University Hospital Birmingham NHS
NHS Foundation Trust

Annual Report and Accounts ***2005/6***

This annual report covers the period 1 April 2005 to 31 March 2006

Presented to Parliament pursuant to Schedule 1, paragraph 25(4)
of the Health and Social Care (Community Health and Standards) Act 2003

Contents

1. Chairman's Statement

Welcome to the Annual Report of the University Hospital Birmingham NHS Foundation Trust (UHB) for the year 2005/6. In this year, our first full year as an NHS Foundation Trust, we have used the freedoms and responsibilities afforded to us by NHS Foundation Status to begin to change the way we deliver care and work for our patients, staff and community.

Amongst our biggest achievements in the 2005/6 are:

- Gaining HM Treasury approval to build a £545m new super hospital for Birmingham

- The opening of a new world-class facility for patients with Leukaemia, which will support the development of new treatments, the creation of new jobs and support Birmingham's economic and social regeneration.

- Establishing a Learning Hub, to broaden access to jobs and training for unemployed local people. We are delivering this in partnership with Job Centre Plus, the Learning and Skills Council, Birmingham City Council, further education colleges, the Construction Project Alliance and Consort (our New Hospital Joint Venture partner), with the help of a £700,000 grant from the European Social Fund. By 2010 the hub will have supported at least 750 people to gain a job in healthcare or other sectors.

- Investing in new facilities and improving old environments. In 2005/6 our major investments have included:

    - The installation of a new type of X-ray machine called a Computerised Tomography (CT) scanner and a Magnetic Resonance Imaging (MRI) scanner at Selly Oak Hospital
    - The opening of the PET (Positron Emission Tomography) Centre, the first outside the South East, to aid more accurate cancer diagnosis
    - An extension to our Liver Outpatients' Department
    - A new off-site facility for the manufacture of sterile fluids
    - A new off-site medical records facility
    - Upgrade of clinical environments at both Selly Oak Hospital and the Queen Elizabeth Hospital

- A number of important investments in new consultant posts in stroke services, diabetes, dermatology, anaesthetics, burns, ear, nose and throat, trauma and neurosurgery.

Our direction continues to be shaped by our Board of Governors and our Membership. In 2005/6 we have stratified our 92,000 membership and now have 1,700 Level 3 members who desire the most active involvement. Members and Governors seminars have continued throughout the year, providing insight and welcome feedback into the organisation, its services and the environment in which we operate. Through the Board of Governors and our Patient & Carer Councils, our members and Governors are helping to shape our organisation's priorities.

The years ahead will be challenging as we prepare to move into Birmingham's first new hospital to be built in 70 years, complete major reform of our workforce and pay structures, while at the same time delivering the cost reduction and improvements in efficiency and productivity required. I am confident that we can achieve all that is necessary to ensure that UHB remains at the forefront of NHS Foundation trusts, delivering world-class care to our patients.

I would like to take this opportunity to thank our Chief Executive Mark Britnell, who soon leaves UHB to take a new role as Chief Executive of the newly-formed South Central Strategic Health Authority, for his extraordinary contribution to our Trust. We wish him well in his new role. From July 1 Chief Operating Officer Julie Moore takes up the position of Chief Executive (Acting).

I should like to conclude by thanking everyone who has contributed to the success of the last year – our staff, our Governors, the Board of Directors and our members. I look forward to working together with you all in the future.

John Charlton
Chairman

2. Chief Executive's Statement

I have had five great years as Chief Executive of UHB and I look back with particular pride on our achievements during 2005/6.

We have treated nearly half a million patients in the last 12 months and have sustained performance against challenging targets. Some 98% of patients have been treated, admitted or discharged from our accident and emergency (A&E) department within the four-hour target; we have made significant improvements to the speed of cancer diagnosis and treatment and sustained some of the lowest inpatient and outpatient waiting times in the NHS. We are very close to patients waiting no more than the 10-week target for an outpatient appointment and 12 weeks for inpatients.

Through prudent stewardship of precious financial resources we have also achieved a balanced financial position before exceptional items for the 11th successive financial year.

While we can be proud of our achievements last year (and, hopefully achieve an 'excellent' or 'good' rating when the Healthcare Commission make their pronouncement in the Autumn of 2006), we acknowledge that more needs to be done in some areas. We have made major progress in reducing waiting times for MRI and CT scanning to a maximum of 26 weeks, but more needs to be done to reduce waiting times for all diagnostic tests, in particular Endoscopy.

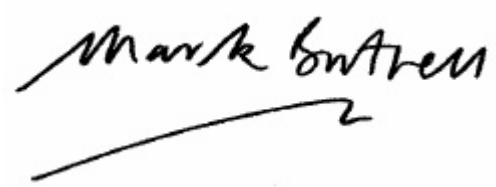
We have reduced the incidents of the resistant hospital bug MRSA (Methicillin-Resistant Staphylococcus Aureus) by 32% but we must be ever vigilant in this fight to ensure that our improvement in infection control continues as fast as possible.

I praise and applaud the 6,600 staff of UHB who has worked hard to achieve these results. I would like to thank our staff, volunteers, managers, governors and directors for their dedication, care and commitment to the people we serve.

We finally received approval for our new hospital PFI on April 12 of this year and completed signed contracts on June 6. Having worked on the scheme for the past eight and a half years it makes me very proud to know that a world-class facility will be built in Birmingham.

So it is with mixed emotions I leave UHB in July to take up the role of Chief Executive of South Central Strategic Health Authority, one of the ten new SHAs recently announced by the Secretary of State for Health Patricia Hewitt.

I am obviously delighted to be taking on such an important role for the NHS, but I will miss the staff at UHB. We have some of the finest staff in the NHS and I know they will go from strength to strength as the new hospital rises from the ground.



Mark Britnell
Chief Executive

June 15, 2006
Date

3. Background Information

3.1 University Hospital Birmingham NHS Foundation Trust (UHB)

University Hospital Birmingham NHS Foundation Trust (UHB) runs two hospitals, the Queen Elizabeth and Selly Oak, which are situated 1.5 miles apart in South Birmingham.

The annual budget in 2005/6 was £371 million and by the end of the year more than 6,600 people were working for UHB across more than 40 disciplines providing traditional district general hospital services for the adult population of South Birmingham and specialist acute treatments for people in the West Midlands and beyond.

Around 500,000 patients came to UHB for their care last year, ranging from simple outpatient appointments to major life-saving procedures.

UHB is the leading teaching hospital in the West Midlands with strong links to the University of Birmingham and for the last four consecutive years has achieved the Healthcare Commission's maximum 'three stars' rating for performance.

UHB works in collaboration with its academic partners to promote multi-disciplinary research and there is a strong emphasis on clinical and translational research, turning academic ideas into practical benefits for patients. UHB is the major provider of NHS Research and Development in the West Midlands and is also proud to host the Royal Centre for Defence Medicine (RCDM).

On 1 July 2004 we achieved Foundation status under the Health and Social Care (Community Health and Standards) Act 2003, which brought with it not only a number of benefits and advantages for patients and the community as well as financial freedoms for the organisation, but also different operating and functioning requirements from that as a NHS trust.

UHB has around 92,000 members and a Board of Governors which includes 24 members of the public (local people, patients and staff), who have been elected as representatives. Sections 5, 6 and 7 provide more detail of the Board of Directors, Governors and the membership.

3.2 Birmingham New Hospitals Project (BNHP)

The most significant event of 2005/6 was HM Treasury approval of BNHP. This project will provide a facility which will support the transformation and modernisation of acute and mental health services in South Birmingham during the first part of this century. The £545 million project is being developed by UHB in partnership with Birmingham & Solihull Mental Health NHS Trust.

The Project, which will be funded through a Public Finance Initiative (PFI), received approval on April 12 of this year, signed contracts were completed on June 6 and we reached financial close on June 14, 2006. Construction work has commenced and the project is due for completion in 2012.

As it will be the first new hospital to be built in Birmingham for 70 years, there is an unprecedented level of support for the project within the City. The new secondary and tertiary care hospital, which has the capacity for over 1,200 beds, will be built on the Queen Elizabeth Hospital site in Edgbaston.

3.3 Other background

Future UHB developments as well as research and development are explained in Section 4.1.1 Operational Summary. Details of accounting policies, external auditors, fixed assets, are outlined in Section 4.4.

