The Dudley Group of Hospitals
NHS Foundation Trust

Annual Report and Accounts **2010/11**

incorporating Quality Report and Accounts





Your Hospital of Choice

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Annual Report and Accounts 2010/11; incorporating Quality Report and Accounts

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Content Page

All information contained in this report was correct at the time of publication.

Chairman's welcome

Welcome to this year's Annual Report, my first since taking up the role of Chairman on 1st November 2010, in what has been an interesting year for the Trust and the wider health economy. The unveiling of the Equity and Excellence: Liberating the NHS White Paper introduced a period of intense change for the NHS, perhaps more so than at any other time in its 62 year history. To quote Sir David Nicholson, currently Chief Executive of the NHS and soon to be Chief Executive of the NHS Commissioning Board, "a change so big it can be seen from space!".

I am pleased to have joined the Trust in challenging times as we steer the organisation into very new territory. The national landscape is going to place even more emphasis for NHS services to put patients and local communities at the heart of everything we do. We are proud that we have a workforce that provides excellent care and works hard to ensure we build on our firm foundations as we embed the new reforms.

The Trust Board of Directors has seen some significant changes this year, not least with Alf Edwards' retirement and my appointment as Trust Chair, but also the appointment of our new Director of Operations and Transformation Richard Beeken, new Non Executive Director David Bland and associate Non Executive Director Richard Miner. (See more on page 77)

Our Council of Governors continues to strengthen our accountability to patients and the public and provides valuable input at all levels across the organisation. This year they have been involved with our annual planning process, given very useful insights and helped develop ideas we can take forward as an organisation to help improve patient care. I am delighted that our Council is well equipped to take on the challenges from the NHS reforms and we look forward to further constructive engagement with, and development of, the Council over the coming months and years.

I am pleased to have joined an organisation that is progressive and with a highly motivated and professional workforce, committed to providing the best possible care to patients. I want to thank all our staff for their hard work over the last 12 months and for their commitment to meeting the challenges that lie ahead.

Chairman

John Edwards CBE

Chief Executive's overview

We are pleased to welcome more than 500 staff from Dudley Adult Community Services to the Trust as part of the Department of Health's move to transform community services. From 1st April 2011 we will have services based firmly in our community for patients with long-term conditions, acute care needs, rehabilitation, end of life care and audiology. Some of the real highlights of the year have been the big efforts in the Emergency Department to meet another challenging winter, consistent high performance on the cancer and 18 week waiting targets and very low infection rates for MRSA and C.difficile.

During the year we have renewed our commitment to achieve excellence in clinical care, and developed a strategy to improve how patients experience the care they receive – all underpinned by Transformation and Listening into Action (LiA).

Our staff make the biggest difference to our patients and that's why we have put staff, those who know the most, at the heart of change with LiA. Already more than a 1,000 staff have said how they feel about working for the Trust, and what changes they want to make to improve patient care, since the launch of LiA.

Several clear themes have emerged, including putting the patient first, valuing our staff and improving customer care, and these themes will determine and influence some changes across the Trust over the next few months.

Both programmes enable us to take a fresh look at how we deliver our services in these tough financial times, and the new financial year will be the toughest we've ever seen. Making positive changes to streamline what we do will help us to continue to provide the best quality care and services to our patients within the constraints we face. We can build on our excellent reputation and ensure The Dudley Group of Hospitals is the best place to both work and receive healthcare in the West Midlands. To do that, dedication and commitment from our staff is vital.

We show our appreciation to that hard work, whether from clinical or non clinical staff, with our Committed to Excellence awards ceremony in recognition of the important contribution they make to the service we offer.

We have more reasons to celebrate having seen our governance risk rating amended from red to amber-green following Monitor's decision to remove the Trust from significant breach of its Terms of Authorisation because of its poor Accident and Emergency (A&E) performance and Board governance in 2008/09.

It was gratifying also to receive some very positive feedback from the Care Quality Commission (CQC) following their visit in January 2011to see how we operate on a day to day basis.

A number of our key staff have achieved national, and international, recognition for their specialties, including Consultant Urologist Mr Paul Anderson who was invited to speak at Europe's prestigious Annual European Association of Urology (EAU) Congress in March. Consultant Rheumatologist Professor George Kitas achieved silver in the National Clinical Excellence Awards for his "exceptional" contribution to the NHS. Our Autologous Stem Cell Transplantation Programme for patients with

Leukaemia, received The Joint Accreditation Committee ISCT-EBMT (JACIE) accreditation for performing to an agreed standard of excellence.

Our hospitals are very busy places and we continue to see demand for our services increase year on year. It's amazing to think our dedicated team of staff last year:

- Delivered 4,865 babies
- Cleaned more than 5,000 miles of corridor
- Treated 98,100 patients in the Emergency Department
- Served more than 900,000 meals
- Treated 494,500 outpatients
- Saw 39,380 day cases
- Cleaned and folded more than 2.5 million items of linen
- Answered more than 91,250 helpdesk calls

Finally I would like to welcome our new Chairman and Trust Board members. As we enter what will be some of the most challenging financial times the NHS has seen, I am confident with our strongest asset, our staff, we can continue to deliver the best possible healthcare to our patients.

Chief Executive

Paula Clark

Report from the Board of Directors

The Dudley Group of Hospitals NHS Foundation Trust is the main provider of Hospital services to the populations of Dudley, significant parts of the Sandwell Borough and smaller, but growing, communities in South Staffordshire and Wyre Forest.

Currently we serve a population of around 400,000 people from three sites at Russells Hall, Guest Outpatient Centre in Dudley and Corbett Outpatient Centre in Stourbridge, providing the full range of secondary care services and some specialist services for the wider populations of the Black Country and West Midlands regions.

The Trust was authorised by Monitor, the independent regulator of NHS foundation trusts, to commence operation as an NHS Foundation Trust from 1st October 2008.

The Trust's hospitals form part of a Private Finance Initiative (PFI) with Summit Healthcare and its service providers: Interserve Facilities Management and Siemens Healthcare.

The Directors are delighted to report that with effect from 1st April 2011 the adult community services section of the Dudley PCT Provider Services function has transferred under the management of the Foundation Trust. It is the intention of the Board of Directors to formally apply to Monitor to make changes to our constitution to reflect this change, including changing the name of the Organisation to '*The Dudley Group NHS Foundation Trust'.*

Page 57 of this Annual Report details our contractual arrangements with local Primary Care Trusts (PCTs) for the provision of services and details of our performance against key national priorities can be found within the Quality Report on page 32 of this Annual Re.

In 2010/11, as the UK economy moved into recession, the NHS in England began to readjust to much lower levels of funding growth than enjoyed previously. This was manifest in local PCTs seeking to reduce levels of spending on patient care, especially in the acute sector. This reduced level of 'real' funding has coincided with growing demand on our services in Dudley and increased customer expectations. The Trust has at the same time been working hard to improve its performance against national and local waiting and access targets, particularly in its Emergency Department (a prime source of Monitor finding the Trust to be in breach of its Terms of Authorisation in 2009) and our patients overall experience of our services. Against this background our overall business achievements in 2010/11 have been commendable and can be summarised as:

- Financial surplus of £275,000;
- Monitor financial rating of 3 (out of 5 maximum);
- Achievement of the 18-weeks national maximum waiting targets for both admitted and non admitted patients;
- Further reductions in healthcare associated infections, now among the lowest in the West Midlands;
- Achievement of the four hour waiting target in A&E;
- Significant further investment in additional substantive clinical staff and equipment.

The Trust has set as its key strategic vision to be the clear 'hospital of choice' for its core resident populations in the Dudley Metropolitan Borough Council wards, the Wyre Forest and the west of Sandwell. During 2010/11 the Trust was in a sense the 'victim of its own success' attracting around 9 per cent more patients presenting with emergency conditions than estimated by local Primary Care Trusts and funded through their contracts. Whilst the unplanned nature of this increase resulted in the Trust having to create more clinical capacity at short notice (often staffed by very expensive agency staff) the national NHS funding regime in place provided additional payment by PCTs at only 30 per cent of NHS tariff. The Trust effectively incurred a financial loss for each additional patient admitted above PCT contracted

levels and the extent of this factor was the principal reason that we were unable to realise our planned financial surplus for the year. Nonetheless a small surplus of £275,000 was realised for the year.

Responding to this unprecedented demand on services placed particular strain on clinical departments during the year. This was exacerbated by delays in the discharge of medically fit patients into community settings or to their homes and we continued to experience significant delays in 2010/11 where patient resettlement was the responsibility of colleagues in primary care or social services. It is, once again, to the credit of clinicians across specialties that, despite these issues, the vast majority of performance targets were either achieved or exceeded during the year, while the Trust's Quality Report and Accounts (see pages 32 to 68) illustrates continued improvements in the overall quality of care provided to our patients.

Eighteen months ago the Trust experienced difficulty meeting the four hours maximum waiting target in Accident & Emergency. Monitor, informed us in December 2009 that its Board had found the Trust to be in 'significant breach' of its authorisation as a foundation trust due to concerns about missing this important national target and, by extension, about our arrangements for governance. As noted, the overall CQC performance target of 98 per cent was in fact achieved for 2009-10 and improved upon for 2010/11 and in December 2010, Monitor's Board informed the Trust that they were satisfied that the Trust was now complying fully with its Terms of Authorisation.

Once again, during 2010/11 the Trust took the decision to invest heavily in front line clinical services to continually improve the quality of care to patients.

From April 2010, the Department of Health has introduced a system of legal registration of service providers in England and requires a clear demonstration and evidence of the achievement of standards of healthcare. In support of our application for registration from that date, the Trust made declarations to the CQC and shared its development plans in a number of clinical areas including the ongoing training of clinical staff (and the appropriate recording of this) and the improvement of the quality and availability of clinical notes. It is pleasing to note that the Trust was among the first cohort of NHS Trusts awarded full and unqualified registration by the CQC from April 2010 and the CQC's unplanned visit to the Trust in 2011 has resulted in moderate or minor required changes to practice.

In view of the impact of the UK recession on the local economy, the Trust has adopted a policy of settling the invoices of local suppliers promptly. In 2010/11 the Trust settled 99 per cent of trade invoices within 30 days and in February 2010 a national survey declared the Trust the promptest payer within the NHS.

As an NHS Foundation Trust we have made no political or charitable donations during 2010/11.

To promote improved patient safety, the Trust has continued its programme of directors' patient safety walkabouts and has worked closely with patient groups and Members and Governors of the Foundation Trust to develop a more responsive service to patients.

In addition, the Trust has invested heavily in medical equipment during the year and during 2010 commissioned a £7m new multi-tiered staff car park at Russells Hall Hospital.

In summary, 2010/11 has been a challenging year for the Trust in both a clinical and business sense but has also been a year of significant and sustained achievement.

Your Hospital of Choice: Patients

Our services as of the 1st April 2011

Russells Hall Hospital	Corbett Hospital Outpatient Centre	Guest Hospital Outpatient Centre	Community Services
Anaesthetics	Anaesthetics provide some services at Corbett	Outpatient clinics including: • Dermatology • Gastroenterology • Neurology • Pain Management • Renal • Respiratory	Audiology
Anticoagulation	Dietetic clinic		Blood Borne Virus
Audiology	Integrated Living Team		Chronic Obstructive Pulmonary Disease (COPD) Respiratory Nurse Service
Cancer services			
Cardiology			
Clinical Haematology	Multi-professional rehabilitation		Continence Service
Critical Care Unit	Orthotics		Dermatology
Day Case Unit	Outpatient clinics including: • Cardiology • Dermatology • Gastroenterology • Obstetrics and Gynaecology • Older Persons and Stroke • Trauma and Orthopaedics • Urology		Diabetes Specialist Team (Primary Care)
Dermatology			District Nursing
Diabetes and Endocrinology		Pharmacy	ENT – Ear, Nose and Throat
Dietetics		Physiotherapy	Heart Failure
Emergency Assessment Unit		Surgical pre-operative assessment	Macmillan Community Palliative Care Team
Emergency Department (Accident and Emergency)			
Fracture clinics		Radiology (X-ray)	Neurology Primary Care Service (including MS and Parkinson's Nurse specialists)
Gastroenterology			
Genito-urinary medicine			
Head and Neck surgery including Ear, Nose and Throat (ENT) and Maxillofacial			
Maternity		Speech and Language Therapy	Occupational Therapy
Medical and clinical inpatient services			
Medical High Dependency Unit			Palliative Care Support Team (Joint Agency)
Neurology			Physiotherapy
Obstetrics and Gynaecology	Pharmacy		Physiotherapy – Orthopaedic Assessment
Older Persons and Stroke	Phlebotomy (blood tests)		Podiatric Surgery
Oncology			

Ophthalmology	Physiotherapy		Podiatry – community and biomechanical
Orthodontics	Podiatry		Sexual Health
Orthoptics	Radiology (X-ray, DEXA bone scanning)		Speech and Language Therapy
Orthotics	Speech and Language Therapy		Stroke Rehabilitation
Outpatients	Wheelchair service		Thunderburds – rapid response team to help prevent hospital admissions
Paediatrics and Neonatology			
Pain Management			Tissue Viability (including leg ulcer)
Pathology			Virtual Ward
Pharmacy			
Phlebotomy (blood tests)			
Plastic Surgery			
Podiatry			
Pre-operative assessment			
Psychology			
Radiology (X-ray, MRI and CT scanning)			
Renal			
Respiratory Medicine			
Rheumatology			
Speech and Language Therapy			
Surgery including breast, colorectal, upper and lower GI and vascular			
Surgical Assessment Unit (for GPs)			
Surgical High Dependency Unit			
Theatres			
Therapy Services including Physiotherapy and Occupational Therapy			
Trauma and Orthopaedic including fracture neck of femur unit			
Urology			
Women and Children's Outpatient Department			

Patient safety

We give priority to the delivery of high quality care to all patients by ensuring that patient safety is at the heart of everything we do.

While it is important for us to meet national targets and to remain in financial balance, this must not be achieved at the expense of the safety of our patients. As part of this we ask all staff to complete incident forms if things do go wrong so that we can investigate the circumstances, learn lessons and change practice, when relevant.

We provide safe, high quality care to many thousands of people every year but sometimes, despite our best efforts, things can and do go wrong. If a patient is harmed as a result of a mistake or error in their care, we believe that they, their family or those who care for them, should receive an apology, be kept fully informed as to what has happened, have their questions answered and know what is being done in response. This is something that we call being open.

Being open, learning from our mistakes and changing practice contributes to the high quality of care we aspire to.

Eliminating mixed sex accommodation

The Dudley Group of Hospitals NHS Foundation Trust is pleased to confirm that we are compliant with the Government's requirement to eliminate mixed-sex accommodation, except when it is not in the patient's overall best interest, or reflects their personal choice.

We have the necessary facilities, resources and culture to ensure that patients who are admitted to our hospitals will only share the room where they sleep with members of the same sex, and same-sex toilets and bathrooms will be close to their bed area. Sharing with members of the opposite sex will only happen when clinically necessary (for example where patients need specialist equipment such as in the critical care unit), or when patients actively choose to share (for instance in the renal dialysis unit).

If our care should fall short of the required standard, we will report it. We will also set up an audit mechanism to make sure that we do not misclassify any of our reports.

We will publish the results of that audit on the Trust's website and we have the existing compliance for 2010 and for 2011 on the website at:

http://www.dgoh.nhs.uk/your-stay-in-hospital/single-sex-accommodation

Service and operational improvements

This section highlights just some of the service and operational improvements throughout the Trust during the year.

Second Magnetic Resonance Imaging (MRI) scanner

Our aim to offer patients faster quality imaging and more accurate diagnosis, along with shorter waiting times, took a step forward with plans finalised to take delivery of a second MRI scanner at Russells Hall Hospital.

The installation of the Siemens Magnetom Verio 3T is complete and the first patient was scanned on Tuesday 3rd May 2011. The superior speed and resolution of this state-of-the art scanner will improve image quality and increase the number of patients we can see. The scanner will also be wider, offering 33 per cent more space to help reduce the claustrophobic feeling some patients feel.

The Trust is already offering a successful service and our consultant radiologists and dedicated MR radiographers are highly experienced in MRI, and the installation of the second scanner will enhance the service we offer our patients.

Therapy Services

Our Therapy Services team has implemented a series of improvements to offer occupational and physiotherapy patient's instant access to appointments. The Trust is replacing postal referrals with fax and phone calls to reduce inevitable delays when patients are referred by letter from their GPs.

The new system means patients can be phoned on their mobile or landlines and offered an appointment, improving their choice of appointment.

Patients referred for physiotherapy treatment, at their outpatient appointment, are now given the choice of receiving their physiotherapy assessment on the same day or booking their appointment for a more convenient time. Again this provides further choice to patients, and they can start their physiotherapy treatment sooner. More than 90 per cent of patients are seen by a physiotherapist within thirty minutes of arrival.

The outpatient therapy team surveyed patients about their preferred time of appointment and, as a result, have extended their opening times from 4.00pm to 6.00pm every day making access to our services easier for people at work.

In April 2010 we started a full seven day physiotherapy and occupational therapy service to elective orthopaedic patients. We are now working from 8.00am to 6.00pm so that patients can receive more rehabilitation before they go home, which helps with getting patients home faster.

Professor Kitas National Clinical Excellence silver award

Consultant Rheumatologist Professor George Kitas achieved silver in the National Clinical Excellence Awards in the 2010 round in recognition of his “exceptional” contribution to the NHS.

Significantly fewer awards were made this year than in previous years, according to Mary Holt, Head of Advisory Committee on Clinical Excellence Awards (ACCEA) Secretariat. In England and Wales just 317 awards were made compared to 601 in 2009.

Head of Research and Development and Clinical Director of Ambulatory Medicine from 2008 to 2011, Professor Kitas paid tribute to previous recipients of the National Clinical Excellence Awards, Dr Jane Flint and Dr Barry Jones, and said it was “a great honour” to follow in their footsteps.

Orthotics

During the year (2010/11) the 20 week waiting times for Orthotics patients have been halved and urgent cases can be seen within 72 hours, which represents a significant reduction in waiting times for the 10,000 patients seen each year across three clinics.

Moving to a larger space at the rear of Therapy Services on the ground floor at Russells Hall Hospital, and taking on an extra member of staff, enabled more patients to be seen.

We give patients the best and most efficient service, offering convenient appointments to best suit our patients.

The Trust trialled a laser scanner that takes a laser image of the limb and gives more accurate definition and manufacturing to get the right fit every time. The scanner was used alongside the more conventional plaster cast which would still be needed in some cases. We are investigating the possible long-term use of a scanner.

Biochemistry and Paediatric Diabetes Team

A new testing service was launched to help young patients monitor their diabetes without the need to come to hospital for a blood test.

The Glycosylated Haemoglobin (HbA1c) test measures how well diabetes is being controlled over the previous three months. It should be performed four times a year to keep diabetes under control and prevent health problems associated with poorly controlled diabetes.

Biochemistry and the Paediatric Diabetes team devised a testing kit for young people to take blood samples at home instead of coming into hospital, because persuading adolescents to come to hospital can be difficult. This new way of collecting samples has proven to be hassle-free and helps young people overcome their blood testing phobias.

The system has been well accepted by parents, including parent representatives of the PCT juvenile diabetes group. We receive about six to 10 cards per week which represent children who may feel upset by attending an adult phlebotomy session.

Ear Nose and Throat (ENT)

During the year the Trust appointed Mr Matthew Weller, ENT Consultant with paediatric interest, giving additional capacity to the department. Mr Mundit Jindal, ENT Consultant with otology interest, replaced Mr Frank Wilson who retired last year.

ENT has developed a voice clinic with Speech and Language Therapy (SLT) to aid more rapid diagnosis, treatment and resolution of symptoms for patients with hoarse

voice. The clinic is run on alternate Monday mornings and, although in its infancy, early feedback from patients has been very positive.

Patients with a hoarse voice are seen by an ENT consultant and a speech and language therapist. Both patient and therapist can see images of the vocal cords – this instant visual feedback helps direct their therapy and the patients receive a resolution more quickly.

Urology

Urology has seen a number of changes to improve the service to our patients. We have developed and started new minimally invasive surgery.

A ‘one stop prostate clinic’ has also been developed to improve prostate cancer care, reduce waiting times and offer patients more outpatient slots. From referral to biopsy results, patients only wait four weeks for a diagnosis as opposed to seven or eight weeks. This clinic has been designed and set up now ready to start.

Since the appointment of Consultant Urologist Mr Chakravarti in May 2010, the Trust has developed keyhole laparoscopic surgery for patients with kidney disease or kidney cancer replacing the traditional open surgery method. The gold star treatment offers patients many benefits including faster recovery, very little pain and little or no bleeding.

Enhanced Recovery Programme

The major service initiative in general surgery for 2010/11, which is ongoing, has been the development of the Enhanced Recovery Programme (ERP) – this new approach being aimed at preoperative and postoperative care for patients, to help reduce patients’ length of stay in hospital and improve their surgery outcomes.

The programme includes working with GPs to improve patients’ conditions before they come to hospital specifically around blood pressure, haemoglobin, nutrition, as well as advice on exercise and smoking cessation.

The Enhanced recovery programme has been introduced this year after successful introduction of the laparoscopic colorectal surgery programme which began in June 2007.

During 2010/11 approx 35-40 staff nurses, including allied professionals as well as junior and senior medical staff have attended ERP workshops at other centres where enhanced recovery has been successfully introduced. An ERP specialist has been recently seconded from the physiotherapy department to educate ward staff around early mobilisation and pre-op education of patients. The improvements have already shown a significant reduction in hospital stay – from 10 to five days for laparoscopic colorectal surgery – and the long term aim will be improved quality of care for our patients.

Red Cross Home from Hospital scheme

The Red Cross Home from Hospital scheme was developed during 2010/11 to help those patients who are ready to leave hospital but may need some additional short-term support.

Trained Red Cross volunteers offer help for patients at their home upon discharge, providing respite for carers and helping patients regain their confidence in managing themselves at home.

Jointly funded by The Dudley Group of Hospitals and NHS Dudley, the scheme aims to reduce the amount of time patients spend in hospital and the likely need for certain patients to be re-admitted.

Home from Hospital takes patients over 18 years of age and living in the Dudley local authority catchment area, and is offered for six weeks after a patient has left hospital.

The scheme currently supports 30 to 40 patients a month and has reduced the length of stay in hospital for those patients by two days.

Avoiding hospital admission

NHS Dudley(Primary Care Trust) funding has enabled the Trust to offer patients extra support in the Emergency Assessment Unit from an additional medical consultant, nurse, therapist and social worker, which may help patients to stay in their own homes.

Extended consultant medical hours ensure patients are reviewed by a senior clinician. We have introduced a dedicated social worker who offered ‘social care’ emergency patients an alternative to admission to hospital.

Once the scheme has been evaluated, it is likely to run again in the winter of 2011/12.

Sandringham Ward

Sandringham Ward was re-opened during the year to offer continuing care for patients from acute medical wards at Russells Hall Hospital who are medically fit for discharge but whose discharge has been delayed.

The facility, owned by Dudley and Walsall Mental Health NHS Trust, provides care, rehabilitation and confidence building to 20 hospital patients awaiting social services intervention including:

- A package of care
- Transfer to community intermediate care facility for further rehabilitation
- Transfer to their own home
- Transfer to a nursing home

Sandringham has proved successful in providing a more appropriate home-like environment to prepare patients for eventual discharge.

Partnership Arrangements

The Trust played a key role in the Local Health Economy Urgent Care Scheme to help prevent patients being admitted to hospital and facilitate smooth and timely discharge.

This engagement with local health economy partners led to the development of links with the Dudley Community Services, Virtual Ward scheme, the expansion of a community intermediate care team as well as additional step down beds at Tiled House Residential Home, a facility previously managed by Dudley Metropolitan Borough Council (MBC).

The evaluation processes regarding the relative success of these schemes, in relation to the very difficult winter the Trust experienced from an emergency admissions perspective, are currently under way.

Care Transfer Arrangements

The Trust has lead on the negotiations with Dudley MBC and the PCT to ensure there are clear and consistent standards of responses and expectations of each partnership organisation to ensure patients are transferred safely, efficiently and appropriately from hospital to either a PCT community care setting or domiciliary or care home setting commissioned by the council.

Women and Children's Services

Due to the birth rate in the Maternity Unit significantly increasing during 2010/11, to the point of approaching 5,000 births per year, the Trust has provided additional investment in the service to recruit a further five midwives. An 'over recruitment' has been secured which will mean, the predicted number of midwives to births ratio will come down to 1:36.

ThinkGlucose – care for patients with diabetes

The ThinkGlucose project was launched across the Trust in August 2010 to improve the treatment of inpatients with diabetes as a secondary diagnosis.

The campaign was launched in response to the National Diabetes Audit which found that 20 per cent of all inpatients in The Dudley Group of Hospitals had diabetes, and that these patients stayed longer in hospital and had poorer outcomes than similar patients without diabetes.

Just six months into the campaign those patients admitted to Russells Hall Hospital with diabetes as a secondary diagnosis have seen major improvements to their care. Access to diabetes specialists has improved, with dedicated inpatient specialist nurse rounds six days a week, and senior consultant rounds twice weekly. In addition, there has been a major staff education programme for medical and nursing staff.

The Healthcare Commission 2007 National Survey of patients with diabetes found they stay on average 2.6 days longer than patients without diabetes. Length of stay in the Trust since August 2010 has seen a significant downward trend and has reduced from 8.13 days to 7.34 days.

We hope to build on this success in the future, to ensure that inpatients with diabetes have the same outcomes as those without.

The Dudley Group of Hospitals Staff Bank

In April 2010, the Trust implemented an internal Staff Bank to provide a temporary staff work force supporting nursing posts in clinical areas and later expanded to include clerical staff. We determined that by providing this service ourselves it would save money, be more effective and more easily controlled in respect of ensuring staff had appropriate prerequisite skills, than using an external agency to provide this for us. The internal Staff Bank provides temporary staffing to cover the following:

- Vacancies;
- The opening of extra beds to match demand;
- Long-term leave including sick leave and maternity leave;
- Specialist support that can only be provided by agencies charging premium rates e.g. in theatres, critical care, high dependency;
- Short-term leave mainly sickness absence.

The reduction in agency usage has been a particular success, achieved by the focused recruitment to the Staff Bank from within and outside the Trust, resulting in development of a service that has been able to better meet the demands of the Trust.

Listening and learning

The Trust values and welcomes all feedback to help us ensure we meet the needs and expectations of our patients, their families, our staff and our stakeholders; as a Foundation Trust we are also legally obliged to take consideration of our Members' views as expressed through our Council of Governors.

The Trust has a number of systems in place for obtaining patient feedback:

- Lead nurse walkrounds allow time for face to face patient feedback
- Our Governors provide feedback from our members and wider communities
- Patient and Public Experience Steering Group
- NHS Choices and Patient Opinion online feedback
- Patient Advice and Liaison Service (PALS)
- Complaints data
- Surveys
- Liaison with our Local Involvement Network (LINk), Health Select Committee and MPs
- Holding and attending community events

See pages 37 to 42 of our Quality Report and Accounts for more information about our priorities for patient experience.

No formal consultations have taken place during the year; however we maintain close contact with our Local Involvement Network (LINk), patient groups and the Health and Adult Social Care Select Committee. We have worked with the Select Committee on their 2010/11 review of Dignity in Care for Older People in Acute Settings and plan to implement regular meetings to discuss the ongoing change under the current healthcare reform.

Patient Advice and Liaison Service (PALS) – welcoming concerns, comments and compliments

At The Dudley Group of Hospitals we try to make sure that our service is the best it can be but sometimes, despite our efforts, things can go wrong. The Patient Advice and Liaison Service, or 'PALS', is here to help when patients or relatives have concerns and, whenever possible, will try to help put things right. PALS does this not only by working to help individuals but also aiming to improve services by contributing to the quarterly Patient Experience Report which is presented to the Board.

The report includes complaints, concerns, claims and compliments information and also 'patient stories' either delivered on behalf of patients by PALS or directly from a patient. The Patient Experience Report is also monitored at an operational level by the Patient and Public Experience Steering Group and the Council of Governors.

The PALS team acts as the first point of contact for patients who need help with a concern and will provide advice, support and information. During 2010/11 our PALS team helped 1,075 people with a wide variety of concerns and queries. Our PALS team can be contacted on 0800 073 0510.

Below are some examples of changes to be made and changes made as a result of PALS concerns during 2010/11:

- Visitors were concerned about availability of car park value cards. Following meetings with Interserve (our Private Finance Initiative partner) the number of cards available was doubled to meet demand;
- Department produced notices advising patients that students may be present and that they may ask for solely qualified member of staff, if preferred;
- Switchboard advised patients on how to obtain up-to-date information on out-of-hours pharmacies;
- Trust computer system now able to record if patient has a learning disability to enable staff to be aware of potential extra needs;
- Trust website updated to reflect changed visiting hours on some wards;
- Patient information leaflet amended after patient pointed out one part of procedure not clearly specified;
- Individual staff counselled by managers regarding issues, including practice and attitude;
- Arranged numerous meetings for patients and relatives to meet with respective clinicians and managers or nursing staff to resolve concerns.

Complaints

Our aim is to be 'the hospital of choice' to all our patients and we are proud that every year we receive many compliments directly to our services. This year we received 757 formal thank you cards; this does not include the many verbal thanks we receive. We do recognise occasionally things go wrong and we believe we should do everything we can to put things right if this happens and learn from any mistakes we may have made.

The complaints team works closely with the PALS to resolve people's concerns or complaints in a way suitable for them. The national complaints system now has only two stages: local resolution direct with the Trust and the second stage with the health ombudsman. Complainants can now expect a single response from several providers (where a complaint may cross organisations) and they are also able to complain about a provider to the commissioning body.

The Trust ensures every complaint is investigated thoroughly and lessons are learnt. We encourage complainants to meet with staff to discuss their concerns in detail to allow us the opportunity to fully resolve their concerns.

The number of complaints against patient activity during 2010/11 was 0.05 per cent. During the year we received 332 complaints, a decrease of 9 per cent on the previous year. The Trust has acknowledged all complaints within three working days of receipt and we now agree a timescale for response with the complainant. Complainants dissatisfied with their response from the Trust can request the Health Service Ombudsman accept it for further review. During the year no complaints were accepted by the Health Service Ombudsman.

