to meet the 2050 targets for 80% reduction in carbon emissions from 2000 figures.

## Ready for anything

We are required to have plans in place to deal with any major emergency situation and to have practised our response in readiness. This may be an incident outside the hospital involving mass casualties or any situation that could affect our ability to provide our normal services.

We comply with the Civil Contingencies Act 2004 and the NHS Emergency Planning guidance 2005 and associated regulations and guidance.

We test our preparedness through table top exercises designed to show up gaps in the plans. Where we have real incidents they demonstrate very clearly whether or not our plans are robust. Each occasion is a learning opportunity.

In May 2009 we had a 'white powder' incident that activated our chemical incident plan. This involved working with the other emergency services and, in A&E, caring for people who had been involved.

This was followed shortly afterwards by the H1N1 swine flu outbreak.

Planning proved invaluable during the swine flu outbreak. It came at a time when the Trust was facing its normal winter pressures alongside an unseasonably early start to norovirus, which closed a number of wards to new admissions.

The Pandemic Flu planning group met weekly and developed plans to manage effectively the impact of swine flu during the peak weeks to ensure that the capacity issues could be addressed.

In total 380 patients required hospitalisation between 31st August 2009 and 31st January 2010. Some required an inpatient stay of less than 24 hours. The peak in admissions occurred during week commencing 16th November with 20 adult in-patients and 26 paediatric in-patients with suspected or confirmed swine flu. Of these, 13 patients required admission to critical care areas. This was a good test of the flu plans and they proved to be robust, with no critical or essential services being compromised.

During the outbreak the Trust bought swab testing equipment for our Microbiology unit. This gave a rapid and confirmed diagnosis of whether patients had H1N1 or normal seasonal flu and proved to be a valuable asset in the management of isolation beds.

When it became available, the swine flu vaccine was quickly taken up by our front line clinical staff. The response has been very good, with 3,365 of around 4,000 eligible staff (84%) having accepted the vaccine by the end of March 2010. The Trust followed Department of Health guidance in generally confining the offer of vaccination to priority groups of health workers.

The next challenge facing the Trust is to implement robust business continuity plans throughout the hospital. Starting with our critical and essential services, this will ensure that the hospital can continue to provide such services during any disruptive challenge we may face. This is an ongoing project and will be our main emergency planning focus during the next financial year.

## Research at the speed of light

University Hospital has the first clinician in the UK to use a £250 million synchrotron machine in Oxfordshire for medical research. Dr Sulé-Suso hopes his research, which uses infrared light to identify markers on single cancer cells, will speed up diagnosis of lung cancer and result in fewer biopsies.

Lung cancer patients currently have a low survival rate so it would be a big step forward to cut down the time people must wait for treatment to begin. Dr Sulé-Suso hopes a breakthrough could be just four years away.

*Photograph courtesy of The Sentinel.*

*Dr Josep Sule Suso working on a breakthrough in lung cancer diagnosis*

# Specialised Services

University Hospital provides a full range of general acute services for our local population and is a tertiary centre, providing specialised services for people from a much wider area.

## Paediatric Intensive Care

Our Paediatric Intensive Care Unit (PICU) is part of the West Midlands networked system of paediatric intensive care. It is purpose-built for intensive care and the staff treat around 350 patients each year.

The unit is key to the provision of specialist paediatric spinal and complex paediatric orthopaedic surgery in the Trust and supports the level 3+ paediatric oncology and tertiary paediatric respiratory services.

The medical and nursing team maintains excellent outcomes on the unit. Standardised Mortality Ratios have consistently been less than 1.0, indicating that there are fewer patient deaths than predicted from the illness severity of the patients admitted.

Staff in our PICU have this year led the setting up of a regional retrieval service for children needing intensive care. The service takes responsibility for identifying a suitable bed and sends a trained team to transfer the patient from the admitting hospital to the specialist intensive care bed the child needs.

Our staff further support the service by providing outreach training to hospitals referring to our unit. They teach effective management of the patient until the retrieval team arrives to take over, ensuring the best possible outcome for the child.

## Spinal surgery

Spinal surgery is an area where we are not currently meeting the national waiting time target. Demand currently exceeds capacity throughout the country, so we are often unable to offer patients on our waiting list earlier appointments with other providers.

We currently have one locum and four permanent spinal surgeons, two of whom perform scoliosis deformity correction. This is a very long and complex operation that has to be supported by a number of specialist teams followed by a period in intensive care. It requires co-ordination of many different elements. If any become unavailable the operation has to be postponed, to everyone's distress.

In the face of a national shortage of spinal surgeons the team at University Hospital has been working differently to try and make the best possible use of the resources we have.

This includes a spinal practitioner post to ensure full utilisation of theatre time and a referral triage to ensure tests are carried out before the patient sees the consultant. This alone has so far reduced the overall pathway by three months. Virtual reviews mean patients do not necessarily have to attend the hospital and some of the spinal work will be carried out by our neurosurgeons to give us more capacity and flexibility.

## Neonatal Intensive Care Unit

Our Neonatal Intensive Care Unit (NICU) is a designated level 3 Neonatal Unit within the Staffordshire Shropshire and Black Country Newborn Network. It is a tertiary referral unit offering care to the most premature of infants from around the region, including as far afield as the Welsh Borders. The staff have cared for over 420 babies in the last year.

The 23 bedded unit in the new maternity centre has six intensive care, four high dependency and thirteen special care cots.

This year the unit has started offering a new treatment. Therapeutic Neonatal Hypothermia, or "total body cooling", is an intervention that has been shown in a national trial to reduce the level of disability and brain damage occurring in babies who have birth asphyxia. These babies may have low Apgar scores, the need for ongoing resuscitation or severe acidosis on blood gases at birth and then develop seizures or encephalopathy.

Cooling is believed to reduce secondary brain injury in such babies and hence improve the long term outcome. By cooling baby's temperature to 33-34 degrees C for 72 hours, those babies who would be mildly or moderately affected may have their outcome significantly improved. Our unit started offering this treatment in November 2009.

To improve parents' confidence in looking after their baby at home after a period in NICU, the staff are about to introduce an individualised family-centred care programme. Parents will be offered the opportunity to spend extended time on the unit, learning how to care for their baby under the supervision of staff. This will lessen the anxiety attached to taking a premature baby home and may lead to a reduction in the number of inappropriate re-admissions to the children's wards for supportive and reassurance needs.

# Service and workforce transformation

## Transformation in action

In order to be fit for purpose and to support clinicians in providing the best service in the new hospital, directors made the decision over two years ago to introduce a transformation programme. The programme operates under the banner of 'Everyone Improving Quality' and utilises lean management techniques to facilitate change.

We currently have over 25 transformation workstreams, including length of stay, lean discharge, pharmacy, service line management and specific individual department projects.Tremendous benefits have already been achieved in pathology reception processes, stroke care and fractured neck of femur pathways, all of which are led by dedicated clinicians bringing about real change.

The new cancer centre provided an early opportunity to realise the benefits of changing ways of working in a new building. The new centre brought together services that had previously been provided in different parts of the hospital. Chemotherapy and haematology came together in the new day case unit and inpatients from the two specialties are cared for on a single ward.