Policies surrounding the disabled employee, diversity, training and career development, as well as staff consultation, are outlined in Section 8.

4. Operating and Financial Review

4.1 Operational Reporting

4.1.1 Operational summary

UHB produced another strong operational performance during 2005/6 marginally increasing its activity and meeting some new key targets such as the full year 98% A&E target and the cancer targets. UHB has also made good progress in establishing the infrastructure required to meet the challenges of the future. For example:

- Introduction of a Connecting for Health compatible Patient Administration System [Lorenzo] which will allow UHB to develop the potential of the national patient records spine and establish Electronic Patient Records in future years. The introduction of Lorenzo complements the other technological advances undertaken by UHB such as the Pharmacy Information & Communication System (PICS) and Laboratory automation.

- Established systems for ensuring all patients are either fully or partially booked and published its Directory of Services. Both of these initiatives are crucial elements in UHB's response to the national "Choice" programme, where the patient is offered a choice of five hospitals including a private provider.

- Increased MRI and CT scanning capacity to reduce waiting times in line with the commitment to the 18-week referral-to-treatment time target in 2008.

- The Renal strategy has been developed to begin to manage workflows and ensure UHB is integrated into a whole systems approach to improving patient care for all organisations involved with this patient group and acts as a template for development in other specialties.

- Established systems, increased capacity and worked with the Cancer Network to achieve the cancer targets and respond to strategic longer term challenges posed by the "Improving Outcomes Guidance", which aims to improve cancer services.

- Introduced Pay Modernisation for the vast majority of staff via the Consultant Contract and Agenda for Change. The introduction of the Pay Modernisation reforms are beginning to bed down and UHB is developing its strategy to maximise the benefits from the greater flexibility offered by the initiatives.

- UHB has established its Transformation Programme to map service changes for the future on a comprehensive basis, not only to plan for the new PFI build, but also to improve services before, during, and after the physical move.

Further detail on these initiatives is included below.

Whilst UHB has maintained its operational performance in 2005/6 it has not been complacent in establishing the infrastructure for meeting the demands of the future. The further development of these initiatives during the coming year is imperative if operational performance is to be maintained.

4.1.2 Information on key operational performance

a. More patients have been treated and both the numbers waiting and the time taken to receive treatment, have reduced during 2005/6.

Table 1 activity 2004/5 – 2005/6

	2004/5	2005/6	% Increase
Inpatient Finished Consultant Episodes	68,031	68,114	0.1
Day-cases (excluding renal dialysis regular day attenders)	26,808*	28,128	5.0
Outpatient attendances	313,015	316,733**	1.2
A&E Attendances	79,475	80,010	0.7
Total treatments	487,329	492,985	1.1

*2004/5 adjusted to remove contractual change in Day Case activity apportionment to allow year-on-year comparison

** 2005/6 outpatient data includes non-consultant activity which had not been reported in the 2004/5 KH07 report.

Whilst year-on-year activity comparisons must be treated with some caution due to changes in contracting and reporting currency, UHB's clinical activity has remained relatively strong during the last 12 months. Overall clinical activity has increased slightly since 2004/5 with the significant increases appearing in day case and outpatient activity.

The year-on-year increase in emergency activity levelled out during 2005/6 with a very small increase overall [0.7%], inpatient elective activity also remained constant with the largest increase occurring in day case activity which is in line with UHB's Transformation strategy to move more activity to day case.

Outpatient activity, whilst appearing to have increased, does include non-consultant activity which was not included in 2004/5. If non-consultant activity is excluded then UHB undertook approximately 3,000 fewer outpatient appointments compared to the same period in 2004/5. The main reduction has been in review outpatients due to a switch to therapy-led clinics in Trauma and a reduction in follow-up activity across UHB. New outpatients have increased by 2% on the same period in 2005/6.

Final data submissions on indicators relating to the Summer 2006 ratings

1. Existing targets

Indicator	Target	Whole trust		Comments & Data period
A&E 4 hr waits	* Pass 98%+, sig fail <95%	98.7%		Data from April-March.
Cancer - 2 wk wait	* Pass 98%+, sig fail <95%	100%		Data from Q4
Rapid Access Chest Pain Clinic - 2 week waits	* Band 5: 99%+, 4: 90%, 3: 80%	99.6%		Data for Apr-Mar. Data is subject to confirmation
Revascularisation - 3 month waits	* Band 5: <0.1%, 3: <0.2%	0%		Data as at March.
Cancelled Ops not admitted within 28 days	Band 5 < 0.5%	0.2% / 0		Data for April-March. Shown as %age cancelled / no. not readmitted in 28 days.
Bookings (inpatient, outpatient, daycase)	Q123 67% IP & OP, 100% DC, Q4 all 100%	100%		All scores were 100%. Data for Q4 only. Targets for the first three quarters have been met.
Cancer - 1mth from DTT to treatment	target for Quarter 4 is 98%	100.0%		Target came into effect at the start of January 2006. This is data from Q4
Cancer 2 mths from urgent referral to treatment	target for Quarter 4 is 95%	96.7%		Target came into effect at the start of January 06. This is data from Q4. This takes into account of shared breaches and accountability with other Trusts.
O/P Waits (Dec 05 3 mth target)	0	0		Data as at March.
I/P Waits (Dec 05 6 mth)	0	0		Data as at March.
Thrombolysis call to needle	68%	54%		Provisional data April - March
Delayed transfers of care	*Band 3 - 3.5%, 4: 2%, 5: 0.5%	3.4%		Data for April-March.
Provider info re patient choice	Provision of information to nhs.uk	Done		Self Assessment.

* note that these bandings are estimates based on those for the summer 2005 Performance Ratings

2. New National targets

Indicator	National target	Whole trust		Comments & Data period
MRSA	60% reduction between 2003/4 and 2007/8.Trust plans to include a 20% yr on yr reduction from 2005/6	104 (-15%)		Data shows no. of cases between Apr-March, with change from 0304. Trusts will be assessed against numbers in trust plans.
MRI - % waiting 26 wks+	*(To ensure that by 2008 nobody waits more than 18 weeks from GP referral to hospital treatment)*	0.0%		Data as at March
CT - % waiting 26 wks+		0.0%		Data as at March
Data quality on ethnic group for HES data	*Band 4 - 80-90%, Band 5 - 90%+	91.3%		Data from Apr-Dec
Access to genito-urinary medicine (GUM) clinics	*(reduce under-18 conception rate by 50% by 2010 (from 1998))*	n/a		Not relevant for UHBFT.
Drug misusers: information, screening and referral	*(inc. participation of problem drug users in drug treatment programmes by 100% by 2008 (1998 baseline))*	2 yes, 2 no, 1 n/a		Indicator based on series of 5 yes/no questions.
Emergency bed days	reduce emergency bed days by 5% by 2008 (from 2003/4 baseline)	-4.3%		Definition unclear if includes cases transferred to UHBT. Results shown here exclude transfers in. If they were included the overall trust result would have been an increase of 0.2%. These figures show change 0304 to 0405.
Experience of patients				Selected questions from National Patient Survey
Infant health: data completeness	*(reduce health inequalities by 10% by 2010 from 97-99 baseline)*	n/a		Paediatrics not relevant for UHBFT.
Obesity: identification and management in secondary care	Trust assessed on processes in place for the identification and management of obesity in adult inpatients	No		Does the trust identify and onwardly refer adult inpatients (if clinically approp.) with BMI>30 or BMI>27+comorbidities for weight advice and management services.? Yes/no
Participation in audits	*(reduce mortality rates by 2010 from heart disease, stroke and related diseases 40%+ for aged<75, + 40% reduction in inequalities gap overall)*	2		Trust achieved >90% 11 key fields MINAP for definite MI patients, and took part in 2005 MINAP data validation exercise. (1 pt for each)
Compliance with NICE guidelines for self harm in emergency departments	*(reduce mortality by 2010 from suicide and undetermined injury by at least 20%)*	4 yes, 1 n/a		Series of 5 yes/no questions as at 31 March 2006.*
Smoke-free NHS, recording of smoking status and reducing smoking	*(reduce adult smoking rates to <=21% by 2010 +reduction in routine and manual groups to <=26%.)*	2 yes, 1 No		Series of yes/no questions as at 31 March 2006.