Below are some examples of changes made as a result of complaints investigated during 2010/11:

- Junior doctors in Emergency Department educated in management of finger injuries;
- Consultant discussed issues relating to support provided to babies discharged from unit;
- Appointment procedure revised and letters now sent out at least 10 days prior to appointment;
- Review of current Medical Records procedure underway;
- Team of staff now responsible for raising awareness of infection control issues, including audit, training and implementation of required actions;
- Use of appropriate sling highlighted with nursing staff and stocks now maintained locally;
- Training/education given to patients and families to facilitate understanding of dialysis;
- All paediatric take home medication prescribed is checked by hospital pharmacist to ensure appropriate paediatric dosage for child's weight and age;

- Weekly returns for all patients who develop or are admitted with a pressure ulcer. Database updated accordingly;
- Root cause analysis undertaken for all patients who develop a grade three or above pressure ulcer in Trust;
- All root cause analysis investigation findings fed back to nursing staff at ward meetings;
- Monthly pressure ulcer group to discuss all new cases;
- Increased staff awareness of pressure ulcer development and management, now mandatory training;
- New nursing documentation for prevention and management of pressure ulcers;
- Patient information leaflet for prevention and management of pressure ulcers to encourage patient involvement;
- All staff supplied with a pressure ulcer grading guide to support grading of pressure ulcers.

Patient information

Patient information is part of the PALS service and is coordinated by the patient information officer.

The Trust has more than 400 leaflets on various conditions and treatments, as well as aftercare advice. Information is produced in plain English and made available in large print, audio, Braille and alternative languages on request.

The Trust has a clear policy which details the process for developing, producing, ratifying and archiving all the Trust patient information ensuring information is kept up-to-date.

A new design template was approved by the Board of Directors and an online portal to enable trained staff to produce good quality patient information was introduced.

This year the Trust has produced a handy fold out pocket size visitor guide available across all three sites. It includes a map and information on car parking, visiting times, how to become a Foundation Trust member, preventing infections and other on-site facilities.

Hospital Volunteer service

More than 400 volunteers from the local community give their time on a regular basis to make a real difference to patients, visitors and staff at the Trust. The Hospital Volunteer Service is part of our PALS service and is managed by the volunteer co-ordinator. Individuals volunteer for a variety of reasons including: the satisfaction of knowing that they are doing something for others, the chance to make new friends, to gain experience of a busy hospital environment, to gain confidence and strengthen interpersonal skills. Volunteers are asked to pledge a minimum of 100 hours.

Some of the tasks volunteers have undertaken include:

- Mealtime assistance
- Changing patients' drinking water
- Distributing and collating patient surveys
- Clerical support
- Patient friends
- General ward volunteers
- Outpatient hosts
- Emergency Department hosts
- X-ray Department support
- Main reception way-finding
- Enquiry desk
- Chaplaincy

The dedicated work of all our volunteers is highly valued by the Trust, and it is pleasing to realise that volunteers also get satisfaction from their role. The following comments were received from volunteers:

What our volunteers say:

"Being able to help others is an awesome privilege and is a fabulous use of my spare time."

"I had been considering a career in nursing for some time. Volunteering helped me to know that it was right choice."

"My confidence has grown whilst volunteering and I have met so many wonderful people."

Your Hospital of Choice: Staff

The Trust is the second largest employer in the Dudley borough with 3445 (as of 31st March 2011) whole time equivalent (WTE) staff, an increase of 188 WTE staff from 2010. The table below gives a breakdown of staff numbers by professional group.

Staff Grouping	As at 31st March 2011 WTE	As at 31st March 2010 WTE
Professional Scientific and Technical	145	426
Non-Clinical	993	670
Additional Clinical Services	659	627
Medical and Dental	477	425
Nursing and Midwifery Registered	1171	1109
Total	3445	3257

The Health and Safety team are particularly proud of the benefits achieved with the continuing reduction in reported accidents within the organ, due to employee involvement. As well as heightening staff awareness by motivating them to take avoiding action when recognising a workplace hazard or the dangers of poor working practices. The Trust's Health and Safety Department is committed to raising Occupational Health and Safety awareness amongst all of its employees and that of its partners. The Trust held a Health, Safety and Environmental Awareness Week in October 2010. The Trust remains convinced that it can continue to lead rather than follow other organisations in the application of best practice in maintaining its Occupational Health and Safety awareness programme.

Violence towards frontline clinical staff continues to be an issue with an increase in reported incidents in the last year. This is further evidenced by a 33 per cent increase in security incidents attended by the security team. Sanctions are taken against offenders ranging from warning letters to exclusion and, where appropriate, criminal prosecution.

The working relationship between Trust and IFM Security managers continues to be a very good example of partnership work and problem solving. In particular we have strengthened ties with the Dudley Safe Guarding Group in relation to monitoring acknowledged vulnerable adults who frequently attend the Emergency Department in crisis or children admitted to wards.

Our sickness absence rates continue to fall with the Trust finishing at 4.00 per cent this year, which is below the target for the year of no more than 4.3 per cent (from 1st April 2010 – 31st January 2011).

The labour turnover has reduced this year to 8.23 per cent for the year from 10.37 per cent last year and we are continuing with a programme for line managers on how to handle employment related topics.

Labour turnover 2010/11

Q1	2.03%
Q2	2.68%
Q3	1.49%
Q4	2.03%
Full year	8.23%

Equality and diversity report

The Trust has a rolling programme of equality impact assessments linked to the review of policies and services in the Trust. Each policy or service originator is responsible for completing an impact assessment and publishing this on the Trust website. HR Management publishes, on our web site, the diversity statistics for the Trust and compares them to the local population.

Equality and diversity impact assessments have been a high priority in the Trust over the last 12 months, to ensure that the Trust is offering the best possible service to a complete cross section of the community. All our policies are equality and diversity impact assessed before being approved. We are passionate about maintaining both our employment statistics from NHS Jobs and our training activity to ensure that everyone is able to access jobs and training that are right for them.

During 2011/12 the Trust will continue to follow up action plans set by wards and departments on the service equality impact assessments. This, with the rolling programme for reviewed and new services and policies, will be the focus for the year. All impact assessments, policies and statistics will continue to be reviewed and published on the Trust website.

Again this year we have been awarded the Two Ticks Disability Symbol – a national standard which recognises that we are positive about employing disabled people.

The Trust is committed to employing people with disabilities. It is the Trust's policy to interview all candidates with a disability who meet the minimum essential criteria as identified on the job person specification.

The vast majority of job applications are now processed through NHS Jobs which maintains anonymity of applicants during the short-listing process and our recruitment and selection process includes discrimination awareness training.

Breakdown of Disability employment statistics

		% Breakdown of All Job Applications Received	% of Job Applications Short listed	% of Job Applications Appointed
Disabled Person	**Yes**	3.59%	16.38%	0.54%
	No	95.71%	13.01%	0.52%
	Undisclosed	0.69%	13.89%	0.00%

Communicating with staff and patients

In a 24/7 operation it is always a challenge to ensure that everyone is communicated with. We have developed a number of ways of doing this which include the ever popular Trust intranet The Hub, where staff can access information on organisational issues, policies, news and views from colleagues. It is also used to gather views from staff before decisions are taken through online surveys and polls.

Our staff and members magazine 'Your Trust' is published quarterly and is available on the Hub. Our Chief Executive provides a monthly team briefing with updates on the Trust's strategic direction together with any new policies published that month. This is a great way of getting information out to everyone including those who do not have regular access to The Hub.

Work has continued with our clinical directors to ensure each month they are provided with a statement of their directorates' financial position. This enables them to make proactive decisions about budget management. Each budget holder has now been trained on E-Budgeting and this provides online up-to-date budget information. Messages about Foundation Trust performance can also be communicated via The Hub and the Chief Executive's team briefing.

In the current financial climate Directors are constantly considering how best to maintain quality of care and employee satisfaction. Board workshops take place every quarter to fully understand how we can maintain financial balance and jobs.

NHS workforce statistics

An analysis of our workforce statistics indicates they are comparable with both the local Dudley population and other NHS Acute Trusts. Historically the Trust has seen a higher proportion of female workers than males, and this is typically reflected across other NHS Acute Trusts.

Age	Workforce	
	1st April 2009 to 31st March 2010	1st April 2010 to 31st March 2011
18-19	0.2%	0.1%
20-24	7.4%	5.8%
25-29	12.5%	13.1%
30-34	11.4%	12.5%
35-39	13.4%	12.3%
40-44	15.0%	15.0%
45-49	15.7%	15.1%
50-54	11.0%	12.2%
55-59	8.0%	8.2%
60-64	4.6%	4.8%
65+	0.8%	0.9%
Gender		
Male	17.0%	17.0%
Female	83.0%	83.0%
Ethnicity		
White	75.0%	73.0%
Mixed	0.8%	1.0%
Asian or Asian British	9.7%	9.6%
Black or Black British	2.7%	2.6%
Other	1.5%	1.6%
Not stated	10.3%	12.2%

Staff engagement report

Our Directors and Governors regularly visit wards and departments to talk to staff and patients to gather feedback and see first-hand how their decisions make a high level impact on daily life in the Trust. This year the Directors have also started a rolling programme of 'back to the floor' sessions to be more visible to frontline staff (see Listening into Action below).

Listening into Action

September 2010 saw the launch of our Listening into Action (LiA) programme which is designed to empower each and every member of staff to make changes to our services for the benefit of patient care.

LiA was launched by Chief Executive Paula Clark in September 2010 with a series of five ‘big conversations’ to find out what mattered most to our staff. More than 500 people came along to these events to air their views and suggest big action changes to the way we work and deliver patient care.

Their feedback was captured and collated and several clear themes were identified:

- Improving patient care;
- Improving patient experience;
- Supporting teams to deliver the best care;
- Communication;
- Valuing staff;
- Understanding the big picture — why we do the job we do;
- Getting the basics right including putting the safety of our patients at the heart of everything we do;
- Working better together in teams.

The feedback told us that IT and customer care were also areas in need of improvement. As a result, we held several LiA conversations tackling each one in turn.

Staff also felt our senior management team could be more visible to frontline staff. As a result, six Directors go ‘back to the floor’ every few weeks to gain firsthand experience of other people’s roles.

Paula Clark worked alongside a cleanliness support worker for a half-day shift; Head of Human Recourses Annette Reeves shadowed a ward clerk for a morning; Director of Nursing Denise McMahon shadowed a porter in the Emergency Department and Paul Assinder has worked with the Security Department.

Also, as a result of the LiA events and hearing what staff said was important to them, we have:

- Given every member of staff a name badge so patients and visitors always know who they are talking to;
- Changed visiting times to twice daily for a trial period for the benefit of patients and their visitors;
- Looked at improving signage around the hospitals and created a signage Group to investigate further;
- Provided way finder maps for patients and visitors;
- Developed better ways to train our staff.

LiA is has proven to be a successful way for ward teams and departments to introduce the changes they want to see. More than 50 teams expressed an interest in using the LiA way of working and ten were chosen as the first teams to try it in their areas. For example:

- Maternity Outpatients are using LiA to reduce waiting times for patients;
- The Acute Stroke team want to ensure all patients arriving at the Emergency Department with a stroke are admitted to a specialist stroke ward within four hours;
- Paediatrics and Neonatal staff want to use LiA to find more efficient ways of working to improve the quality of care they give to patients.

LiA is putting our staff, who know the most, at the centre of change to help us prioritise the changes that will be of most benefit to our patients.

See overleaf 'You said – we did …' which lists the events and changes to services that have come directly from staff attending LiA conversations.

Transformation

Our transformation team has been running a series of Lean Action Weeks (LAWs) to compliment the LiA events, and teams have been given the time to concentrate their efforts into looking at service efficiency and ways to make changes.

Across all directorates, including corporate functions, members of staff from different areas have come together for eleven LAWs to focus on improving the way we deliver care in, for example, General Surgery, Rheumatology, Elderly Care and Outpatients.

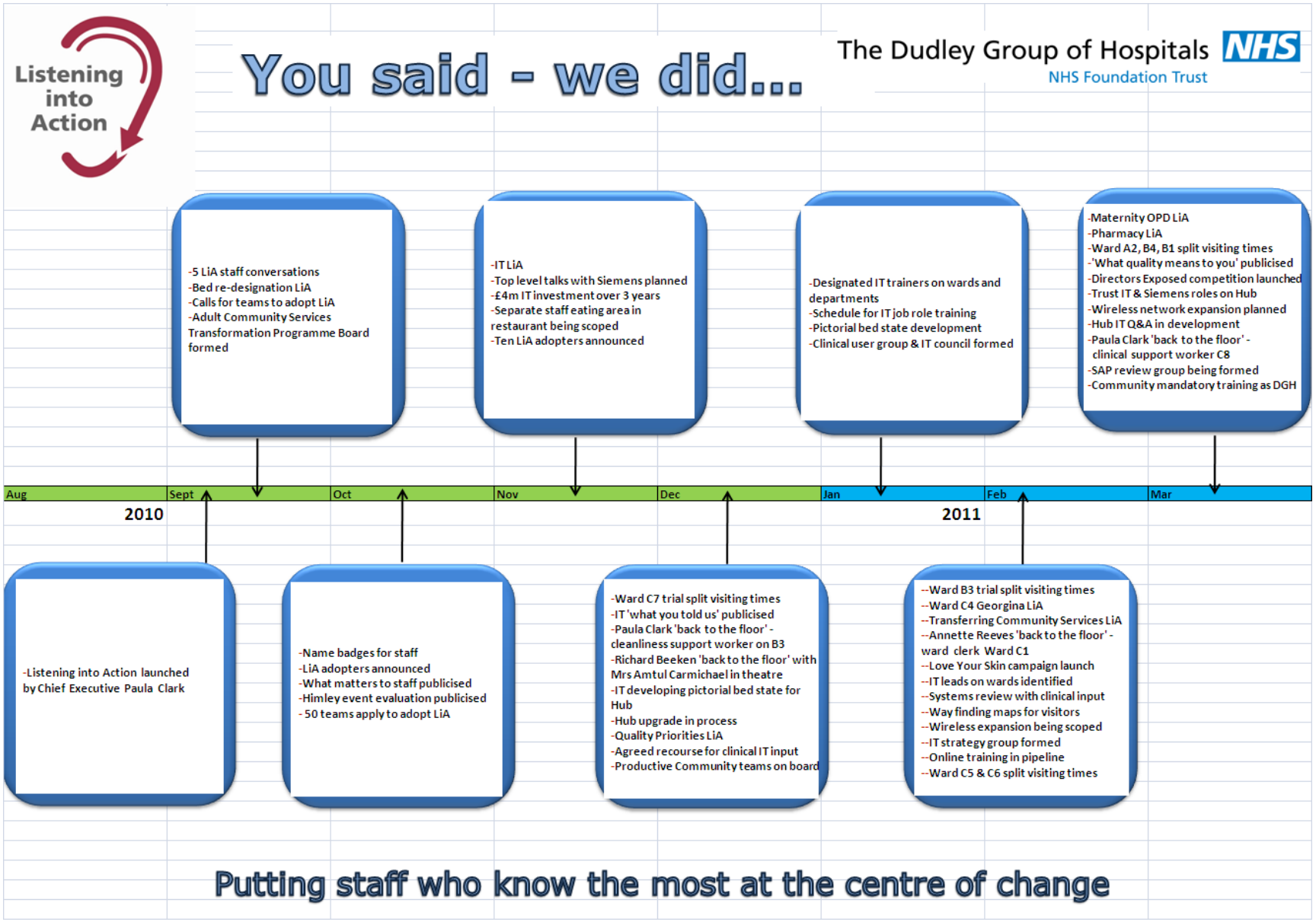
Transformation also scrutinises the way we maintain patient records and how we run our appointment booking system.

Nineteen teams have been involved in the transformation project supported by 25 members of staff who have been trained to facilitate the lean (more efficient) way of working. Already 150 people are using lean methodology which incorporates Productive Ward and The Productive Operating Theatres (TPOT).

Productive Ward – Releasing Time to Care is part of a national project to help ward teams decide how best to run their wards so they can reduce wasted time and interruptions to spend more time directly caring for patients. In the past year, it has been successfully used on 12 wards.

One of TPOT's aims is to boost the theatre team performance by improving communication and collaboration. Already all 12 theatres are using TPOT.

Transformation is about finding more efficient ways of working while increasing the quality of care our patients receive.


Listening into Action
You said - we did...
The Dudley Group of Hospitals
NHS
NHS Foundation Trust
-5 LiA staff conversations
-Bed re-designation LiA
-Calls for teams to adopt LiA
-Adult Community Services Transformation Programme Board formed
-IT LiA
-Top level talks with Siemens planned
-£4m IT investment over 3 years
-Separate staff eating area in restaurant being scoped
-Ten LiA adopters announced
-Designated IT trainers on wards and departments
-Schedule for IT job role training
-Pictorial bed state development
-Clinical user group & IT council formed
-Maternity OPD LiA
-Pharmacy LiA
-Ward A2, B4, B1 split visiting times
-'What quality means to you' publicised
-Directors Exposed competition launched
-Trust IT & Siemens roles on Hub
-Wireless network expansion planned
-Hub IT Q&A in development
-Paula Clark 'back to the floor' - clinical support worker C8
-SAP review group being formed
-Community mandatory training as DGH
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar
2010
2011
-Listening into Action launched by Chief Executive Paula Clark
-Name badges for staff
-LiA adopters announced
-What matters to staff publicised
-Himley event evaluation publicised
- 50 teams apply to adopt LiA
-Ward C7 trial split visiting times
-IT 'what you told us' publicised
-Paula Clark 'back to the floor' - cleanliness support worker on B3
-Richard Beeken 'back to the floor' with Mrs Amtul Carmichael in theatre
-IT developing pictorial bed state for Hub
-Hub upgrade in process
-Quality Priorities LiA
-Agreed recourse for clinical IT input
-Productive Community teams on board
--Ward B3 trial split visiting times
--Ward C4 Georgina LiA
--Transferring Community Services LiA
--Annette Reeves 'back to the floor' - ward clerk Ward C1
--Love Your Skin campaign launch
--IT leads on wards identified
--Systems review with clinical input
--Way finding maps for visitors
--Wireless expansion being scoped
--IT strategy group formed
--Online training in pipeline
--Ward C5 & C6 split visiting times
Putting staff who know the most at the centre of change

National staff survey

The 2010 National survey was completed between October and December 2010. All members of staff in the organisation were invited to respond to the survey, which was a change from last year when we only invited a sample of 850 randomly chosen people to respond which is the CQC requirement. The findings above are based on the CQC sample and these results have been fully analysed at 4 levels

1. Compared to national average results for 2010
2. Compared to last years Trust results
3. Compared to Other local Trust results
4. Individual Directorate results

We have also looked at the free text comments from the survey to support us in compiling action plans both at a Directorate level and a Trust level.

The Chief Executive and Head of Human Resources are holding a series of focus groups to help fully understand the results of the National Staff Survey and we will be using our LiA and transformation approaches to support staff to make positive changes in their work environment. All these results have been reported to the Trust Board and progress on the action plans will be followed up at the Directorate meeting with line management.

Further work is being done by the Human Resources team to understand how the best in class Trusts are achieving results and this will be feed into any future actions.

The tables below show our response rate for the survey and also the top and bottom four key findings of the staff survey.

	2008/09	**2009/10**	**2010/11**	**Trust improvement/ deterioration**
Response rate	Trust	Trust	Trust	% increase/ decrease
	41%	33%	32.3%	-0.7%

	2009/10		**2010/11**		**Trust improvement/ deterioration**
Top 4 Key Findings	Trust	National average	Trust	National average	% increase/ decrease
Percentage of staff using flexible working options	67%	70%	83%	63%	16%
Percentage of staff believing the Trust provides equal opportunities for career progression or promotion	92%	90%	95%	90%	3%
Percentage of staff witnessing potentially harmful errors, near misses or incidents last month	34%	37%	30%	37%	4%
Percentage of staff suffering work related stress in last 12 months	25%	28%	24%	28%	1%

	2009/10		2010/11		Trust improvement/ deterioration
Bottom 4 Key Findings	Trust	National average	Trust	National average	% increase/decrease
Percentage of staff receiving job-relevant training, learning or development in last 12 months	81%	78%	68%	78%	-13%
Percentage of staff agreeing their role makes a difference to patients	85%	90%	83%	90%	-2%
Percentage of staff able to contribute towards improvements at work	59%	61%	49%	62%	-10%
Percentage of staff who feel they work in an effective team	New question for 2010		71%	73%	n/a

Quality Report and Accounts 2010/11

Statement on quality from the Chief Executive

I am delighted to present this, our third, Quality Report and Accounts to share our quality goals and achievements from our hospitals and announce our new quality priorities in particular, for our new Adult Community Services directorate.

Our aim is to provide high quality care for all of our patients, and through this Quality Report and Accounts we will:

- Firstly, define what we use to determine the quality of our patient care, in effect this is asking the following three things:
    - Do patients receive good quality clinical care (clinical effectiveness)?
    - Are patients safe in our hands (patient safety)? and,
    - Does the Trust provide a clean, friendly environment in which patients are happy with the personal care and the treatment they receive (patient experience)?
- Secondly, decide priorities which are designed to achieve meaningful improvements in the standard of care;
- Thirdly, design methods for measuring, documenting and acting on the things which determine the quality of patient care. Furthermore, the Trust provides patient care in the hospital and the community. It strives to provide good quality care in both environments.

At the time of writing we are undergoing a period of massive change in the NHS and just one of those changes is the transfer of adult community services into The Dudley Group.

We hope the Quality Report and Accounts is helping to build a picture of quality measures and priorities we have in place in our local healthcare services. A summary of current and previous priorities can be seen on the table on page 35; more information on each priority can be found on the page numbers listed in the table. This includes progress made to date, as well as our targets for 2011/12.

We have spent time this year considering and planning the Trust's five year strategy and have developed our strategic objectives in six key areas – Quality, Innovation, Productivity, Prevention, Patient Experience and Staff Engagement (national QIPP agenda plus our own two local objectives). This has helped us to ensure we will keep quality at the heart of everything we do.

Our aim is to provide the highest quality care to our patients so we believe, through the wide range of measures and checks detailed in this report, the overall quality of care delivered at The Dudley Group of Hospitals is good and in line with that of other similar Trusts both locally and nationally. You will see on pages 62 to 64 we exceed or at least meet all but two of the national standards. For MRSA it is recognised we have a difficult target to meet and we only missed it by one case this year (it is of note that Monitor considers six MRSA cases the ceiling). We still have some of the lowest infection rates in the region with our C difficile rates reducing by a further 44 cases from last year.

We understand like other hospitals in the West Midlands region we have work to do to ensure our stroke patients spend at least 90 per cent of their time on a dedicated stroke ward. Our failure to meet this target in 2010/11 was a direct result of the massive increase in emergency admissions to Russells Hall Hospital beyond previous years and levels estimated by our commissioners. We continue to re evaluate the use of our beds to help achieve this target. However we are pleased that we exceed the target for ensuring the early scanning of suspected stroke/TiA patients enabling us to treat people more effectively and quickly.

We have recognised there is some way to go to ensuring our patient's experience of our services matches that we would all expect and we still have work to do to ensure we drive down the number of pressure ulcers acquired in hospital. We have the measures in place to ensure we are alerted to any such quality issues early so we may address them before they become an issue.

Our Quality Goals

Our quality goals in relation to the three dimensions of quality as mentioned above (clinical effectiveness, patient experience and safety) are:

- to exceed all internal quality targets, and
- to be recognised as the highest quality service provider by patient groups, staff and other stakeholders

In the past, our progress in improving patient experience based on the national inpatient survey, has been modest. This is unacceptable to our organisation and we are developing a patient experience strategy that clearly demonstrates what we intend to achieve and the methods we will use to improve patient experience. The Commissioning for Quality and Innovation Payment Framework (CQUIN) for patient experience (see page 57) sets out how we will measure ourselves for our host commissioners, NHS Dudley.

Measuring Quality

We have implemented a performance dashboard which, at the click of a mouse, gives senior managers access to real-time data on quality. This is helping to ensure any quality issues are resolved in a timely manner. The dashboard contains both our priority indicators as set out in this report and many other indicators and measures used to monitor quality.

We have also continued to develop and use our Nursing Care Indicator audits as a tool to measure the quality of care we give to patients on our wards. Patient notes tell an important story to the health professionals treating the patient, so it is essential that they are fully completed and give a snapshot of the care given to patients. The audits assess the following areas within patient notes:

- Patient observations
- Pain management
- Manual handling and falls risk assessment
- Tissue viability – prevention of pressure ulcers
- Nutrition assessment and monitoring
- Medications
- Prevention of infection
- ThinkGlucose programme to monitor diabetes

Monitoring our hospital standardised mortality ratio (HSMR) is of utmost importance to us and we are committed to monitoring our rates to ensure they remain consistent with national levels (see page 65 for more detail on HSMR). Other ways in which we measure and monitor quality are detailed from page 51.

I hope you will find useful the information on the quality priorities we have chosen to focus on, the ways in which we assure ourselves of quality of care and a selection of the targets, both national and local, we use to form a picture of quality across the Trust. Overall we consider the Trust has had a good year in providing quality care meeting or exceeding all but two of the national standards and in particular having positive assessment from external organisations such as the Care Quality Commission's unannounced visit, PCT and West Midlands Quality Review Service. We would appreciate any feedback you would like to give us on both the format and content of the account but also the priorities we have chosen. You can either phone the communications team on 01384 244404 or email communications@dgh.nhs.uk

I can confirm that, to the best of my knowledge, the information contained in this document is accurate.

Signed:

Paula Clark

Chief Executive Date:

Quality priorities summary

The table below gives a summary of the quality priorities we have used for the last two years and also those we will be working towards next year (2011/12).

Priority	2009/10	2010/11	Priority for 2011/12	Comment	More info
(a)Increase the number of patients who rate their overall care highly (b) Increase of patients who would recommend DGOH services to a friend or relative	√ achieved	*We are improving but there is still work to do* *Slight decrease*	Priority one	Following a slight decrease in the number of patients who would recommend the Dudley Group of Hospitals to a relative or a friend we will retain and refresh our focus on improving the whole patient experience	P38
Reduce avoidable stage three and four acquired pressure ulcers in our hospital and ensure a robust reporting mechanism established in community care settings	N/A	N/A	Priority two - new this year	Our dedicated tissue viability team will ensure systems are robust to prevent and manage pressure ulcers. We aim to reduce current rates by 50%. Community services will be ensuring a robust system for recording is set up and rolled out across the services.	P43
Reduce our MRSA rate in line with national and local priorities	√ achieved	√ achieved	Priority three The two infection control priorities are merged into one.	Trust has sustained investment in our Infection Control Team who have successfully embedded effective systems.	P45
Reduce our Clostridium difficile rate in line with (or better than) local and national priorities	√ achieved	√ achieved			
Increase the number of patients who undergo surgery for hip fracture within 36 hours from admission (where clinically appropriate to do so)	N/A	*New priority*	Priority four	The Trust will continue to drive improvements to all aspects of this priority.	P48
Maintain reduced numbers of cardiac arrest calls	√	√	Not included as a priority	There has been a dramatic improvement from 32 per month in 2008 to around 13 per month by the end of March 2011 and so this issue no longer remains a challenge for the Trust.	P36

Choosing our priorities for 2011/12

In December 2010, we invited more than 40 staff, patients and governors to attend a Listening into Action (LiA) event to ask key questions around quality. LiA is a programme of staff engagement events to encourage staff and stakeholders to become involved in generating ideas to improve patient experience and service efficiency across the Trust (see page 27 for more information on LiA). This event was held to agree our quality priorities for 2011/12.

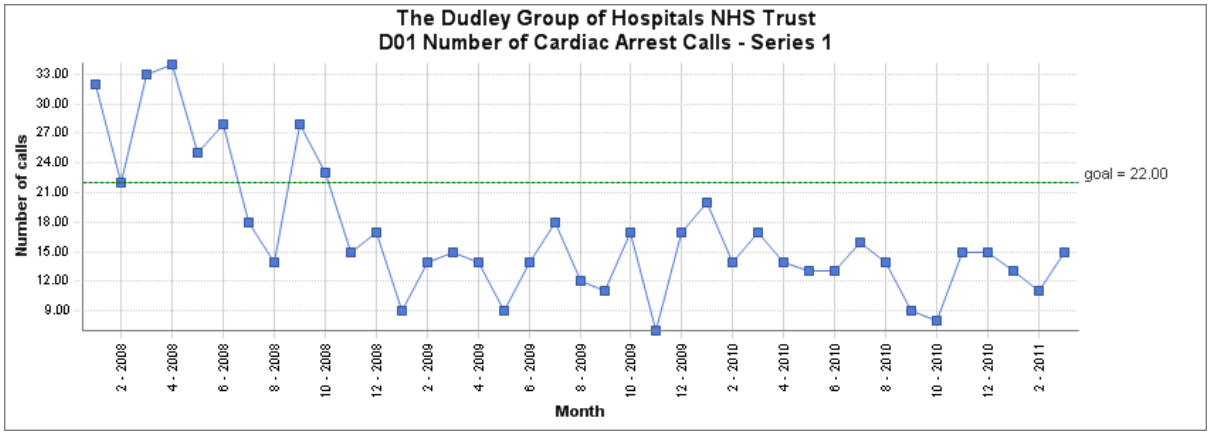
Some other quality priority suggestions raised by our patients, governors and public during the year included:

- Communication between organisations and professionals
- Being treated with dignity and respect
- Staff taking the 'time to care'
- Communication and changes of appointment times

Our Council of Governors also took the time to produce a paper to highlight what they felt 'good quality hospital care' looked like and key areas the Trust could focus on. The paper was part of the work undertaken by the Governors' Service Strategy working group and was used by the Trust in setting its strategy and Annual Plan delivered to Monitor (our independent regulator).

<u>Reduction in cardiac arrest calls priority</u>

At the above LiA event it was noted that the cardiac arrest project (priority one last year) had been a major success leading to a reduction from 32 cardiac arrest calls per month in 2008 to 13 per month in 2010/11 (see graph below). This had been achieved by identifying those patients at risk, monitoring them carefully and escalating the clinical care to appropriate professionals to prevent cardiac arrest. Actions have included the redesign of observation charts used by nurses, the strengthening of the outreach team of specialist nurses and the setting up of an emergency 24 hour response team, which includes senior medical staff.



It was decided at the event we will concentrate our efforts into maintaining the reduced number of cardiac arrest calls and replace it with a new priority for 2011/12, namely reducing pressure ulcers.

Hospital acquired infections priority

It has been noted that we have made excellent progress in the last few years reducing the number of cases of MRSA and Clostridium difficile (see graphs page 46 and 47). It was agreed by staff and patients at the event that our infection control systems and procedures are now so well established that we could combine reducing the infection rates from both organisms into one priority. However, we remain committed to maintaining and improving the progress made so far.