New developments that have benefited patients include extended opening hours (8am to 10pm) on the day case unit, giving more choice for treatment times. A new emergency triage unit on the inpatient ward means that around 20 to 30 patients each week go straight to the ward for immediate specialist treatment rather than having first to attend A&E.

The acute stroke service transformation project began in 2008 but the major benefits have been seen during this year.

The stroke unit is now housed at the Royal Infirmary. An outreach team provides support to A&E and other wards, and staff 'pull' stroke patients quickly into the acute stroke unit where they are cared for by the specialist team and early specialist therapy is initiated. There is greater multi-disciplinary working and a philosophy of 24 hour rehabilitation for patients.

In the first quarter of the year average length of stay on the unit was eight days, down from 14 in the same period of the previous year. The majority of stroke patients coming through A&E have a CT scan within four hours and thrombolysis rates of 10% are better than the national average.

The mortality rate on the unit, which is already among the best in the country, was down from 9% in July 2008 to 5% a year later.

The unit's staff have been involved in the transformation process and now record positive ward staff surveys and reduced sickness levels.

The success of ***Everyone Improving Quality*** was recognised at the Lean Healthcare Academy in their 2009 annual awards where University Hospital won the Lean Champion of the Year, Lean Organisation of the Year and Productive Ward Services categories.

North Staffordshire has been awarded a Health Innovation and Education Cluster grant in recognition of the success of our transformation programme, the development of Keele University Medical School and the work of the Healthcare Skills and Careers Academy.

The programme is extremely important as we head into the next decade in order to drive through real change and modernise healthcare within North Staffordshire to deliver efficient, effective care with a measurably enhanced patient experience.

## Fit for the Future and our new hospital

Fit for the Future is an ambitious project to improve the health of people across North Staffordshire.

Along with patients, the public and partner organisations NHS North Staffordshire and NHS Stoke-on-Trent, we are working to design new services and facilities around patients' needs. This means providing better health services in local communities as well as improved specialist hospital services and treatment.

By 2012 improvements to local health services will include more outpatient services at community hospitals and health centres, more services in the community and support to help staff work in different ways to deliver better care for patients.

The most visible signs of change are the new hospital buildings. Haywood Hospital, which is run by NHS Stoke on Trent, opened in autumn 2009.

Construction work at University Hospital is on track. The £300m building programme will bring all University Hospital's acute services on to one site at the City General.

In April 2009 we moved in to our new Maternity Centre and in July we moved in to the adjacent new Cancer Centre.

Both centres now provide an environment for our patients that reflect the expertise of our staff.

## Our new Maternity Centre

Around 6,000 babies are born in our Maternity Centre each year. 1,500 of these are born in our Midwife Birth Centre which is vastly improved from the community ward in the old building. The midwife-led service has 11 en-suite delivery rooms with hydrotherapy baths to help with pain relief. The women stay in their own room throughout labour, the birth and post-natal care, as everything they need is either in the room or can be brought to them.

There is also a special room with a birthing pool for those who choose this option for their delivery.

Shortly after moving into the new facility the Midwife Birth Centre won an All Party Parliamentary Group on Maternity award for 'Tailoring Services to the Needs of the Fathers'. Their 'Preparation for Birth' classes provide fathers with a definite role to play during labour and the birth of their child, increasing their confidence and helping them feel more supportive.

The theatres have state-of-the-art equipment and much improved facilities for women who have more complex needs. The 16 rooms on the delivery suite now include high dependency rooms and a larger room for multiple births and women with a disability who need more space.

Each of the two inpatient wards has four 4-bedded bays and 12 single rooms. All are en-suite and have excellent catering facilities for women and their partners.

The antenatal facilities are light, airy, welcoming and, most importantly, discreet. Instead of the old curtained cubicles, women are now seen in consulting rooms which provide privacy and promote dignity.

The neonatal unit is startlingly different from the old unit. Our level three facility provides intensive care for new babies in North Staffordshire and beyond in the most modern environment that reflects the quality of the service. There are three sections for intensive, high dependency and special care. Parents who want to stay with their babies can be accommodated in the six en-suite family rooms.

The new Maternity Centre has been very well received by patients and staff and, along with the Cancer Centre, gives a taste of what is to come when we move into the main new hospital buildings.

## Our new Cancer Centre

The new Cancer Centre has brought together services that used to be housed in different parts of the hospital.

The new radiotherapy department has the most up to date technology in the country with its four new linear accelerators. The new machines target tumours with pinpoint accuracy and minimal damage to surrounding tissue. Treatment time for many tumours has reduced, some from 25 minutes to two minutes. The department now treats 1,000 patients each week.

The design of the day case unit achieves a balance between patients being safely visible to staff but having privacy if they want it.

The inpatient ward has a mix of four 4-bedded bays and single rooms, all en-suite, and the isolation rooms now have natural light and more comfort for the patients.

Two services have been introduced to the new centre. It now has a 4-bedded emergency assessment bay so cancer patients can go straight to the expert care they need 24 hours a day without having to attend A&E first.

The new brachytherapy suite provides specialist treatment for gynaecological cancers as day case procedures. Previously, patients were referred to other hospitals as inpatients for two or three days at a time.

Formally opening the new centre, Professor Mike Richards, National Cancer Director, said, "Cancer affects one in three people and they need the very best care and the very best technology in an environment as relaxed from fear as possible. We can now say that, in North Staffordshire, you have got that. This now needs to be replicated across the country as you have set the tone for everywhere else. All districts must aspire to make tremendous facilities like this available for their patients."

## UNIVERSITY HOSPITAL TOPS ORGAN DONATION TABLE

2009/2010 was an exceptionally good year for organ donation at University Hospital of North Staffordshire. For the first year ever the Trust was the biggest provider of organs for transplant from all the Midlands hospitals with a total of 17 proceeding organ donors.

Julie Pascoe, organ donation nurse specialist, was delighted with the numbers. She said, "Organs from these 17 organ donors have been transplanted in centres around the UK, in fact one set of lungs even went to Switzerland.

"This has enabled 61 people to receive whole organ transplants, transforming their quality of life. In many cases this has been life saving. None of this would have been possible without the dedicated work of all the staff at University Hospital. On behalf of all the transplant recipients and their families we would like to take this opportunity to thank them and those they have worked with."