Key for traffic lights:

Strong performance, markedly better than target or national rate

Performance at or above target or national rate

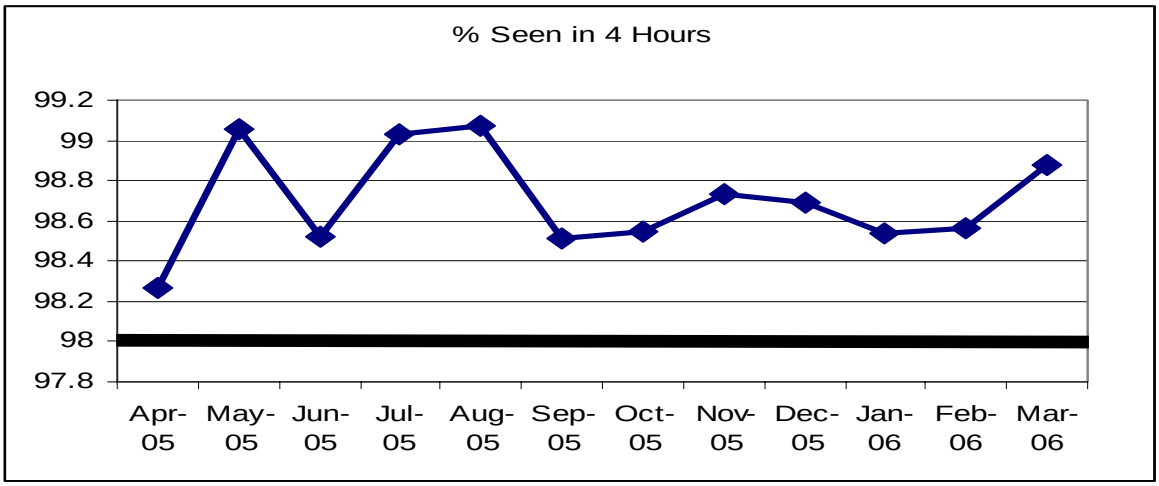
Performance slightly below target or national rate

Weak performance markedly below target or national rate

Health Informatics, 24/05/2006

c. Emergency activity

UHB has maintained its performance on A&E waiting times with 98% of patients being seen, treated or discharged within the four-hour target.



d. Cancer Targets

UHB has maintained its performance on the 14-day cancer waiting time target with a 100% of GP urgently-referred patients seen within two weeks. As noted in the 2004/5 Annual Report the 31-day and 62-day treatment targets have been extremely challenging for UHB. A large amount of effort has been focussed on ensuring no patients wait more than 31 days from decision to treat to actual treatment. A new role of Patient Tracker was developed and introduced to monitor and speed up the process, and both electronic and manual data monitoring systems established. UHB has successfully met the target of 98% of patients waiting less than 31 days from decision to treat to treatment in the final quarter of 2005/6 [UHB actual performance 100%]. UHB also met the target of 95% of cancer patients being treated within 62 days of urgent GP referral. UHB's actual performance was 96% against this target.

e. Infection Control

UHB continued to concentrate on improving its performance on healthcare acquired infections and in particular MRSA. UHB has a particularly vulnerable population due to the types of patients and the treatments it offers and has higher than average rates of these infections. The unusual case mix for UHB which includes a large proportion of high risk patients and small proportion of low risk patients (the lack of Paediatrics and Obstetrics/Gynaecology particularly) produces a lower performance when compared with other teaching hospitals.

An electronic surveillance system was introduced during 2005/6 added to a communications campaign and targeted activity on areas of high incidence to ensure UHB maintained its long term progress in reducing MRSA infections.

UHB performance for 2005/6 has shown a considerable improvement on 2004/5 with a 32% reduction on the same period last year and the lowest level of MRSA infection for the last five years:

Financial year	Total no of bacteraemia	Rate of bacteraemia per 1,000 bed days [as per DH calculation]
2001/02	189	0.55
2002/03	169	0.49
2003/04	123	0.35
2004/05	154	0.43
2005/06	104	0.29

UHB continues to focus on further initiatives to reduce the levels of MRSA and further analysis is being undertaken to review the marked increase in MRSA rates during January and February.

f. Research and Development highlights

R&D remains a key activity of UHB and enhances its reputation with the public. Our close relationship with our academic partners (especially the University of Birmingham) remains a key element in our success.

This year has been a busy one for research. Compared with 2004/5, the number of registered projects has increased from 185 to 196. Despite concerns about the possible impact of EU legislation, the number of commercially-sponsored studies has also increased from 54 to 57.

The output from UHB employees continues to cover a wide spectrum of research and a few examples are selected to highlight the importance and breadth of research supported by UHB:

- New mathematical modelling used to improve radiation dose for the treatment of cancer
- A new method (ELISA) of determining the diagnosis of bacterial infections after surgery has been shown to offer easier diagnosis
- A study at UHB showed that exercise training helps patients with chronic lung disease
- A study at UHB showed the high risk to the patient who obtains a kidney from a paid donor outside the UK (this practice is illegal in the UK)
- A direct approach to the local community improves rates of organ donation
- Improved and different methods of assessing patients with rectal cancer improves outcome
- A simple and rapid method for meshing split-skin grafts is effective
- A method of surgical repair of ruptures of the hamstring tendon is effective (from the RCDM)

g. Head and Neck Oncology

UHB has established a head and neck oncology centre as defined in 'Improving Outcomes in Head & Neck Cancers' guidance published in November 2004.

In developing this proposal UHB has worked closely in partnership with clinicians and management from Sandwell and West Birmingham Hospitals NHS Trust (SWBH) in determining an appropriate service model for the future. Central to this will be the establishment of one central multi-disciplinary team (MDT) for the Pan Birmingham Network and, within a reasonable timeframe, the delivery of all major head and neck cancer surgery on the Queen Elizabeth Hospital site.

h. Renal Services

As mentioned in the 2004/5 Annual Report UHB has developed an integrated strategic vision for managing the forecasted growth in the renal population over the next 10 years. UHB has agreed in principle a partnership development involving SWBHT and Heart of Birmingham Primary Care Trust. The focus of the development is to provide greater support to GPs and ensure patients are treated nearer to their own homes in order to manage the demand for secondary renal care facilities. It is hoped to establish this innovative new service in the first six months of the coming financial year.

i. Imaging

Additional CT and MRI scanners were opened on the Selly Oak site in the first quarter of 2005/6. The additional scanners have improved response times within the A&E Department and allowed for the streaming of inpatient and outpatient activity which has also reduced waiting times. The additional capacity has also supported the reduction in diagnostic times for cancer patients enabling UHB to improve on its performance against National Cancer Targets. UHB also achieved the national target with regard to no patients waiting more than 26 weeks for an MRI or CT scan by the end of March 2006. UHB achieved this target by reviewing its processes and utilising additional capacity to remove a group of long waiting time patients from the waiting list.

j. Choose and Book

UHB successfully met the 100% target for all outpatients, inpatients and day cases being either partially or fully booked by December 2005. The success in establishing the Booking Centre, has led to the development of a further strategy to centralise all booking functions, maximise the use of electronic transcribing and re-orientate the role of medical secretaries.

4.1.3 UHB's Aims and Objectives

UHB's Annual Plan for 2005/6 sets out an ambitious programme of corporate objectives under each of the themes of our Corporate Strategy 2003-2010. A full list of objectives and progress achieved against each is available on our website www.uhb.nhs.uk for reference.

Each Director was reviewed on their progress against achieving objectives at key points in the year and progress was reported quarterly to the Board of Directors. Progress against each objective was colour-coded as follows:

	No progress made/not able to achieve. Expected that task will not be completed to timetable.
	Some progress made. Task may not be completed to timetable.
	Substantial progress made/achieved. Task has been/will be completed to timetable.

At the end of 2005/6, of the 140 objectives in the Annual Plan, 113 (80%) were achieved, 25 (18%) are work in progress and two (2%) were not achieved.

The areas of significant underachievement were as follows:

- Members Opinion Survey: postponed to early 2006/7 due to financial constraints.
- Key targets: meeting the 60 minute call-to-needle thrombolysis target.

These will be addressed in UHB's objectives in 2006/7.