Patient experience priority

We are committed to improving our whole patient experience and it is felt that in priority one part of our measures is; *patients who rate their overall care highly*, encompasses all of the issues raised at the quality LiA. We recognise all of the above elements have to be in place for patients to feel they have received a good overall level of care (see page 51 for more information on how we review the quality of our services)

Our Priorities

Priority one	**Hospital**	**Community**
	(a) Increase the number of patients who rate their overall care highly from 89.3 per cent in the 2010 national inpatient survey to 91 per cent and **(b) Show an increase in patients who would recommend The Dudley Group of Hospitals services to a friend or relative.**	**Increase the number of patients who rate their overall satisfaction with community services care and treatment from 94 per cent in the 2010/11 CQUIN (Commissioning for Quality and Innovation) patient experience survey to 96 per cent.**

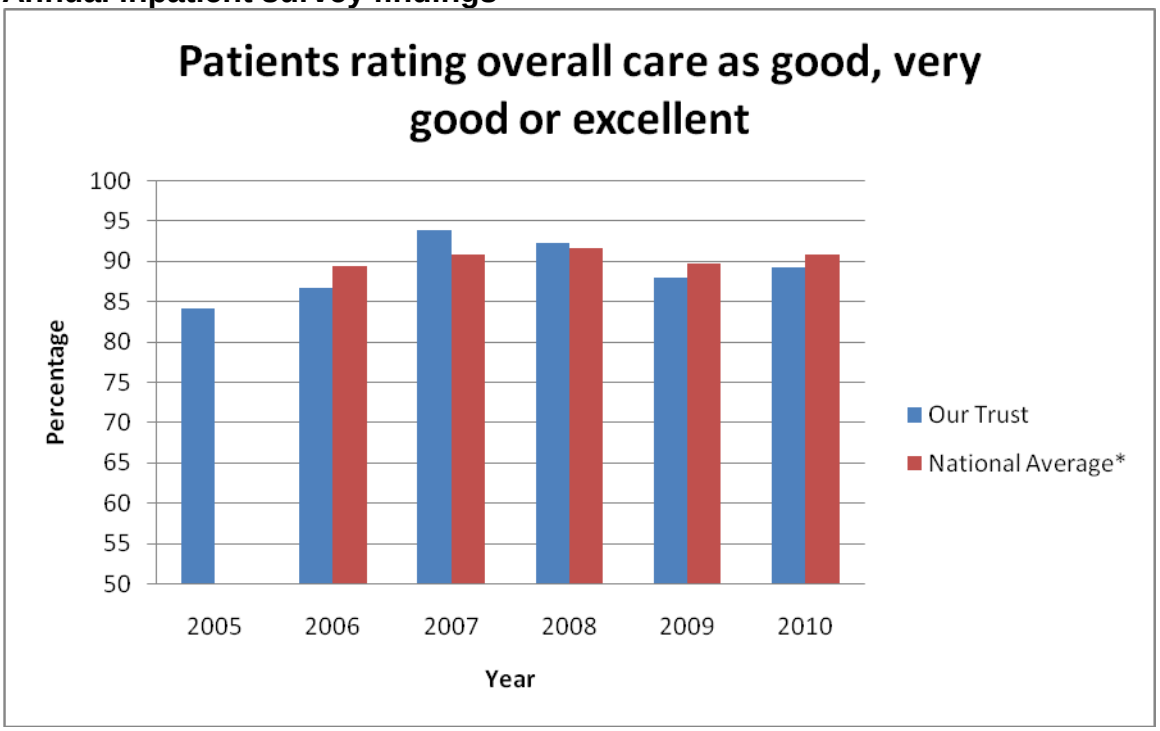
Progress last year (2010/11) (hospital)

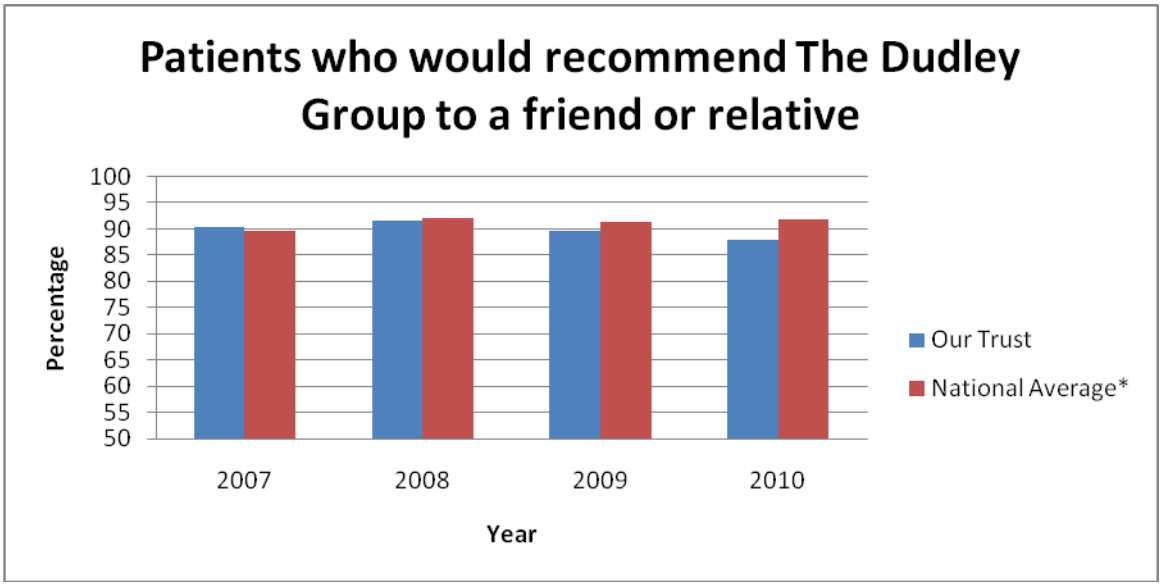
We are really pleased that 89.3 per cent of patients surveyed rated their care highly. We know that when patients come into hospital they expect the clinical care they receive to be of the highest quality. With this priority we are trying to ensure that the overall experience patients have of our services can match this high quality clinical care. We are disappointed to have seen a slight decrease in the number of patients

responding positively to the question “would you recommend the hospital to a friend?” and we need to do more to gain your recommendation. In the 2010 inpatient survey the score was 88 per cent (2009 89.5per cent).

We are keeping this priority for 2011/12 as this is very important to us and to our patients.

Annual inpatient survey findings





*****National Average = Picker Institute Europe average. Picker undertake the inpatient survey for around 75 hospital trusts in England

To increase the number of patients who rate their overall care highly from 89.3 per cent to 91 per cent

Patients said:

"I have private healthcare but could not have received a better service."

"This time I was really impressed – thank you – huge improvement."

To show an increase in patients who would recommend The Dudley Group of Hospitals to a friend or relative

Patients said we could improve:

"Keeping patients in the picture if there are any delays."

"Our food."

"The nurses and doctors were really good, but I wasn't given any advice on aftercare."

How we measure and record patient experience (Hospital)

The Trust takes part in the annual National Patient Survey programme which systematically gathers the views of patients about the care they have recently received. This takes place once a year so gives a 'snapshot' of care provided at that moment in time.

We believe that listening to what patients tell us about their experiences is the best way for us to learn and improve. In 2011/12 we are refreshing our real-time surveys to improve the way we listen and make changes. Our enthusiastic team of volunteers will carry out the surveys with patients in order to offer complete confidentiality.

We also measure our patient experience by listening to our Local Involvement Network (LINk) and Health Select Committee, feedback from patient concerns, complaints and compliments as well as feedback posted on NHS Choices.

Developments planned this year (2011/12) (Hospital)

We recognise that by listening to patients, visitors and staff we can improve our services to better meet your expectations.

To make sure that our services are responsive to your needs we are, this year, refreshing real-time survey systems so the views of our patients can quickly be used to make improvements and build upon the information you have already given us. In 2011/12 we are also planning to:

- Improve patient information
- Pilot shared decision-making tools (e.g. leaflets, videos) to help patients make the right decisions about their treatment
- Increase reporting of 'you said, we did' — where patients or relatives have made suggestions for improvements we will tell you what we have been able to do about it
- Further develop our Patient and Public Experience Steering Group to encompass quality of care. The new 'Patient Experience and Quality of Care Steering Group' will be chaired by Non-Executive Director David Bland

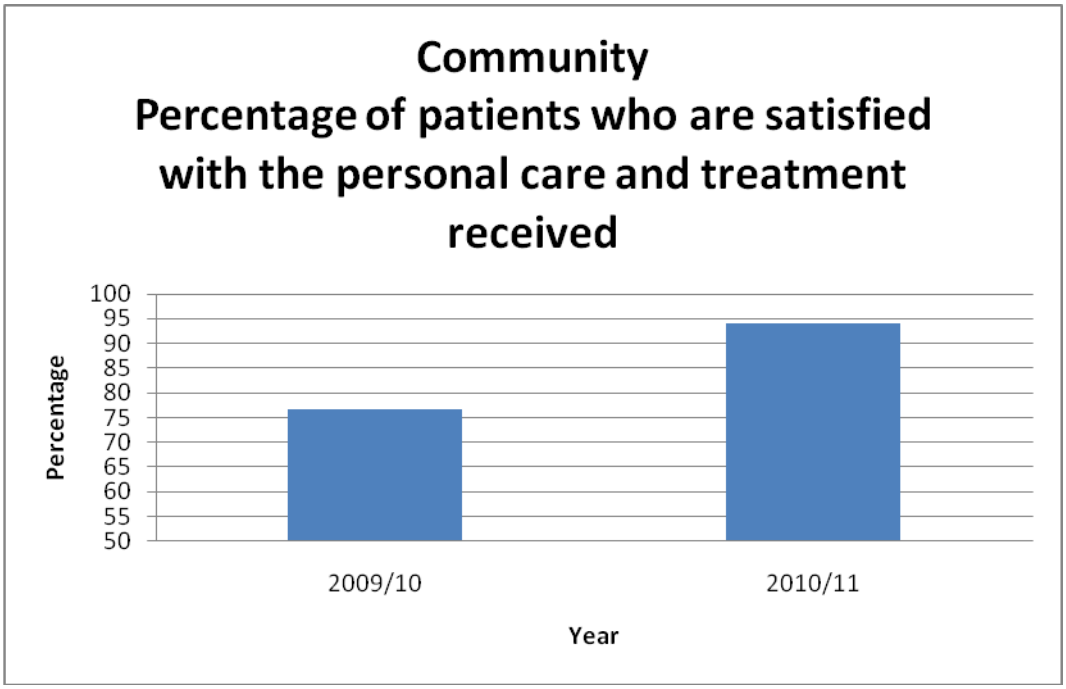
Current status (Community)

We are really pleased 94 per cent of our patients who were surveyed in 2010/11 said that overall they were satisfied with the care and treatment they received from community services. We are trying to ensure the overall experience patients have of our services is continually improved to give the highest standards of care.

The Community services surveyed last year (2010/11) as set by Commissioning for Quality and Innovation (CQUIN) scheme were:

- Wound care/Dermatology
- Diabetes
- Continence
- Chronic Obstructive Pulmonary Disease (COPD)

2010/11 CQUIN survey findings



How we measure and record this priority (Community)

The Trust takes part in the CQUIN (Commissioning for Quality and Innovation) patient experience survey which systematically gathers the views of patients about the care they have recently received in the community. This takes place twice a year with the collection of baseline information early in the year and a repeat audit to measure our improvements.

Developments planned this year (2011/12) (Community)

In 2011/12 we will build on our 2010/11 learning and continue to ask if patients:

- Have been involved in decisions about their care and treatment
- Are given enough time to discuss their condition with healthcare professionals
- Are satisfied overall with our services and any comments they have to help us improve the care we provide

We will use this information to improve our services.

Community services to be surveyed, set by Commissioning for Quality and Innovation (CQUIN) scheme for 2011/12, will be:

- Wound Care/Dermatology
- Diabetes
- Continence
- Early Intervention (Virtual Ward)

We aim to extend our surveys across all of our community services.

Details of how we are progressing with this priority will be reported to our Board of Directors on a quarterly basis as part of our patient experience report.

Board sponsor: Denise McMahon, Director of Nursing

Operational lead: Mandy Green, Communications Manager

Priority two	Hospital	Community
	Reduce avoidable stage three and four hospital acquired pressure ulcers through the year, so that at the final quarter of 2011/12 (Jan-Mar) the number for the last quarter of 2010/11 has been reduced by 50 per cent.	**Ensure there is a robust, accurate data collection system in place and, for those patients on a district nurse caseload, reduce through the year avoidable stage three and four community acquired pressure ulcers.**

Patient story

"I felt dirty when they told me I had pressure ulcers. I know it's not a dirty disease but that's how I felt. It was very depressing. If it wasn't for the nurses here, I wouldn't have known I had them. They saw them straight away and now they're sorting them out for me."

Rationale for inclusion

It was estimated in 2004 that the NHS in the UK spent £1.4-2.1bn treating pressure ulcers. These figures are a conservative estimate. Ninety per cent of this cost is nursing time. Pressure ulcers are difficult to treat and slow to heal and prevention is therefore a priority. Evidence suggests that between four and 10 per cent of patients admitted to UK district hospitals develop a pressure ulcer. In 2008/09 this equalled just over 51,000 pressure ulcers (source HES data).

There is a national campaign for pressure ulcer management. The aim of 'Your skin matters' is no avoidable pressure ulcers in NHS provided care and we decided to embed the campaign (called locally '*We* Love Your Skin') into the Quality Report and Accounts as a key priority. Alongside this national drive to reduce the incidence of pressure ulcers, feedback from our patients, staff and our clinical quality framework confirms this as a priority (CQUINS see page 57).

Current status

We have introduced new robust systems for the monitoring and recording of pressure ulcers followed by the launch of a campaign, '*We* Love Your Skin', to raise awareness across the Trust of the importance of this issue and the correct ways to prevent, record and manage pressure ulcers. Our six Trust Directors featured on the campaign posters and were photographed exposing body parts most prone to pressure ulcers. A competition was also held for staff to guess which body part belonged to which Director, further raising awareness. Once we have established a robust reporting mechanism for community acquired pressure ulcers will ensure this is rolled out across all community services.

This approach has helped to give a very serious issue a high profile and made it evident to staff at all levels just how important this is to patients and therefore to the Trust. The '*We* Love Your Skin' campaign has led to an increase in recording of pressure ulcers and we expect this to continue as the campaign becomes embedded across the Trust.

At the end of quarter four (Jan – Mar 2011) we had 32 grade three and four pressure ulcers recorded (in the hospital), and we have set out to reduce that figure by at least 50 per cent by the last quarter of 2011/12.

How we measure and record this priority

The Trust has a dedicated Tissue Viability team of senior nurses which offers advice and support to all departments in preventing and managing pressure ulcers. The team also monitor the levels of ulcers across the organisation. There is also a dedicated community based tissue viability specialist.

Pressure ulcers, also called pressure sores and bed sores, are graded one to four with four being the most serious. When a patient is identified as having a pressure ulcer it is reported onto the tissue viability database via a weekly report from all wards to the team.

If pressure damage is noted within 72 hours of admission this is not considered to have developed in hospital. This time frame is agreed regionally by the Strategic Health Authority. It is recognised that pressure damage can occur but not be visible immediately.

If a patient develops a pressure ulcer stage three or four, or if a pressure ulcer deteriorates to a three or four while the patient is in hospital, the lead nurse will undertake a detailed investigation called a root cause analysis. The results of the investigation are discussed at the weekly pressure ulcer monitoring group. Following the discussion of the results an action plan is agreed and the plan is monitored to ensure we learn lessons from every occurrence and actions are taken to reduce the risk of further pressure ulcers occurring.

Developments planned for this year (2011/12)

Actions being undertaken to achieve the Trust target include:

- Continuing to embed the '*We* Love Your Skin' campaign;
- Working together across community and acute healthcare settings to develop a pressure ulcer pathway to promote effective prevention of pressure ulcers;
- Continuing to ensure mandatory tissue viability training for all nursing staff;
- Promoting the use of the new hospital nursing documents developed by the Tissue Viability team for the prevention and management of pressure ulcers. This includes a chart to record and monitor the number of times a patient is turned and the checks made on the affected area. They were introduced for use throughout the hospital during February 2011;

- Identifying all patients at risk of developing a pressure ulcer and any patients with a pressure ulcer to ensure they have both the pressure ulcer prevention information and the pressure ulcer management information as appropriate;
- Embedding the use of the tissue viability documentation across the Trust through the use of the link nurses on each ward, who have protected time each week to perform this function;
- Updated pressure ulcer prevalence documentation, and improved care planning, to be implemented 1st May 2011 in the community services;
- Regular audits of use of the documentation for pressure ulcers;
- Ensure a robust recording system is set up across community services.

Board Sponsor: Denise McMahon, Director of Nursing

Operational Lead Hospital: Lisa Turley, Tissue Viability Lead Nurse

Operational Lead Community: Gill Weale Tissue Viability Specialist Community Services

Priority three:	**Reduce our MRSA and *Clostridium difficile* rates in line with the national and local priorities. MRSA Bacteraemia (blood stream infections) target is no more than 2 post 48hr cases; *C.diff* is no more than 77 post 48hr cases in 2011/12.**

Progress last year (2010/11)

We have continued our good work to maintain consistently low levels of MRSA Bacteraemia and *C.diff* infections across the Trust. This work together with work with our community colleagues has meant we have seen further reductions in our overall *C.diff* rates, 44 less cases than the previous year and MRSA Bacteraemia rates remain low, see graph over.

Feedback from our patients, staff, community groups, Governors and the national drive to have a zero tolerance to hospital acquired infections has meant we have decided to keep both our MRSA and *C.diff* priorities but to combine them into one priority.

The drive to reduce healthcare associated infections, which includes MRSA Bacteraemia and *C.diff,* continues to get more and more challenging. Where numbers have already been reduced to the minimal background level for that particular organism, the Trust is working to maintain this low rate.

MRSA Bacteraemia and *C.diff* numbers are divided into pre and post 48 hours cases. Only the post 48 hours cases are attributed to the Trust, meaning the patient acquired it in hospital. Pre 48 hours cases mean the patient was already developing the infection before they were admitted to hospital. The Trust as part of the local health economy has to record both pre and post 48 hours cases.

In 2010/11 the Trust has continued to reduce the *C.diff* post 48 hours cases below the target locally agreed with the PCT. The agreed target was no more than 113 cases and at the end of the year and the Trust recorded only 82.

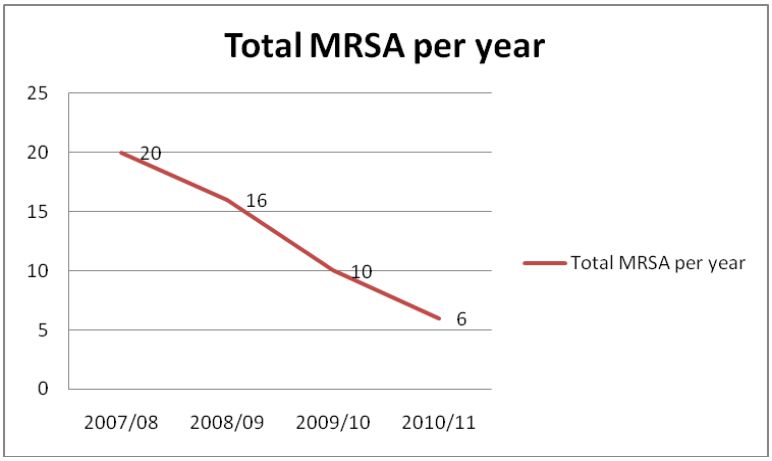
The Trust did not achieve the agreed target of no more than two post 48hr MRSA Bacteraemia cases but missed the target by only one case, total three. All were investigated but no common theme was found. The Trust was disappointed as it had continued to work hard on controlling the rates. There was an agreement with Monitor that our threshold is six post 48 hour cases before they consider formal interventions and so this target was achieved.

How we measure and record this priority

MRSA and C difficile – when our Pathology laboratory has a positive result the information is fed directly into the MESS (Mandatory Enhanced Surveillance System) national database. From here the data for all trusts is collated and sent to the Health Protection Agency (HPA) for publication.

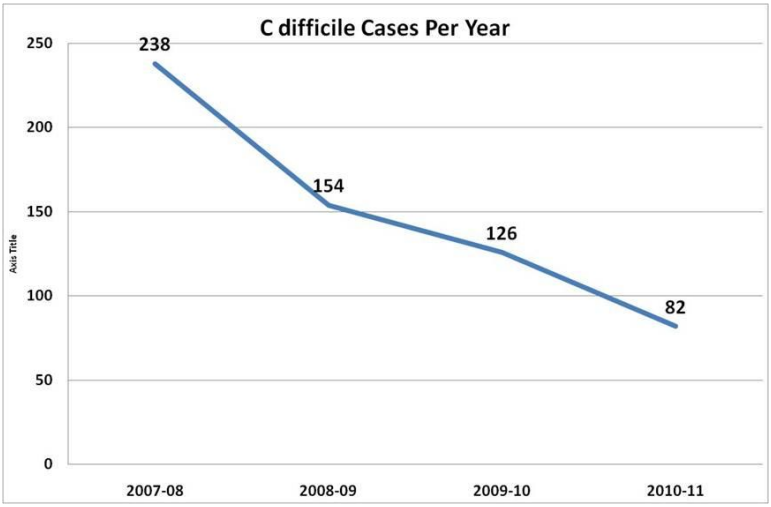
Current status MRSA

The graph below shows the continued reduction of MRSA bacteraemia cases (pre and post 48 hou, i.e. patients who had MRSA before being admitted to hospital and those who acquired it whilst in hospital) from a total of 19 in 2007/08 to a total of six in 2010/11.



Current status *C. diff*

The graph below shows the total number of *C.diff* cases recorded greater than two days after admission, showing the continued reduction from a total of 238 in 2007/08 to a total of 82 in 2010/11.



Developments planned for this year (2011/12)

Our main aims are to reduce our MRSA Bacteraemia rate in line with national and local targets. We will continue to be measured on only the post 48 hours cases and the target again this year is no more than two. This is very challenging and has been recognised by Monitor (our independent regulator), who have again agreed a threshold of six post 48 hours cases before they consider formal interventions. We have already extended our screening programme to include all emergency patients admitted and those planned patients who we screen before they come into hospital for a procedure.

Our second main aim is to reduce our *C.diff* rate in line with national and local targets. The Trust target for 2011/12 is no more than 77 post 48 hours cases.

Actions planned to achieve the above aims:

- Updating the policy and training for the taking of blood cultures;
- Developing training videos in conjunction with Clinical Skills for Aseptic Technique and cannulation;
- Undertaking additional infection control training sessions for special organisms;
- Publicising aims on World Hand Hygiene Day in May 2011;
- Introducing disposable mops for all areas of the Trust;
- Taking part in the National Patient Safety Agency (NPSA) prevention of central line infection in Critical Care Unit project;
- Undertaking the Surgical Site Surveillance of non-mandatory procedures;
- Integrating the Infection Prevention and Control services across all Trust services including acute and community.

Board sponsor: Denise McMahon

Operational lead: Dawn Westmoreland, Consultant Nurse, Infection Prevention & Control

Priority four	**Increase the number of hip fracture patients who undergo hip fracture surgery within 36 hours from admission to the Emergency Department (where clinically appropriate to do so).**

Patient story

"I came in on the Friday and had my operation on the Saturday morning. The standard of nursing care has been better than I expected – you do hear one or two negative things about the hospital in the newspaper and so I didn't expect it to be as good as it was. It's been brilliant."

Current status

Good hip fracture care depends on minimising the delay before the operation. Delays that are not clinically necessary can contribute towards a poorer result for the patient. Russells Hall Hospital was in the top five hospitals out of 193 listed in the National Hip Fracture Database (NHFD) for 2010/11. This achievement by the fracture neck of femur (hip fracture) team recognises the high quality care given to our hip fracture patients.

The NHFD is a joint venture between the British Geriatrics Society and the British Orthopaedic Association, and is designed to facilitate improvements in the quality and cost effectiveness of hip fracture care. The database stores information looking at the performance of different hospitals across the country. Here, our hip fracture practitioners are responsible for keeping the database up-to-date with the support of our data analyst.

The Trust has come a long way in developing its hip fracture services and has a designated Hip Fracture Suite. A dedicated team of nurses look after patients from admission to discharge and the ortho-geriatric team stabilise the patient prior to surgery and support in the management of the patient after surgery. The Consultant Orthogeriatrician runs a falls clinic, since many patients fracture their hip following a fall. Patients also have a dedicated orthopaedic doctor who keeps their families informed of their progress.

Delivering good care for patients with hip fractures is challenging and involves many health professionals. The quality of care varies considerably across the country and this achievement by our hip fracture team translates into high quality care for a vulnerable and frail group of patients.

Progress last year (2010/11)

- Organised a patient experience conference in January 2011at which patients gave an account of their experience alongside the professionals;
- Introduced a dedicated bed manager for Trauma and Orthopaedics to reduce delay of patients waiting for a bed;
- Commenced multidisciplinary team and nurse led discharge to facilitate efficient and effective discharge;
- Trauma co-ordinator who meets relatives within 24 hours of patients' admission;
- Reviewed the integrated care pathway to improve multidisciplinary working;
- Raised awareness of falls risk assessment and purchase of bed and chair alarms to reduce risk of patient falling;
- Introduced bespoke patient menus to aid recovery.

How we measure and record this priority

As soon as a patient is admitted to hospital with a hip fracture, data is submitted to the National Hip Fracture Database (NHFD). This data remains live until the patient has completed all of their care, including any intermediate care and rehabilitation if necessary, following their surgery.

Developments planned for 2011/12

- Implementation of patient group directives to be used by hip practitioners for pain relief and intravenous fluids;
- Development of the enhanced recovery pathway to capture patient experience and enhance the patient journey;
- Reduction of pressure ulcers developed in hospital to help recovery and enable patients to go home as quickly as possible.

Board sponsor: Richard Beeken

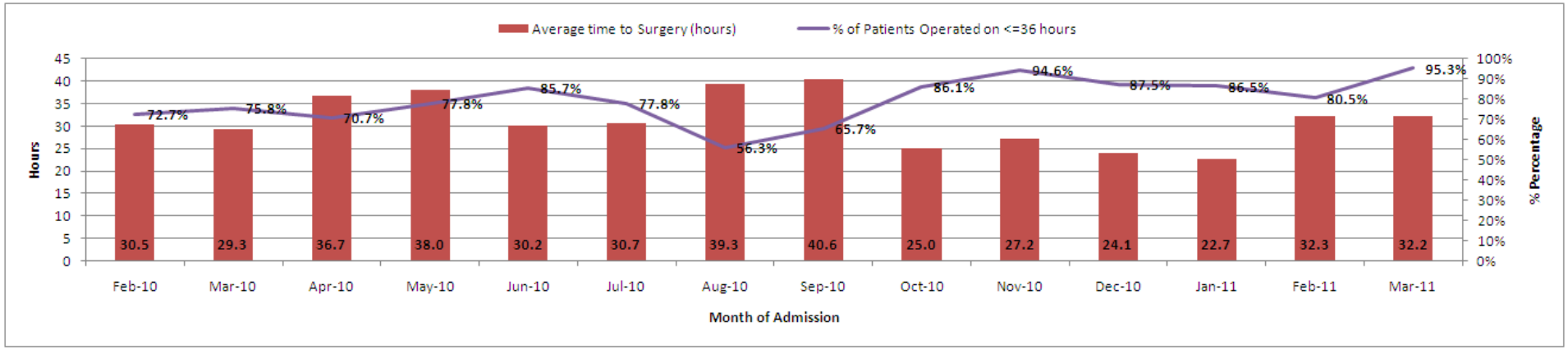
Operational lead: Jennie Muraszewski, General Manager

Current status

National Hip Fracture Database Summary (1st February 2010- 31st March 2011) Time to Surgery Analysis (patient operation performed only)

-	Indicator	Month Patient Admitted														
		Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Grand Total
Operated Patients Only	Total No. of Patients Admitted	35	36	43	36	36	36	32	36	37	37	49	40	41	43	**537**
	No. of Patients Operated	33	33	41	36	35	36	32	35	36	37	48	37	41	43	**523**
	Average time to Surgery (hours)	**30.5**	**29.3**	**36.7**	**38.0**	**30.2**	**30.7**	**39.3**	**40.6**	**25.0**	**27.2**	**24.1**	**22.7**	**32.3**	**32.2**	**31.2**
	No. of Patients Operated on within 36 hours	24	25	29	28	30	28	18	23	31	35	42	32	33	41	**419**
	% of Patients Operated on within 36 hours	**72.7 %**	**75.8 %**	**70.7 %**	**77.8 %**	**85.7 %**	**77.8 %**	**56.3 %**	**65.7 %**	**86.1 %**	**94.6 %**	**87.5 %**	**86.5 %**	**80.5 %**	**95.3 %**	**80.1 %**

Source: NHFD - Hip Fracture Patients. Data correct to: 12/04/2011. Date of Admission (1st - 31st Mar 2011). Data is correct at the time of publication



Review of services

During 2010/11 The Dudley Group of Hospitals NHS Foundation Trust provided and/or sub-contracted 38 NHS services. The Trust reviewed all the data available to them on the quality of care in all of these NHS services.

The above reviews were undertaken in a number of ways. With regards to patient safety, the Trust Executive and Non Executive Directors undertake weekly Patient Safety Leadership Walkrounds. When relevant, actions plans are developed after the walkround, with an overall picture of issues raised by staff, discussed at the Trust wide Patient Safety Group meetings. These commenced in January 2009 and remain ongoing and a regular schedule is in place.

Also covering patient safety, but including the second element of quality (effectiveness), are the morbidity and mortality reviews undertaken by the Chairman, Chief Executive, Medical Director and Non Executive Director who is chair of the Audit Committee. External review is provided by the Acting Medical Director of NHS Dudley. These occur on an 18 month rolling programme, covering all services. Each service presents information from a variety of sources including: internal audits, national audits, peer review visits, as well as activity and outcome data such as readmission rates, day case rates and standardised mortality rates (see page 65 for more detail on our hospital mortality figures).