*Julie Pascoe wants you to think about signing onto the donor register*

# Our Trust Board

Our Board comprises five executive directors, five non-executive directors and a non-executive chairman, all of whom have voting rights. There are also five non-voting executive Board members. Some of these directors sit on sub-committees of the Board, as well as the Board itself. This is summarised in the table below:

| **Membership of Trust Board sub-committees** | **Remuneration** | **Audit** | **Governance and risk** | **Charity** |
|---|---|---|---|---|
| Julia Bridgewater Chief Executive (director from 13th July 2007) | | | ✓ | ✓ |
| Chris Calkin Director of Finance/ Deputy Chief Exec (from 1st January 2008) | | | ✓ | ✓ |
| Vanessa Gardener Chief Operating Officer (from 14th September 2009) | | | ✓ | |
| Robert Courteney-Harris Medical Director (from 1st January 2008) | | | | ✓ |
| Elizabeth Rix Chief Nurse (from 1st January 2010) | | | ✓ | |
| Mike Brereton Chairman (from 15th November 2006) | Chair | | Chair | Chair |
| Professor Paulene Collins Non-executive Director (from 15th February 2007) | ✓ | ✓ | ✓ | |
| Kevin Fox Non-executive Director (from 1st July 2006) | ✓ | ✓ | ✓ | |
| Professor Andy Garner Non-executive Director (from 16th November 2006) | ✓ | ✓ | ✓ | |
| Keith Norton Non-executive Director (from 1st October 2006) | ✓ | Chair | ✓ | ✓ |
| Ian Tordoff Non-executive Director (from 1st July 2006) | ✓ | ✓ | | |
| **OTHER BOARD MEMBERS DURING 2009/10** | | | | |
| Sarah Byrom Chief Nurse (until 30th November 2009) | | | ✓ | |

*Julia Bridgewater Chief Executive*

*Chris Calkin Director of Finance / Deputy Chief Exec*

*Robert Courteney-Harris Medical Director*

*Vanessa Gardener Chief Operating Officer*

*Elizabeth Rix Chief Nurse*

*Sarah Byrom Chief Nurse*

*Mike Brereton Chairman*

*Professor Andy Garner Non-executive Director*

*Professor Paulene Collins Non-executive Director*

*Keith Norton Non-executive Director*

*Ian Tordoff Non-executive Director*

*Kevin Fox Non-executive Director*

**The four non-voting members of the Board are:**

Andrea Green, Director of Foundation Trust Development (director from 1st October 2006)

Margot Johnson, Director of Human Resources (from 17th October 2003)

Jane Marshall, Director of Strategy and Planning (from 1st February 2009)

Andrew Underwood, Director of Corporate Services (from 1st December 1998)

## Board appointments

During the financial year, Vanessa Gardener, who had taken up the post of Acting Chief Operating Officer in the previous year, was appointed to the post substantively on 14th September.

Sarah Byrom, Chief Nurse, took up an external secondment on 1st June 2009 and left the Trust at the end of November 2009. Julie Smith took up the role of Acting Chief Nurse from 1st June 2009 to 23rd August 2009. Eliizabeth Rix, who joined us on secondment on 24th August 2009, was appointed substantively to the post of Chief Nurse at the start of the calendar year.

## Remuneration

Our Trust Chairman and non-executive directors are appointed through a formal recruitment process by the NHS Appointments Commission. They are appointed to serve for an initial term of four years. The chairman works a minimum of three to three and a half days a week and the non-executive directors two and a half days a month. Their remuneration is fixed nationally. They receive no pension.

Our executive directors are appointed by formal appointment panels and have standard substantive NHS contracts. The notice period for executive directors is six months. Retirement and severance conditions are in line with national contractual arrangements.

Remuneration for executive directors is fixed by the Remuneration Committee which comprises the Chairman and non-executive directors. Remuneration is benchmarked to be in line with the salaries for similar posts in other large trusts and annual increases are in line with recommendations by the Secretary of State for Health.

University Hospital does not operate a bonus system and directors do not receive performance-related pay. Nonetheless, their performance is subject to annual appraisal.

Where directors have joined or left our Trust during 2009/10 this is indicated in the previous table of Board and Committee memberships.

## New cancer centre raises the bar

Professor Richards, National Cancer Director, was astounded by the environment in the new cancer centre when he performed the official opening in December 2009.

He said, “Cancer affects one in three people and they need the very best care and the very best technology in an environment as relaxed from fear as possible. We can now say that the people of North Staffordshire and the surrounding areas have got that.

“This standard needs to be replicated across the country as you have set the tone for everywhere else. I have spoken to patients whose treatment started in the old facilities and they cannot believe the transformation. Natural light and open space is everywhere.”

Commenting on the state of the art linear accelerators, Professor Richards said, “The new radiography equipment means tumours can be treated so precisely that people can be seen as day cases instead of spending nights in a hospital bed.”

Mike Brereton, Trust Chairman, said: “The size of the area, the natural light and the standard of care means no one has seen a service like this in North Staffordshire before. We have always provided great care but we now have facilities that are some of the best in Britain.”

*Mike Brereton, Chairman, (left) with Mike Richards at the formal opening of the new cancer centre, a very happy occasion*

Details of remuneration, pension etc for directors who served in 2009/10 are given in the following tables.

## Remuneration report – gross pay

| Director | 2009/10 Salary | 2009/10 Other remuneration | 2009/10 Benefits in kind | 2008/9 Salary | 2008/9 Other remuneration | 2008/9 Benefits in kind |
|---|---|---|---|---|---|---|
| | Bands of £5,000 | Bands of £5,000 | Rounded to the nearest £'000 | Bands of £5,000 | Bands of £5,000 | Rounded to the nearest £'000 |
| Mrs J Bridgewater Chief Executive | 165-170 | - | - | 160-165 | - | - |
| Mr R Courteney-Harris Medical Director | 30-35 | 130-135 | - | 30-35 | 130-135* | - |
| Mrs S Byrom Chief Nurse until 01.06.09 | 15-20 | - | - | 100-105 | - | - |
| Mrs J Smith Acting Chief Nurse 01.06.09 to 23.08.09 | 25-30 | - | - | N/A | N/A | N/A |
| Mrs E Rix Chief Nurse from 24.08.09 | 60-65 | - | - | N/A | N/A | N/A |
| Mr C Calkin Director of Finance | 130-135 | - | - | 130-135 | - | - |
| Mrs V Doyle Chief Operating Officer (to December 2008) | N/A | N/A | N/A | 130-135 | - | - |
| Mrs V Gardener Chief Operating Officer (from December 2008) | 105-110 | - | - | 25-30 | - | - |
| Mr M Brereton Chairman | 20-25 | - | - | 20-25 | - | - |
| Mr K Norton Non-executive director | 5-10 | - | - | 5-10 | - | - |
| Mr I Tordoff Non-executive director | 5-10 | - | - | 5-10 | - | - |
| Mr K Fox Non-executive director | 5-10 | - | - | 5-10 | - | - |
| Prof A Garner Non-executive director | 5-10 | - | - | 5-10 | - | - |
| Prof P Collins Non-executive director | 5-10 | - | - | 5-10 | - | - |

**This figure has been restated from the 2008-09 Annual Report*

The remuneration information disclosed in the table above has been subject to audit.

Included in the salary costs disclosed above is an amount of £34,936 paid to Abertawe Bro Morgannwg University NHS Trust in respect of Mrs E Rix for the period 24th August 2009 to 31st December 2009.

The Trust has made no payments in respect of early termination of directors' service contracts in either 2009/10 or 2008/09.

There are four non voting executive members of our Trust Board who have direct accountability to the Chief Executive for their areas of responsibility. These directors have no formal voting rights on our Trust Board, although they do attend our Trust Board meetings and report on their areas in terms of strategy, performance and risks associated with their areas of responsibility. Their remuneration is not disclosed.