4.1.4 UHB and the services we provide

As outlined in the Background, UHB runs two hospitals, the Queen Elizabeth and Selly Oak.

It is the leading teaching hospital in the West Midlands with strong links to the University of Birmingham and for the last four consecutive years has achieved the Healthcare Commission's maximum 'three stars' rating for performance.

UHB works in collaboration with its academic partners to promote multi-disciplinary research and there is a strong emphasis on clinical and translational research particularly the areas of cancer, cardiovascular (heart and lungs) science, inflammation, infection and transplantation. UHB is also the major provider of NHS Research and Development in the West Midlands.

As a specialist teaching Trust, UHB provides the full range of hospital services:

- District hospital services catering for the vast majority of everyday acute health needs among the adult population of South and Central Birmingham
- Regional services such as renal, cancer, neurosciences, burns and cardiac services for the population of the West Midlands
- Supra-regional services, including liver and heart transplant programmes, for patients throughout the UK

UHB has four Clinical Divisions (and one Facilities Division) each led by a Divisional Director who is a clinician, supported by a Divisional Director of Operations accountable to the Chief Operating Officer.

The distribution of services between the two sites is as follows:

Queen Elizabeth Site	Selly Oak Site
General and Breast Surgery	Accident & Emergency
Neurosciences	Medical Assessment Unit (MAU)
Cardiac Services	General Medicine and Elderly Care
Renal/Urology Services	Trauma
Liver	Vascular surgery
ENT & Maxillofacial Services	Burns and Plastics
Endocrinology	Stroke Services
GI Medicine and Surgery	Hearing Assessment & Rehabilitation Centre
Oncology	Rheumatology
QED (Quick and Early Diagnosis Unit)	Diabetes
Haematology	Critical Care
Respiratory Centre	Day Surgery Unit
Critical Care	Dermatology
	Ophthalmology

The RCDM provides dedicated training for defence personnel and is a focus for medical research. Whilst the RCDM is based at Selly Oak Hospital, defence personnel are fully integrated throughout both sites and treat both military and civilian patients. UHB also holds the contract for providing medical services to military personnel evacuated from overseas via the Aero medical service.

The Wellcome Trust Clinical Research Facility (CRF) is also hosted by the Trust at the Queen Elizabeth Hospital and is Britain's largest biomedical charity. This development is a joint initiative between University Hospital Birmingham and University of Birmingham Medical School.

4.1.5 Building the future of UHB

a. Transformation Programme

The main focus for service modernisation and configuration revolves around the Transformation Programme, which is a highly-structured programme based on a Programme Board supported by seven work streams.

The Transformation Programme seeks to identify new ways of working by 2010 to ensure UHB maximises the benefits accruing from the proposed new hospital build and ensures it is fit-for-purpose to meet all of its corporate objectives during this period. The programme is a UHB-wide and ambitious programme which seeks to co-ordinate a number of modernisation programmes within one over-arching structure. The Programme is led by the Director of Organisational Development who holds executive responsibility for the delivery of the programme. UHB has adopted a matrix approach to ensure all of the workstreams inter-link and move forward in a co-ordinated and systematic way. The work streams over seen by the Programme Board are detailed below:

- Clinical Redesign
- Clinical Information and Automation

- Workforce Development
- New Hospital Physical Move
- Patient and Public Involvement
- Sift Facilities Management Services [Hotel Services]

Each of the work streams are cross-cut by the Communications and Capacity and Service Planning work streams and underpinned by the New Hospital Clinical Planning Reference Group.

b. Workforce Planning

UHB has been doing a lot of work to remodel the workforce plan. The changes effecting the medical staff and the need to redesign our workforce is one of our biggest challenges.

A key objective is to focus on productivity and managing pay progression with greater accountability.

It has been agreed that we will focus on staff groups working differently, developing new roles and concentrating on workforce productivity. Our approach is now going to move away from planning around professional groups to planning around models of care.

c. Improving Working Lives

UHB successfully achieved Improving Working Lives – Practice Plus standards. The Improving Working Lives Standard (IWL) is a blueprint by which NHS employers and staff can measure the management of human resources. Organisations are kite-marked against their ability to demonstrate a commitment to improving the working lives of their employees.

We are now looking at how we can continue to build on the work that has been done to date to be an employer of choice, including healthy lifestyles for staff.

d. Human Resources and Payroll Joint Venture

UHB has made good progress in the last 12 months towards establishing a formal business partnership with a private sector partner for the provision of HR and Payroll services. The aim of this partnership is to generate a new revenue stream for UHB, to improve the quality of responsiveness of the HR function through more streamlined and efficient administrative processes, and to develop the potential of an outsourced HR and Payroll brand which could be used in the wider NHS. Tenders are being evaluated and once a decision is made, the proposed agreement will be submitted to Monitor for scrutiny. We would anticipate that this commercial joint venture will be formally established during 2006/7.

e. Pay Modernisation

In common with all the trusts, UHB began to implement Agenda for Change. The Board took the decision not to comply with the national implementation date of September 2005 in order to ensure that the job evaluation process was conducted

thoroughly and that the Trust could manage the financial implications more appropriately, including consistency checking. The plan is to complete this work by the end of the Summer. UHB is implementing the Knowledge and Skills Framework as a baseline for developing skills and also to manage the pay progression system.

f. Clinical Information and Automation

In line with the Connecting for Health initiative, UHB successfully replaced its Patient Administration System (PAS) on January 30, 2006. The project involved the training of over 1,700 staff to use the new system. The replacement of the old PAS, which was over 25 years old, allows UHB more flexibility and functionality in developing its Clinical Information strategy. The initial benefits for UHB include linking to the national patient records spine and provides the functionality to link to the national Choose and Book system, the new service for GP referral combining electronic booking and a choice of time, date and place.

UHB has completed the second stage of rolling out its Pharmacy Information and Communication System (PICS). Over 75% of all acute beds are now covered by the electronic prescribing system which has resulted in enhanced clinical care, reduced drug errors and more effective prescribing management. The final stage of the PICS roll out will be undertaken during 2006/7.

UHB has also approved an initial investment into the automation of the laboratories to further streamline lab processes, reduce waiting times and increase efficiency. The first stage of the laboratory automation strategy will be undertaken in 2006/7. The Trust is also developing a Picture Archiving System (PACS) for electronically managing images such as plain film, MRI and CT. A Business Case will be developed in 2006/7.

g. MidTECH

The NHS Intellectual Property Hub for the West Midlands (MidTECH) is hosted by UHB. MidTECH has recently been awarded further funding of £750k from the DTI following the third round of bids against the Public Sector Research Exploitation (PSRE) Fund.

This funding, over the next three years, will allow MidTECH to continue to develop its capacity and capability to identify and commercialise intellectual property and innovations on behalf of member NHS organisations.

MidTECH has recently completed a move to dedicated premises near to the hospitals, which are co-located with the region's Medilink organisation to expedite working with industry.

h. Pan Birmingham Decontamination Project

This project has involved eight of the Trusts in the city working together to find an optimal, state-of-the-art solution to improve both the quality and facilities for decontamination across the city. An initial option appraisal carried out by the project team indicated a preferred solution that reduced the existing seven processing units down to no more than two or three sites.

Following extensive evaluation and negotiation a preferred bidder was selected. The project is expecting to reach Financial Close around June/July 2006 and commence service delivery in the summer of 2007.

4.1.6 Trends and factors underlying current and future performance

During 2005/6 UHB has had to react to a number of internal and external factors, which have emerged during the year, although their main impact is likely to be felt in the forthcoming years. The three main trends are detailed below:-

- **Patient Choice**

UHB established the main infrastructure to support the expansion of the Choose and Book Programme during 2005/6 with the further development of the Booking Centre, the implementation of a new Choose and Book compatible PAS in January 2006 and the introduction of Indirectly Bookable Services, which allows patients to negotiate in- and outpatient appointments with GPs to suit their convenience, in the final quarter of 2005/6. Whilst only 7% of patients are currently using the Indirectly Bookable Service it is likely that this number will grow rapidly during 2006/7 particularly as the link to the main Choose and Book system is due to be in place by the second quarter of the financial year thereby allowing direct booking via an electronic link. The extension of Choice of five providers to all Foundation Trusts in May 2006 will also increase the impact of 'Choice' for UHB. UHB is working with its main local Commissioners and tertiary referrers to ensure it maintains and grows its patient population.