Following consultation with our patients last year and the results of our national patient surveys, conducted by the Care Quality Commission, we also monitor safety, clinical effectiveness and patient experience through a variety of methods:

- Senior nurse walk rounds – conducted weekly unannounced visits by the Director of Nursing or one of her senior team to check key nursing care standards. Our Governors observe, talk to relatives, patients and staff and provide feedback on the rounds;
- Nursing care indicators – monthly audits of key nursing interventions and their documentation. The results are published, monitored and reported to Trust Board monthly by the Director of Nursing;
- Productive ward series – part of our Transformation programme, looks at ‘releasing time to care’ by making time and productivity changes. It allows clinical staff to have more time directly with patients;
- The Outpatient Management Board – oversees the action plan arising out of the national outpatient survey and other key operational changes such as changes to clinic templates to help reduce waiting times;
- Smiley face surveys – real-time patient surveys that give a basic feel for our patients’ experience’s of the services;
- External assessments including:
    - Retaining our NHS Litigation Authority Level One and achieving Level One for maternity services;
    - Nursing and Midwifery Council review of our training for students received a ‘good’ rating;

- NHS Dudley commenced a series of Appreciative Enquiry Visits beginning with reviewing the nutrition arrangements at the Trust. NHS Dudley staff were accompanied by patient/public representatives and they interviewed staff and visited wards to look at practice and talk with patients. The results of the visit were very positive and an action plan was drawn up for the minor points of concern raised.
- October 2010, the West Midlands Quality Review Service assessed the Urgent Care, Critical Care, Vascular and Stroke and TIA services of the whole of Dudley as part of a regional peer review. The results of the review were generally positive although a number of concerns about the local associated mental health services, the use of trolleys for patients in the Emergency Assessment Unit and some staffing levels were noted. The Trust has taken action to rectify the issues under its direct control and working with partner organisations on other areas.

The income generated by the NHS services reviewed in 2010/11 represents 99.4 per cent of the total income generated from the provision of NHS services by The Dudley Group of Hospitals NHS Foundation Trust for 2010/11.

Participation in national clinical audits and confidential enquiries

During 2010/11, 45 national clinical audits and seven national confidential enquiries covered NHS services the Trust provides.

During that period the Trust participated in 40 (89 per cent) national clinical audits and seven (100 per cent) national confidential enquiries of the national clinical audits and national confidential enquiries, in which it was eligible to participate.

The national clinical audits and national confidential enquiries the Trust was eligible to participate in and actually participated in, and for which data collection was completed during 2010/11, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits (Department of Health List)

TITLE	Lead	Eligible (Y/N)	Participate (Y/N)	% Submitted
Perinatal and Neonatal				
Centre for Maternal and Child Enquiries (CMACE): Perinatal mortality	J Edwards	Y	Y	100
National Neonatal Audit (NNAP)	Dr S Mahadevan	Y	Y	100
Children				
Paediatric Pneumonia	Dr R Mudgal	Y	Y	99
Paediatric Asthma	Dr R Mudgal	Y	Y	100
Paediatric Fever	Mr N Stockdale/Dr T Kippax	Y	Y	100

TITLE	Lead	Eligible (Y/N)	Participate (Y/N)	% Submitted
Childhood Epilepsy	Dr A Sharma	Y	Y	*
Diabetes (RCPH National Paediatric Diabetes Audit)	Dr A Mohite	Y	Y	100
Acute Care				
Emergency Use of Oxygen		Y	N	
Adult community acquired pneumonia	Dr M Chaudri	Y	Y	67
Adult NIV (Non Invasive Ventilation)	Dr M Chaudri	Y	Y	100
Pleural Procedures		Y	N	
Cardiac Arrest	Dr P Innes	Y	Y	100
Vital Signs in Majors	Mr R Paw	Y	Y	100
Adult Critical Care Unit ICNARC (Intensive Care National audit & Research Centre)	Dr J Sonksen	Y	Y	100
Potential Donor Audit (NHS Blood & Transplant)	Dr J Sonksen	Y	Y	100
Long Term Conditions				
National Diabetes Audit (NDA)	Dr H Siddique	Y	Y	100
Heavy Menstrual Bleeding	Dr H Morsi	Y	Y	100
Chronic Pain	Dr H Mutagi	Y	Y	100
Ulcerative colitis and Crohn's Disease (National IBD Audit)	Dr S Cooper	Y	Y	100
Parkinson's Disease	Dr S Duja	Y	Y	100
European COPD audit	Dr M Chaudri	Y	Y	52
Adult Asthma		Y	N	
Bronchiectasis		Y	N	
Elective Procedures				
National Joint Registry: hip, knee and ankle replacements	R Rai	Y	Y	100
Hip replacements PROMS (Patient Outcome Reported Measures)	K Holmes	Y	Y	92
Knee replacements (PROMS)	K Holmes	Y	Y	91
Hernia (PROMS)	K Holmes	Y	Y	47
Varicose Veins (PROMS)	K Holmes	Y	Y	52
National Vascular Database	Mrs S Shiralker	Y	Y	20
Carotid Interventions	Mrs S Shiralker	Y	Y	94
Cardiovascular Disease				
Familial Hypercholesterolaemia	Dr M Labib/ L Higginson	Y	Y	100

TITLE	Lead	Eligible (Y/N)	Participate (Y/N)	% Submitted
Myocardial Infarction National Audit Programme (MINAP)	Dr J Martins	Y	Y	100
Heart Failure Audit	Dr J Martins	Y	Y	100
Stroke Care (National Sentinel Stroke Audit)	Dr AK Banerjee	Y	Y	100
Renal disease				
Renal Registry: renal replacement therapy	Dr KA Shivakumar/ B Capewell	Y	Y	100
Patient Transport	J Pain/B Capewell	Y	Y	100
Renal Colic	Dr R Blayney	Y	Y	100
Cancer				
National Lung Cancer Audit (LCA)	H Coyle	Y	Y	96
National Bowel Cancer Audit Programme (NBOCAP): bowel cancer	H Coyle	Y	Y	100
Data for Head and Neck Oncology (DAHNO)	Dr C Brammer	Y	Y	100
Trauma				
National Hip Fracture Database (NHFD)	Mr S Quraishi	Y	Y	100
Trauma Audit & Research Network (TARN): severe trauma		Y	N	
National Falls and Bone Health Audit	Dr A Michael	Y	Y	98
Blood Transfusion				
Use of Platelets	Dr C Taylor	Y	Y	100
O neg blood use	Dr C Taylor	Y	Y	100

*Commences May 2011 and the Trust has registered.

As well as the national audits tabled above, from the Department of Health list, the Trust has also taken part in these further national audits:

National Clinical Audits (Other)

TITLE	Lead	Eligible (Y/N)	Participate (Y/N)	% Submitted
Pain in children (College of Emergency Medicine)	Dr T Kippax	Y	Y	100
Adult Asthma (College of Emergency Medicine)	Mr I Dukes	Y	Y	100
National Mastectomy and Breast Reconstruction Audit	Mr M Ali	Y	Y	100
National Oesophago-gastric Cancer Audit	Mr J Dmitrewski/ H Coyle	Y	Y	100
Royal College of Physicians Continence Care Audit	Dr S Duja	Y	Y	100
National Audit of Dementia: dementia care	Dr A McGrath	Y	Y	100

National Confidential Enquiries

The reports of eight national clinical audits were reviewed by the provider in 2010/11 and the Trust has taken, or intends to take, the following actions to improve the quality of healthcare provided:

- Commence a seven day per week rapid access clinic for high risk Transient Ischaemic Attack patients;

Title	Lead/Contact	Participated Yes/No	% Submitted
NCEPOD (National Confidential Enquiry into Patient Outcome & Death): Perioperative Care	Dr N Fisher/A Dufill	Y	100
NCEPOD: Cardiac Arrests	A Duffill	Y	Ongoing
NCEPOD: Surgery In Children	A Duffill	Y	Ongoing
NCEPOD: Parenteral Nutrition	A Duffill	Y	52
NCEPOD: Elective/Emergency Surgery in the Elderly	A Duffill	Y	94
CMACE; (Centre for Maternal & Child Enquiries); Stillbirths	J Edwards	Y	100
CMACE; Neonatal Deaths	J Edwards	Y	100

- Appointed a further Stroke consultant;
- Seven day per week consultant ward rounds for Stroke;
- Number of beds allocated to dementia patients to be increased for more effective care and overall observation;
- Continue and enhance the dementia care training for clinical staff;
- Extend service for dementia patients into EAU this will prevent unnecessary admission and distress to patients;
- Increase in dedicated slots in the memory screening clinic for a more accurate diagnosis and therefore more appropriate care;
- Integrated working and education with community services for continence care;
- Agreement on continence lead for elderly care;
- Appointment of continence nurse;
- Introduction of the Diabetes Outreach Team;
- Job plans altered for consultants, registrars and trainees in diabetology specialty;
- Improved education of clinical staff in the importance of diabetes management;
- Developed and implemented a minimum notification criteria in the emergency department to refer potential donors so staff can identify and refer these to the Specialist Nurse Team;
- Improved referral for potential donors to Specialist Nurse Team;

- For patients who have had a fall, telephone triage criteria put into place for appropriate referral; those with high risk are seen in the consultant-led falls clinic and those with low risk are seen in the community;
- The consultant-led falls clinic provides full cardiological, neurological, gait and osteoporosis assessment;
- Pain scoring of all children with limb injuries at triage in the Emergency Department and specific analgesia proforma attached to notes;
- Improved training of all medical and nursing staff in the Emergency Department on the British Thoracic Society and College of Emergency Medicine guidelines on asthma.

The reports of 139 local clinical audits were reviewed by the provider in 2010/11 and the Trust has taken, or intends to take, the following actions to improve the quality of healthcare provided:

- Pathologists issuing interim reports when delays are likely due to additional testing to ensure any necessary treatment occurs in a timely manner;
- All paediatric forearm fractures, within agreed criteria, to be treated with removable casts and to ask Emergency Department to take over the management of such patients. The outcome is that now Emergency Department treat such cases using the set guidelines so leading to a reduction in unnecessary visits to the fracture clinic, which benefits the patient;
- Improved use of high cost antifungals for haematology/oncology patients;
- Reduction in pre-operative testing in Orthognathic Surgery;
- Improved training of junior doctors with regards to intra and inter hospital transfers of critically ill patients;
- Reduction in duplication of documentation with regards to pre-assessment and anaesthetic charts;
- Protected CT and ultrasound scanning slots during working weekdays for emergency surgical admissions reducing delays in diagnosis and treatment;
- Improved updated blood transfusion records;
- Introduction of in-house database for biologics in rheumatology;
- Introduction of Chloraprep for skin preparation for invasive procedures in neonatal unit to reduce risk of infection;
- Improved junior doctor clerking when assessing for urinary tract infection in children;
- More timely system for senior doctor review of women in obstetric day assessment unit ;
- Clear guidelines on the use of Bortezomib (Velcade) in Haematology;
- Standardisation of Dexamethasone and biphosphonare treatment for multiple myeloma;

- Development of a self-medication policy as part of the 'ThinkGlucose' campaign;
- All stroke care nurses trained in performing swallowing assessments;
- Reassessment of distal radius fracture fixation policy in Orthopaedics;
- Review of working patterns of anaesthetists to reduce the risk of delays in undertaking elective caesarean sections;
- Urethral rather than tympanic route used for the recording of temperature of all patients in Intensive Care unit.

Research and Development

The Trust participates in large multicentre trials in the fields of cancer, cardiology and musculoskeletal medicine, undertaking both academic and commercial studies. The provision of a dedicated laboratory in the Clinical Research Unit has been instrumental in facilitating participation in commercial research, providing specimen storage and centrifuges for sample preparation.

Recruitment can be broken down into interventional and observational studies. During the year 364 patients were recruited into interventional and 794 into observational studies. Approximately six per cent of these subjects were recruited into commercial studies.

The Trust is co-sponsor of TRACE RA, a large multi-centre placebo-controlled clinical trial, with a target recruitment of 3,808 subjects, investigating the use of statins in patients with rheumatoid arthritis (RA). The Trust also hosts two Arthritis Research Campaign clinical research fellows. One researcher is investigating lipid profiles; the other is designing an educational intervention to reduce cardiovascular disease in RA sufferers.

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee, was 1,158.

Commissioning for Quality and Innovation Payment Framework (CQUIN) framework

A proportion of the Trust's income in 2010/11was directly related to this framework and is valued at £3.36m as part of our PCT contract and a further £172k is achieved via our specialised services contract. The sum is variable based on 1.5% of our activity outturn and conditional on achieving quality improvement and innovation goals. These are agreed between the Trust and any person or body they have a contract, agreement or arrangement with for the provision of NHS services through the Commissioning for Quality and Innovation Payment Framework. We haven't yet agreed the final settlement figure as some targets are still contingent upon outstanding information. However, for the purpose of the year end accounts, we assumed 75% achievement for the PCT schemes and 100% achievement for specialised services. This would equate to approx £2.7m.

Further details of the agreed goals for 2010/11 and for the following 12 month period are available electronically at http://www.dgoh.nhs.uk/quality/cquins

CQUINS report 2010/11 (Hospital)

Summary of goals

Goal no.	Description of goal	Quality Domain(s)
1	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	Safety
2	Improve responsiveness to personal needs of patients	Patient Experience
3	Missed doses	Safety
4	Warfarin prescribing medicines acute	Safety
5	Smoking acute	Safety Effectiveness
6	ThinkGlucose	Safety Effectiveness Patient Experience
7	Tissue viability	Safety Effectiveness
8	Dementia pathway	Effectiveness
9	Breastfeeding	Effectiveness
10	End of life care Advance Care Planning (ACP) enables patient choice and preferences, improves patient experience and quality of care	Experience Effectiveness

We have rated last year's CQUINS on a red amber green basis dependent on whether we achieved the target set with the PCT. We fell short of meeting the two for tissue viability and patient experience and we have actions in place to ensure the quality of care in these areas is improved and, in fact, both are quality priorities for this year.

CQUINS report 2011/12 (Hospital)

Summary of goals

Goal no.	Description of goal	Quality Domain(s)
1	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	Safety
2	Improve responsiveness to personal needs of patients	Patient Experience
3	Tissue viability – reduce the incidence of grade three & four hospital/community acquired pressure ulcers	Safety Effectiveness
4	Antimicrobial stewardship – reduce the incidence of healthcare associated infections	Safety Effectiveness
5	To improve the health of the population by ensuring that all patients who smoke and drink at harmful levels are identified and provided with brief advice by trained staff.	Safety Effectiveness
6	Mental Health – psychiatric liaison team set up, reviewed and improved	Safety Effectiveness Patient experience

CQUINS for 2011/12 (Community)

Summary of goals

Goal no.	Description of goal	Quality Domain(s)
1	Improve responsiveness to personal needs of patients	Patient experience
2	To deliver shared pressure ulcer care across acute and community services	Safety Effectiveness
3	Joint care planning for stroke patients	Safety Effectiveness Patient experience
4	Ensure patients are successfully maintained out of hospital in their own home by the virtual ward service	Safety Effectiveness Patient experience

Care Quality Commission (CQC)

The Dudley Group of Hospitals is required to register with the Care Quality Commission and our current registration status is 'licensed' with no conditions attached to registration.

The Care Quality Commission has not taken enforcement action with The Dudley Group of Hospitals during 2010/11.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

In January 2011 we had a planned visit to review our compliance against the 16 Essential Standards of Quality and Safety set out by the CQC. Assessors visited various parts of Russells Hall Hospital and Corbett Outpatients Centre to check our compliance to the standards. Overall the report was very positive about our services highlighting just six minor concerns and one moderate concern with the standards. To ensure we make the necessary improvements, we have submitted our action plan to the CQC who will monitor our progress against it.

Quality of data

The Dudley Group of Hospitals NHS Foundation Trust submitted records during 2010/11 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. The percentage of records in the published data (based on April – January 2011 SUS data):

According to the NHS Information Centre's Data Quality Dashboard reports, the Trust's average data quality for all fields was 99.5% of which:

The following included the patient's valid NHS number:

- 99.4% for admitted patient care; National average was 98.4%
- 99.8% for outpatient care; National average was 98.8%
- 97.6% for accident and emergency care, National average was 91.6%

The following included the patient's valid General Medical Practice Code:

- 100% for admitted patient care; National average was 99.8%
- 100% for outpatient care; National average was 99.7%
- 100% for accident and emergency care. National average was 99.7%

The Trust Information Governance Assessment Report overall score for 2010/11 was 52 per cent and was graded red – not satisfactory, which indicated that not all of the level two requirements were achieved; however, improvement plans are in place to ensure the key requirements are achieved as soon as possible, and the Trust expects to have reached a satisfactory score by October 2011.

The Dudley Group of Hospitals NHS Foundation Trust was not subject to a Payment by Results clinical coding audit during 2010/11 by the Audit Commission because only Trust's within the bottom 30 in terms of auditing performance from the previous year (2009/10) had an audit.

The Trust's next scheduled audit will be between August 2011 and March 2012.

During 2010/11 there were two incidents involving personal data. The first involved a set of patient notes being delivered to the wrong health centre. The information was never in the public domain and the Trust reviewed its policy on the transportation of health records. In the second case, a member of the public received incorrectly addressed patient letters intended for a GP practice. Outgoing mail is now subject to an audit programme of regular sampling of letters.

Quality overview – performance against selected quality indicators

The Trust has a number of different Key Performance Indicators (KPI) reports and dashboards which are available and used by a wide variety of staff groups monitoring quality on a day-to-day basis. The main repository for the reporting of the Trust's key performance indicators and measures is a web based dashboard. This is available to all senior managers, matrons and clinicians and currently contains over 130 indicators, grouped into the domains of Quality, Performance, Workforce and Finance.

The dashboard displays the performance of the indicators by month, quarter and year to date and the majority of them have historic data going back three years or more. There are also charts showing current financial year performance and trend line graphs to help the users see the current performance of each of the indicators. There are weekly and daily sections as well as views which just show the CQC, Monitor, CQUIN and PCT contractual measures.

Separate to this, a weekly e-mail is sent to senior managers and clinicians which include the A&E, Referral To Treatment, Stroke and Cancer targets.

Further, on a monthly basis Ward Performance Reports are sent to all wards, which include a breakdown of performance by ward based on Nursing Care Indicators,

Ward Utilisation, Adverse Incidents, Governance and Workforce Indicators and Patient Experience scores.

A monthly report also goes to the Trust's Finance and Performance meeting and management executive meeting showing the Trust's performance against CQUIN, Monitor and CQC targets. A Performance Management report is also submitted to NHS Dudley containing performance against all national and locally set KPI's. The Trust also uses CHKS Ltd, who is a leading UK provider of comparative healthcare information, as a Business Intelligence monitoring tool. Some senior managers have access to the West Midlands SHA comparative performance tables to enable the Trust to benchmark itself against other trusts.

Our quality indicators have remained the same for 2011/12 as the Board and our stakeholders believe these take into consideration both national and local targets which will be important to patients and give a good overall view of the Trust's quality of care.

The tables below and overleaf cover the three dimensions of quality and reflect our quality priorities, topics we know are important to patients and those targets we are measured on locally and nationally.

Patient experience metrics:

	Actual 2007/08	**Actual 2008/09**	**Actual 2009/10**	**Actual 2010/11**	**National Average 2010/11**	**Target 2011/12**
% of patients that would recommend hospital to a relative/ friend**	90.4%	91.5%	89.5%	88%	91.8%	95%
% of patients who would rate their overall care highly**	93.8%	92%	88%	89.3%	90.8%	91%
% of patients who spent less than 4 hours waiting in A&E (national target)	98.1%	95.9%	98.1%*	98.8%*	96.9% West Midlands only	95%***
% of patients who felt they were treated with dignity and respect**	97.4%	95.9%	94.6%	96%	95.6%	N/A

*Dudley health economy mapped figure Data source:

**Data from national inpatient surveys conducted for CQC

National Average = Picker Institute Europe average. Picker undertake the inpatient survey for around 75 hospital trusts in England

*** A&E 4 hour wait target was 98% for Quarter one of 2010/11 and 95% for Quarter 2 to 4.

Safety measures:

	Actual 2007/08	**Actual 2008/09**	**Actual 2009/10**	**Actual 2010/11**
Patients with MRSA infection/1,000 bed days*	N/A	0.07	0.04	0.01
Patients with C difficile infection/1,000 bed days*	1.45	0.97	0.9	0.51
Number of cases of Deep Vein Thrombosis presenting within three months of hospital admission Source: Patient Administration System	49	48	48	35

*Data source: Numerator data taken from infection control data system and denominator from the occupied bed statistics in patient administration system. *NB MRSA/C difficile figures may differ from data available on HPA website due to different calculation methods and Trust calculations using most current Trust bed data.*

Clinical outcome measures reported:

	Actual 2007/08	Actual 2008/09	Actual 2009/10	Actual 2010/11
Trust Readmission Rate for Surgery Vs Peer group West Midlands SHA Source: CHKS Signpost	4.6% Vs 4.1%	3.9%* Vs 4.3%	4.1% Vs 4.2%	4.4% Vs 4.7%
Number of cardiac arrests Source: logged switchboard calls	397	250	170	145
Never events – events that should not happen whilst in hospital Source: adverse incidents database	0	0	0	0

*3.8 per cent for 2008/09 in the 2009/10 report was April 2008 to February 2009 only

Our performance against key national priorities and National Core Standards

National targets and regulatory requirements	Actual 2007/08	Actual 2008/09	Actual 2009/10	Actual 2010/11	Target 2011/12
The Trust has fully met the CQC core standards, and national targets	24/24	23/24	23/24	N/A	N/A
A maximum two-week wait for standard Rapid Access Chest Pain Clinics	99.98%	99.89%**	99.90%	99.64% 99.88% West Mids SHA Apr-Dec	95%
Genito-urinary medicine – percentage of patients offered an appointment within 48 hours	N/A	99.59%	99.83%	99.66% 99.9% West Mids SHA Apr-Dec	98%
Percentage of patients who have operations cancelled for non-clinical reason to be offered another date within 28 days	100%	100%	100%	100% 97.9% West Mids SHA Apr-Dec	98.5%
Clostridium difficile year on year reduction	N/A	154*	126	81 N/A West Mids SHA	No more than 77 No more than 126 Monitor Target
MRSA – maintaining the annual number of MRSA bloodstream infections as per the PCT contract	N/A	16 (only seven of which were post 48hrs)	10 (only two of which were post 48 hrs)	3 N/A West Mids SHA	No more than 2 No more than 6 Monitor Target

National targets and regulatory requirements cont.	Actual 2007/08	Actual 2008/09	Actual 2009/10	Actual 2010/11	Target 2011/12
Screening all elective in-patients for MRSA	N/A	N/A	100%	100% Apr-Mar	100%
Stroke patients spending 90% of their time on stroke unit	N/A	N/A	N/A	68.30% 67.87% West Mids SHA Apr-Jan	80% by the end of Mar 2011
Suspected stroke/TiA scanned < 24hrs of presentation	N/A	N/A	N/A	76.11% 47.66% West Mids SHA Apr-Jan	60%
Maximum time of 18 weeks from point of referral to treatment (admitted patients)	N/A	92.4%	95.8%	97.03% 93.37% West Mids SHA Apr-Jan	95%
Maximum time of 18 weeks from point of referral to treatment (non-admitted patients)	N/A	96.15%	99.1%	99.25% Apr-Jan 98.04% West Mids SHA Apr-Jan	90%
Two week maximum wait for urgent suspected cancer referrals from GP to first outpatient appointment	100%	100%	98%	96.8% 94.97% West Mids SHA Apr-Feb	93%
A maximum wait of 31 days from decision to treat to start of treatment for all cancers	100%	100%	99.3%	99.8% 98.68% West Mids SHA Apr-Feb	96%
A maximum wait of 62 days from urgent referral to treatment of all cancers	100%	99.9%	86.5%	87% 85.53% West Mids SHA Apr-Feb	85%
Proportion of women receiving cervical cancer screening test results within two weeks	90%	90%	32.12%***	98.60% Data Not available West Mids SHA	98%
Percentage of patients waiting five weeks or less for diagnostic tests	N/A	99.73%	99.58%	98.34% Apr-Mar Data Not available West Mids SHA	100%

All figures are final year end data for 2010/11 unless stated otherwise.

N/A applies to targets not in place at that time.

*The outcome of verification of year end data for 2009/10 was confirmed after publication of the 2008/09 report which stated a figure of 152

**The outcome of verification of year end data for 2009/10 was confirmed after publication of the 2008/09 report which stated a figure of 99.98 per cent

*** There was a print error in last year's Quality Report and Accounts stating this figure was 97%, this was the quarter 4 figure. The reason the per cent is now less is due to the year end figure being inserted. The low figure is due to a national increase in women coming forward for screening following a very high profile celebrity death from cervical cancer.

Hospital Standardised Mortality Ratio

We are committed to ensuring the best possible outcome for our patients at The Dudley Group of Hospitals and were disappointed with the mortality ratio of 115.5 assigned to us by Dr Foster for 2009/10. Our internal monitoring systems, which include audits, mortality and morbidity reviews and detailed reviews in areas where mortality alerts have been generated, have not raised any concerns. The Trust also works with CHKS, an external independent organisation that provides comparative performance data in a number of areas, including mortality.

CHKS use a similar but alternative methodology to calculate mortality risk called the Risk Adjusted Mortality Index (RAMI). Using an additional analysis methodology helps us to identify and investigate areas that may be of concern. The RAMI position for the same period as Dr Fosters data was 91, and for the current year to date is 88. These figures will be adjusted as part of a rebasing process, but we are not anticipating our final RAMI to raise concerns.

Using CHKS has given the Trust additional reassurance around mortality performance. Indeed mortality alerts raised via the Care Quality Commission (CQC) give us further reassurance as our responses have required no additional investigation due to the robustness of our processes. Additionally our published response to Dr Foster Good Hospital Guide evidencing our robust methodology was supported by NHS Dudley and acknowledged by the Strategic Health Authority, Monitor and the CQC.

The Trust is not alone in having a retrospective increase in Dr Foster's mortality ratio applied to our performance. The government has also raised concerns over the inherent difficulties associated with Risk Adjusted Mortality modelling and its suitability for comparing organisational performance.

As a consequence a new measure, Summary Hospital-level Mortality Indicator (SHMI) is due to be introduced in April 2011 to address these issues and provide a single standard across the country. Even with this standard measure the government's steering group has said that:

> *"While it is acknowledged that variation in quality of care is likely to have an adverse impact on the number of avoidable deaths, it cannot be assumed that a high SHMI – or any other summary level indicator – of deaths is necessarily the result of poor quality of care"*

ANNEX

Comment from NHS Dudley (received 29/04/2011)

NHS Dudley is pleased to provide a supporting statement for The Dudley Group of Hospitals NHS Foundation Trust Quality Report and Accounts for 2010/11. We have carefully reviewed the contents of this report and believe the content is a true and accurate reflection of the performance information recorded by the Trust. As such we are happy to endorse it.

We applaud the work done within the Trust to improve the recognition of deteriorating condition of patients and the associated reduction of cardiac arrests. This represents an important contribution to patient safety.

Following the transfer of some community services into the new Dudley Group of Hospitals NHS Foundation Trust, we value the alignment of the Trust's priorities and goals across both hospital and community services going forwards to 2011/12.

We share the Trust's concern about the number of patients developing pressure ulcers and are extremely pleased to see this as a priority for significant improvement this year.

We also shared the Trust's disappointment with the Hospital Mortality rate published by Dr Foster this year and continue to work closely with Trust colleagues to review and monitor deaths in hospital.

Finally we welcome a strengthened focus on listening to patients and improving patient experience in 2011/12.

Comment from Dudley Local Involvement Network (received 20/04/2011)

Dudley Local Involvement Network (LINk) welcomes the opportunity to contribute to the Quality Report and Accounts.

We work across Dudley Borough to listen to the community and hear their experiences and comments about the services that they receive. We therefore share the concern expressed by Chief Executive Paula Clark regarding her disappointment that levels of patient experience has not improved as much as the Trust would like. In addition to being consulted about Quality Priorities on an ongoing basis being represented on the Trust's Patient and Public Experience Steering Group and being involved in the quality priority Listening into Action event, LINk has enabled the voice of Dudley residents to be heard and, whilst we also hear from people whose expectations of the services they have received have not been met, we must also remember the many people in Dudley who cannot compliment our hospitals and the staff enough.

As the Trust has now taken on board some of our community services it is good to see that when setting their priorities for the coming year these services have been taken into account.

The priorities this year will be important to the people of Dudley. We know that they want to be satisfied with the quality of the service that they receive; we know that the

possibility of acquiring a pressure ulcer is a concern to people; we know that people really do worry about catching MRSA and C-diff whilst in hospital; we know that the trust has a good record in operating swiftly on hip fractures and that we want this to continue

All of these priorities are important and LINk will work hard with Dudley residents and The Dudley Group of Hospitals NHS Foundation Trust to ensure that they are maintained.

Comment from the Overview and Scrutiny Committee (received 14/04/2011)

The quality priorities were considered at the OSC (Overview and Scrutiny Committee) meeting held on the 6th April 2011. Unfortunately, due to the proximity to year end processing and other constraints, the OSC was unable to provide a supporting narrative this year. However the Committee agreed to develop subsequent work plans to incorporate the Quality Report and Accounts issues to support year round dialogue to ensure relevance amongst Dudley's communities is maintained.

Comment from the Trust's Council of Governors (received 07/04/2011)

The Council of Governors acknowledges the progress made by the Trust during the last 12 months and in particular the involvement of, or consultation with, Governors on several occasions. It also acknowledges the transparency and co-operation received from the Trust Board and senior staff, without which it would be difficult to function effectively e.g. influencing in a positive way the strategy of the Trust.

Governors have been regularly informed about the Trust Transformation programme including receipt of a number of slide presentations followed by question and answer sessions. This has ensured the Trust was made aware of the views of the Trust Membership with opportunity given for suggestions to be considered. A number of suggestions have been put forward by Governors which have been incorporated into the Transformation programme. These have been made in writing, paper, verbally or by participation in the Listening into Action (LiA) group sessions which have resulted in changes in the way the Trust operates. The LiA events are proving to be a successful means of communication of good ideas from the Trust staff working on the front line, and although specifically designed for staff, have been a useful tool for Governors when they have been invited to attend, such as the Quality LiA.

Governors wrote a paper highlighting the right of our patients to receive 'good quality hospital care'. Supported by the Council of Governors it sets out some expectations for quality:

- Good clinical care
- An efficient service which includes – prompt responses and a good use of resources
- The provision and availability of suitable food
- A friendly welcoming environment in which patients and visitors feel important and cared for

- A clean hospital and a quiet, peaceful environment, especially at night
- Good communications – between staff, patients, visitors and any other appropriate persons

The list is by no means exhaustive, but Governors are alerted to patients' views by their own experiences in hospital, talking to Trust Members and by taking part in unannounced senior nursing staff 'ward assessment visits', which give Governors the chance to obtain up-to-date views of our patients about their experience whilst in hospital. On the whole patients find the medical and nursing care to be very good although, inevitably, there are some instances where we get things wrong. Patients welcome the opportunity to be able to talk with Governors during these visits. Items brought to the attention of Governors are discussed at both the Service Strategy Sub Committee and full Council of Governors.