## Remuneration report – directors' expenses

| Full Name | Title | Value £ |
|---|---|---|
| Mr M Brereton | Chairman | 1,991.12 |
| Mrs J Bridgewater | Chief Executive | 948.76 |
| Mr C Calkin | Director of Finance | 1,173.80 |
| Mrs V Gardener | Chief Operating Officer | 137.75 |
| Mrs S Byrom | Chief Nurse | 214.78 |
| Prof P Collins | Non-Executive Director | 1,814.72 |
| Mr K Fox | Non-Executive Director | 802.22 |
| Prof A Garner | Non-Executive Director | 253.72 |
| Mr K Norton | Non-Executive Director | 1,635.05 |
| Mr I Tordoff | Non-Executive Director | 650.35 |
| **Total for 2009-2010** | | **9,622.27** |

## Remuneration report – pensions

| Director | Real increase in pension at age 60 | Real increase in pension lump sum at age 60 | Total accrued pension at age 60 at 31st March 2010 | Lump sum at age 60 related to accrued pension at 31st March 2010 | Cash equivalent transfer value at 31st March 2010 | Cash equivalent transfer value at 31st March 2009 | Real increase in cash equivalent transfer value | Employer's contribution to stakeholder pension |
|---|---|---|---|---|---|---|---|---|
| | Bands of £2,500 | Bands of £2,500 | Bands of £5,000 | Bands of £5,000 | £'000 | £'000 | £'000 | £'000 |
| Mrs J Bridgewater Chief Executive | 0-2.5 | 0-2.5 | 50-55 | 150-155 | 895 | 813 | 42 | - |
| Dr R Courteney-Harris Medical Director | 0-2.5 | 0-2.5 | 40-45 | 120-125 | 786 | 706 | 44 | - |
| Mrs S Byrom Chief Nurse until 01.06.09 | N/A | N/A | N/A | N/A | N/A | 550 | N/A | N/A |
| Mrs E Rix Chief Nurse from 24.08.09 | 0-2.5 | 0-2.5 | 25-30 | 85-90 | 498 | 429 | 15 | - |
| Mr C Calkin Director of Finance | 0-2.5 | 0-2.5 | 60-65 | 185-190 | 1,557 | 1,426 | 59 | - |
| Mrs V Gardener Chief Operating Officer | 2.5-5 | 10-12.5 | 15-20 | 55-60 | 236 | 169 | 59 | - |

The pensions information disclosed in the table above has been subject to audit.

## Declarations of interest

| NAME | DATE FROM | DATE TO | POSITION | INTEREST |
|---|---|---|---|---|
| **Executive directors** | | | | |
| J Bridgewater | April 2009 | March 2010 | Chief Executive | No interests to declare |
| E Rix | Jan 2010 | March 2010 | Chief Nurse | No interests to declare |
| R Courteney-Harris | April 2009 | March 2010 | Medical Director | Private practice at the Nuffield Hospital |
| V Gardener | Sept 2009 | March 2010 | Chief operating Officer | No interests to declare |
| C Calkin | April 2009 | March 2010 | Director of Finance/ Deputy Chief Executive | Trustee of HfMA to 11th December 2009<br>Lecturer at Keele (MBA Finance module and ad hoq presentations<br>Spouse employed by the Trust |
| A Underwood | April 2009 | March 2010 | Director of Corporate Services and Fit for the Future Project | No interests to declare |
| M Johnson | April 2009 | March 2010 | Director of Human Resources | No interests to declare |
| J Marshall | April 2009 | March 2010 | Director of Strategy and Planning | No interests to declare |
| A Green | April 2009 | March 2010 | Director of Foundation Trust Development | No interests to declare |
| **Non-executive directors** | | | | |
| M Brereton | April 2009 | March 2010 | Chairman | No interests to declare |
| K Norton | April 2009 | March 2010 | Non-executive director | Director/Company Secretary and Honorary Treasurer of Newport (Shropshire)Cottage Care Trust Ltd |
| K Fox | April 2009 | March 2010 | Non-executive director | No interests to declare |
| I Tordoff | April 2009 | March 2010 | Non-executive director | No interests to declare |
| A Garner | April 2009 | March 2010 | Non-executive director | Dean for Health at Keele University<br>Non-executive Chair of Dermal Technology Lab Ltd |
| P Collins | April 2009 | March 2010 | Non-executive director | Trustee – Prees Medical Fund (registered charity)<br>Lay Chair of Continuing Health Care Funding Review Panels at West Midlands Strategic Health Authority and South Staffordshire PCT |

## Summary financial statements

A commentary on our financial position is included earlier in this report in Our Headline Finances. The following pages are our Summary Financial Statements.

The Trust has presented its accounts under International Financial Reporting Standards (IFRS) for the first time in 2009/10.

The ***Statement of Comprehensive Income*** shows how much money we earned and how we spent it. The main source of our income is primary care trusts, with which we have agreements to provide services for their patients.

Our biggest expense is on the salaries and wages of our staff. On average during this year we employed the equivalent of 6,359 full-time staff (compared with 6,102 last year). The actual number of people working for the Trust is more because a number work part-time (therefore, the full-time equivalent is less).

We also spend money buying services from other parts of the NHS, mainly ambulance transport for our patients.

We buy clinical and general supplies, maintain our premises, some of the costs of which are payable to our PFI partner, and pay for gas and electricity, rent and rates. We also allow for depreciation, the wearing out of buildings and equipment which needs to be replaced.

Our ***Statement of Financial Position*** summarises our assets and liabilities. It tells us the value of the land, buildings and equipment we own and of supplies we hold in stock for the day to day running of the hospital. It also shows money owed to us and the money we owe to others, mainly for goods and services received but not yet paid for. From 2009/10 under International Financial Reporting Standards it also shows buildings and equipment that are legally owned by our PFI partner and related borrowings which will be settled through the unitary payments we make over the term of the PFI contracts.

The ***Statement of Cash Flows*** shows where the money has come from, the way in which cash has been used and any net increase or decrease in cash during the year.

The ***Better Payment Practice Code*** shows how quickly we pay our bills. As a result of our deficit our performance against this policy has been poor compared with previous years.

We also include details of a number of other aspects of our financial position.

**STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2010**

| | **2009/10 £000** | 2008/09 £000 |
|---|---|---|
| **Revenue** | | |
| Revenue from patient care activities | **355,968** | 321,104 |
| Other operating revenue | **52,970** | 50,238 |
| Operating expenses | **(463,216)** | (371,706) |
| **Operating surplus (deficit)** | **(54,278)** | (364) |
| **Finance costs** | | |
| Investment revenue | **70** | 679 |
| Other gains and (losses) | **(126)** | (168) |
| Finance costs | **(621)** | (394) |
| **Surplus/(deficit) for the financial year** | **(54,955)** | (247) |
| Public dividend capital dividends payable | **(7,515)** | (7,597) |
| **Retained surplus/(deficit) for the year** | **(62,470)** | (7,844) |
| **Other comprehensive income** | | |
| Impairments and reversals | **(16,937)** | (5,448) |
| Gains on revaluations | **12,539** | 0 |
| Receipt of donated/government granted assets | **605** | 801 |
| Transfers from donated and government grant reserves | **(885)** | (580) |
| **Total comprehensive income for the year** | **(67,148)** | (13,071) |