- **Pay Modernisation**

UHB has reached agreement with the vast majority of the Consultant body who wished to take up the option of transferring to the new contract. Negotiations with the Local Negotiating Committee with regard to agreeing consultant objectives for 2006/7 are at an advanced stage with agreement likely in the first quarter of the financial year. Great strides have also been made in implementing Agenda for Change for all other staff and full implementation is due for the end of the first quarter in 2006/7. In order to maximise the benefits offered by Agenda for Change, UHB is currently agreeing core objectives for all staff and is developing new roles such as the Hospital at Night support workers to maximise the flexibility of the new pay spine with a role which undertakes both clinical and clerical duties out of hours.

The introduction of the radical Department of Health initiative Modernising Medical Careers and the expanded European Working Time Regulations in 2009 will result in fewer junior medical staff being available to undertake service duties 24 hours a day, seven days a week. In order to minimise the impact on service provision during the transition to the revised medical career structure UHB is actively reviewing its medical workforce plan. In order to meet the challenge of fewer medical staff in training out-of-hours, UHB has developed and approved a three-year Hospital at Night Programme which seeks to maximise the use of non-medical staff in the provision of care and target medical resources more efficiently.

- **18-Week Treatment Targets**

The experience during 2005/6 of meeting the challenging cancer targets has provided UHB with an insight into the challenge offered by the reduced waiting time targets due in 2008. Not only does the target offer a clinical challenge to UHB to remove a group of outpatient, diagnostic and inpatient activity to achieve the target, but also a logistical challenge to put in place tracking systems to identify patients at risk of breaching the target. The experience of inherited waiting times which are a big issue in tertiary treatment centres, requires careful consideration both by UHB and its commissioners if the target is to be achieved and maintained. UHB is working closely with its main Commissioners to achieve reductions in diagnostic waits, agreeing protocols for referral rates and jointly developing admission avoidance/bed day reduction initiatives to support the achievement of the target.

4.1.7 Key constraints

- **Facilities**

Many of UHB's services are provided from outdated estate, split across two sites a mile apart. UHB has undertaken a number of steps to address sub-optimal clinical configuration over the last three years. This includes the centralisation of general and emergency medicine at the Selly Oak Hospital site and the transfer of most surgical services to the Queen Elizabeth Hospital site. Optimal configuration will not, however, be achieved until the opening of the Birmingham New Hospital.

UHB has invested significantly in maintaining environmental standards in old parts of the estate through a rolling programme of refurbishment of wards, toilets and other patient and public areas. To maintain service provision we persist with mixed sex ward accommodation and a sub-optimal number of single bedrooms. These issues prevent us from achieving the levels of patient satisfaction we would like for inpatients on a number of privacy and dignity indicators. Whilst we make every effort to maximise patient dignity and comfort, we will not be in a position to fully address these issues until we transfer into the New Hospital.

- **Infection Control**

As mentioned above the age of the Estate does not lend itself to modern infection control procedures and the relatively low access to side rooms also impinges upon UHB's response to Infection Control issues. UHB has made significant progress during 2005/6 in reducing the incidence of MRSA via the re-enforcement of good practice, increased access to infection control products, process changes and improved surveillance. The quality of the facilities and number of side rooms pose a key challenge to UHB's ongoing improvement initiative in this area. The opening of the new hospital will remove many of these constraints.

4.1.8 Development of organisation-wide quality improvements

- **Point-of-Care Pregnancy Testing**

This has been a UHB-wide review of where pregnancy testing is done by staff other than in the labs. It involved labs, pharmacy, stores, nursing, radiology imaging, and equipment trainer and was facilitated by CGSU. We have introduced new standardised kit for testing, controlled the ordering and costs, and have ensured only appropriate staff are trained in a bid to increase competence levels and reduce risk of incorrect testing. The project was initiated as a result of serious incidents relating to incorrect reading of tests done by non-lab staff.

- **MRSA Database**

The database was developed by the Health Informatics Team to support the IC Strategy/Policy by helping local staff manage patients that have tested positive for MRSA in the previous two years. It allows such patients to be tracked and flagged up at admission which results in greater efficiencies including better use of side rooms and planning for operation lists.

- **Portable Oxygen Supply**

A review of the portable oxygen supply was carried out following clinical risk incidents raised by anaesthetists. The review allowed UHB to assess actual need, rationalise supply to appropriate areas and ensure appropriate training for porters and also resulted in a cost saving.

4.1.9 Environment

The concept of UHB as a community asset is encapsulated as an aim of UHB's Corporate Strategy. The fundamental principle that health and regeneration are strongly interwoven is well established. In 2005/6 we have introduced initiatives that support this philosophy, including:

- A UHB Improving Health strategy
- Development of an Environmental Policy
- Implementation of a Waste Strategy
- Energy Management strategies
- A Green Travel Plan
- Procurement of Fair Trade products
- Creation of a Learning Hub
- Employment creation eg Leukaemia Centre
- Volunteering Strategy

4.2 Patient Care

4.2.1 Healthcare Commission

The Healthcare Commission has introduced a new approach to reviewing the performance of healthcare organisations. This 'Annual Health Check' looks at a broader range of performance than the previous star rating system. It includes:

- Existing targets
- Core standards
- Value for Money
- Use of Resources
- New national targets

In 2005/6 we established a comprehensive monitoring system to measure compliance against this new framework. The first ratings will be announced in the Summer/Autumn of 2006 and we expect to achieve a 'good' or 'excellent' rating, subject to confirmation of the final details of how ratings will be made.

4.2.2 National Surveys

UHB participates annually in the national programme of patient surveys from the Healthcare Commission. During 2004/05, there were surveys of A&E and Outpatients. Divisional action plans were developed from the results which are monitored through the performance review mechanism. The survey for 2005/06 is of inpatients and the results are due to be published by the Healthcare Commission during the Spring.

4.2.3 Complaints Handling

UHB's complaints policy is in line with the 2004 NHS Complaints regulations. During 2005/06, 99% of complainants received an acknowledgement letter within two working days and 83% received a full response from the Chief Executive within 20 working days. If a complainant is dissatisfied, a meeting will be offered and a tape recording is made of this meeting and given to the complainant. Complainants are advised of sources of support in making a complaint via The Independent Complaints Advocacy Service (ICAS) which supports patients and their carers wishing to pursue a complaint about their NHS treatment or care, and are also advised of the Patient Liaison Service **(**PALS). If a complainant remains dissatisfied with the local resolution stage of the complaints process, a leaflet is given or sent to them on the second stage (independent stage) of the complaints process managed by the Healthcare Commission.

During the year 496 complaints were received. As the 2005/6 year closed, 39 complaints had been referred to the Healthcare Commission and four cases had been referred to the Parliamentary and Health Service Ombudsman.

4.2.4 Patient Liaison Service (PALS)

PALS has continued to grow and received approximately 1,550 contacts from patients and visitors this year. Contacts have increased by 10-15% since last year. Approximately 30% of contacts to PALS were general enquiries for information about the service. The remainder of contacts revealed issues with the following top five themes:

- Communication
- Clinical treatment
- Outpatient Appointments delay/cancellation
- Attitude of staff
- Inpatient Appointments delay/cancellation

As a result, a number of improvements have been introduced including improved written communication for patients waiting for procedures such as angiograms and the development of a working party looking at a UHB-wide protocol for diabetes management. In addition a new database has been introduced to collect PALS data. Future reports will ensure meaningful data that clearly reflects patient's experiences and views of the service.

4.2.5 Patient & Carer Councils

Patients, Governors and Foundation members are all represented on UHB's four Divisional Patient & Carer Councils. The councils focus on service improvements and feedback received from patients and carers. They are chaired by a patient or carer and in the spirit of partnership, the vice chair is the Associate Director of Nursing for the relevant division.

Councils also have sub-groups to concentrate on key issues raised through feedback from patients and carers and these include nutrition and catering, infection control and the environment, and patient information. Plans are in place to extend these groups across UHB so that councils can work together to make improvements within common themes.

Over the next 12 months, UHB plans to increase the number of black and minority ethnic (BME) representatives on the council by placing advertorials in specific BME publications and working with Public Governors to encourage participation from people within their communities.