Cleanliness and patient safety is a top priority for everyone so it is extremely pleasing to note the major strides forward in reducing instances of MRSA and C Diff. The Council of Governors receives regular updates and presentations throughout the year showing the progress.

Governors feel they have used their roles in a positive way to influence the strategy of the Trust and will continue to do so despite the major changes that lie ahead for the NHS, acute hospitals and Foundation Trust Governors alike.

Statement of directors' responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2010-11;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2010 to June 2011
    - Papers relating to Quality reported to the Board over the period April 2010 to June 2011
    - Feedback from the commissioners dated 20th April 2011
    - Feedback from governors dated 7th April 2011
    - Feedback from LINks dated 20th April 2011

    - The Trusts complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 23rd May 2011
- The national patient survey 7th April 2011
- The national staff survey 16th March 2011
- The Head of Internal Audits annual opinion over the trusts control environment dated 24th May 2011
- CQC quality and risk profiles dated Jan '10, Sept '10, Oct '10, Nov '10, Dec '10, Feb '11, March '11

The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered. The performance information reported in the Quality Report is reliable and accurate. There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.

The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed 106 definitions, is subject to appropriate scrutiny and review; and the Quality Report has Been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitornhsft.gov.uk/annual reporting manual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitornhsft.gov.uk/annualreportingmanual)).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

NB: sign and date in any colour ink except black

Date 26th May 2011 Chairman

Date 26th May 2011 Chief Executive

Independent Assurance Report to the Council of Governors of The Dudley Group of Hospital NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of The Dudley Group of Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of the content of The Dudley Group of Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 201 I (the "Quality Report").

This report, including the conclusion, has been prepared solely for the Council of Governors of The Dudley Group of Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting The Dudley Group of Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 20 II , to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and The Dudley Group of Hospitals NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

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

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 20 I 0111 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

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

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

- Board minutes for the period April 201 0 to March 20II.
- Papers relating to Quality reported to the Board over the period April 20 I 0 to March 20II.
- Feedback from the Commissioners dated *29/04/20 II.*
- Feedback from the Council of Governors dated *07/04/2011.*
- Feedback from LINKS dated *20/04/20 II*
- The Trust's 2010111 complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009. (Due to the timing of our work we have reviewed Quarter I (June 20I0), 2 (September 20I0) and 3 (December 20I0) for 2010/11).
- The 20I0 national patient survey and local patient survey dated *31/03/20* II.
- The 20I0 national staff survey.

- The Head of Internal Audit's annual opinion over the Trust's control environment dated *31 /03/20* II.
- Care Quality Commission quality and risk profiles dated March 20 II.

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

Assurance work performed

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

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

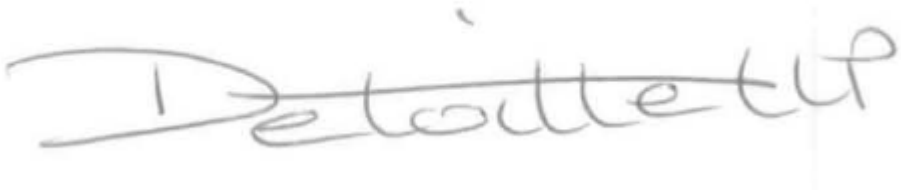
A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 3 I March 20II, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual.



Deloitte LLP

Chartered Accountants

Birmingham

I June 20II

Council of Governors and Members

The Council of Governors is responsible for holding the Trust Board of Directors to account for its stewardship of the organisation; the majority of our Governors are elected through our Membership. Our Council of Governors was formed with effect from the 1st October 2008 and consists of 39 Governors in total:

Public elected – 20 Governors

Staff elected – 6 Governors

Appointed from our key stakeholders – 13 Governors

A table summarising the Council of Governors and the constituencies they represent can be found on pages 71.

The Trust Board works closely with our Council of Governors with regular Director attendance at both full Council meetings and the Sub Committees of the Council. The Council is consulted by the Board on the determination of its strategy.

The Board is accountable to the Council of Governors ensuring it meets its Terms of Authorisation. General meetings of the Council of Governors are held in public. During the year 2010/11, the Council of Governors has met formally on five occasions. The 8th July meeting was held in private because of the general election and 22nd July held in private as an extraordinary meeting to approve the appointment of Chair and Non Executive Directors.

The Council of Governors operates through the following sub-committees:

- Communications and membership sub-committee
- Service strategy sub-committee
- Patient and public experience sub-committee (a sub-committee of the Trust with representation from the Council of Governors)

- Remuneration sub-committee
- Appointments sub-committee

The Council of Governors has the following key roles:

- Appointment of the Chair, including appraisal and performance management
- Appointment of the Non Executive Directors
- Appointment of external auditors
- Advising the Trust Board on the views of Members and the wider community
- Ensuring the Board of Directors complies with its terms of authorisation and operates within that licence
- Recruitment and engagement of Members
- Advising on strategic direction

The Trust Secretary holds a register of Governors' Interests which is available for public inspection at the Foundation Trust headquarters. Should you wish to view the register, please contact the Trust Secretary on (01384) 456111 ext. 1168.

Governor & Executive attendance at Full Council meetings 2010/11		08/04/2010	08/07/2010 Governor meeting (private)	22/07/2010 Extraordinary	21/10/2011	13/01/2011
Appointed	**Constituency/organisation**					
Pamela Boucher	DGoH volunteers	✓	✓		✓	
Gill Cooper (commenced July '10)	NHS Dudley		✓		✓	✓
Sarah Dugan (commenced Feb 10, retired Mar 11)	Dudley PCT	✓	✓		✓	✓
Cllr. Lesley Faulkner	Dudley MBC	✓	✓	✓		
Neal Gisborne (commenced April '10)	Partner Organisations		✓	✓	✓	
Simon Hairsnape (commenced Sept '10)	Worcestershire PCT				✓	✓
Brian Hanford (retired Aug '10)	Worcestershire PCT					
Phillip Higgins	West Midlands Ambulance Service		✓	✓		
Beverley Hill (retired Oct '10)	Sandwell PCT	✓				
Cllr. Anne Hingley	Wyre Forest DC	✓		✓	✓	✓
Rafat Hussein (left Nov '10)	Dudley Youth Council	✓				
Professor Martin Kendall	University of Birmingham Medical School	✓	✓	✓		
Professor Linda Lang	Wolverhampton University School of Health & Wellbeing		✓	✓	✓	✓
Mary Turner	Dudley Council for Voluntary Services	✓	✓		✓	✓

Governor & Executive attendance at Full Council meetings 2010/11		08/04/2010	08/07/2010 Governor meeting (private)	22/07/2010 Extraordinary	21/10/2011	13/01/2011
Public elected	**Constituency/ Organisation**					
Richard Brookes	Brierley Hill	✓	✓	✓	✓	✓
Peter Totney	Brierley Hill	✓	✓	✓	✓	
Steve Waltho	Brierley Hill		✓	✓	✓	
Nazir Ahmed (commenced July '10)	Central Dudley					
P D Gupta	Central Dudley	✓		✓	✓	✓
Atif Janjua	Central Dudley	✓		✓	✓	
John Balmforth	Halesowen	✓	✓	✓	✓	✓
Jane Beard	Halesowen					
Rob Johnson	Halesowen	✓	✓	✓	✓	✓
Rosemary Bennett	North Dudley	✓	✓	✓	✓	✓
Bill Etheridge (commenced July '10)	North Dudley			✓	✓	✓
Harvey Woolf	North Dudley	✓	✓	✓		✓
Kacey Akpoteni	Rest of the West Midlands	✓	✓	✓	✓	
Janet Robinson	Rowley Regis	✓				
Diane Jones	South Staffordshire	✓	✓	✓	✓	✓
Darren Adams	Stourbridge		✓			✓
Catherine Earle	Stourbridge		✓	✓	✓	
Roy Savin	Stourbridge	✓	✓	✓	✓	✓
Vacant	Tipton					
Pat Siviter	Wyre Forest	✓	✓	✓	✓	✓
Staff elected						
Ian Dukes	Medical & Dental	✓		✓	✓	
Jane Elvidge (resigned Jan '11)	Allied Health Professionals & Health Care Scientists		✓		✓	
David Ore	Non Clinical Staff	✓	✓	✓	✓	
Graham Russell	Nursing & Midwifery	✓	✓		✓	
Jane Southall	Nursing & Midwifery	✓	✓	✓	✓	✓
Simon Tovey (retired Dec '10)	Partner Organisation's Staff		✓	✓	✓	
Board of Directors (current)						
Paul Assinder	Director of Finance & Information	✓	✓	✓		✓
David Badger	Non Executive Director	✓	✓	✓	✓	✓
Ann Becke	Non Executive Director	✓	✓		✓	✓
Richard Beeken (commenced June '10)	Director of Operations & Transformation		✓			
Paula Clark	Chief Executive	✓	✓		✓	✓
David Bland (commenced Aug 1'0)	Non Executive Director				✓	
John Edwards (commenced Nov '10)	Chairman				✓	✓
Jonathan Fellows	Non Executive Director				✓	✓
Paul Harrison	Medical Director					
Denise McMahon	Nursing Director	✓	✓		✓	✓
Richard Miner (commenced Nov '10)	Non Executive Director					
Annette Reeves (commenced May '10)	Head of Human Resources		✓			✓
Kathryn Williets	Non Executive Director					✓

Board of Directors (current)						
Janine Clarke (left May '10)						
Alf Edwards (retired Oct '10)	Chairman	✓	✓	✓	✓	
Ruth Serrell (left June '10)	Acting Director of Operations	·	·	·	·	·

Membership of Council Committees 2010/11

Governor lead responsibilities

- Darren Adams Lead Governor
  Chair, Communication & Membership Sub Committee
- Harvey Woolf
  Chair, Appointments Committee
- Rob Johnson
  Chair, Governor Development Group
- John Balmforth
  Chair, Service Strategy Sub Committee

Governor resignations and elections

Governors were appointed on 1st October 2008 for a three year period.

In accordance with our Constitution, the Trust uses the method of single transferable voting for all elections. This system allows voters to rank candidates in order of preference and, after candidates have either, been elected or eliminated, unused votes are transferred according to the voters next stated preference. Electoral Reform Service (ERS), which is an external agent, has been appointed by the Trust to oversee the election process. The following organisations have appointed new Governors to the Trust Council during the year:

Appointing organisation	Name of Governor
PFI partners – Interserve	Neal Gisborne
NHS Dudley	Gill Cooper
Dudley Youth Council	Kyle McAleer
Worcestershire PCT	Simon Hairsnape

During the year, the Trust received two resignations of elected members from the Council of Governors. Two vacancies arising from resignations received in the previous financial year were filled for a three-year term using the prescribed election process. Elections for remaining vacancies will be run in early April 2011 in accordance with the election rules, as stated in the Constitution. The tables below set out the movement of Governors during the year as a result of resignation:

Resignation date	Ward/constituency	Name of Governor
January 2011	Staff elected: AHP & HCS	Jane Elvidge
December 2010	Staff elected: Partner Organisations	Simon Tovey

Election date	Ward/constituency	Number of eligible voters	Total votes cast	Election result
July 2010	Public elected: Central Dudley	1766	344	Nazir Ahmed
July 2010	Public elected: North Dudley	1095	218	Bill Etheridge

Engagement with Governors and Members

The Trust encourages and supports Governors in raising their profiles within their constituencies. The 'Governors out there' pilot supports Governors to undertake their important role in finding out what people think and bringing that feedback to the Trust Board of Directors. Governors have been busy out and about in their communities and have attended a number of community and support groups, including Cole Street Wives, Pilkington, Halesowen Cancer Support and Fibromyalgia Support Group. Governors have also participated in various other community events including Dudley Metropolitan Council Area Committee meetings, Dudley Carers Forum, Zoar Methodist Church community event and other community engagement events.

We hold quarterly Council of Governors meetings which include presentations and question and answer sessions with key clinicians and staff from across the Trust to help Governors understand how the hospitals work.

The Non Executive Directors attend Council of Governor meetings on a regular basis and Non Executive's participate at Governor sub-committees to ensure we are seeking and listening to the views of our Governors and Members at Board level.

Contact procedures for people to talk to their Governors and/or Directors of the Trust Board

There are several ways our Members or members of the public can contact either their Governor or a member of the Trust Board of Directors:

- At our public Council of Governors meetings held quarterly
- At our Annual General Meeting for Members

  (*dates for both of the above from the FT office or on www.dgoh.nhs.uk*)
- Telephone our Foundation Trust office on 01384 456111 ext. 1168
- Email: foundationmembers@dgh.nhs.uk or governors@dgh.nhs.uk
- Write to: Freepost RSEH-CUZB-SJEG, 2nd Floor C Block, Russells Hall Hospital, Pensnett Road, Dudley, DY1 2HQ

Several of our Governors are also happy to be contacted directly and their details can be found on the Members section of our website or by telephoning 01384 456111 extension 1168.

Developing our Membership

Membership recruitment and engagement

This year we have further promoted our membership to our local communities and the importance of having a voice by encouraging them to share with us their experiences. All of our events this year have been successful in terms of promoting the Trust and some have also been successful in increasing membership. We strive to ensure our membership is reflective of the communities we serve and membership is open to anyone over the age of 14 years who live in one of our constituencies, which are based on geographical boundaries.

The table below shows the top five most successful engagement activities.

Top five most successful recruitment activities during 2010/11

Date	Event	Members recruited
01/12/2010	Health and Environment Fair – Halesowen College	300
16/09/2010	Dudley College Fresher's Fayre	178
	Volunteers/via post/through Governors	161
	Dudley College careers event	85
	From appointment letters	62

At the end of March 2011 we had a total of 11,970 public members (including Outside of West Midlands). We are now working towards our target of 13,000 by 2013 and engaging further with our members.

Projected membership growth

Membership goals	Current	2011/12	2012/13
Public (excluding outside of the West Midlands	11,692	12,750	13,250
Staff (excluding partner organisations)	4,391	3,982	3,982
Total	16,083	16,732	17,232

Our membership database is cleansed on a quarterly basis to remove Members who have moved away or deceased to ensure that the information we hold about our Members is as up-to-date as possible.

We continue to strive to ensure our membership is reflective of the communities we serve. Geographically, we are overrepresented in most constituencies, particularly our Dudley constituencies that make up the majority of our membership base. This year we have focused our efforts on recruiting members from our underrepresented groups and we have managed to increase our underrepresented socio-economic Members by 27.8 per cent (279 members).

Membership Report as at 31st March 2011		
Public constituencies	Number of members	Active members
Brierley Hill	1,512	412
Central Dudley	2,009	523

Halesowen	1,030	197
North Dudley	1,210	307
Rest of West Midlands	1,059	509
Rowley Regis	989	123
South Staffordshire	419	87
Stourbridge	1,516	387
Tipton	1,125	113
Wyre Forest	823	31
Total	**11,692**	**2,689**

Membership report continued…

Staff constituencies	**Number of members**	
Medical and Dental	521	
Nursing and Midwifery	1,383	
AHPs and Scientists	1,581	
Non Clinical	906	
Total	**4,391**	
Partner Organisations	638	

Membership breakdown by age, gender and ethnicity

	Membership	
	1st April 2009 to 31st March 2010	**1st April 2010 to 31st March 2011**
Age		
0-16	184	191
17-21	1,156	1,749
22+	8,842	9,380
Not stated	320	372
Gender		
Male	4,036	4,405
Female	6,466	7,287
Ethnicity		
White	9,327	10,232
Mixed	175	220
Asian or Asian British	609	761
Black or Black British	173	242
Other	48	61
Not stated	170	176

Our main aim is to recruit members to be actively involved with the Trust but people can become involved as little or as much as they want. The Trust has two levels of membership: passive and active. We are pleased that we have increased our 'active' membership by 925 members his year taking our total active membership (including outside of the West Midlands) to 2,748. All Members will continue to:

- Receive information about the Trust via our 'Your Trust' magazine;

- Be involved in shaping the future of healthcare in Dudley by sharing their views;
- Be able to vote for the Governor for their constituency;
- Be able to stand for election to represent their constituency;
- Be invited to attend our health fairs and member tours.

Our health events continue to prove a real success with our members. Many have learned more about our services, including our younger members who have shown a keen interest in the work of our Trust. We have held 10 Members health events, ranging from health fairs to behind-the-scenes tours and seminars with 430 Members and their guests attending these events.

Board of Directors

The Board of Directors was established and constituted to meet legal minimum requirements as stated in the Health and Social Care (Community Health and Standards) Act 2003, and the requirements of the NHS Foundation Trust Code of Corporate Governance published by Monitor.

A Board evaluation process is in place to enable it to undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors, in line with the Combined Code.

The Board of Directors Nominations Committee works closely with the Council of Governors' Appointments Committee to review the balance and appropriateness of Board members skills and competencies. Board effectiveness is assessed annually and the process is monitored by the Appointments Committee. The Board is satisfied that the balance experience and skill set of Board members remains fit for purpose.

Non Executive Directors can only be removed by a 75 per cent vote of the Council of Governors following a formal investigatory process, and the taking of independent legal advice, in accordance with guidance issued by Monitor.

A Register of Directors' Interests is held by the Board Secretary and is available for inspection on request.

Saxton Bampfylde Ltd was engaged by the Trust to lead the executive search for both the Chair and Non Executive posts in the Trust during 2010. This consisted of both external advertising and directly approach candidates with suitable experience for both roles.

The appointments committee on behave of the Council of Governors were fully involved and represented the majority vote for all stages of the recruitment process, therefore fulfilling the Trusts statutory duties as outlined by Monitor.

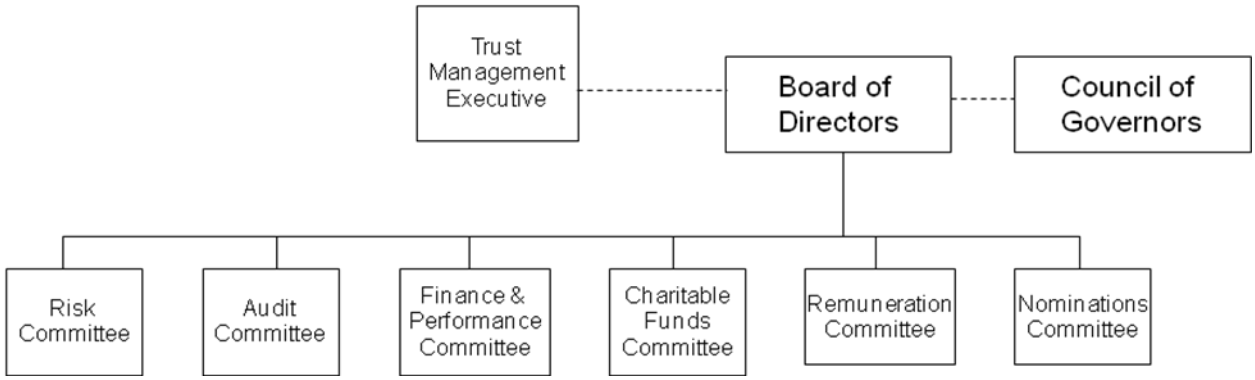
Directors in post during the financial year

Position	Name	Commencing	Term
Chairman	Alf Edwards	08.02.94	31.10.10
Chairman	John Edwards	01.11.10	31.10.13
Chief Executive	Paula Clark	01.10.09	
Director of Finance and Information	Paul Assinder	22.08.05	
Acting Director of Operations	Ruth Serrell	23.10.09	30.06.10
Director of Operations and Transformation	Richard Beeken	15.06.10	
Director of Human Resources	Janine Clarke	05.11.02	18.07.10
Medical Director	Paul Harrison	01.06.06	
Director of Nursing	Denise McMahon	12.05.08	
Non Executive Director/Deputy Chairman and Senior Independent Director	David Badger	01.12.02	31.12.12
Non Executive Director	Ann Becke	01.11.05	30.10.12
Non Executive Director	Jonathan Fellows	25.10.07	30.09.11
Non Executive Director	Kathryn Williets	01.05.04	30.04.12
Non Executive Director	David Bland	01.08.10	31.07.13
Association Non Executive Director	Richard Miner	01.10.10	30.09.13

All executive directors have a five year term of office.

More detailed information about each Director can be found on pages 79 onwards.

Board of Directors Committee Structure



Board and committee meetings attendance

		Attendance at Board of Directors out of 12
Alf Edwards	Chair	6 (out of 7)
John Edwards	Chair	5 (out of 5)
David Badger	Non Executive Director/ Deputy Chair/ Senior Independent Director	11
Ann Becke	Non Executive Director	11
Jonathan Fellows	Non Executive Director	8
Kathryn Williets	Non Executive Director	10
David Bland	Non Executive Director	6 (out of 7)
Richard Miner	Associate Non Executive Director	6 (out of 6)
Paula Clark	Chief Executive	12
Paul Assinder	Director of Finance and Information	11
Janine Clarke	Director of Human Resources	1 (out of 2)
Paul Harrison	Medical Director	8
Denise McMahon	Nursing Director	10
Ruth Serrell	Acting Director of Operations	3 (out of 3)
Richard Beeken	Director of Operations and Transformation	8 (out of 9)

Alfred Edwards – Chairman (retired 31st October 2010)

Alf has had plenty of experience of working within an NHS environment due to previous responsibilities of chairing the Trust's Audit Committee and the PFI Project Board from the project outset. Following two terms as a Non Executive Director helping to form the Trust, Alf became Chairman in November 2001.

Prior to being involved in the Trust, Alf gained a wealth of expertise as the managing director of successful private sector companies which provided exposure to, and responsibility for, financial and business development. His previous roles also gained him a wide international exposure to sales and marketing.

As a chartered electrical engineer, Alf is still a practicing Consultant Engineer. Outside of the working environment, Alf enjoys participating in activities within his local community.

John Edwards CBE – Chairman (commenced 1st November 2010)

John joined the Trust on 1st November 2010. He is the former Chief Executive Officer of Advantage West Midlands (AWM), the regional development agency. In 2008, John was awarded a CBE for services to the regional economy

John is a Quantity Surveyor and Project Director by profession and spent his early career in the private sector. He joined the Rural Development Commission, where he worked in a number of operational roles and finally as Chief Executive. Continuing is

interest in economic development and regeneration, John joined Business in the Community in 1998 as Managing Director of Regeneration.

John joined AWM in 2000 where he oversaw an investment budget of £350m. AWM was independently evaluated: by the National Audit Office, as an excellent organisation achieving the maximum 4 start rating and by PWC, as the most effective of the Regional Development Agencies with every £ invested delivering over £8 of benefit for the West Midlands.

Since 2008 he has continued to advise both government bodies and private companies on strategic economic regeneration policies and their impacts. John is a Consultant to Squires, Sanders & Dempsey (UK) LLP an international law practice. He is also a Principal Fellow at the University of Warwick's Warwick Manufacturing Group (WMG) where he is overseeing the development of the International Institute for Product and Services Innovation (IIPSI), John chairs the IIPSI Board.

John is committed to help lead Dudley Group to become an even better performing organisation committed to providing the best quality care to all our patients

David Badger – Non Executive Director, Deputy Chairman and Senior Independent Director

David was appointed as a Non Executive Director in 2002 following many years experience of public service in local authority and community regeneration settings.

David led many education, training and health initiatives which involved local communities through the development of stakeholder groups as well as community participation in strategic planning.

Management roles included direct responsibility for major capital and revenue budgets, Private Finance Initiatives for schools, school governance and financing and human resources.

Appointed as Deputy Chairman and Senior Independent Director of the Trust in 2008, David is committed to the continuing development of the Trust and the relationship with the local community. To this end he is particularly keen to promote and support relationships between the Trust Board, Governors and our Members.

Ann Becke – Non Executive Director

Ann brings to the Trust 26 years experience in global sales and marketing as Head of Professional Services for BT. Her career in BT was mainly in consultative sales and sales management where she provided strategic direction and leadership.

A graduate in World Class Service Management from Leeds University, she is a trained coach and mentor and was instrumental in setting up a global BT external client 'women in business' network to promote talent in the boardroom. She was recognised as a member of the BT talent pool and was a role model for the delivery of inspirational leadership, customer satisfaction and diversity. She was also a member of the PPI (Patient and Public Involvement forum) gaining valuable insight into the NHS.

Ann has been Chair and Vice-Chair of the Chernobyl Children's Lifeline (Wolverhampton/Kinver Link) charity for the past 16 years and is actively involved in both the local and business community raising awareness and significant funding to support the aims of the charity. Ann is a very active member of the community and in 2009, Kinver Rotary Club recognised Ann with an award for outstanding service in the local community.

In her role as a Non Executive Director, Ann also has a lead role in Safeguarding, both within the Trust and the wider health economy, in emergency planning and in art and the environment. She is also a Trustee of Dudley Clinical Education Centre's Charity and represents the Trust on the Dudley Children's Executive Board.

Jonathan Fellows – Non Executive Director

Jonathan brings with him 10 years of experience operating at executive level on boards of large publicly listed companies. He has also spent eight years successfully leading and growing private equity backed businesses.

Jonathan has led major cost reduction projects in three public companies and increased shareholder value in every company worked for.

He has extensive experience of raising finance for major capital projects and implementing cost control and reduction. He is also well practiced in delivering business visions, improving customer service, PR and communications.

Jonathan is a Fellow of the Chartered Association of Certified Accountants and a member of the Association of Corporate Treasurers.

Kathryn Williets – Non Executive Director

Kathryn joined the Trust as a Non Executive Director in May 2004, bringing with her a background in criminal, family and childcare law. She qualified at the Bar in 1989 and then re-qualified as a solicitor in 1994. She holds a teaching qualification and has taught in a range of legal subjects. Kathryn is a member of the Law Society.

Kathryn is currently a sole practitioner providing agency services to other solicitors' firms, and to Local Authorities, in the areas of childcare and family law. She lives in Halesowen. She spent some years involved in school governance, and is a former Chair of the Governing Body at Manor Way Primary School.

During the process to achieve Foundation Trust status, Kathryn delivered presentations to stakeholders, partners and the public. As a member of the Trust Board, Kathryn is interested in public and patient issues, especially those surrounding elderly care. She is also keen to contribute to audit and governance policies implemented by the Trust. She chairs the Charitable Funds working group. She is the Trust lead on issues of patient safety and security management.

David Bland – Non Executive Director (commenced 1st August 2010)

David joined the Trust in August 2010 and brings extensive senior level experience, particularly in running complex multi-site service businesses. He has a strong mix of strategic and operational skills developed during many years of international consultancy work.

From his time in the hospitality industry with Bass plc and Intercontinental Hotels Group plc, David brings a real understanding of how to deliver excellent and consistent customer service.

More recently, David has been working with a number of private equity-backed companies, as well as acting as a mentor to several young people starting businesses with the Prince's Trust.

Richard Miner – Associate Non Executive Director (commenced 1st October 2010)

Richard, who is an accountant by trade, was previously a Non Executive Director at Birmingham East and North Primary Care Trust where he chaired the Audit Committee and World Class Commissioning Team.

Richard has led the Adult Community Services Transformation Programme Board.

Executive Directors

Paula Clark – Chief Executive

Paula joined the Trust as Chief Executive on 1st October 2009 from Burton Hospitals NHS Foundation Trust.

During her four years as Chief Executive of Burton Hospitals, she led the trust through turn-round and on to Foundation Trust status in 2008.

Paula has worked in the NHS for the past 18 years, with 10 years at Chief Executive level.

Her career in the NHS has spanned a wide range of sectors, including Chief Executive of Erewash Primary Care Trust and senior roles at Southern Derbyshire Health Authority, Nottingham City Hospital and Derbyshire Ambulance Service.

Before joining the NHS, Paula worked in sales and marketing in the pharmaceutical industry and was a member of the Chartered Institute of Marketing. She was also a lecturer in Marketing and Business Studies at Clarendon College, in Nottingham, and led their public relations function.

Paul Assinder – Director of Finance and Information

Paul brings to the Trust Board 31 years of experience in financial management and audit in large commercial and NHS organisations. With the last 20 years of his career at Finance Director level, Paul has significant experience of Board level challenges. This has included negotiating a major Private Finance Initiative deal to a financial close.

Today, as the Director of Finance and Information for The Dudley Group of Hospitals, one of his roles is to develop and implement the financial aspects of the Trust's strategy. While championing the highest financial standards, audit and governance standards, Paul is also interested in developing clinical performance and

accountability frameworks. He is leading the Trust's Service Line Performance Management Initiative.

Qualified as a chartered and certified accountant, with a degree in Economics and Management, Paul has written widely and lectured on NHS finance matters.

He is a member of a wide range of professional bodies and networks and is a trustee of the Healthcare Financial Management Association and a Non Executive Director of the Birmingham Enterprise Agency.

Richard Beeken – Director of Operations and Transformation (commenced 15th June 2010)

Richard joined the Trust in June 2010 from South Staffordshire and Shropshire Healthcare NHS Foundation Trust where he spent two-and-a-half years as Chief Operating Officer.

He has held a variety of senior positions within the NHS since graduating from the NHS Management Training Scheme. This is his third Executive Director post.

He has worked as Divisional Manager of Surgical Services at Royal Wolverhampton Hospitals and Chief Operating Officer at Birmingham Children's Hospital before moving to South Staffordshire and Shropshire Healthcare NHS Foundation Trust in 2007.

Richard is responsible for service delivery in our clinical services, delivered through our clinical directorate structure, as well as leading on the Trust-wide Transformation programme which aims to deliver efficiency and quality gains in the future through effective service redesign. Richard is also the executive responsible for Facilities and Estates through the management of the PFI contract.

Paul Harrison – Medical Director

As Medical Director and Consultant Haematologist, Paul has a varied role with both clinical and managerial responsibilities.

His medical background as a Haematologist has given him wide clinical experience and he is a Fellow of both the Royal College of Physicians and the Royal College of Pathologists. He is particularly interested in medical education and has served as Regional Specialty Advisor for both the Royal College of Physicians and the Royal College of Pathologists.

He has previously chaired the Regional Training Committee, is currently Chair of the Haematology Specialty Advisory Committee and was previously an examiner for the Royal College of Pathologists. He currently sits on the Intercollegiate Committee for Haematology and both the Royal College of Physicians and the Royal College of Pathologists' Working Groups looking at revalidation for doctors. Paul is also called upon to lecture and advise on a variety of clinical, managerial and professional topics and has previously been a member of the Chapter S HRG Expert Working Group.

He previously undertook the role of Lead Cancer Clinician during which time he successfully expanded cancer services while maintaining financial balance, ensuring the Trust met cancer waiting time targets.