**STATEMENT OF FINANCIAL POSITION AS AT**
31 March 2010

| | **31 March 2010** | 31 March 2009 | 1 April 2008 |
|---|---|---|---|
| | **£000** | £000 | £000 |
| **Non-current assets** | | | |
| Property, plant and equipment | **185,079** | 249,731 | 219,596 |
| Intangible assets | **944** | 298 | 258 |
| Trade and other receivables | **1,255** | 796 | 0 |
| **Total non-current assets** | **187,278** | 250,825 | 219,854 |
| **Current assets** | | | |
| Inventories | **7,278** | 6,266 | 5,306 |
| Trade and other receivables | **41,825** | 51,826 | 95,730 |
| Cash and cash equivalents | **19** | 5 | 6 |
| **Total current assets** | **49,122** | 58,097 | 101,042 |
| **Current liabilities** | | | |
| Trade and other payables | **(28,252)** | (36,544) | (37,792) |
| Other liabilities | **0** | (15) | (9) |
| Borrowings | **(242)** | (118) | (114) |
| Provisions | **(548)** | 0 | 0 |
| **Total current liabilities** | **(29,042)** | (36,677) | (37,915) |
| **Non-current liabilities** | | | |
| Borrowings | **(19,904)** | (18,660) | (1,820) |
| Trade and other payables | **(2,973)** | (1,422) | 0 |
| Provisions | **(137)** | (671) | (483) |
| **Total non-current liabilities** | **(23,014)** | (20,753) | (2,303) |
| **Total assets employed** | **184,344** | 251,492 | 280,678 |
| **Financed by taxpayers' equity** | | | |
| Public dividend capital | **172,393** | 172,393 | 188,508 |
| Retained earnings | **(40,578)** | 16,481 | 22,099 |
| Revaluation reserve | **48,328** | 57,537 | 65,211 |
| Donated asset reserve | **3,032** | 3,350 | 3,649 |
| Government grant reserve | **1,169** | 1,731 | 1,211 |
| **Total taxpayers' equity** | **184,344** | 251,492 | 280,678 |

## STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2010

| | 2009/10 £000 | 2008/09 £000 |
|---|---|---|
| **Cash flows from operating activities** | | |
| Operating surplus/(deficit) | **(54,278)** | (364) |
| Depreciation and amortisation | **18,412** | 16,679 |
| Impairments and reversals | **65,007** | 7,243 |
| Transfer from donated asset reserve | **(506)** | (524) |
| Transfer from government grant reserve | **(379)** | (56) |
| Interest paid | **(191)** | (85) |
| Dividends paid | **(7,515)** | (7,597) |
| (Increase)/decrease in inventories | **(1,012)** | (960) |
| (Increase)/decrease in trade and other receivables | **9,542** | 43,434 |
| Increase/(decrease) in trade and other payables | **(5,998)** | 1,175 |
| Increase/(decrease) in other current liabilities | **(15)** | 0 |
| Increase/(decrease) in provisions | **14** | 188 |
| **Net cash inflow/(outflow) from operating activities** | **23,081** | 59,133 |
| Interest received | **69** | 679 |
| (Payments) for property, plant and equipment | **(23,457)** | (45,998) |
| Proceeds from disposal of plant, property and equipment | **141** | 2,431 |
| (Payments) for intangible assets | **(686)** | (80) |
| **Net cash inflow/(outflow) before financing** | **(852)** | 16,165 |
| Public dividend capital received | **0** | 35,000 |
| Public dividend capital repaid | **0** | (51,115) |
| Other loans received | **1,078** | 0 |
| Capital element of finance leases and PFI | **(212)** | (51) |
| **Net increase/(decrease) in cash and cash equivalents** | **14** | (1) |
| **Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year** | **5** | 6 |
| **Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year** | **19** | 5 |

## STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

| | Public dividend capital (PDC) £000 | Retained earnings £000 | Revaluation reserve £000 | Donated asset reserve £000 | Gov't grant reserve £000 | Total £000 |
|---|---|---|---|---|---|---|
| **Balance at 31 March 2008** | 188,508 | 22,099 | 65,211 | 3,649 | 1,211 | 280,678 |
| Retained surplus/(deficit) for the year | 0 | (7,844) | 0 | 0 | 0 | (7,844) |
| Transfers between reserves | 0 | 2,226 | (2,226) | 0 | 0 | 0 |
| Impairments and reversals | 0 | 0 | (5,448) | 0 | 0 | (5,448) |
| Receipt of donated/ government granted assets | 0 | 0 | 0 | 225 | 576 | 801 |
| Transfers from donated asset/gov't grant reserve | 0 | 0 | 0 | (524) | (56) | (580) |
| New PDC received | 35,000 | 0 | 0 | 0 | 0 | 35,000 |
| PDC repaid in year | (51,115) | 0 | 0 | 0 | 0 | (51,115) |
| **Balance at 31 March 2009** | **172,393** | **16,481** | **57,537** | **3,350** | **1,731** | **251,492** |
| Retained surplus/(deficit) for the year | 0 | (62,470) | 0 | 0 | 0 | (62,470) |
| Transfers between reserves | 0 | 5,411 | (5,411) | 0 | 0 | 0 |
| Impairments and reversals | 0 | 0 | (16,002) | (681) | (254) | (16,937) |
| Net gain on revaluation of property, plant, equipment | 0 | 0 | 12,204 | 264 | 71 | 12,539 |
| Receipt of donated/ government granted assets | 0 | 0 | 0 | 605 | 0 | 605 |
| Transfers from donated asset/gov't grant reserve | 0 | 0 | 0 | (506) | (379) | (885) |
| **Balance at 31 March 2010** | **172,393** | **(40,578)** | **48,328** | **3,032** | **1,169** | **184,344** |

**Better Payment Practice Code**

The target is to pay trade creditors within 30 days of receipt of a valid invoice.

| | 2009/10 Number | 2009/10 £000 | 2008/09 £000 |
|---|---|---|---|
| Total bills paid | 86,511 | 165,911 | 176,286 |
| Total bills paid within target | 80,236 | 151,878 | 167,398 |
| Percentage of bills paid within target | 93% | 92% | 95% |

**Cumulative year on year Trust financial position**

| Year | Turnover £000 | Surplus/(deficit) £000 |
|---|---|---|
| 1997/98 | 152,393 | (1,199) |
| 1998/99 | 165,535 | (1,246) |
| 1999/2000 | 182,744 | 1,279 |
| 2000/01 | 193,823 | 1,225 |
| 2001/02 | 212,576 | 18 |
| 2002/03 | 235,801 | 4 |
| 2003/04 | 257,641 | 3 |
| 2004/05 | 295,327 | 41 |
| 2005/06 | 299,619 | (15,059) |
| 2006/07 | 333,855 | 311 |
| 2007/08 | 393,915 | 3,990 |
| 2008/09 | 372,499 | 3,008 |
| 2009/10 | 408,938 | 5,312 |
| Cumulative break-even position | | (2,313) |

**Management costs**

| | 2009/10 £000 | 2008/09 £000 |
|---|---|---|
| Management costs | 12,310 | 9,105 |
| Income | 408,938 | 372,497 |
| Percentage of income | 3.01% | 2.44% |

To demonstrate that we are running our Trust properly we are required to publish a number of statements which are signed by our Chief Executive on behalf of our Trust Board. These statements cover our financial affairs as well as a number of other aspects of managing our Trust.

Our external auditor also checks our accounts and other aspects of our work and we are required to publish statements from them confirming that they are satisfied with what we have done. These formal statements are reproduced on these pages.