4.2.6 Patient & Carer Information

UHB's policy for written information is followed for patient information. A small steering group chaired by the Head of Patient & Public Affairs reviews patient information against the criteria set out in the policy. An essential step is for clinical governance review of all patient information with regard to the treatment of a clinical condition. An electronic system for staff producing patient information has been in place since July 2005 and from April 1, 2006, all patient information will have to be submitted electronically.

Internally, controls are in place to ensure that funding is available for the production of the information, that duplication of patient information is avoided and that staff are guided to sources such as the National Institute of Clinical Excellence website. Guidance for staff on a checklist for good practice in producing patient information is available on the intranet and it is based on the Department of Health toolkit for patient information.

4.2.7 Patient Information Committee

We will be establishing a monthly information committee which will be chaired by the Public Relations Manager and attended by the Director of Patient and Public Affairs, representatives from UHB's Board of Governors, Patient & Carer Councils and Foundation Membership. This forum will enable patients, governors and members to feedback comments and suggestions that relate to patient and public information materials for example, site signage, leaflets, posters and internet content. This forum will enable us to address inconsistencies and ensure that signage and leaflets are produced in a clear and uniform way.

4.2.8 UHB Patient and Public Involvement Forum (PPIF)

PPIF members visited various areas of the Trust to gain a better understanding of how the Trust works and what services it provides.

PPI Forum were invited into the Clinical Governance Unit to see the process used for the draft declaration for the Healthcare Commission Annual Health Check, and as a result were supported to provide their comments accordingly.

4.2.9 Volunteers

Volunteers make a unique and valuable contribution to patients, visitors and staff at UHB. Volunteering is an important expression of citizenship. Volunteers commit time and energy for the benefit of society and the community they choose to serve. Many of our current volunteers are patients, ex-patients, carers, relatives or friends of patients, ex-employees or local residents.

To support and further develop volunteering at UHB a strategy and policy for volunteers has been developed. The emphasis of the strategy is to support the corporate aim of becoming a community asset by supporting citizenship. The policy provides a framework for the recruitment, placement, induction, training and ongoing support for volunteers.

Joint funding was agreed between UHB and UHB Charities for a Voluntary Services Coordinator to oversee the development of voluntary services across the Queen Elizabeth and Selly Oak hospitals.

A recognition and award scheme for volunteers was introduced at the Volunteers Luncheon in December 2005. Each of UHB's volunteers was awarded a certificate for each year they have actively volunteered for UHB. For each five years a volunteer has been active, a badge to recognise this achievement was also awarded. Eighty four volunteers attended the luncheon and between them they had contributed 824 years as a volunteer.

The Volunteer Council, chaired by Public Governor Derek Hickson, is now well established and working effectively to provide peer support for volunteers.

4.3 Stakeholders

UHB works with many partners to provide the best possible services to patients and to fulfil our long term objectives. Amongst our most important stakeholder organisations are:

- Other NHS organisations eg South Birmingham and other primary care trusts, local hospitals, BBC Strategic Health Authority and clinical networks
- Consort, our New Hospital partners
- Royal Centre for Defence Medicine
- University of Birmingham
- University of Central England
- Birmingham City Council
- Government agencies, particularly Advantage West Midlands
- Commercial partners including Alliance Medical
- A number of voluntary organisations

UHB sees partnership-working as vital to achieving its objectives for healthcare and being a community asset. UHB is active in partnerships at local, city-wide and regional levels.

Working with Birmingham City Council, Government Office for the West Midlands, regional development agency Advantage West Midlands and Sainsbury's, UHB is influencing over £1bn of investment in the Selly Oak area.

UHB plays a full role in the Birmingham Health and Well-Being Partnership which reports directly to the City Strategic Partnership. UHB takes a particularly active role in training through the Birmingham Health and Skills Task Force which brings together the Learning and Skills Council, City Council, Acute and Primary Care Trusts, Strategic Health Authority, community and voluntary sectors to develop a strategic and integrated skill and training strategy for healthcare. The key ACTIVATE and Learning Hub projects are described elsewhere. UHB has active partnerships with its local schools.

Technology is key to improved healthcare and local prosperity. UHB is a member of the main Board of Central Technology Belt (CTB). CTB was set up after the first Rover crisis four years ago to diversify the economy of a corridor stretching from Birmingham to Malvern into knowledge-intensive industries. CTB has a focus on medical technology and actively supported UHB's proposal for a Leukaemia Centre.

UHB is a leading member of Advantage West Midlands' Medical Technology Cluster Group which brings together the public and private sectors to develop a strategy for medical technology.

UHB works directly with the Government Office for the West Midlands on regeneration issues; most recently to organise a regional conference on Health and Regeneration as part of the UK's Presidency of the European Union.

Of particular note are the following ventures delivered with our key partners in 2005/06:

4.3.1 West Midlands Leukaemia Centre

With Advantage West Midlands' financial support of some £2.25m (one of the first times AWM has funded an NHS Trust) in March 2006 we opened a new, state-of-the-art clinical and research centre for Leukaemia. Based on proven clinical excellence, this centre will be of national and international significance, creating over 100 jobs and testing some 25 new drug treatments over the next five years.

The Leukaemia Centre is an example of translational research.

4.3.2 PET Scanner

In July 2005 the first PET Scanning Centre outside the South East Region opened at the Queen Elizabeth Hospital, the result of a four-year collaboration between UHB and Alliance Medical. The centre will scan approximately 4,000 patients each year. This scanner allows metabolically-active tumours to be seen on the PET scan to provide more accurate imaging for many cancers than from the standard practice of using CT alone.

4.3.3 ACTIVATE and The Learning Hub

UHB will face far more competition for workers over the next five years and beyond. This is particularly so for those aged 25 to 44. The white labour supply will fall substantially across Birmingham while that from BME communities will rise by more than 100,000 by 2015. Broadening access to our jobs and training is essential for business as well as regeneration reasons.

ACTIVATE provides direct training through three weeks induction and then three weeks placement. The project, which won the 2004 Health Service Journal award for recruitment and retention, is aimed at training unemployed people into healthcare jobs. Working with partner trusts ACTIVATE has so far trained over 600 people with positive outcomes with 65% gaining a job or moving into further education. Four out of every ten beneficiaries are from BME groups. UHB is financed 100% by European Social Fund until March 2007 and UHB is now being paid by the Learning and Skills Council to pilot the ACTIVATE model in other parts of the public sector.

The Learning Hub still targets unemployed people but complements ACTIVATE by "brokering" people into jobs. It works by focusing on community and employer engagement so that target groups are far more aware of the jobs available; producing individual training action plans for clients and referring clients to the most appropriate further training (which could include ACTIVATE); sifting applications for employers so reducing their costs; and working with clients to improve the quality of final application forms. Working with Fair Cities this often includes pre-employment training which again improves the quality of those applying for jobs. The Hub which is called "Building Health" covers both healthcare and construction jobs arising from the New Hospital and is aimed at the whole of the health and social care sector.

The Hub Team is a best-practice example of cross-sector partnership working and is made up of secondees from key stakeholders including Job Centre Plus, the Learning and Skills Council, Birmingham City Council, further education colleges, the Construction Employment Alliance and Consort (the New Hospitals joint venture partner). UHB has been awarded a £700,000 European Social Fund grant by the Learning and Skills Council to support the Hub's revenue costs.

Staff are operating now from temporary accommodation but we aim for the £2.25m permanent, purpose-built, Learning Hub to be fully open on the Queen Elizabeth site by January 2007 and will also house ACTIVATE, other vocational training initiatives, basic skill training for existing staff and a focal point for UHB's relationships with local schools and communities. The aim is, by 2010, for the Hub to have provided employment support to over 4,000 people with at least 750 people gaining a job in healthcare or other sectors.

4.3.4 Voluntary Sector Partnerships

- **WRVS**

The Trust has worked in partnership with the WRVS for many years. A WRVS co-ordinator is in post supported by the WRVS. WRVS volunteers are in place in many areas at Selly Oak Hospital and provide a valuable service to patients and staff. A recent project to establish volunteers in the discharge lounge in the Raddlebarn Suite at Selly Oak Hospital has been very successful.