Key operational achievements have involved the establishment of new services in Dudley. These include a nurse-led open access deep vein thrombosis diagnostic/treatment service and a peripheral blood stem cell transplantation programme. He also reconfigured working practices in the Haematology department to develop a fully integrated team-based approach by medical staff.

Denise McMahon – Nursing Director

A nurse for 30 years, Denise started her nurse training in 1978 at Walsall Manor Hospital having been a nurse cadet for two years.

Denise was a senior nurse in medicine and then a general manager for medicine and surgery until she became Deputy Nurse Director in 1997. Two years later, she moved to the Royal Orthopaedic Hospital, in Birmingham, as Director of Nursing and Operations and then on to Kettering General in 2001 as Director of Nursing and Midwifery.

In addition to her corporate responsibilities as Director of Nursing, specific responsibilities include professional leadership for the nursing and midwifery strategy and Director of Infection Prevention and Control, a role in which she has considerable experience. She also holds the Director lead role for Governance.

Denise is passionate about patient care and has continued to do clinical shifts throughout her career.

Ruth Serrell – Acting Operations Director (left 30th June 2010)

Ruth Serrell was Acting Director of Operations for The Dudley Group of Hospitals from October 2009 to June 2010 after serving in a number of roles at the Trust.

After starting as a student nurse in 1982, Ruth moved into NHS management in 1995 when she took up the post of nurse manager of a Russells Hall Outpatient Department.

After a spell as nurse practitioner in the Urology Department at the Trust, Ruth became the Head of Patient Care Services at Mary Stevens Hospice in Stourbridge, in April 1998.

After moving to Wolverhampton City PCT in September 2003, where she served as the Network Director for the Greater Midlands Cancer Network and Black Country Cardiac Network, Ruth rejoined the Trust as Performance Director in August 2007.

Janine Clarke – Director of Human Resources (left 18th July 2010)

Janine has many years experience of human resources and organisational development in a variety of organisations including a local authority, two NHS acute trusts and a Not for Profit housing organisation. She has held director level positions at three of these organisations, managing large-scale workforce and organisational change to respond to drivers for change. Janine has also contributed to successful mergers and acquisitions.

With an MA in Strategic HR, Janine has a deep understanding of the wide spectrum of HR and organisational development covering resourcing, employee relations,

industrial relations, reward, training and development, change management and health and safety.

Her LLB (Honours) degree also provides her with knowledge of various aspects of commercial law.

Audit Committee

The Audit Committee provides the Trust Board with an objective view of the financial systems used by the Trust and makes sure the statutory obligations, legal requirements and codes of conduct are followed.

The Audit Committee has met four times during the year and has reviewed its effectiveness and reported this to the Board of Directors. The Committee has fully discharged its responsibilities for reviewing the effectiveness of systems of internal control and governance.

		Attendance out of 4
Jonathan Fellows (Chairman)	Non Executive Director	4
David Bland	Non Executive Director	1 (out of 2)
David Badger	Non Executive Director	3
Kathryn Williets	Non Executive Director	3
Ann Becke	Non Executive Director	2
Richard Miner	Associate Non Executive Director	1 (out of 2)
PriceWaterhouse Coopers LLP	External auditors representative	2 (out of 2)
Deloitte LLP	External auditors representative	4
Deloitte LLP	Internal auditors representative	2 (out of 2)
RSM Tenon	Internal auditors representative	4

Independence of external auditors

To ensure that the independence of external auditors is not compromised where work outside the audit code has been purchased from the Trust's external auditors, the Trust has a policy for the approval of additional services by the Trust's external auditors.

Nomination Committee

The Trust's Nomination Committee meetings are called on an ad hoc basis when an appointment needs to be made. The Committee operates to review and evaluate the Board structure and expertise, as well as to agree a job description and person specification for the appointments of the Chief Executive and Executive Directors. The Committee also identifies and nominates suitable candidates for such vacancies and recommends its proposed appointment for Chief Executive to the Council of Governors.

		Attendance out of 2
Alf Edwards	Chair (till 31.10.10)	1 (out of 1)
John Edwards	Chair (from 01.11.10)	1 (out of 1)
Jonathan Fellows	Non Executive Director	1 (out of 1)
David Bland	Non Executive Director (from 01.08.10)	1 (out of 1)
David Badger	Non Executive Director	2
Kathryn Williets	Non Executive Director	2
Ann Becke	Non Executive Director	1
Richard Miner	Associate Non Executive Director (from 01.10.10)	1 (out of 1)
Paula Clark	Chief Executive	2

Sustainability Report

The Trust takes its sustainability responsibilities very seriously and the NHS Operating Framework 2008/09 sets out the contributions the NHS can make to reduce its carbon impact. The Trust supports the view that it should measure and progressively reduce its own carbon footprint in order to save resources and contribute to reducing the impact of its activities on the environment.

We work very closely in this matter with our Private Finance Initiative (PFI) partner, Summit Healthcare, who has a responsibility under the PFI contract to purchase utility resources and manage their effective use and also to dispose of waste that is created by the Trust and its partners. The Trust has a Sustainable Development Group comprising senior technical, financial and procurement management personnel, drawn from the Trust and its PFI partner, whose responsibilities are directly linked to the environmental agenda.

Target areas at present are the procurement process of the Trust, the segregation of waste materials and the effective use of energy.

Our strategy

The Trust's overall sustainability strategy has been developed in the context of having re-developed the hospitals as part of a major PFI including installing energy efficient new plant in modern healthcare facilities. Supporting the district general hospital at Russells Hall are two outpatient centres that help minimise travel distances for patients.

The Trust's strategy can be considered under six headings:

- Building Energy Management
- Travel
- Procurement
- IT

- Waste/recycling
- Raising awareness

Building Energy Management

The Trust's 'Sustainable Development Group' will receive regular updates from the Energy Committee on energy usage and energy savings schemes.

Travel

The Trust will continue to work with its 'Green Travel Plan' designed to reduce car journeys by 10 per cent over a five-year period (base line year is 2010) and evaluate the recently introduced cycle to work scheme.

Procurement

The Trust will continue to follow good practise in the procurement of sustainable products by following the Office of Government list of Sustainability Minimum Mandatory Standards 'Quick Wins'.

IT

The Trust will continue to purchase IT equipment (through Siemens Plc) from market leaders in the manufacture of environmentally responsible equipment.

Waste/recycling

The Trust has set up a waste/recycling group to improve its arrangements for controlling waste and recycling. This Committee reports to the Sustainable Development Group on a regular basis.

Raising awareness

The Sustainable Development Group will work with the communications manager to raise awareness about the sustainability agenda among staff and the Trust's stakeholders.

Governance

The Trust's Sustainable Development Group is responsible through the Trust Management Executive to the Trust Board of Directors. The group is chaired by the Trust's Deputy Director of Operations. An annual energy and carbon reduction report to the Trust Board will monitor and show how the Trust and its PFI Partners are progressing.

Summary of Performance

There are a number of contributing factors which relate to the efficiency and effectiveness of using energy and other utility services in the Trust at the present time:

(a) The increased demand for cooling facilities within clinical areas of the estate. Large areas of the hospital are ventilated by natural ventilation only
(b) The increased use of modern computer technology and the tendency for staff to leave equipment on standby when not in use
(c) The use of the hydrotherapy pool facilities
(d) Though there are areas of the buildings that have movement sensors fitted to the lighting systems, there are significant other areas where the lighting is left on. This needs to be managed and controlled by those who use the facilities

Area	Measure	Non-Financial data (applicable metric)	Non-Financial data (applicable metric)	Measure	Financial data (£k)	Financial data (£k)
		2009/10	2010/11		2009/10	2010/11
Greenhouse Gas Emissions	Electricity (Kwh) Gas (Kwh) Oil (Kwh)	54,268 GJ 206,912 GJ 10,931 GJ	16,353,056 kwh 57,101,132 kwh 2,927,778 kwh	Electricity (Kwh) Gas (Kwh) Oil (Kwh)	£2,443,252	£1,082,520 £1,159,368 £128,770
Waste Minimisation and Management	Absolute values for total amount of waste produced by the Trust (tonnes) Methods of disposal	-	1774.32 tonnes Landfill = 484.54 tonnes Recycled = 189.33 tonnes Incinerated = 1,100.45 tonnes	Total expenditure on waste disposal	£426,000	£434,520.18 £34,523.47 £2,794.76 £397,201.95
Finite Resources	Water (metre cubed)	190,262 M^3	187,929 M^3	Water (metre cubed)	£357,977	£367,638

Future priorities and targets

Through the Sustainable Development Group the Trust will:

Building Energy Management

- Regularly report energy use through to users
- Implement schemes to reduce energy use and assess impact during any transition

Travel

- Review its Green Travel Plan in line with new parking and cycling facilities available

Procurement

- Undertake survey of printer usage in Trust HQ to rationalise and reduce number of printers
- Extend electronic procurement system to all users
- Gain Board level support for sustainable procurement policies
- Provide clear advice for budget holders on sound purchasing principles to incorporate environmental and energy considerations into a Trust policy

IT

- Identify the main areas of energy consumption
- Identify and implement opportunities for reducing energy consumption, assessing the impact of each during transition

Waste/recycling

- Evaluate trial in six areas of reducing plastic used in the collection of sharps
- Quantify the saving in carbon by recently introduced recycling of cardboard and plastic waste
- Extend arrangements for separating recyclable elements of products from non recyclable ones e.g. for furniture

Regulatory Ratings

The Trust set the 2010/11 regulatory ratings plan based on the annual risk assessment of the coming financial year 2010/11. Analysis for each area of rating compared with that expected in the Annual Plan is summarised below:

Financial risk rating

The Trust planned for a rating of ‘three’ in the Annual Plan. The Trust entered the Financial Year with plans to decrease agency costs along with other cost

improvement targets. This was also on the back of a reduction in the amount of income the Trust would receive for emergency activity. The Trust's overall performance for the year showed an EBITDA Margin of £19.8m, 7.6 per cent, equivalent to £2.7m below plan and net surplus at £275k, £1.8m below plan. Although the Trust encountered a difficult 2010/11, financially we were still able to deliver a rating of 'three' on our final outturn.

Governance risk rating

The Trust planned for a rating of 'Amber-green' in the Annual Plan. In December 2009, Monitor's Board determined that the Trust was in 'Significant Breach' of its terms of authorisation as an NHS Foundation Trust for Conditions 2 (General Duty), 5 (Governance) and 6 (Healthcare Standards), with specific concerns expressed about the Trust's inability to achieve the A&E four hour wait target for two quarters in 2009/10 and 2 quarters in 2008-09. This led to the Trust receiving a 'Red' rating from Monitor. During 2010/11 we have successfully achieved all healthcare targets and indicators as set out in Monitor's Compliance Framework. This led to Monitor removing the conditions placed on the Trust in Quarter 3 and the achievement of our planned 'Amber-green' rating.

Mandatory services

The Trust planned for a rating of 'Green' in the Annual Plan. The Trust made no changes to the range of services provided, nor to mandatory assets during the year. A rating of 'Green' was maintained throughout all quarters.

2009/10	**Annual Plan 09/10**	**Q1 09/10**	**Q2 09/10**	**Q3 09/10**	**Q4 09/10**
Financial risk rating	5	4	5	5	4
Governance risk rating	Green	Amber	Amber	Red	Red
Mandatory services	Green	Green	Green	Green	Green

2010/11	**Annual Plan 10/11**	**Q1 10/11**	**Q2 10/11**	**Q3 10/11**	**Q4 10/11**
Financial risk rating	3	3	3	3	3
Governance risk rating	Amber-green	Red	Red	Amber-green	Amber-green
Mandatory services	Green	Green	Green	Green	Green

Financial performance

In line with the rest of the NHS, the Trust has endured a difficult year financially in 2010/11. Total income has increased by 2.6 per cent to £260.3 million with an Earnings Before Interest, Taxation, Depreciation and Amortisation (EBITDA) of £19.8 million which equates to 7.6 per cent of turnover. This financial performance means that the Trust achieves an overall Financial Risk Rating of three from Monitor.

The key financial impact experienced by the Trust linked to a change in rules regarding the tariff for non-elective admissions. This mandated a new 30 per cent marginal tariff for non-elective activity that exceeded a threshold based on the 2008/09 outturn (adjusted for any major changes). Non-elective work continued to grow to unprecedented levels requiring the opening of additional beds and the knock-on cancellation of elective work. Providing appropriate care for the increased level of non-elective admissions required the opening of additional beds at significant stepped costs. Due to the new 30 per cent funding regime for additional activity, the Trust was not properly recompensed for the extra costs with lost income estimated to be £4.362m for the year. In addition, further income was lost due to the unfortunate cancellation of elective work as a result of the non-elective pressures.

Table 1 highlights the impact of the above, showing the significant increase in expenditure over plan that exceeded the level of income growth. As a result, the Trust achieved a much lower surplus of £0.275 million in comparison to the planned surplus of £2.102 million estimated at the start of the financial year.

Table 1: Trust Financial Performance 2010/11

	Plan	Actual	Variance
	£000	£000	£000
Income	255,194	260,347	5,153
Expenditure	(232,674)	(240,550)	(7,876)
EBITDA	**22,520**	**19,797**	**(2,723)**
Net Surplus	**2,102**	**275**	**(1,827)**
EBITDA Margin	8.8%	7.6%	(1.2%)
EBITDA % Plan Achieved	92.4%	87.9%	(4.5%)
Return on Assets	5.4%	2.5%	(2.9%)
IS Surplus Margin	0.8%	0.1%	(0.7%)
Liquidity Days	55.1	44.4	10.7

Income and Expenditure

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

	Plan	Actual	Variance	Notes
	£000	£000	£000	
Activity Income	240,227	241,509	1,282	**1**
Other Clinical Income	2,556	4,362	1,806	
Other Operating Income	12,411	14,476	2,065	**2**
Total Income	**255,194**	**260,347**	**5,153**	
Pay Spend	(142,686)	(150,942)	(8,256)	**3**
Non-Pay Spend	(89,988)	(89,608)	380	**4**
Total Expenditure	**(232,674)**	**(240,550)**	**(7,876)**	
EBITDA	**22,520**	**19,797**	**(2,723)**	**5**
Retained Surplus	**2,102**	**275**	**(1,827)**	

Activity Income

The Trust signed contracts totalling £239.0m for 2010/11 including £3.5m for specific quality improvements. The main PCT contracts are held with Dudley (£177.4m), Sandwell (£30.6m), South Staffordshire (£8.6m) and Specialised Services (£11.4m).

The activity plan was based upon signed contracts with PCTs that is income secured rather than 'at risk'. Following a significant over-performance against PCT contracts during 2009/10, plans for 2010/11 were based on a more realistic level of modelled activity but also contained a level of deflation to take account of the impact of PCT commissioning intentions. This was particularly relevant for outpatients (previous year outturn equated to 496,723 attendances/procedures but the plan was reduced to 473,729 attendances/procedures).

	Annual Plan	Outturn	Variance	Growth (%)
Accident & Emergency attendances	96,041	98,567	2,526	2.6%
Elective spells	48,552	48,075	(477)	(0.1%)
Non-elective spells	51,666	56,117	4,451	8.6%
Outpatient attendances/ procedures	473,729	504,076	30,347	6.4%

The Trust achieved an over-recovery against other clinical income following positive agreements with NHS Dudley and Sandwell PCT regarding repatriating a proportion of the funds lost via the new 30 per cent tariff price for non-elective activity. This agreement reflected recognition of the financial pressures faced by the Trust and provided extra resource to facilitate the management of activity pressures encountered via the long winter period.

Other Operating Income

The Trust successfully attracted other operating income in excess of planned levels, notably for training and education and research and development. The Trust received the final year of financial support for the PFI scheme and remained well within the private patient income cap.

Pay Spend

Pay costs exceeded the budget plan by £8.256 million. This was a direct impact of the significant increase in work which, at its peak, necessitated the opening of 63 additional beds. During the year, the budgeted establishment increased from 3,621 to 3,677 Whole Time Equivalents. This included significant investment for additional nursing staff. Over the same period, the staff contracted to the Trust grew from 3,257 to 3,445 Whole Time Equivalents. The Trust has actively sought to reduce vacancies during the year, particularly for nurses via successful recruitment days. At the inception of the financial year, the Trust created its own internal staff bank and this has developed successfully to the point that it now meets 90 per cent of all unmet nursing shifts. The corollary of this change coupled with a concerted effort to eliminate premium rate working is a significant reduction in both agency and waiting list/overtime expenditure. Agency costs are sometimes necessary to ensure safe

staffing levels on wards but the costs are significantly higher than contracted or bank staff. Due to the increased contracted staffing levels and success of the bank, agency costs have reduced from £6.595 million expended in the first six months of the year to £3.577 million expended in the second six months of the year. The ultimate aim of the Trust is to eradicate premium rate working completely.

Non-Pay Spend

Additional non-pay spending has occurred as a direct result of additional activity with significant unplanned spends occurring on satellite dialysis costs, pathology consumables, surgical instruments, dressings, disposable items, patient appliances and cleaning equipment. In addition, non-pay spend has also increased on computer equipment, external consultancy support linked to improved efficiency, advertising linked to nurse recruitment and legal expenses.

EBITDA

EBITDA for the year as a whole fell below plan linked to the additional costs of managing non-elective pressures and the corresponding reduced level of income. The reduction in agency spend and other premium costs enabled the Trust to remain profitable overall with a trading deficit experienced in April and May (when agency costs were at their peak) and August and December (when the level of income is usually lower).

Capital and Cash

In 2010/11 the Trust invested £9.6 million on new facilities and equipment. The construction of the multi-tiered car park was completed in December 2010. This scheme commenced in 2009-10 and in total was a £7.2 million scheme which provided the Trust with 691 additional staff car parking spaces. The second largest investment was the upgrade of North Wing. The Trust spent £1.3m on external cladding to improve the building structure and increase the energy efficiency of the building. Further substantial investment was made in the replacement of medical equipment and enabling works for replacement imaging equipment.

Investment 2010/11	**Amount**
	£000
Multi Tiered Car Park	5,412
Medical Equipment	1,255
North Wing Upgrade	1,293
Imaging Equipment Enabling Work	686
Information Technology	281
Other Works including PFI Lifecycle	713
Total	**9,640**

The Trust ended the year with a healthy cash balance of £33.4 million, all held within the Government Banking Service. This will be used to support our planned capital expenditure over the next three years.

During 2010/11 the Trust operated with a Prudential Borrowing Limit (PBL) set for the year by Monitor of £162.2 million of long-term borrowing. The Trust maintained,

but did not utilise, a committed working capital facility with Barclays Bank of £10 million.

During 2010/11 the Trust continued its policy of paying all local suppliers at the earliest opportunity to support the local economy during these difficult economic times. The Trust continues to perform strongly against the best practice payment policy target of 95 per cent compliance. During 2010/11 the Trust paid 99.5 per cent of non-NHS invoices in value terms and 98.5 per cent in quantity terms.

Better payment code of practice

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

	2009/10		2010/11	
	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	50,284	135,016	47,468	113,042
Total non-NHS trade invoices paid within target	49,584	134,368	46,760	112,508
Percentage of non-NHS trade invoices paid within target	99%	100%	99%	100%

Audit Information

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

After making enquiries, the Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the account.

The Trust can confirm that it has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance. This guidance discusses how public sector organisations should charge for information.

Countering fraud and corruption

The Trust takes its responsibility towards countering fraud and corruption in the NHS very seriously.

The Trust's Fraud and Corruption Policy lays down its absolute commitment to maintaining an honest, open and well-intended atmosphere within the Trust. This commitment is the cornerstone of an anti-fraud culture, championing the deterrence and prevention of fraud and the rigorous investigation of any cases of fraud or corruption. Where fraud is proven, the Board will apply all available sanctions e.g. disciplinary/criminal action, and use of the civil law to recover funds.

A statement that accounting policies for pensions and other retirement benefits are set out in the notes to the accounts and details of senior employees' remuneration can be found in page 105 of the remuneration report.

Accounts

For the Period 1st April 2010 to 31st March 2011

Foreword to the Accounts

These accounts for the period 1 April 2010 to 31 March 2011 have been prepared by The Dudley Group of Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 in the form which Monitor, the Independent Regulator of NHS Foundation Trusts, has, with the approval of the Treasury, directed.

Signed

Date 26th May 2001

Paula Clark

Chief Executive

Statement of Accounting Officer's Responsibilities for The Dudley Group of Hospitals NHS Foundation Trust

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

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

and losses and cash flows for the financial year.

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

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

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

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

Signed

Paula Clark
Chief Executive

Statement of Directors' Responsibilities In Respect of The Accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

- make judgements and estimates which are reasonable and prudent;

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

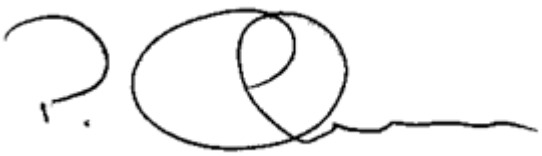
By order of the Board

Signed

Paula Clark

Chief Executive Date: 26th May 2011

Signed



Paul Assinder

Director of Finance Date: 26th May 2011

Statement on Internal Control

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental

assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Dudley Group of Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Dudley Group of Hospitals NHS Foundation Trust for the year ended 31 March 2011 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

The Director of Nursing has Board level responsibility for the Trust's risk management policies and processes. The Trust operates a Risk Sub-committee of the Board. This Committee meets monthly to review corporate and directorate specific risks and associated mitigation plans. Each Directorate of the Trust operates independent Risk Management Groups that report through to the Corporate Group. The Risk Sub-Committee is chaired by a Non-Executive Director.

Ongoing training in risk management is undertaken through the management structure, enhanced by specific sessions on both general risk management and clinical risk, delivered as part of the Trust's 3 year statutory training programme and the Trust Induction Programme. Good practice is disseminated through the risk managed structure to the directorate groups.

The Trust has developed an Integrated Governance Strategy that brings together arrangements for managing both clinical and other risks. During 2010-11 the Trust implemented a change in the Committee structure which saw the introduction of a Risk Committee to replace the previous Integrated Governance Committee. This strengthened our governance arrangements and systems of internal control further to ensure that we effectively address the different set of challenges that we will face in the future.

The risk and control framework

The Trust's Risk Management Policy and Strategy provides guidance on the identification and assessment of risk, and on the development and implementation of action plans designed to reduce risk.

All the Trust's Directorates are required to undertake continuous risk management to maintain risk registers and to implement agreed action plans. Progress in these areas is monitored by the Risk Committee. The Trust Board also undertakes its own

collective risk assessment. The Trust uses a dedicated action monitoring system 'Performance Analyser' to track completion of actions and evidence these.

Information risks are also managed and controlled through this risk management process. The Trust has a Caldicott and Information Governance Group (CIGG), which reports into the Risk Committee. The Trust uses and completes the NHS Connecting for Health Information Governance Toolkit and has also been through an extensive audit process. This indicated that the Trust was operating just below Level 2 in some areas of information governance. The Trust has an action plan in place to ensure that level 2 is achieved in all areas in early in 2011-12. The Deputy Medical Director is the Trust's Caldicott Guardian and the Director of Finance & Information has Board level responsibility for Information Governance. In 2008-09 the Trust completed a programme of encryption of all sensitive and clinical information leaving the Trust and a review of physical security of IT equipment. Instituted improvements have been continued in 2010-11.

An Assurance Framework has been developed, and approved by the Trust's Board of Directors, that identifies:

- the risks to the achievement of the Trust's objectives;
- the action plans put in place to address those risks; and
- the independent assurance mechanisms that relate to the effectiveness of the Trust's system of internal control.

The Dudley Group of Hospitals NHS Foundation Trust is fully compliant with the requirements of registration with the Care Quality Commission (CQC). The CQC has not taken enforcement action with the Trust during 2010-11.

The Trust has implemented and maintains a number of arrangements to monitor improvements in quality. These include the use of performance dashboards, a clinical audit programme, the review and introduction of Quality Care Indicators, Nursing Care Indicators and robust monitoring against local and national targets for Healthcare Associated Infections (HCAI).

The Trust has participated in a scheduled review by the CQC in January 2011 where all 16 essential standards of quality and safety were assessed. As a consequence there were no conditions imposed on our registration. The final report identified that there were some (moderate or less) improvements required for 6 of these standards. To ensure we are compliant with the standards as soon as possible, the Trust has provided the CQC with robust action plans which will be monitored on a regular basis by the Board of Directors and inspectors from the CQC.

The Trust is currently on Level 1 (CNST) for both areas covered by the NHSLA. During 2010-11 the Trust received a review from the NHSLA which resulted in an improvement to Level 1 for our Maternity Service.

As part of business planning the Trust undertakes risk scenario modelling, to ensure risk is properly considered when producing long term plans.

The Trust is committed to involving stakeholders as appropriate in all areas of the Trust's activities. This includes informing and consulting on the management of any significant risks. Key stakeholders include Dudley PCT, our PFI partners Summit

Healthcare (Dudley) Ltd, voluntary groups, the Council of Governors, the FT Members, patient groups, patients, the local community and the Local Authority Overview and Scrutiny Committee. General public awareness of the strategy is achieved through its presentation to the Council of Governors, explicit references within the Trust's annual report and by ensuring the general availability of the strategy on the Trust's website.

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

The Foundation Trust in partnership with our PFI Provider has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaption Reporting requirements are complied with.

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

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

The Trust's Corporate Business Plan represents the principal mechanism which the Board uses to review economy, efficiency and the effective use of resources. This sets an Annual Delivery Plan, which is aligned to the Trust's strategic objectives. As accounting officer, I have overall accountability for delivery of this Plan and am supported by the executive directors who have delegated accountability and responsibility for delivery of specific targets and performance objectives. These are formally reviewed and monitored on a monthly basis by the Trust Board and its Committees. Independent assurance on the use of resources is provided through the Trust's internal audit programme, Audit Committee and external agencies such as Monitor, External Audit and the CQC.

For the 2010-11 financial year, the Trust received a rating of '3' from Monitor for its financial risk rating'. The key processes that are embraced within the Trust in order to ensure that resources are used economically, efficiently and effectively centre around a robust budget setting and a control system which includes activity related budgets and periodic reviews during the year which are considered by Executive Directors and the Trust Board. The budgetary control system is complemented by a clear set of Standing Financial Instructions, Scheme of Delegation and Financial Approval Limits. This process enables regular review of financial performance by highlighting areas of concern via variance analysis.

A component of the Trust's financial planning is the implementation and delivery of a Cost Improvement Programme which is monitored by the Trust Board monthly. The Trust has undertaken a clinical risk assessment of individual savings proposals. The Trust compares its reference costs with national tariffs to highlight the potential areas of inefficiency and compares its use of resources with other acute Trusts.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of Internal Control is informed by the work of the Internal Auditors and the Executive Managers within the NHS Foundation Trust who have responsibility for the development and maintenance of the Internal Control Framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the External Auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of Internal Control by the Trust Board, the Audit Committee and the Risk Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Assurance Framework and the Trust's risk management system provide me with evidence that the effectiveness of controls to manage the risks to the Trust achieving its principal objectives have been reviewed. The Trust undertakes regular surveys of its patients, staff and other stakeholders to gather views on the Trust. My review is also informed by the work of external assessors including:

- Care Quality Commission.
- Monitor.
- Health and Safety Executive.
- NHS Litigation Authority (assessment of Risk Management Standards).
- Dr Foster and CHKS (clinical benchmarking organisations).
- External Audit.
- Peer Reviews.
- The Head of Internal Audit's Opinion.

Each level of management, including the Board, reviews the risks and controls for which it is responsible. I, together with the Board will monitor the implementation through the robust risk reporting structures, defined in the Integrated Risk Management Policy and Strategy and the Assurance Framework.

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual. The Assurance Framework and effectiveness of the systems of internal control in relation to the Quality Report are consistent with the Trust's overall system of internal control and the Board have been assured that the Quality Report presents a balanced view and that the data is accurate.

There are no areas of significant issue that have been flagged in the Trust's system of internal control based on the work undertaken by the Trust's Internal Auditors. Whilst not significant issues in themselves, there were four audit reports which received a limited assurance opinion. These were Professional Registration, Policy management and two Data Quality Audits. The first two have subsequently received

a follow up audit and reasonable progress was found to have been made on the recommendations. There are currently actions plans being implemented in relation to the Data Quality reports.

In December 2009, Monitor's Board determined that the Trust was in 'Significant Breach' of its terms of authorisation as an NHS Foundation Trust for Conditions 2 (General Duty), 5 (Governance) and 6 (Healthcare Standards), with specific concerns expressed about the Trusts inability to achieve the A&E 4 hour wait target for 2 quarters in 2009-10 and 2 quarters in 2008-09. The Trust demonstrated a sustained period of compliance with all healthcare targets and indicators during last two quarters of 2009-10 and all of 2010-11. This led to Monitor lifting the conditions placed on the Trust in Q3 of 2010-11.

Conclusion

I believe that the Statement on Internal Control is a balanced reflection of the actual control position. No significant internal control issues have been identified.

Signed

Paula Clark

Date: 26th May 2011

Chief Executive

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS AND BOARD OF DIRECTORS OF THE DUDLEY GROUP OF HOSPITALS NHS FOUNDATION TRUST

We have audited the financial statements of The Dudley Group of Hospitals NHS Foundation Trust for the year ended 31 March 20 II which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Cash Flow Statement and the related notes I to 27. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor - Independent Regulator of NHS Foundation Trusts.

This report is made solely to the Council of Governors and Board of Directors ("the Boards") of The Dudley Group of Hospitals NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the accounting officer and auditor

As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code of NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

• give a true and fair view of the state of the Trust's affairs as at 3 l March 20 ll and of its income and expenditure for the year then ended;

• have been properly prepared in accordance with the accounting policies directed by Monitor - Independent Regulator ofNHS Foundation Trusts; and

• have been prepared in accordance with the requirements of the National Health Service Act 2006.