## Our external auditor

Our accounts are externally audited by the Audit Commission to meet the statutory requirements of the Department of Health. They received fees of £252,000.

## Pension costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. 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. As a consequence it is not possible for our Trust to identify our share of the underlying scheme assets and liabilities. Therefore the scheme is accounted for as a defined contribution scheme and the cost of the scheme is equal to the contributions payable to the scheme for the accounting period.

## Full accounts

A full set of audited accounts for University Hospital of North Staffordshire NHS Trust is available on request or can be viewed and downloaded on our website, www.uhns.nhs.uk

**Julia Bridgewater**
Chief Executive

**Chris Calkin**
Director of Finance

# STATEMENT ON INTERNAL CONTROL 2009/10

## 1. Scope of responsibility

The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets, for which I am personally responsible as set out in the Accountable Officer Memorandum.

In order to achieve these objectives a governance and management framework has been established which includes

- An annual Performance Management Framework which monitors and manages achievement of the Trust's strategic objectives. The Trust Board agrees a set of key performance indicators at the start of each financial year. These include national and local targets which are reviewed each month by the Trust Board and the relevant sub committees
- Each executive director has a defined set of operational areas of responsibilities and these are linked to the delivery of the strategic objectives
- The Trust's Standing Orders, Risk Management policies and Standing Financial Instructions are reviewed and updated annually and these are supported by a detailed Scheme of Reservation and Delegation of powers
- Ongoing internal and external reviews of the governance structures in place across the organisation including the Board development programme
- Ongoing partnership working towards the delivery of the Fit for the Future project which includes the new hospital, a redesign in the way in which some services are delivered across North Staffordshire and liaison with key partners within the Local Health Economy including the Strategic Health Authority.

These arrangements have been further strengthened during 2009/10 with

- A continuing programme of involvement and engagement with members of the public, community groups, patient groups and health scrutiny committees as set out in the Involvement Strategy
- Continuing to hold open public board meetings
- The continuation of pre public board meeting briefings, where members of the public have the opportunity to focus on specific issues coming out of the Trust Board papers
- Delivery of 'Listening into Action', a staff engagement programme that has helped to build a positive and sustainable system of staff engagement
- Continued to evolve the assurance framework during 2009/10 to build on the assurances received
- Regular meetings with partner organisations including the local PCTs and Local Authorities
- Achievement of compliance with all Care Quality Commission core standards which demonstrates a level of robustness in service delivery not previously achieved
- Becoming a member of the national programme for Local Improvement in Patient Safety (LIPS)
- Development of a trust wide mortality review group reporting to the Clinical Governance Committee
- Development and roll out of service line management across the Trust for implementation from April 2010
- Significant improvements in reducing hospital acquired infections, with both C Diff and MRSA rates below targets set
- A positive report from the Care Quality Commission Hygiene inspection.
- Audit committee development programme
- Revised terms of reference for the main sub committees of the Board
- Divisional performance reviews alternate months and full six month reviews
- Appointment of a new Chief Nurse, Chief Operating Officer and Deputy Chief Operating Officer
- Corporate ownership of the cost improvement programme required by the organisation; integration with performance processes and the establishment of a Programme Management Office to oversee it.

As Accountable Officer, I work with a number of partner organisations and report on the progress of the Fit for the Future programme and other developments including the 18 weeks health economy group. This progress is monitored by the Strategic Health Authority. An Annual Financial Plan is submitted to the Strategic Health Authority, in addition to financial monitoring returns on a monthly basis. The monthly returns go to the Strategic Health Authority and are then reported to the Department of Health.

As Chief Executive I attend regular meetings with the Chief Executives of NHS North Staffordshire and NHS Stoke on Trent. These meetings concentrate on local and immediate priorities. The Strategic Health Authority attend some of these meetings and support the output and agreed actions.

The Trust continues to build engagement and public accountability and scrutiny through work with the four local overview and scrutiny committees and the two local LINKs. We have continued to work closely with them this year to ensure stakeholders are involved in understanding the work, achievement and challenges of the Trust. The Trust is committed to actively reporting and listening to their views.

The Trust has facilitated a series of "Big Conversations" with the public throughout 2009/10 as part of the Trust Involvement Strategy. The process has secured the public views on seven services and three governance topics of patient safety and quality, accountability and finance. The Trust has continued with the journey to achieve Foundation status and built membership to over 700 public members, with over 100 expressions of interest in becoming a Governor. The Trust continues to build communication with members about the work at the Trust.

The Trust declared full compliance against all CQC standards in the mid year and annual health check declarations. The national standards have been fully embedded into the Trust Assurance Framework and Risk and Assurance registers. The Trust registered with the

Care Quality Commission in January 2010 and received confirmation of registration without conditions in the second wave of national announcements by the CQC.

### 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 organisation's policies, aims and objectives
- 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 University Hospital for the year ending 31 March 2010 and up to the date of approval of the annual report and accounts.

### 3. Capacity to handle risk

The Trust is committed to providing high quality services in a safe and secure environment. As Chief Executive, supported by the Trust Board, I have overall responsibility and accountability for all aspects of risk management within the Trust, making sure that the organisational objectives are supported by a robust structure and resources are in place to ensure this occurs.

We continued to use the Assurance Framework we developed in autumn 2008. The Risk Management and Assurance Strategy and Policy was updated in 2009, the terms of reference for the Audit Committee and Governance and Risk Committee were reviewed and agreed in March 2010. The risk management process is led through the Executive Structure which outlines the key areas of responsibility in achievement of the organisation's objectives for each Executive. The Executives have the responsibility to provide leadership for the risk management process in these key areas and there is a corporate risk register in place. Ownership at a local level is achieved through operational managers having responsibility for risk identification, assessment and control and divisional risk registers are in place. Extreme corporate risks are reported to the Governance and Risk Committee and Executive Committee on a monthly basis, alongside the performance report which also includes exception reporting in respect of key risks.

The Clinical Governance, Audit and Risk team has provided training in assessing and managing risk throughout the year. During 2009/10 the Trust has continued to develop 'Datix' as the system from which the Trust seeks assurance in respect of its key objectives. The Trust utilises Datix to register risks, controls, assurances, gaps in controls and supporting evidence. Datix continues to be utilised to provide information and evidence to support our assurance framework, our annual health check declaration and to provide regular reports to the Trust Board and its sub committees to give assurance in respect of the risks facing the organisation.

During 2009/10, the Trust has reviewed the assurance framework, corporate risk register and risk management processes in readiness for the revised objectives and new system of regulation led by the CQC.

The Trust has several areas where staff have been supported to learn from good practice in risk management. These include the work of the Risk Management Panel, the Clinical Governance Committee and the departmental Mortality and Morbidity meetings. Key reporting is embedded into risk assessment and assurance processes (for instance through the Patient Safety and Quality Report and the Corporate Performance Report).

### 4. The risk and control framework

The Trust Risk Management and Assurance Strategy and the Assurance Framework have provided an integrated approach to managing risk that considers all aspects of risk including clinical, non-clinical, strategic, organisational and financial risks.

The Assurance Framework includes the strategic objectives, strategic risks, controls, and positive assurance, gaps in control and/or assurance and remedial action. The aim of the Trust is to minimise its exposure to clinical, financial and operational risk. The methodology for this is in accordance with sound risk management practices.