- **Home from Hospital**

This voluntary scheme supports patients who are newly discharged from hospital and who may not have family or friends immediately available to help out. Home from Hospital volunteers will do shopping for newly-discharged patients, help them with letters/forms and keep them company for periods during the day.

- **Birmingham Voluntary Services Council (BVSC)**

We have developed links with the BVSC to explore volunteering opportunities that we can offer to our local community.

4.3.5 Playing our part in Birmingham Life

UHB is a Board Member of the Fair Cities Partnership. This national pilot aims to improve the employment prospects of BME communities in Birmingham. Fair Cities works closely with ACTIVATE and The Learning Hub. UHB is also a founder member of the Diversity Partnership which has a similar aim of broadening access to health and social care jobs to BME communities.

4.4 Finance and Performance

With a turnover in 2005/6 of £379 million, UHB is a large Foundation Trust. In order to be licensed as a Foundation Trust, UHB had to demonstrate to the Department of Health and the Regulator that it had the necessary resources and capacity to succeed as a foundation hospital. The Trust has achieved a small surplus of £38,000 before exceptional items on March 31, 2006.

UHB has posted an audited overall net deficit. This is wholly due to a £3.6m charge for the write off of buildings that have already been demolished as part of the enabling works for the new hospital. This is a non-cash expense and as such is treated as an exceptional item in the Trust's accounts with no impact on operating performance.

The first full year as a Foundation Trust has been financially challenging due to the volatility of income under Payment by Results (PbR) and the significant cost pressures associated with pay modernisation.

As a Foundation Trust, UHB opted to fully implement PbR rather than adopting a minimum income guarantee. UHB has contracts with over 60 PCTs and receives further income for specialist services from specialist consortia and national funding bodies such as National Specialist Commissioning Advisory Group (NSCAG), which was established in 1996 to advise Ministers on the identification and funding of services where central intervention into local commissioning of patient services was necessary for reasons of clinical effectiveness, equity of access and/or economic viability.

During 2005/06 UHB delivered on its overall contracted activity.

4.4.1 Income & Expenditure

The table below compares the original planned income and expenditure with the outturn position for a full 12 months.

Financially, the past year has seen UHB face many challenges including the additional costs associated with pay modernisation. For example, the implementation of the consultant contract and costs associated with maintaining compliance with European Working Time Regulations for junior doctors created significant additional financial pressure during the year.

4.4.2 Summary income and expenditure – plan v. outturn

UHB Summarised Income and Expenditure (£M's)		
	Plan 2005/06	**Outturn Position 2005/06**
Income	371.3	378.6
Expenditure	(350.8)	(357.9)
EBITDA	20.5	20.7
Depreciation	13.1	12.8
Dividend	8.3	8.3
Interest	0.9	0.7
I&E before exceptional items	0	0
Exceptional items	(20.0)	(3.6)

Please note: in line with the business plan there has been no necessity to exercise the Prudential Borrowing Limit or to use its overdraft facility.

The provision of healthcare accounts for £305 million of total income.

UHB has a number of income streams which are not linked directly to patient care. The most significant of these is levy funding for education and research which accounts for £32m in 2005/06, equivalent to 8.4% of UHB's total income.

The education and research funding is comprised of four main elements. These include the Service Increment for Teaching (SIFT), recognising the cost of training medical undergraduates from the University of Birmingham and the Medical and Dental Education Levy (MADEL) which supports the salary costs of post graduate doctors in training. The values of SIFT and MADEL in 2005/06 are £14m and £12m respectively.

The third component of the education levy is Non-Medical Education and Training (NMET) accounting for £0.9m in 2005/06. Finally the Trust receives £5m to support Research and Development activities including a contribution to the costs of operating the Wellcome Trust Clinical Research Facility.

4.4.3 Accelerated Depreciation

The current balance sheet includes the value of all fixed assets including UHB's buildings. Depreciation on these assets is charged against the Trust's Income and Expenditure account each year based on the value and expected remaining life of the asset. The average remaining life of the Trust's buildings is approximately 30 years. Once financial close has been reached on the PFI, UHB will need to adjust the remaining life of those assets that will not be used once the new hospital is operational. This means that the full value of depreciation will be charged on an accelerated basis over five years rather than over 30 years.

NHS accounting rules mean that accelerated depreciation charges resulting from PFI projects are negated for NHS Trusts by an additional transaction made with the NHS bank. However, this facility does not extend to Foundation Trusts who are required to recognise the full impact of accelerated depreciation in their accounts.

For 2005/6 accelerated depreciation of £3.5m has been applied and is the reason why there is a deficit of this amount. This is an exceptional item. For the next five years this figure will increase to approximately £20m per annum.

As depreciation is not a cash expense the financial standing of UHB is not affected in terms of its underlying performance, risk rating from Monitor, or its operating surplus.

4.4.4 Capital Expenditure Plans

UHB's capital expenditure plans which run alongside the development of the new hospital come to a total of £57 million over the next three years. Currently it is anticipated that it will be necessary to borrow against the Prudential Borrowing Limit during these years, but not in 2006/07.

Of the £57 million capital programme, £9m is being spent on protected buildings which will be retained under the existing estate.

We are carrying all land at the District Valuer's valuation of 31 March 2005. The Selly Oak Hospital land is owned freehold and Queen Elizabeth Hospital is on a long-term lease from Birmingham City Council due to expire 29 September 2932.

In 2005/6 UHB invested £18.7m capital financial resources in new facilities and improving old environments. A summary of the major investments is provided below:

Category	**Capital Invested £m**
New Hospital Enabling Works inc:	
▪ New Sterile Fluids Manufacturing facility	3.759
▪ Trust HQ relocation/Seminar Suite/Genetics Centre (Morris House)	1.461
▪ Crèche relocation	0.048
▪ Other	0.616
Equipment Replacement	2.955
IT Strategy and Infrastructure	0.742
Backlog maintenance and statutory standards	0.746
Modernisation:	
▪ Additional CT/MRI	3.024
▪ West Midlands Leukaemia Centre	1.816
▪ Liver Outpatients Department extension	0.272
• New Linear Accelerator	1.602
• Other	1.616
Total	18.657

4.4.5 Payroll

UHB now pays 110,000 members of staff in the NHS operating from offices in Oxford, Stoke and Coventry. We piloted the implementation of the Electronic Staff Record. There were number of problems regarding system implementation although they have been reducing during the last few months.

4.4.6 Value for Money

Agreement of a balanced financial plan for 2005/06 required UHB to deliver cash releasing efficiency savings of 1.7%. In order to achieve this, a formal cost improvement programme (CIP) was agreed across all Divisions and Corporate areas. This programme involved a combination of both cost reduction and income generation schemes including non-pay savings arising from improved purchasing and rationalisation of product ranges, increased private patient activity and renegotiation of a number of external contracts. Significant savings were also achieved through improved theatre utilisation in Ophthalmology and Plastic Surgery and the transfer of ENT activity from Good Hope.

In addition to the agreed CIP, further efficiency savings were targeted through a Corporate Review, totalling £1.5m. This focused on UHB-wide initiatives including a review of all vacancies prior to advert and delivery of further non-pay savings through the establishment of a Product Evaluation Group.

During 2005/6 benchmarking has been carried out in a number of areas across UHB including theatre utilisation, clinical support services and commercially outsourced contracts which are reviewed against similar service provision in similar acute teaching trusts outside of London. Data shows that UHB can demonstrate national best value in terms of price, quality and the management of demand in the vast majority of the 46 commercial services contracts that are managed on behalf of UHB, including those overseen on behalf of other local NHS establishments.

Further evidence of value for money is provided through the publication of reference costs, which confirmed that in overall terms UHB's services were provided at the national average cost (i.e. an index of 100) based on the latest full year cost and activity data (2004/05).

4.4.7 Changes in accounting policies by UHB in the 2005/6

These have been made in three areas:

- As a result of becoming a Foundation Trust, UHB has chosen not to apply an annual indexation to its assets to arrive at carrying value but has chosen to revalue Land & Building using a professional valuation every five years and by valuing operational equipment at cost less depreciation.

- UHB has been advised by Monitor to amend its accounting treatment on Government Grants to bring treatment in line with UK GAAP and as a result a prior year adjustment has arisen. Notes 1.6 and 17 of the Accounts give more detail.