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

• the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006; and

• the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

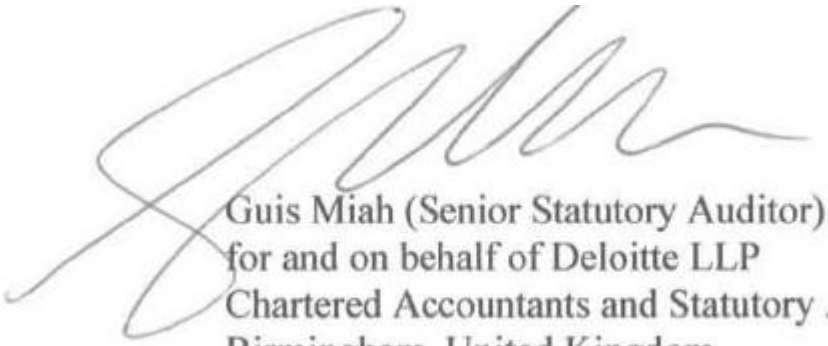
We have nothing to report in respect of the following matters where the National Health Service Act 2006 requires us to report to you if, in our opinion:

• proper practices have not been observed in the compilation of the financial statements; or

• the NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources

Certificate

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



Guis Miah (Senior Statutory Auditor)
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
Birmingham, United Kingdom
1 June 2011

Remuneration report

Remuneration Committee (unaudited information)

The remuneration Committee is a sub group of the Board which determines the appropriate levels of remuneration for the Executive Directors and senior managers. Remuneration levels are normally determined by reference to such factors as those applying in equivalent organisations, changes in responsibility and salary increases agreed for other NHS staff.

		Attendance out of 1
Alf Edwards	Chair	1
David Badger	Non Executive Director	1
Jonathan Fellows	Non Executive Director	0
Kathryn Williets	Non Executive Director	1
Ann Becke	Non Executive Director	1

Additional advice was given to the Remuneration Committee by the Chief Executive and the Director of Finance and Information.

Remuneration for Executive Directors does not include any performance-related elements.

No significant financial awards have been made to past senior managers during the period of this report.

The terms and conditions for the Executive Directors and senior managers of the Trust are included in their individual contracts of employment which includes notice periods and any termination arrangements.

Salary and Pension entitlements of Senior Managers (subject to audit) 2010/11

A) Remuneration

Name and Title	Note	2010/11			2009/10		
		Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	* Benefits in Kind (Rounded to the nearest £100)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	* Benefits in Kind (Rounded to the nearest £100)
		£000	£000	£00	£000	£000	£00
Paula Clark, Chief Executive	a	175 - 180			90 - 95		
Paul Farenden, Chief Executive	b				90 - 95		
Paul Assinder, Director of Finance & Information		140 - 145			140 - 145		
Paul Harrison, Medical Director		60 - 65	105 - 110		60 - 65	106-110	
Paul Brennan, Director of Operations	c	100 - 105		3,600	135 - 140		6,500
Richard Beeken, Director of Operations & Transformation	d	95 - 100					
Janine Clarke, Director of Human Resources	e	80 - 85		2,300	100 - 105		6,100
Denise McMahon, Nursing Director		120 - 125			115 - 120		
Ruth Serrell, Performance Director	f	25 - 30			40 - 45		
Roger Callender, Associate Director		70 - 75			70 - 75		
Alfred Edwards, Chairman	g	25 - 30		400	45 - 50		400
John Edwards, Chairman	h	15 - 20		300			
David Badger, Non Executive Director		15 - 20			15 - 20		
Kathryn Williets, Non Executive Director		10 - 15		100	10-15		
Ann Becke, Non Executive Director		10 - 15		100	10 - 15		100
David Wilton, Non Executive Director	i				10 - 15		
Jonathon Fellows, Non Executive Director		10 - 15			10 - 15		
David Bland, Non Executive Director	j	5 - 10		300			
Richard Miner, Associate Non Executive Director	k	5 - 10					
Aggregate Total		960 - 1,045	105 - 110	7,100	940 - 1,015	106 - 110	13,100

Notes

*Benefits in kind relate to leased cars in respect of the Executive Directors and home to base travel reimbursement for Non Executive Directors

a Paula Clark commenced 1st October 2009
b Paul Farenden retired on 30th September 2009
c Paul Brennan left 31st May 2010
d Richard Beeken commenced 15th June 2010
e Janine Clarke left 18th July 2010
f Ruth Serrell commenced 23rd October 2009 and left on 1st July 2010
g Alfred Edwards retired on 31st October 2010
h John Edwards commenced on 1st November 2010
I David Wilton left 15th January 2010
j David Bland commenced 1st August 2010
k Richard Miner commenced 1st October 2010

B) Pension benefits

Name and Title	Note	Real increase in pension at age 60 (bands of £2,500)	Real increase in lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31/03/2011 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31/03/2011 (bands of £5,000)	Cash Equivalent Transfer Value at 01/04/2011 To nearest £1,000	Real Increase in Cash Equivalent Transfer Value To nearest £1,000	Cash Equivalent Transfer Value at 31/03/2011 To nearest £1,000	Employers Contribution to Stakeholder Pension To nearest £100
		£000	£000	£000	£000	£000	£000	£000	£00
Paula Clark, Chief Executive		5.0 - 7.5	15.0 - 17.5	40 - 45	120 - 125	697	43	740	0
Paul Assinder, Finance Director		0 - 2.5	5.0 - 7.5	45 - 50	145 -150	963	(68)	895	0
Paul Brennan, Director of Operations	1	0 - 2.5	2.5 - 5.0	50 - 55	160 - 165	841	33	874	0
Richard Beeken, Director of Operations & Transformation	2	2.5 - 5.0	7.5 - 10.0	20 - 25	70 - 75	271	(7)	264	0
Janine Clarke, Director of Human Resources	3	0 - 2.5	2.5 - 5.0	35 - 40	110 - 115	584	(15)	569	0
Paul Harrison, Medical Director	4	2.5 - 5.0	7.5 - 10.0	50 - 55	150 - 155	810	(58)	752	0
Denise McMahon, Nursing Director		2.5 - 5.0	7.5 - 10.0	45 - 50	145 - 150	870	(38)	832	0
Ruth Serrell, Performance Director	5	0 - 2.5	0 - 2.5	30 - 35	90 - 95	493	(60)	433	0

Notes
1 Paul Brennan left on 31st May 2010
2 Richard Beeken commenced on 15th June 2010
3 Janine Clarke left on 18th July 2010
4 Medical Director figures shown include accrued benefits and contributions in respect of full salary, which will include both management and medical contributions
5. Ruth Serrell left on 1st July 2010

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Signed

Paula Clark, Chief Executive **Date** 26th May 2011

The Dudley Group of Hospitals NHS Foundation Trust

Statement Of Comprehensive Income

For The Year Ended 31 March 2011

	Note	Year Ended 31 March 2011 £'000	Year Ended 31 March 2010 £'000
Operating Income from operations	3 & 4	260,349	253,693
Operating Expenses of operations	5	(249,430)	(239,887)
OPERATING SURPLUS / (DEFICIT)		**10,919**	**13,806**
FINANCE COSTS			
Finance income	8	347	230
Finance expense - financial liabilities	9	(9,206)	(9,521)
Finance expense - unwinding of discount on provisions		0	0
PDC Dividends payable		(1,785)	(2,653)
NET FINANCE COSTS		**(10,644)**	**(11,944)**
Corporation tax expense		0	0
Surplus/(Deficit) from operations		**275**	**1,862**
SURPLUS/(DEFICIT) FOR THE YEAR		**275**	**1,862**
Other comprehensive income			
Impairments		(193)	(45,351)
Revaluations		29	12,939
Receipt of donated assets		19	37
Asset disposals		0	0
Other recognised gains and losses		(82)	(112)
Actuarial gains/(losses) on defined benefit pension schemes		0	0
Other reserve movements		0	0
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE PERIOD		**48**	**(30,625)**
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		**48**	**(30,625)**

The notes on pages 5 to 37 form part of these accounts.
All income and expenditure is derived from continuing operations.

There are no Minority Interests in the Trust, therefore the surplus for the year of £275,000 (2009/10 £1,862,000) and the Total Comprehensive Income of £48,000 (2009/10 Expense of £30,625,000) is wholly attributable to the Trust.

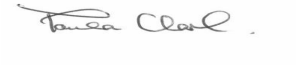
The Dudley Group of Hospitals NHS Foundation Trust

Statement Of Financial Position

As At 31 March 2011	Note	31 March 2011	31 March 2010
Non-current assets		£'000	£'000
Intangible assets	10	838	1,111
Property, Plant and Equipment	11	203,193	203,410
Investment Property		0	0
Other Investments		0	0
Trade and other receivables	13	7,826	6,627
Other Financial assets		0	0
Tax receivable		0	0
Other assets		0	0
Total non-current assets		211,857	211,148
Current assets			
Inventories	12	3,183	2,949
Trade and other receivables	13	6,131	8,858
Other financial assets	24.7	0	10,000
Tax receivable		0	0
Non-current assets for sale and assets in disposal groups	11.6	1,078	0
Cash and cash equivalents	19	33,441	26,925
Total current assets		43,833	48,732
Current liabilities			
Trade and other payables	14	(10,609)	(10,665)
Borrowings	18	(4,231)	(4,065)
Other financial liabilities		0	0
Provisions	16	(613)	(834)
Tax payable	14	(3,108)	(2,910)
Other liabilities	15	(1,338)	(1,594)
Liabilities in disposal groups		0	0
Total current liabilities		(19,899)	(20,068)
Total assets less current liabilities		**235,791**	**239,812**
Non-current liabilities			
Trade and other payables		0	0
Borrowings	18	(154,020)	(158,089)
Other financial liabilities		0	0
Provisions		0	0
Tax payable		0	0
Other liabilities		0	0
Total non-current liabilities		(154,020)	(158,089)
Total assets employed		**81,771**	**81,723**
Financed by Taxpayers' equity			
Public Dividend Capital		20,927	20,927
Revaluation reserve		37,156	37,423
Donated asset reserve		248	311
Available for sale investments reserve		0	0
Other reserves		0	0
Income and expenditure reserve		23,440	23,062
Total taxpayers' equity		**81,771**	**81,723**

The financial statements were approved by the Board of Directors and authorised for issue on their behalf by:

Signed



Paula Clark, Chief Executive

Date: 26th May 2011

The Dudley Group of Hospitals NHS Foundation Trust

Statement of Changes in Taxpayers Equity
For The Year Ended 31 March 2011

	Public Dividend Capital £'000	Revaluation Reserve £'000	Donated Asset Reserve £'000	Income and Expenditure Reserve £'000	Total £'000
Taxpayers' Equity at 1 April 2009	**20,927**	**70,426**	**386**	**20,609**	**112,348**
Surplus / (Deficit) for the year	0	0	0	1,862	1,862
Impairments	0	(45,351)	0	0	(45,351)
Revaluations	0	12,939	0	0	12,939
Receipt of donated assets	0	0	37	0	37
Other recognised gains/losses	0	0	(112)	0	(112)
Other reserve movements	0	(591)	0	591	0
Taxpayers' Equity at 31 March 2010	**20,927**	**37,423**	**311**	**23,062**	**81,723**
Surplus / (Deficit) for the year	0	0	0	275	275
Impairments	0	(193)	0	0	(193)
Revaluations	0	29	0	0	29
Receipt of donated assets	0	0	19	0	19
Other recognised gains/losses	0	0	(82)	0	(82)
Other reserve movements	0	(103)	0	103	0
Taxpayers' Equity at 31 March 2011	**20,927**	**37,156**	**248**	**23,440**	**81,771**

The Dudley Group of Hospitals NHS Foundation Trust

Statement of Cash Flows
For The Year Ended 31 March 2011

	31 March 2011 £'000	31 March 2010 £'000
Cash flows from operating activities		
Operating surplus/(deficit) from continuing operations	**10,919**	**13,806**
Operating surplus/(deficit) of discontinued operations	0	0
Operating surplus/(deficit)	**10,919**	**13,806**
Non-cash income and expense:		
Depreciation and amortisation	8,868	9,605
Impairments	0	1,205
Reversals of impairments	0	0
Transfer from the donated asset reserve	(82)	(112)
Amortisation of PFI credit	0	0
(Increase)/Decrease in Trade and Other Receivables	1,722	(333)
(Increase)/Decrease in Other Assets	0	0
(Increase)/Decrease in Inventories	(234)	(677)
Increase/(Decrease) in Trade and Other Payables	(661)	2,495
Increase/(Decrease) in Other Liabilities	(256)	(308)
Increase/(Decrease) in Provisions	(221)	(198)
Tax (paid) / received	197	307
Movements in operating cash flow of discontinued operations	0	0
Other movements in operating cash flows	10	144
NET CASH GENERATED FROM/(USED IN) OPERATIONS	20,262	25,934
Cash flows from investing activities		
Interest received	400	181
Purchase of financial assets	(80,000)	(90,000)
Sales of financial assets	90,000	100,000
Purchase of intangible assets	(99)	(648)
Sales of intangible assets	0	0
Purchase of Property, Plant and Equipment	(8,646)	(6,140)
Sales of Property, Plant and Equipment	10	27
Net cash generated from/(used in) investing activities	1,665	3,420
Cash flows from financing activities		
Public dividend capital received	0	0
Public dividend capital repaid	0	0
Loans received	0	0
Loans repaid	0	0
Capital element of finance lease rental payments	0	0
Capital element of PFI Obligations	(4,153)	(4,511)
Interest paid	0	0
Interest element of finance lease	0	0
Interest element of PFI Obligations	(9,206)	(9,521)
PDC Dividend paid	(2,052)	(2,975)
Cash flows from (used in) other financing activities	0	37
Net cash generated from/(used in) financing activities	(15,411)	(16,970)
Increase/(decrease) in cash and cash equivalents	**6,516**	**12,384**
Cash and Cash equivalents at 1 April	26,925	14,541
Cash and Cash equivalents at 31 March	**33,441**	**26,925**

Accounting Policies and Other Information

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

1 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services. Income is recognised in the period in which services are provided, for patients in whose treatment straddles the year end this means income is apportioned across financial years on the basis of length of stay. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

2 Expenditure on Employee Benefits

Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

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

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

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

The NHS Pension scheme is subject to a full valuation every four years by the Government Actuary. The latest published valuation relates to the period 1 April 1999 to 31 March 2004 which was published in December 2007 and is available on the NHS Pensions Agency Website.

The notional deficit of the scheme was £3.3 billion as per the last scheme valuation by the Government Actuary for the period 1 April 1999 to 31 March 2004. The conclusion of the valuation was that the scheme continues to operate on a sound financial basis.

Employer contribution rates are reviewed every four years following the scheme valuation, on advice from the actuary. At the last valuation it was recommended that employer contribution rates should continue at 14% of pensionable pay. From 1 April 2008, employees' pay contributions will be on a tiered scale from 5% to 8.5% of their pensionable pay.

3 Expenditure on Other Goods and Services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

4 Property, Plant and Equipment

Recognition

Property, Plant and Equipment is capitalised where:

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

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

For property assets the frequency of revaluations will be at least every five years, in line with Monitor's view.

The fair value of land and buildings are determined by valuations carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The valuations are carried out primarily on the basis of modern equivalent cost for specialised operational property and existing use value for non-specialised operational property. The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value.

Assets under construction are valued at cost and are subsequently revalued by professional valuers when they are brought into use if factors indicate that the value of the asset differs materially from its carrying value. Otherwise, the asset should only be revalued on the next occasion when all assets are revalued.

Subsequent expenditure

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

Depreciation

Items of Property, Plant and Equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

The Trust depreciates its non-current assets on a straight line basis over the expected life of the assets after allowing for the residual value. Useful lives are determined on a case by case basis. The typical lives for the following assets are:

Asset Category	Useful Life (years)
Buildings	As per valuer's estimate
Engineering Plant & Equipment	5 - 15
Medical Equipment	7 - 10
Transport Equipment	7
Information Technology	5 - 8
Furniture & Fittings	5 - 10

Freehold land is considered to have an infinite life and is not depreciated.

Property, Plant and Equipment which has been reclassified as ‘Held for Sale’ ceases to be depreciated upon reclassification.

Assets in the course of construction and residual interests in off-balance sheet PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

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

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

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

Impairments
In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

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

De-recognition
Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

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

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met. Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated assets
Donated property, plant and equipment are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated property, plant and equipment are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to other operating revenue. Similarly, any impairment on donated assets charged to other operating revenue is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value of the donated asset is transferred from the donated asset reserve to the Income and Expenditure Reserve.

Private Finance Initiative (PFI) transactions
PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in the Annual Reporting Manual issued by Monitor, are accounted for as 'on-balance sheet' by the Trust. The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16. An equivalent financial liability is recognised in accordance with IAS 17.

The annual contract payments are apportioned between the repayment of the liability, a lifecycle element, a finance cost and the charges for services. The finance cost is calculated using the implicit interest rate for the scheme. The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

The lifecycle element is established on the lifecycle plan contained within the financial model. Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value. The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively. Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

5 Intangible Assets

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably. Where internally generated assets are held for service potential, this involves a direct contribution to the delivery of services to the public.

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Purchased computer software licences are capitalised as intangible non-current assets where expenditure of at least £5,000 is incurred and amortised over the shorter of the term of the license and their useful lives.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. Subsequently intangible assets are measured at fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation and impairment

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Asset Category	Useful Life (years)
Software Licences	5

6 Government Grants

Government grants are grants from Government bodies other than income from Primary Care Trusts or NHS Trusts for the provision of services. Grants from the Department of Health, including those for achieving three star status, are accounted for as Government grants as are grants from the Big Lottery Fund. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure the grant is held as deferred income and released to operating income over the life of the asset in a manner consistent with the depreciation charge for that asset.

7 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In, First Out (FIFO) method.

8 Cash and Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours.

9 Financial Instruments and Financial Liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made. Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below. Regular way purchases or sales are recognised and de-recognised, as applicable, using the settlement date. All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

Financial assets are categorised as 'Fair Value through Income and Expenditure' or Loans and receivables. Financial liabilities are classified as 'Fair value through Income and Expenditure' or as 'Other Financial liabilities'.

Financial assets and financial liabilities at 'Fair Value through Income and Expenditure'

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities. These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments with are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS debtors, accrued income and 'other debtors'. Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset. Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available for sale financial assets

Available for sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long term assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available for sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. When classified as 'available for sale' are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in ' Finance Costs' in the Statement of Comprehensive Income.

Other Financial liabilities

All (other) financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities. Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset. For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

10 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability. The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

11 Provisions

The NHS Foundation Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit which both use HM Treasury's pension discount rate of 2.9% in real terms.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 16, but is not recognised in the Trust accounts.

Non-clinical risk pooling
The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

12 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 21 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 21, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

13 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) net cash balances held with the Government Banking Services, excluding cash balances held in GBS accounts that relate to a short-term working capital facility and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

14 Value Added Tax

Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

15 Foreign Exchange
The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. Where the Trust has assets or liabilities denominated in a foreign currency at the statement of financial position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise. Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

16 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in note 35 to the accounts in accordance with the requirements of HM Treasury's *Financial Reporting Manual*.

17 Corporation Tax

The Trust does not foresee that it will have any material commercial activities on which corporation tax liability will arise under the guidance issued by HM Revenue and Customs.

18 Charitable Funds

The Trust is not required to apply IAS 27 in 2010/11 following dispensation obtained by Monitor. However, this only applies to the consolidation of NHS Charitable Funds.

19 Critical accounting judgements and key sources of estimation and uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

- Accounting for PFI
- Application of IFRIC 4 Determining whether an Arrangement contains a Lease
- Application of IFRIC12 Service Concession Arrangements

Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year

- Valuation of Non- Current Assets
- Provisions
- Settlement of Over Performance with Healthcare Purchasers

20 Accounting Standards that have been issued but have not yet been adopted

The following standards and interpretations have been adopted by the European Union but are not required to be followed until 2011/12. These are not expected to impact upon the Trust financial statements.

IAS 24 (Revised) Related Party Disclosures
IAS 27 (Revised) Consolidated and separate financial statements
IFRIC 14 amendment
IFRIC 19 Extinguishing financial liabilities with Equity Instruments
IASB Annual Improvements 2010

21 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

2 Segmental Analysis

The Board as 'Chief Operating Decision Maker' has determined that the Trust operates in one material segment, which is the provision of healthcare services. The segmental reporting format reflects the Trust's management and internal reporting structure.

The Trust has identified segments in line with the thresholds in IFRS 8, applying the requirement of the ARM to consider expenditure instead of income as income is not analysed between segments in our monthly finance report to the Trust Board. Following a significance test of the expenditure segments the Trust found that there were five significant operating segments subject to the external reporting requirements of IFRS 8. Applying the aggregation criteria to the Trust's five significant operating segments found that in all cases the segments had similar economic characteristics, the nature of the services are similar, the nature of the production process are similar, the type or class of customer for the services are similar, the methods used to provide the services are similar and the nature of the regulatory environment is similar.

The Trust's significant operating segments satisfy all of the criteria listed for an aggregation to be deemed appropriate. The five significant operating segments of the Trust are all active in the same business – the provision of healthcare, and all operate within the same economic environment – the United Kingdom. Given that the purpose of disclosing segmental information is to enable users of the financial statements to evaluate the nature and financial effects of business activities and economic environments, reporting a single segment of "Healthcare" would be consistent with the core principle of IFRS 8, as it would show the singular nature of both the business activity and the economic environment of the Trust.

Income from activities (medical treatment of patients) is analysed by customer type in note 3 to the accounts on page 14. Other operating income is analysed in note 4 to the accounts on page 15 and materially consists of revenues from healthcare, research and development, medical education, and the provision of services to other NHS bodies. Total income by individual customers within the whole of HM Government and considered material, is disclosed in the related parties transactions note 22 to the accounts on page 33.

	Year Ended 31 March 2011		Year Ended 31 March 2010	
	£'000	%	£'000	%
Trust Income *	260,349		253,693	
Expenditure - aggregated healthcare segment	(222,230)	85.4%	(213,192)	84.7%
Expenditure - other **	(37,844)	14.6%	(38,639)	15.3%
Total Expenditure	(260,074)	100.0%	(251,831)	100.0%
Operating Surplus	275		1,862	

* Trust income was not split into individual Directorates in the monthly Finance Report to the board during 2010-11 and 2009-10.

** Other Expenditure is made up of Corporate Directorates, Depreciation, Impairments, PFI Finance Lease Interest and Interest Receivable.

3 Revenue from Activities

3.1 Income By Source	Year Ended 31 March 2011 £'000	Year Ended 31 March 2010 £'000
NHS Foundation Trusts	0	0
NHS Trusts	16	37
Strategic Health Authorities	0	0
Primary Care Trusts	244,372	237,564
Local Authorities	7	0
Department of Health - grants	0	0
Department of Health - other	0	216
NHS Other	0	0
Non NHS: Private patients	68	106
Non-NHS: Overseas patients (non-reciprocal)	57	56
NHS injury scheme (was RTA)	1,482	1,242
Non NHS: Other	89	99
Total income from activities	**246,091**	**239,320**

This income is also analysed by income type below:

3.2 Revenue from Activities	Year Ended 31 March 2011 £'000	Year Ended 31 March 2010 £'000
Elective	50,966	52,373
Non Elective	87,621	79,375
Outpatient	46,320	41,892
A&E	8,495	7,745
Other NHS Clinical Income	47,821	55,335
Income at Tariff	**241,223**	**236,720**
Private Patients	68	106
Other non-protected clinical income	4,800	2,494
Total income from activities	**246,091**	**239,320**

As an NHS Foundation Trust, the majority of income in respect of patient care is received under Payment By Results (PBR), which is intended to reimburse Trusts based on the actual activity delivered using the National Tariff of procedure prices.

The Terms of Authorisation set out the mandatory goods and services that the Trust is required to provide (protected services). All of the income from activities before private patient income shown above is derived from the provision of those services.

Other NHS Clinical Income comprises the following services pathology; rehabilitation; community support services; radiology; renal services; patient transport services; and high cost drugs/devices/appliances.

3.3 Private Patient Income

	2010/11 £'000	2009/10 £'000	Base Year £'000
Private Patient Income	68	106	119
Total Patient Related Income	245,989	239,214	134,515
Proportion (as percentage)	0.03%	0.04%	0.09%

Section 44 of the 2006 Act requires that the proportion of the private patient income to the total patient related income of NHS Foundation Trusts should not exceed its proportion whilst the body was an NHS Trust in 2002/03. The note above shows that the Trust continues to be compliant.

4 Other Operating Revenue

	Year ended 31 March 2011 £'000	Year ended 31 March 2010 £'000
Research and development	1,402	1,028
Education and training	7,797	7,891
Charitable and other contributions to expenditure	0	0
Transfer from donated asset reserve in respect of depreciation on donated assets	83	93
Non-patient care services to other bodies	1,783	1,946
Profit on disposal of fixed asset investments	0	0
Profit on disposal of intangible fixed assets	0	0
Profit on disposal of land and buildings	0	0
Profit on disposal of other tangible fixed assets	0	9
Gain on disposal of assets held for sale	0	0
Reversal of impairments of assets held for sale	0	0
Amortisation of PFI deferred credits		
Main scheme	0	0
Additional lifecycle assets received	0	0
Other	3,193	3,406
Total other operating income	**14,258**	**14,373**

Other income is derived from Staff Recharges £1,294,000 (2009/10 £1,234,000); Pharmacy Drugs £931,000 (2009/10 £872,000); and numerous other small amounts.

5 Operating Expenditure	Year ended 31 March 2011	Year ended 31 March 2010
5.1 Operating Expenses	£'000	£'000
Services from NHS Foundation Trusts	84	82
Services from NHS Trusts	170	186
Services from other NHS Bodies	93	3,397
Purchase of healthcare from non NHS bodies	31	419
Employee Expenses - Executive directors	1,016	963
Employee Expenses - Non-executive directors	131	125
Employee Expenses - Staff	150,711	142,020
Drug costs	22,984	21,512
Supplies and services - clinical (excluding drug costs)	20,154	17,852
Supplies and services - general	982	880
Establishment	2,253	2,213
Research and development	0	143
Transport	2,286	1,869
Premises	3,134	3,392
Increase / (decrease) in bad debt provision	101	164
Other impairment of financial assets	0	0
Depreciation on property, plant and equipment	8,496	9,339
Amortisation on intangible assets	372	266
Impairments of property, plant and equipment	0	1,205
Impairments of intangible assets	0	0
Reversal of impairments of property, plant and equipment	0	0
Reversal of impairments of intangible assets	0	0
Audit fees		
audit service - statutory audit	58	79
audit services - audit related regulatory reporting	16	0
Other auditor's remuneration		
further assurance services	0	0
other services	0	20
Clinical negligence	5,373	4,078
Loss on disposal of investments	0	0
Loss on disposal of intangible fixed assets	0	0
Loss on disposal of land and buildings	0	0
Loss on disposal of other property, plant and equipment	10	134
Loss on disposal of assets held for sale	0	0
Impairments of assets held for sale	0	0
Legal fees	0	0
Consultancy costs	1,253	720
Training, courses and conferences	0	0
Patient travel	0	0
Car parking & Security	0	0
Redundancy & early retirements	0	75
Hospitality	0	0
Publishing	0	0
Insurance	0	0
Other services, eg external payroll	0	0
Losses, ex gratia & special payments	0	0
Other	29,722	28,754
TOTAL	**249,430**	**239,887**

Other expenditure includes £26,118,000 (2009/10 £25,017,000) in relation to payments to the Trust's PFI Partner for services provided & numerous other small amounts.

5.2 The Late Payment of Commercial Debts (interest) Act 1998
During the year 2010/11 (2009/10 £nil) the Trust was not charged interest for the late payment of commercial debts.

6 Operating Leases

6.1 Payments recognised as an expense	Year ended 31 March 2011 £'000	Year ended 31 March 2010 £'000
Minimum lease payments	42	40
Contingent rents	0	0
Sub-lease payments	0	0
	42	40
Total future minimum lease payments Payable:		
Not more than one year	30	29
Between one and five years	55	35
After 5 years	0	0
Total	85	64

7 Employee Expenses and Numbers

7.1 Employee Costs

	Year Ended 31 March 2011			Year Ended 31 March 2010		
	Total	Permanent	Other	Total	Permanent	Other
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	117,917	114,425	3,492	107,700	91,387	16,313
Social security costs	9,047	8,809	238	8,168	6,814	1,354
Pension costs - defined contribution plans Employer's contributions to NHS Pensions	13,191	13,024	167	12,144	10,786	1,358
Termination benefits	0	0	0	0	0	0
Agency/contract staff	11,572	0	11,572	15,046	0	15,046
Total	151,727	136,258	15,469	143,058	108,987	34,071

7.2 Average Number of Persons Employed

	Year Ended 31 March 2011			Year Ended 31 March 2010		
	Total	Permanent	Other	Total	Permanent	Other
Medical and dental	435	406	29	462	183	279
Administration and estates	680	656	24	609	545	64
Healthcare assistants and other support staff	638	638	0	127	123	4
Nursing, midwifery and health visiting staff	1,141	1,014	127	1,490	1,338	152
Nursing, midwifery and health visiting learners	11	11	0	12	3	9
Scientific, therapeutic and technical staff	431	426	5	599	567	32
Bank and agency staff	137	0	137	264	0	264
Total	3,473	3,151	322	3,563	2,759	804

7.3 Employee Benefits

7.4 Retirements due to Ill-health

During the period 2010/11 there were 4 (in 2009/10 there were 2) early retirements from the Trust on the grounds of ill-health.

The estimated additional pension liabilities of these ill-health retirements will be £334,838 (2009/10 £110,376).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division, and therefore there is no liability or provision in the Trust accounts.

These retirements represented 1.06 per 1,000 (2009/10 0.62 per 1,000) active scheme members.

7.5 Sickness Absence

The detail of staff sickness / absence from work for the year are:

	2010/11	2009/10
Absence Full Time Equivalent (FTE)	48,631	45,997
Available Employee Time (FTE) for the year	1,214,786	1,139,403
Sickness Rate	4.00%	4.04%

7.6 Exit Packages

The Trust's expenditure does not include payments relating to staff exit packages in either the current or previous year.