During 2009/10 the Trust Board and Governance and Risk Committee, on behalf of the Board, have reviewed the risks and received regular reports that included where remedial action was required.

The Trust aims to empower all staff to assume responsibility for contributing to effective risk management by setting out a framework that meets the needs of day to day risk management practice and encourages a freedom to act hierarchy. The key elements of the Trust risk management strategy are to standardise assessment, to manage and to control identified risks appropriately, whether clinical, non clinical or financial. This is achieved through a sound organisational framework which supports early identification of risk. The Trust uses the Datix system to register risk and to capture near misses and critical incidents.

The Trust operates a weekday review of serious incidents reported in order to ensure swift and proportionate action and a weekly review of incidents and risks to identify any trends or correlation in risks or incidents. The Trust has an embedded risk framework at a corporate level. The divisional performance reviews ensure that any significant divisional risks are discussed and escalated to Executive Directors and the Board where required.

The Trust reports all serious untoward incidents to the Strategic Health Authority and the PCTs. A root cause analysis for all such incidents is completed.

The Trust Board received regular reports highlighting those extreme risks that are considered to be business critical and put the achievement of the strategic objectives at risk. Additions and removals from the register are noted at each meeting.

The Trust has addressed two areas identified as having control weaknesses through the Internal Audit programme. These were data quality in sickness absence reporting and Estates Contract Management. The Trust received an opinion of limited assurance in respect of car parking income and continued to make improvements in this area.

### Compliance with Care Quality Commission Standards

Prior to the health check declaration the non-executive directors participated in a review of some of the standards in detail, reviewing the controls and assurance that support our health check declaration. This challenge allows for a review of the risks. The Governance and Risk Committee received the detailed report on compliance and the Board declared full compliance with the Care Quality Commission standards for better health at the mid year and end of year declaration.

### Compliance on data security

The Trust recognised that information is a vital asset, both in terms of the clinical management of individual patients and the efficient management of services. In the management of and use of all information there is a need to achieve an appropriate balance between confidentiality and openness. It is a fundamental requirement that robust security arrangements are in place to safeguard any personal information relating to patients, staff and to commercially sensitive information. The Trust recognised the need to share patient information with other health organisations and other agencies in a controlled manner consistent with the interests of the patient and, in some circumstances, the public interest.

To ensure that all information is efficiently and legally managed, the Trust has established an Information Governance Steering Group (IGSG). The work of the IGSG focuses on the following areas

- Legal Compliance
- NHS Confidentiality and Records Management Codes of Practice
- Information Security
- Information Quality Assurance

Membership of the IGSG is aligned to the Department of Health Information Governance responsibility and accountability framework which includes

- Identifying the areas of highest risk
- Developing plans to mitigate and then remove these risks
- Ensuring staff understanding and compliance

The IGSG develops appropriate policies and procedures which minimise risk and provide a robust governance framework for information management. The IGSG also monitors, advises and reports on the Trust's compliance against a range of mandated performance indicators. Through these performance indicators the IGSG is able to identify and evaluate risks. The IGSG ensures the Trust is alerted to any significant risks and also proposes remedial actions. During 2009/10 compliance with use of the NHS number, data flow mapping and the encryption programme were highlighted as concerns. Full compliance is complex and work will continue during 2010. The Trust utilised the Information Governance Toolkit and achieved an overall score of amber. The main area of concern is information security assurance and an action plan is being developed for 2010/11 moving forward.

### Compliance with equality, diversity and human rights legislation

The Trust recognised the importance of compliance with equality, diversity and human rights both in terms of patients and staff. Throughout 2009/10 the Trust has had in place the Single Equality Scheme and an action plan to ensure compliance. The Trust established an Equality and Diversity Group to oversee delivery and development of the action plan.

The Trust Board received both an update on the action plan in year and a report on compliance with requirements. Control measures have been in place all year to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

### Compliance with NHS Pensions Scheme regulations

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

### Compliance on climate change

Compliance with Climate Change Adaptation reporting to meet the requirements under the Climate Change Act 2008.

The Trust has undertaken risk assessments and a Carbon Reduction Delivery Plan is in place in accordance with emergency preparedness and civil contingencies requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligation under the Climate Change Act and the Adaptation Reporting requirements are complied with.

### 2010/11 and beyond

The Trust has identified the key risks as

- Delivery of a sustainable system of healthcare within a financially constrained environment whilst ensuring key performance and quality targets are achieved
- Ensuring the delivery of the new Performance Framework, which reflects an increased focus on patient views, outcomes and assurance of the quality of services tosatisfy regulatory requirements including the Care Quality Commission registration requirements and the outcome of the Mid Staffordshire inquiry
- Achievement of financial viability across the local health economy and a system of access for patients that makes sure patients receive the right care in the right environment at the right time

- Achievement of the three year Cost Improvement Plan developed for 2010/11 to 2012/13 and pushing forward cost reduction by improving productivity and efficiency
- Achievement of a clear strategy and robust Integrated Business Plan that is flexible enough to respond to the changing environment of the NHS
- Sustaining active engagement and involvement of staff in driving the improvements in patient safety and patient experience
- Delivery of the Trust's major Private Finance Initiative (PFI) and associated developments in the retained estate. The risks are the impact of major construction works on a busy, operational, hospital site, the affordability of the retained estate element of the programme of works,the service impact of delay or not undertaking parts of the programme, the commissioning of the PFI build and the transfer of services to the new hospital, not achieving anticipated changes in the way clinical services are delivered and service changes from the time the hospital was planned, including capacity issues.

## 5. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. I have been advised on the implications of the result of my review of the effectiveness of internal control by the Audit Committee. Executive Directors within the organisation have responsibility for the development and maintenance of the system of internal control and have provided me with assurance by ensuring Datix and action plans are up to date so that the Trust Board is fully informed of the day to day operational risks faced by the organisation. In addition the Governance and Risk Committee considered the corporate extreme risks on a monthly basis and the Trust Board received monthly reports which included the risks associated with our Fit for the Future programme, the long term financial viability and infection control.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. The Datix risk management system and the reports taken from it provide me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by

- Reports and audit plans from Internal and External Audit
- Annual audit letter
- Feedback from Auditors Local evaluation (ALE) assessment
- Feedback from Healthcare Commission/DOH reviews
- Minutes of Audit Committee
- Minutes of Governance and Risk Committee
- Minutes and summary of Clinical Governance Committee and key actions.
- Achievement of key performance targets as demonstrated through the SHA performance framework
- Achievement of all in year financial duties with the exception of Better Payment Practice Code in respect of NHS Supplies in both number of invoices processed and value
- Accreditations for the NHS Litigation Authority Standards for Acute Trusts (Maternity – level 1)
- Quality and Safety Reports including Health and Safety reports
- PEAT Assessments
- Compliance with the hygiene code
- Patient experience reports incorporating complaints
- Report back from the Big Conversations and action plans
- Inpatient, outpatient and staff surveys.

### Significant control issues

My review has identified that the organisation's significant control issues and key mitigating action in 2009/10 have been:

*Achievement of the A&E four hour wait, 18 week target within trauma and orthopaedics and 62 day cancer wait target in key cancer sites. Mitigating action includes*

- Joint health economy approach to apply lean principles across the whole emergency care pathway in order to achieve the A&E target, with full engagement and reporting to the SHA. The work resulted in the implementation of a new care model within A&E, development and introduction of a lean discharge process to support the reduction of delayed discharges and cancelled operations.
- Engagement with the national support team for 18 weeks, and a health economy programme of work to jointly deliver the target within Trauma and Orthopaedics.
- Leadership by the Director of Cancer services to adopt a new approach to performance manage the new cancer strategy targets, as we do the 18 week target.
- Strong performance management framework across the Trust to monitor and track progress.
- Regular reporting on progress to the Governance and Risk Committee and public Trust Board.

*Achievement of statutory duty to break even*

• The Trust did not achieve the "control total" target of £7.8m set for it by the Strategic Health Authority and the Department of Health in 2009/10. The reason for the shortfall was the outcome of the dispute with the local PCTs requiring a write off of £2.5m of income the Trust had expected to receive. This has resulted in our External Auditor having to issue a Section 19 letter to the Secretary of State informing the Department of Health that the Trust has failed to achieve its statutory duty to break even over the agreed five year period.

*Achievement of financial balance with significant additional activity to that contracted and a significant Cost Improvement Plan (CIP). Mitigating action included*

- Established a programme office and additional external assurance (PWC) to develop robust CIP delivering in 2009/10, plus developed a three year plan moving forward
- Delivered the in year CIP to the SHA requirements
- Engagement of clinical leadership in the savings programme and long term sustainability through rolling out service line management approach from 1 April 2010

*Delayed implementation of the shift to primary care as scheduled in the Fit for the Future plan*

- Moving diabetes services to two community facilities
- Developing shared clinical plans
- Programme management with the PCTs
- Gateway review process supported and a separate gateway review commissioned by University Hospital
- Board focus on plans for activity shift and risks
- Regular health economy non-executive briefing and challenge sessions

*The Trust is committed to working with service users and local communities to ensure they are involved in the development of services and aware of our risks. We achieved this in 2009/10 by*

- Establishment of a Health Improvement Panel to oversee the Trust Involvement Strategy and assist with assessing compliance with the outcomes in the CQC regulations related to patient experience
- Holding Trust Board meetings in public
- Receiving and discussing operational risks and associated reports at the Trust Board Public Meeting
- Presenting to and receiving visits from the Overview and Scrutiny Committees and their members
- Working closely with Overview and Scrutiny Committees and LINks, agreeing the Enter and View Policy with Stoke on Trent LINks in April 2010
- Holding public events, inviting key stakeholders and community groups
- Continued work with key community groups such as neighbourhood forums, minority community groups, hard to reach groups and community voluntary services

### The weaknesses identified in the Annual Audit Letter 2008/09 - priorities for 2010/11

The Annual Audit Letter for 2008/09 recognised that 2008/09 was a challenging year but noted that the Trust had made significant progress. The letter identified weaknesses in a number of areas. These included the Trust delivery of patient services and failure to achieve four of the nationally set performance targets, namely total time in A&E, delayed transfers of care, cancelled operations and operations not rescheduled within 28 days. These key targets continue to be a focus of significant attention by the Trust and the health economy to sustain the improvements made.

The Trust strengthened its budgeting, financial forecasting and delivery of the CIP during 2008/09, however concern remained regarding commissioner contracted activity and development of a long term financial base for the Trust. The Board approved an initial budget for 2010/11 on 26 March 2010 as the contract negotiation was not yet concluded.

The Trust strengthened financial systems in 2008/09, however further action was necessary in respect of payroll and pharmacy. The Director of Finance has overseen improvements in the financial coding structure. Improvements in the process for the production of the Trust's financial statements continue as part of the SLM and SLR roll out and accountability programme. The Board has established a PMO to strengthen the cost improvement programme and developed a three year CIP moving forward.

The Trust had strengthened the governance arrangements over the last two years, however, the letter identified that these could be improved by ensuring the Audit Committee provides the Board with assurance over risk management and clinical governance, the Governance and Risk Committee has an annual work programme and that the work programme pays sufficient attention to the clinical governance risks. Revised terms of reference and work programmes for both the Audit Committee and Governance and Risk Committee will achieve these recommendations.

The Board is refreshing the Integrated Business Plan and has strengthened the business planning process this year to ensure that the Trust remains in financial balance and operates as a going concern. This remains, however, a significant risk.

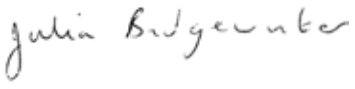
The Board has considered a number of ways that it can make a greater contribution to partnership working across Stoke and Staffordshire and is taking specific actions relating to improvements in public health in respect of smoking and maternity care for minority ethnic mothers, working closely with the Director of Public Health for NHS Stoke.

### Ensuring continuous improvement moving forward

In order to address weaknesses and to ensure continuous improvement of the system of internal control, the Board has overseen the development of a new Assurance Framework in the later part of 2009/10. A new framework has been developed for 2010/11 that improves clarity of the governance and assurance process. The terms of reference and calendar of business for the Audit Committee and Governance and Risk Committee for 2010/11 have been revised to make clear the role of the Audit Committee in respect of effectiveness of internal control. Internal Audit has a role for providing an independent opinion of adequacy and effectiveness of the overall arrangements supporting an assured position.

### 6. Summary

With the exception of the significant internal control issues that I outlined in this statement, my review confirms that University Hospital of North Staffordshire has a generally sound system of internal control that supports the achievements of its policies, aims and objectives.



Julia Bridgewater
Chief Executive

# Independent auditor's report

## Independent auditor's report to the Board of Directors of University Hospital of North Staffordshire NHS Trust

I have examined the summary financial statement for the year ended 31 March 2010 which comprises the Statement of Comprehensive Income, Statement of Financial Position, Statement of Cashflows, Statement of Changes in Taxpayers Equity, Better Payment Practice Code, Cumulative year on year Trust Financial Position, Management Costs.

This report is made solely to the Board of Directors of University Hospital of North Staffordshire NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 49 of the Statement of Responsibilities of Auditors and of Audited Bodies prepared by the Audit Commission.

### Respective responsibilities of directors and auditor

The directors are responsible for preparing the Annual Report.

My responsibility is to report to you my opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements.

I also read the other information contained in the Annual Report and consider the implications for my report if I become aware of any misstatements or material inconsistencies with the summary financial statement. This other information comprises only the unaudited part of the Remuneration Report, the Foreword and the remaining elements of the Operating and Financial Review (which includes the sections entitled : sound finances and getting the basics right; teaching hospital and learning organisation; excellence in healthcare; partnership and social responsibility, specialised services; service transformation; our Trust Board).

I conducted my work in accordance with Bulletin 2008/03 "The auditor's statement on the summary financial statement in the United Kingdom" issued by the Auditing Practices Board. My report on the statutory financial statements describes the basis of my opinion on those financial statements.

### Opinion

In my opinion the summary financial statement is consistent with the statutory financial statements of the University Hospital of North Staffordshire NHS Trust for the year ended 31 March 2010. I have not considered the effects of any events between the date on which I signed my report on the statutory financial statements (10 June 2011) and the date of this statement.

Date: 26 August 2010

Mark Stocks, District Auditor
Audit Commission
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