8 Finance Income

	Year ended 31 March 2011 £'000	Year ended 31 March 2010 £'000
Interest on loans and receivables	347	230
Interest on available for sale financial assets	0	0
Interest on held-to-maturity financial assets	0	0
	347	230

9 Finance Costs - Interest Expense

	Year ended 31 March 2011 £'000	Year ended 31 March 2010 £'000
Finance Costs in PFI obligations		
Main Finance Costs	6,348	6,518
Contingent Finance Costs	2,858	3,003
	9,206	9,521

10 Intangible Assets

10.1 2010/11	Computer Software £'000	Total £'000
Gross Cost as at 1 April 2010	1,732	1,732
Additions Purchased	99	99
Additions Donated	0	0
Disposals	0	0
Gross Cost as at 31 March 2011	1,831	1,831
Amortisation as at 1 April 2010	621	621
Provided during the Year	372	372
Disposals	0	0
Amortisation as at 31 March 2011	993	993
Net Book Value		
Purchased at 1 April 2010	1,111	1,111
Donated at 1 April 2010	0	0
Total at 1 April 2010	1,111	1,111
Net Book Value		
Purchased at 31 March 2011	838	838
Donated at 31 March 2011	0	0
Total at 31 March 2011	838	838

10.2 2009/10	Computer Software £'000	Total £'000
Gross Cost as at 1 April 2009	1,130	1,130
Additions Purchased	648	648
Additions Donated	0	0
Disposals	(46)	(46)
Gross Cost as at 31 March 2010	1,732	1,732
Amortisation as at 1 April 2009	401	401
Provided during the Year	266	266
Disposals	(46)	(46)
Amortisation as at 31 March 2010	621	621
Net Book Value		
Purchased at 1 April 2009	729	729
Donated at 1 April 2009	0	0
Total at 1 April 2009	729	729
Net Book Value		
Purchased at 31 March 2010	1,111	1,111
Donated at 31 March 2010	0	0
Total at 31 March 2010	1,111	1,111

11 Tangible Assets

11.1 2010/11

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Gross Cost at 1 April 2010	222,497	26,350	159,617	1,428	2,673	30,551	135	1,219	524
Additions - purchased	9,522	0	7,340	30	906	936	110	94	106
Additions - donated	19	0	0	0	0	0	0	7	12
Impairments	(193)	0	0	(193)	0	0	0	0	0
Reclassifications	0	0	2,654	0	(2,673)	14	0	5	0
Revaluations	29	0	29	0	0	0	0	0	0
Transferred to disposal group as asset held for sale	(1,113)	(360)	0	(753)	0	0	0	0	0
Disposals	(1,783)	0	0	0	0	(1,745)	(22)	0	(16)
Gross Cost at 31 March 2011	228,978	25,990	169,640	512	906	29,756	223	1,325	626
Accumulated depreciation at 1 April 2010	19,087	0	0	0	0	18,074	129	544	340
Provided during the year	8,496	0	4,431	63	0	3,713	1	203	85
Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation surpluses	0	0	0	0	0	0	0	0	0
Transferred to disposal group as asset held for sale	(35)	0	0	(35)	0	0	0	0	0
Disposals	(1,763)	0	0	0	0	(1,731)	(22)	0	(10)
Accumulated depreciation at 31 March 2011	25,785	0	4,431	28	0	20,056	108	747	415
Net book value (NBV)									
NBV - Owned at 1 April 2010	48,329	26,350	7,302	1,428	2,673	9,711	6	675	184
NBV - PFI at 1 April 2010	154,770	0	152,202	0	0	2,568	0	0	0
NBV - Donated at 1 April 2010	311	0	113	0	0	198	0	0	0
NBV total at 1 April 2010	203,410	26,350	159,617	1,428	2,673	12,477	6	675	184
NBV - Owned at 31 March 2011	52,169	25,990	16,536	484	906	7,368	115	572	198
NBV - PFI at 31 March 2011	150,776	0	148,561	0	0	2,215	0	0	0
NBV - Donated at 31 March 2011	248	0	112	0	0	117	0	6	13
NBV total at 31 March 2011	203,193	25,990	165,209	484	906	9,700	115	578	211

11 Tangible Assets

11.2 2009/10

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Gross Cost at 1 April 2009	280,345	33,651	195,591	1,435	790	46,289	135	1,502	952
Additions - purchased	6,152	0	1,999	0	1,980	2,138	0	35	0
Additions - donated	37	0	0	0	0	37	0	0	0
Impairments	(45,351)	(7,301)	(37,973)	(77)	0	0	0	0	0
Reclassifications	0	0	0	0	(97)	97	0	0	0
Revaluations	70	0	0	70	0	0	0	0	0
Transferred to disposal group as asset held for sale	0	0	0	0	0	0	0	0	0
Disposals	(18,756)	0	0	0	0	(18,010)	0	(318)	(428)
Gross Cost at 31 March 2010	222,497	26,350	159,617	1,428	2,673	30,551	135	1,219	524
Accumulated depreciation at 1 April 2009	39,997	0	6,249	0	0	32,275	126	666	681
Provided during the year	9,339	0	5,340	75	0	3,639	3	196	86
Impairments	1,205	0	1,205	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation surpluses	(12,869)	0	(12,794)	(75)	0	0	0	0	0
Transferred to disposal group as asset held for sale	0	0	0	0	0	0	0	0	0
Disposals	(18,585)	0	0	0	0	(17,840)	0	(318)	(427)
Accumulated depreciation at 31 March 2010	19,087	0	0	0	0	18,074	129	544	340
Net book value									
NBV - Owned at 1 April 2009	55,964	33,651	8,797	1,435	790	10,177	9	836	269
NBV - PFI at 1 April 2009	183,596	0	180,430	0	0	3,166	0	0	0
NBV - Donated at 1 April 2009	788	0	115	0	0	671	0	0	2
NBV total at 1 April 2009	240,348	33,651	189,342	1,435	790	14,014	9	836	271
NBV - Owned at 31 March 2010	48,329	26,350	7,302	1,428	2,673	9,711	6	675	184
NBV - PFI at 31 March 2010	154,770	0	152,202	0	0	2,568	0	0	0
NBV - Donated at 31 March 2010	311	0	113	0	0	198	0	0	0
NBV total at 31 March 2010	203,410	26,350	159,617	1,428	2,673	12,477	6	675	184

11 Tangible Assets

11.3 Analysis of Tangible Assets

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
Net Book Value	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
NBV - Protected Assets at 31 March 2011	191,009	25,800	165,209	0	0	0	0	0	0
NBV - Unprotected Assets at 31 March 2011	12,184	190	0	484	906	9,700	115	578	211
	203,193	25,990	165,209	484	906	9,700	115	578	211
NBV - Protected Assets at 31 March 2010	185,417	25,800	159,617	0	0	0	0	0	0
NBV - Unprotected Assets at 31 March 2010	17,993	550	0	1,428	2,673	12,477	6	675	184
	203,410	26,350	159,617	1,428	2,673	12,477	6	675	184

Protected assets are land and buildings owned or leased by the Foundation Trust, and the disposal of which may affect the Trust's ability to provide it's mandatory goods and services.

11.4 Impairment Losses

The Trust carried out an impairment review of its non-current assets in February 2010. For land, buildings and dwellings the Trust received a valuation report from the District Valuer prepared on a MEA basis. The valuation report was prepared in accordance with the terms of the Royal Institution of Chartered Surveyors' Valuation Standards, 6th Edition, insofar as the terms are consistent with the requirements of HM Treasury, the National Health Service and Monitor. On application of the revaluation there was a fall in value, reflecting the change in market prices, of the Trust's land, buildings and dwellings compared to the carrying value at that time. In line with IFRS the Trust was able to offset the fall in value of its land, buildings and dwellings against any relevant revaluation balances held for the applicable assets. The Trust reviewed the market as at 31st March 2011 and was content that the depreciated values of land, buildings and dwellings, after the application of the revaluation, were in line with the current market valuations.

Impairment of Assets	31 March 2011 £'000	31 March 2010 £'000
Loss or damage from normal operations	0	0
Over specification of assets	0	0
Changes in market price	193	46,556
Reversal of impairments	0	0
TOTAL IMPAIRMENTS	193	46,556

11.5 Asset Valuations

The Trust received a MEA valuation from the District Valuer in February 2010. The updated valuations of the Trust's land, buildings and dwellings were applied to the Trust financial statements in March 2010 and enable the Trust to disclose an up to date position with regard to asset valuations. No significant assumptions were made as part of the valuation process as minimum capital expenditure had been applied to the land and buildings since the previous full revaluation exercise. If the Trust had not received this updated valuation the carrying values of land, buildings and dwellings would have been £33,651,000; £186,001,000 and £1,360,000 respectively.

11.6 Non Current Assets Held For Sale

	Total	Property, Plant and Equipment
	£'000	£'000
NBV of Non Current Assets Held For Sale in disposal groups at 1 April 2010	0	0
Assets classified as available for sale during the year	1,078	1,078
Assets sold during the year	0	0
NBV of Non Current Assets Held For Sale in disposal groups at 31 March 2010	**1,078**	**1,078**
Assets classified as available for sale during the year	0	0
Assets sold during the year	0	0
NBV of Non Current Assets Held For Sale in disposal groups at 31 March 2011	**1,078**	**1,078**

The Board took the decision to sell the housing stock in Ashdown Drive in 2010/11. At the time of the signing of the accounts four houses were part of an open housing market sale with the remainder sold at auction in April 2011.

11.7 Capital Commitments

Commitments under capital expenditure contracts at the end of the period, not otherwise included in these financial statements were £3,333,000 (31 March 2010 £6,366,000). This amount relates entirely to property, plant and equipment. There are no contracted capital commitments for intangible assets.

12 Inventories

12.1 Inventories	Year ended 31 March 2011 £'000	Year ended 31 March 2010 £'000
Materials	3,183	2,949
Work in progress	0	0
Finished goods	0	0
Inventories carried at fair value less costs to sell	0	0
TOTAL Inventories	3,183	2,949

12.2 Inventories recognised in expenses	Year ended 31 March 2011 £'000	Year ended 31 March 2010 £'000
Inventories recognised in expenses	24,513	23,037
Write-down of inventories recognised as an expense	0	0
Reversal of any write down of inventories resulting in a reduction of recognised expenses	0	0
TOTAL Inventories recognised in expenses	24,513	23,037

13 Trade Receivables and Other Receivables

13.1 Trade Receivables and Other Receivables

	Year Ended 31 March 2011	Year Ended 31 March 2010
Current	£'000	£'000
NHS Receivables	3,689	5,211
Other receivables with related parties	0	0
Provision for impaired receivables	(757)	(670)
Prepayments	643	883
PFI Prepayments		
Prepayments - Capital contributions	0	0
Prepayments - Lifecycle replacements	0	0
Accrued income	909	2,198
Corporation tax receivable	0	0
Finance Lease Receivables	0	0
PDC receivable	589	322
Other receivables	1,058	914
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	6,131	8,858
Non Current		
Prepayments	3,923	4,185
PFI Prepayments		
Prepayments - Capital contributions	0	0
Prepayments - Lifecycle replacements	2,469	1,288
Other Receivables	1,434	1,154
TOTAL NON CURRENT TRADE AND OTHER RECEIVABLES	7,826	6,627

Other current and non current receivables include the NHS Injury Scheme (was RTA).

13.2 Provision for impairment of receivables

	As at 31 March 2011 £'000	As at 31 March 2010 £'000
At 1 April	670	539
Increase in provision	117	218
Amounts utilised	(14)	(33)
Unused amounts reversed	(16)	(54)
At 31 March	757	670

13.3 Analysis of impaired receivables

	As at 31 March 2011 £'000	As at 31 March 2010 £'000
Ageing of impaired receivables		
Up to three months	3	0
In three to six months	1	3
Over six months	12	23
Total	16	26
Ageing of non-impaired receivables past their due date		
Up to three months	66	1,027
In three to six months	11	0
Over six months	18	38
Total	95	1,065

14 Trade and Other Payables

	As at 31 March 2011	As at 31 March 2010
Current	£'000	£'000
Receipts in advance	0	0
NHS payables	3,158	3,265
Amounts due to other related parties	0	0
Trade payables - capital	1,047	441
Other trade payables	0	0
Taxes payable	3,108	2,910
Other payables	4,438	3,995
Accruals	1,966	2,964
PDC payable	0	0
Reclassified to liabilities held in disposal groups in year	0	0
TOTAL CURRENT TRADE & OTHER PAYABLES	13,717	13,575
Non-current		
Receipts in advance	0	0
NHS payables	0	0
Amounts due to other related parties	0	0
Trade payables - capital	0	0
Other trade payables	0	0
Taxes payable	0	0
Other payables	0	0
Accruals	0	0
TOTAL NON CURRENT TRADE & OTHER PAYABLES	0	0

Taxes payable consists of employment taxation only (Pay As You Earn and National Insurance contributions), owed to HM Revenue and Customs at the year end.

15 Other Liabilities	As at 31 March 2011 £'000	As at 31 March 2010 £'000
Current		
Deferred Income	1,338	1,594
Deferred PFI credits	0	0
Deferred Government Grant	0	0
Net Pension Scheme Liability	0	0
TOTAL OTHER CURRENT LIABILITIES	1,338	1,594
Non-current		
Deferred Income	0	0
Deferred PFI credits	0	0
Deferred Government Grant	0	0
Net Pension Scheme Liability	0	0
TOTAL OTHER NON CURRENT LIABILITIES	0	0

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

16 Provision for Liabilities and Charges

	Current		Non Current	
	31 March 2011	31 March 2010	31 March 2011	31 March 2010
	£'000	£'000	£'000	£'000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
Other legal claims	80	101	0	0
Agenda for Change	0	20	0	0
Other	533	713	0	0
Total	613	834	0	0

	Total	**Pensions - former directors**	**Pensions - other staff**	**Other legal claims**	**Agenda for Change**	**Other**
	£'000	£'000	£'000	£'000	£'000	£'000
At 1 April 2010	834	0	0	101	20	713
Arising during the year	113	0	0	63	0	50
Utilised during the year	(46)	0	0	(46)	0	0
Reversed unused	(288)	0	0	(38)	(20)	(230)
At 31 March 2011	613	0	0	80	0	533
Expected timing of cashflows:						
- not later than one year;	613	0	0	80	0	533
- later than one year and not later than five years;	0	0	0	0	0	0
- later than five years.	0	0	0	0	0	0
TOTAL	613	0	0	80	0	533

Other Legal Claims include claims under Employers and Public Liability.

Other provisions include assessed liabilities in respect of the balance outstanding for Middle Grade Doctors Pay Award.

The NHS Litigation Authority has included in its provisions at 31 March 2011 £40,426,000 (2009/10 £36,528,000) in respect of clinical negligence liabilities for the Trust.

17 Prudential Borrowing Limit

NHS Foundation Trusts are required to comply and remain within a prudential borrowing limit. This is made up of two elements:

* the maximum cumulative amount of long-term borrowing. This is set by reference to the five ratio tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit; and
* the amount of any working capital facility approved by Monitor.

As per Section 46 of the Act, the Trust has a Prudential Borrowing Limit of £172,200,000 in 2010/11 (2009/10 £182,700,000). The Trust has not borrowed in 2010/11 (2009/10 £ nil) and at 31 March 2011 its long term borrowing was £158,251,000 (2009/10 £162,154,000) in relation to the finance lease of the Trust PFI Scheme. The Prudential Borrowing Limit is the sum of the following:

(i) Maximum cumulative long term borrowing: £162.2M and
(ii) Approved Working Capital Facility not to exceed £10.0M

Financial Ratio	2010/11		2009/10	
	Actual	Plan	Actual	Plan
Maximum Debt / Capital Ratio	62.0%	62.0%	62.0%	55.0%
Minimum Dividend Cover	6.1x	5.7x	5.3x	5.9x
Minimum Interest Cover	2.2x	2.5x	2.5x	2.8x
Minimum Debt Service Cover	1.5x	1.7x	1.7x	1.9x
Maximum Debt Service to Revenue	5.1%	5.2%	5.5%	5.9%

The Trust has an approved working capital facility of £10.0M. The Trust had not utilised any of its working capital facility at 31 March 2011 (2009/10 £ nil).

Further information on the NHS Foundation Trust Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

There has been no necessity to make use of the Trust's Prudential Borrowing Limit or to use its overdraft facility. The decrease in the Trust's Prudential Limit to £162.2M (31 March 2010 £166.7M) is in relation to compliance with the International Financial Reporting Standards (IFRS) which require the assets and liabilities of the Trust's PFI Initiative scheme to be accounted for within its Statement of Financial Position, see note 23 to the accounts.

	2010/11	**2009/10**
	£'000	£'000
Total long term borrowing limit set by Monitor	162,200	166,700
Working capital facility agreed by Monitor	10,000	16,000
TOTAL PRUDENTIAL BORROWING LIMIT	**172,200**	**182,700**
Long term borrowing at 1 April	162,154	166,665
Net actual borrowing/(repayment) in year - long term	(3,903)	(4,511)
Long term borrowing at 31 March	158,251	162,154

18 Borrowings

	As at 31 March 2011	As at 31 March 2010
Current	£'000	£'000
Obligations under Private Finance Initiative contracts	4,231	4,065
Total Current borrowings	4,231	4,065
Non Current		
Obligations under Private Finance Initiative contracts	154,020	158,089
Total Other non Current Liabilities	154,020	158,089

19 Cash and Cash Equivalents

	As at 31 March 2011	As at 31 March 2010
	£'000	£'000
Cash and Cash Equivalents	33,441	26,925
Broken down into:		
Cash at commercial banks and in hand	10	9
Cash with the Government Banking Service	33,431	16,916
Other current investments	0	10,000
Cash and cash equivalents as in Statement of Financial Position	33,441	26,925
Bank overdraft	0	0
Cash and cash equivalents as in Statement of Cash Flows	33,441	26,925

Other current investments were instant access cash deposits held with UK Bank Institutions.

20 Events after the reporting period

On 1 April 2011 the Trust acquired the business of the Adult Services function of the NHS Dudley PCT Provider arm. The turnover of this business is £21 million. In the first year of operation expenditure is planned to be equal to income. 422 employees will transfer over to the Trust as part of this acquisition. The Trust will not be purchasing any land or buildings from Dudley PCT as part of this transaction. A Memorandum of Occupation will be in place between the two bodies to utilise the properties where the services are delivered from.

The Trust has set up an Adult Community Services Transformation Board to oversee the process of harmonising the Community Services with the current acute services. This Board is made up of GP's, PCT representatives, and Trust representatives, and is chaired by a Non-Executive Director from the Trust.

In April 2011 the Trust disposed of eight properties in Ashdown Drive by auction; the remaining four are subject to open market sale completion.

21 Contingencies

The Trust has a possible obligation to award damages in relation to an employment tribunal to the value of £150,000 at 31 March 2011 (2009/10 £100,000). The probability of the success of this claim is low and thus has been included as a contingent liability. The Trust does not have contingent assets.

22 Related Party Transactions

The Dudley Group of Hospitals NHS Foundation Trust is a public benefit corporation which was established under the granting of authority by Monitor, the Independent regulator for Foundation Trusts. Key management personnel, namely the Trust Board Directors and Non Executive Directors, are those persons having authority and responsibility for planning, directing and controlling the activities of the Trust. During the year none of the key management personnel have parties related to them that have undertaken any material transactions with The Dudley Group of Hospitals NHS Foundation Trust. The table below details, on an aggregate basis, key management personnel compensation:

	31 March 2011	31 March 2010
Compensation	£ million	£ million
Salaries and short-term benefits	1.15	1.08
Post-employment benefits	1.00	1.14
	2.15	2.22

The Trust considers other NHS Foundation Trusts to be related parties, as they and the Trust are under the common performance management of Monitor. During the year the Trust contracted with certain other Foundation Trusts for the provision of clinical and non clinical support services. The value of activity undertaken with these organisations was not material to the accounts. The Department of Health is also regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent department. These entities are listed below:

	Year ended 31 March 2011				Year ended 31 March 2010			
	Income	Expenditure	Receivable	Payable	Income	Expenditure	Receivable	Payable
	£ million	£ million	£ million	£ million	£ million	£ million	£ million	£ million
Department of Health	-	-	0.60	-	0.20	-	0.30	-
West Midlands Strategic Health Authority	7.56	0.01	0.04	-	7.60	0.04	0.02	-
Birmingham East & North PCT	11.31	0.23	-	0.23	11.90	-	-	0.05
Dudley PCT	182.20	1.39	2.56	0.14	175.20	2.54	1.43	-
Royal Wolverhampton NHS Trust	-	1.07	-	-	-	-	-	-
Sandwell PCT	31.26	-	0.50	-	31.08	-	0.67	-
South Staffordshire PCT	9.30	-	0.16	-	8.60	-	0.12	-
Wolverhampton City PCT	3.29	-	-	-	3.80	-	0.68	-
Worcestershire PCT	4.83	-	0.03	-	4.09	-	0.97	-

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies. These entities are listed below:

	Year ended 31 March 2011				Year ended 31 March 2010			
	Income	Expenditure	Receivable	Payable	Income	Expenditure	Receivable	Payable
	£ million	£ million	£ million	£ million	£ million	£ million	£ million	£ million
HM Revenue & Excise	-	-	-	-	-	7.50	-	2.91
NHS Blood and Transplant Agency	-	1.90	-	0.05	-	2.06	-	0.07
NHS Business Services Authority	-	4.19	-	0.31	-	3.90	-	0.18
NHS Litigation Authority	-	5.46	-	-	-	4.20	-	-
NHS Pensions	-	-	-	1.68	-	12.10	-	1.59
NHS Professionals	-	-	-	-	-	3.02	-	0.28
Dudley Metropolitan Borough Council	0.22	1.31	-	-	0.16	1.20	-	-

23 Private Finance Initiatives

23.1 PFI schemes on the Statement of Financial Position

The Dudley PFI project provided for the refurbishment and new building of major inpatient facilities at Russells Hall Hospital, the building of new facilities at Guest Hospital and Corbett Hospital. The Capital value of the scheme was £160.2m. The Project agreement runs for 40 years from May 2001 (except IT, which runs for 15 years from completion). The Dudley PFI is a combination of buildings (including hard Facilities Management services) and a significant range of allied and clinical support services.

The standard Unitary Payment changes periodically as a consequence of:

- Inflation (based on RPI and reviewed annually)
- Deductions for poor performance (Deficiency points and financial penalties for poor performance or non-compliant incidents).
- Variations to the Project Agreement (agreed under Variations procedure in the PA)
- 50% of market testing or refinancing impact
- Energy tariff adjuster (the difference between actual energy tariff changes and the uplift that comes through RPI)
- Volume adjuster (computed by comparing actual in patient days against that in the schedule, with a tolerance of plus or minus 3%)

The Trust has the rights to use the specified assets for the length of the Project Agreement and has the rights to expect provision of the range of allied and clinical support services. At the end of the Project Agreement the assets will transfer back to the Trust's ownership.

The PFI transaction meets the IFRIC 12 definition of a service concession, as interpreted in the Annual Reporting Manual (ARM) issued by Monitor, and therefore the Trust is required to account for the PFI scheme 'on-balance sheet' and this means that the Trust treats the asset as if it were an asset of the Trust and the substance of the contract is that the Trust has a finance lease and payments comprise two elements, an imputed finance lease charge and service charges.

	As at 31 March 2011 £'000	As at 31 March 2010 £'000
Gross PFI Liabilities	168,006	171,359
of which liabilities are due		
- not later than one year;	13,986	13,270
- later than one year and not later than five years;	16,924	16,260
- later than five years.	137,096	141,829
Finance charges allocated to future periods	(9,755)	(9,205)
Net PFI liabilities	**158,251**	**162,154**
- not later than one year;	4,231	4,065
- later than one year and not later than five years;	16,924	16,260
- later than five years.	137,096	141,829

The Trust is committed to make the following payments for on-SoFP PFIs obligations during the next year in which the commitment expires:

	31 March 2011 £'000	31 March 2010 £'000
Within one year	4,231	4,065
2nd to 5th years (inclusive)	16,924	16,260
Later than 5 Years	137,096	141,829
Total	**158,251**	**162,154**

Total length of the project (years)	36
Number of years to the end of the project	30

24 Financial Instruments and Related Disclosures

A financial instrument is a contract that gives rise to a financial asset in one entity and a financial liability or equity instrument in another entity. The nature of the Trust's activities means that exposure to risk, although not eliminated, is substantially reduced.

The key risks that the Trust has identified are as follows:

24.1 Financial Risk

Because of the continuing service provider relationship that the Trust has with Primary Care Trusts (PCT's) and the way those PCT's are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Investment Committee.

24.2. Currency Risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

24.3 Market (Interest Rate) Risk

All of the Trust financial assets and all of its financial liabilities carry nil or fixed rates of interest. The Trust is not therefore, exposed to significant interest rate risk.

24.4 Credit Risk

The majority of the Trust's income comes from contracts with other public sector bodies, resulting in low exposure to credit risk. The maximum exposures as at 31 March 2011 are in receivables from customers, as disclosed in note 13 to the accounts. The Trust mitigates its exposure to credit risk through regular review of debtor balances and by calculating a bad debt provision at the end of the period.

24.5 Liquidity Risk

Liquidity risk is the possibility that the Trust might not have funds available to meet its commitments to make payments. Prudent liquidity risk management includes maintaining sufficient cash and the availability to draw funding from the Trusts £10,000,000 working capital facility minimises such risk. The working capital facility level has been derived by taking into consideration the forecast month end cash balances for the coming two years. NHS Foundation Trusts are committed to comply with the Prudential Borrowing Code made by Monitor, the Independent Regulator of Foundation Trusts, and further details of the Foundation Trusts compliance can be found at note 17 “Prudential Borrowing Limit.”

The Trust is therefore not exposed to significant liquidity risk.

24.6 Fair Values

All of the financial assets and all of the financial liabilities of the Trust are measured at fair value on recognition and subsequently amortised cost.

24.7 Financial Assets By Category

The following table shows by category the Trust's financial assets and financial liabilities at 31 March 2011 and 31 March 2010.

Financial Assets	As at 31 March 2011		As at 31 March 2010	
	Total	Loans and Receivables	Total	Loans and Receivables
	£'000	£'000	£'000	£'000
Trade and other receivables excluding non financial liabilities	4,019	4,019	6,872	6,872
Other Investments	0	0	0	0
Other Financial Assets	0	0	10,000	10,000
Non current assets held for sale and assets held in disposal group excluding non financial assets	0	0	0	0
Cash and cash equivalents (at bank and in hand)	33,441	33,441	26,925	26,925
	37,460	37,460	43,797	43,797

Other Financial Assets are fixed term cash investments with UK Bank Institutions

Financial Liabilities	As at 31 March 2011		As at 31 March 2010	
	Total	Other financial Assets	Total	Other financial Assets
	£'000	£'000	£'000	£'000
Borrowings excluding Finance lease and PFI liabilities	0	0	0	0
Obligations under finance leases	0	0	0	0
Obligations under Private Finance Initiative contracts	158,251	158,251	162,154	162,154
Trade and other payables excluding non financial assets	10,609	10,609	10,912	10,912
Other financial liabilities	0	0	0	0
Provisions under contract	613	613	834	834
Liabilities in disposal groups excluding non-financial assets	0	0	0	0
	169,473	169,473	173,900	173,900

25 Third Party Assets

The Trust held £7,924 cash at bank and in hand at 31 March 2011 (31 March 2010 £7,006) which relates to monies held by the Trust on behalf of patients. This has been excluded from cash at bank and in hand figures reported in the accounts.

26 Losses and Special Payments

NHS Foundation Trusts are required to record payments and other adjustments that arise as a result of losses and special payments on an accruals basis, excluding provisions for future losses. In the period reported for 2010/11 the Trust had 43 (2009/10 102) separate losses and special payments, totalling £73,000 (2009/10 £58,000). These were in relation to cash losses and ex-gratia payments to patients.

There were no clinical negligence, fraud, personal injury, compensation under legal obligations or fruitless payment cases where the net payment for the individual case exceeded £100,000.

27 Auditors Liability

In accordance with the Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, the liability of the Trust Auditors, Deloitte LLP is restricted to £1,000,000 in respect of liability to pay damages for losses arising as a direct result of breach of contract or negligence in respect of services provided in connection with or arising from their letter of engagement dated 5 May 2010. In 2009/10 the Trust Auditors were PricewaterhouseCoopers LLP.

Glossary of abbreviations:

A&E	Accident and Emergency
C. diff	Clostridium difficile (infection)
CQC	Care Quality Commission
DGoH	The Dudley Group of Hospitals NHS Foundation Trust
EBITDA	Earnings Before Interest, Taxation, Depreciation and Amortisation
FT	Foundation Trust
GAAP	Generally Accepted Accounting Principles
GP	General Practitioner
HR	Human Resources
IFRS	International Financial Reporting Standards
IT	Information Technology
LINks	Local Involvement Networks
MRSA	Methicillin Resistant Staphylococcus Aureus (infection)

NBV	Net Book Value
NHS	National Health Service
NHSLA	National Health Service Litigation Authority
PALS	Patient Advice and Liaison Service
PBC	Practice Based Commissioning
PbR	Payment by Results
PCT	Primary Care Trust
PDC	Public Dividend Capital
PFI	Private Finance Initiative
R&D	Research and Development
SHA	Strategic Health Authority
WTE	Whole Time Equivalent
VAR	Variance
VAT	Value Added Tax
YTD	Year to Date

This leaflet can be made available in large print, audio version and in other languages, please call 0800 0730510

ਜੇਕਰ ਇਹ ਲੀਫ਼ਲੈੱਟ (ਛੋਟਾ ਇਸ਼ਤਿਹਾਰ) ਤੁਸੀਂ ਆਪਣੀ ਭਾਸ਼ਾ (ਪੰਜਾਬੀ) ਵਿੱਚ ਲੈਣਾ ਚਾਹੁੰਦੇ ਹੋ ਤਾਂ ਕ੍ਰਿਪਾ ਕਰ ਕੇ ਪੇਸ਼ੰਟ ਇੱਨਫ਼ਰਮੇਸ਼ਨ ਕੋ-ਆੱਰਡੀਨੇਟਰ ਨਾਲ **0800 0730510** ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ ਸੰਪਰਕ ਕਰੋ।

यदि आपको यह दस्तावेज आपनी भाषा में चाहिये तो पेशन्ट इनफरमेशन को-आरडीनेटर को टैलीफ़ोन नम्बर **0800 0730510** पर फोन करें।

જો તમને આ પત્રિકા તમારી પોતાની ભાષા (ગુજરાતી)માં જોઈતી હોય, તો કૃપા કરીને પેશન્ટ ઈન્ફોર્મેશન કો-ઓર્ડિનેટરનો **0800 0730510** પર સંપર્ક કરો.

আপনি যদি এই প্রচারপত্রটি আপনার নিজের ভাষায় পেতে চান, তাহলে দয়া করে পেশেন্ট ইনফরমেশন কো-অর্ডিনেটারের সাথে **0800 0730510** এই নম্বরে যোগাযোগ করুন।

أذا كنت ترغب هذه الوريقة مترجمة بلغتك الاصلية (اللغة العربية) , فرجاء أتصل بمنسق المعلومات للمريض **Information Co-ordinator** على التلفون **0800 0730510**

حسب ضرورت اس لیف لٹ کو اپنی زبان (اُردو) میں حاصل کرنے کے لئے براہ مہربانی ٹیلیفون نمبر **0800 0730510** پر پیشنٹ انفرمیشن کو-اورڈینیٹر (مریضوں کے لئے معلومات کی فراہمی کے سلسلے میں افسر) کے ساتھ رابطہ قائم کریں۔