- Finally UHB has been requested in 2005/06 to value partially completed spells at 31 March 2006, and to treat them as accrued income in the Accounts. Notes 1.2 and 17 gives more details.

4.4.8 Private Patient Income (PPI)

PPI was £2.9m which is within the target limit of 1.25%.

4.4.10 External Auditors

UHB's external auditors are KPMG LLP. The audit cost for the year is £117,500 for the statutory audit services, £29,000 of which relates to non-recurring audit work. No additional non-audit work was commissioned, therefore the independence of the auditors was not compromised.

4.4.11 University Hospital Birmingham Charities

The charitable funds for UHB are administered by UHB Charities, a separate legal entity from the Trust. In 2005/06 the Trust received grants of £1.2m from UHB Charities.

4.5 Going Concern

After making enquiries, the directors have a reasonable expectation that UHB has adequate resources to continue in operational existence for the foreseeable future. For this reason UHB has continued to adopt the going concern basis in preparing these accounts.

5. Board of Governors

5.1 Structure of the Board of Governors

UHB's Board of Governors was established in July 2004, with 24 representatives each elected for an initial period of three years. UHB opted to have elected Governors representing patients, staff and the wider public, in order to capture the views of those who have direct experience of our services, those who work for us, and those that have no direct relationship with UHB, but have an interest in contributing their skills and experience to help shape our future. In addition, we have appointed 13 (stakeholder) Governors, who represent some of UHB's key stakeholders.

The Board of Governors consists of:

- 13 public Governors form the Parliamentary Constituencies in Birmingham
- 6 patient Governors, who are members of UHB's four Patient & Carer councils
- 5 staff Governors from the following staff groups:
    - Medical
    - Nursing (2)
    - Clinical Scientist/Allied Health Professional
    - Ancillary, Administrative and Other Staff
- 13 stakeholder Governors

The current composition of the Board of Governors is:

5.1.1. Patient

Rita Bayley
Rosanna Penn
Valerie Jones
Wynford Morgan
Nazir Ahmed
Alan Bailey

5.1.2 Public (by Constituency)

Northfield
Margaret Burdett
Roy Green

Selly Oak
David Spilsbury
Gwyneth Harbun

Hall Green
Brian Hanson
Derek Hickson

Edgbaston
Geoffrey Oates
Sir Richard Knowles

Ladywood
Anne Griffin

Sparkbrook & Small Heath
Abul Hassan

Perry Barr
Nominations sought for election

Yardley & Hodge Hill
Kadeer Arif

Erdington & Sutton Coldfield
Alan Corr

5.1.3 Staff Governors

Professor Robert Allen - left in year (election underway)
Paul Brettle
Carol Rawlings
Barbara Tassa
Anne Waller

5.1.4 Appointed/Stakeholder Governors

Rt Revd Dr John Sentamu (Birmingham Faith Leaders Group) - replaced by the Most Rev'd Vincent Nichols (Archbishop of Birmingham)
Professor David Cox (South Birmingham Primary Care Trust)
Mr Graham Urwin (South Birmingham Primary Care Trust)
Mr Norman Cave (South West Birmingham Partnership for Further Education)
Professor Michael Clarke (University of Birmingham)
Surgeon Vice Admiral IL Jenkins (Ministry of Defence)
Mrs Susan Battle (Birmingham Chamber of Commerce and Industry) - resigned March 2006 (replacement being sought)
Mr David Cragg (Birmingham and Solihull Learning and Skills Council)
Dr Peter Knight (University of Central England)
Cllr James Hutchings (Birmingham City Council)
Ms Gisela Stuart MP (UHB South Birmingham MPs Liaison Group)
Ms Karen Yeomans (Advantage West Midlands)
Mrs Carole Gumbley (South West Area Network of the Secondary Education Sector in Birmingham) - vacant (replacement being sought)

5.1.5 Register of Interests

UHB's Constitution and Standing Orders of the Board of Governors requires UHB to maintain a Register of Interests for Governors. Governors are required to declare interests that are relevant and material to the Board. These details are kept up-to-date by an annual review of the Register, during which any changes to interests declared during the preceding 12 months are incorporated. The Register is available to the public on request to the Foundation Secretary, University Hospital Birmingham NHS Foundation Trust, Trust Headquarters, PO Box 9551, Main Drive, Queen Elizabeth Medical Centre, Edgbaston, Birmingham B15 2PR.

6. Board of Directors

6.1 The composition of the board of UHB is as follows:

6.1.1 John Charlton, Chairman

John Charlton was appointed Chairman of University Hospital Birmingham NHS Trust on December 1, 1998. His initial term of office as Chairman of the Foundation Trust runs through to November 30, 2006.

He served on Birmingham Health Authority (1974-82), was Chairman of South Birmingham Health Authority (1982-91) and an Executive Director of Sandwell Health Authority (1992-96). By profession he is a dentist and has held a number of senior dental positions including Consultant in Dental Public Health for Sandwell Health Authority and was Regional Dental Advisor to the West Midlands Regional Health Authority (1977-80). He is an Honorary Alderman of Birmingham City Council and served as a Councillor for 15 years.

6.1.2 Mark Britnell, Chief Executive

After graduating from the University of Warwick, Mark joined the fast track Management Training Scheme for the NHS and was sponsored by the Australian College of Health Service Executives to work in Melbourne and Sydney before being seconded to the NHSE in 1992.

He joined St Mary's Hospital in London as a General Manager before being appointed as a Director at Central Middlesex Hospital in 1995. In 1997, Mark was asked to lead the project on the Central Middlesex and Northwick Park Hospital merger and was appointed in February 1998 as Director of Operations at UHB. He became Chief Executive in November 2000.

Mark was identified by The Independent newspaper as one of the top 10 Health Service Managers in the UK and was recognised by The Guardian publication as one of the top 12 young public sector leaders in the UK and one of the top 100 public service leaders.

6.1.3 Peter Shanahan, Deputy Chief Executive, Chief Financial Officer

After graduating in Economics, Peter joined the then West Midlands Regional Health Authority as a Financial Management Trainee. Following qualification he held a number of posts in acute and primary care organisations before joining KPMG. Returning to the NHS in 1994 he spent a brief period at a Health Authority before joining UHB in April 1995. He was appointed Director of Finance in February 2000 and Deputy Chief Executive in December 2001.

Peter has lead responsibility for Finance, Procurement, Legal Services, Shared Services Initiatives and led the development of the first Royal Centre for Defence Medicine in partnership with the MoD and local universities.

He led UHB's successful Foundation application and since December 2005 has been Project Director for Birmingham's £545m PFI scheme.

6.1.4 Julie Moore, Chief Operating Officer

Julie commenced her career in healthcare by undertaking a nursing degree, a Master's degree in Health Services Studies and then progressed into nursing management and ultimately Head of Nursing in a large acute teaching trust. During this time, she was seconded to work at the Department of Health to develop strategy for the expansion of nursing roles. She then entered general management and after 12 months was promoted to Director in a large trust in England responsible for acute clinical services.

Julie was appointed to the Executive Director of Operations post at UHB in 2002 and then became Chief Operating Officer as the scope of her post was extended to include all Operations and Clinical Service Development. Julie will take up the role of Chief Executive (Acting) from July 1.

6.1.5 Catherine Elcoat, DBE, Executive Chief Nurse

Dame Catherine is the Executive Chief Nurse and she also has lead responsibility for Allied Health Professionals, Clinical Governance and Patient and Public involvement. Dame Catherine also works as a National Clinical Advisor to the Healthcare Commission for one day each week.

Prior to taking up her role at UHB in May 2001, Dame Catherine was Deputy Head of the NHS Clinical Governance Support Team. She has also worked within the Nursing Directorate of the NHS Executive with responsibility for supporting the Chief Nursing Officer for England in relation to a range of professional issues.

Dame Catherine has an interest in developing multi-professional models of health care and new approaches to clinical care that improve the experience of patients. Dame Catherine received a DBE in the 2002 New Year's Honours list in recognition of her contribution to nursing and healthcare.

6.1.6 Professor Robert A Stockley, Medical Director

Professor Stockley is a Professor of Medicine with an interest in respiratory disease. He runs an internationally recognised research group investigating the basic pathological processes leading to chronic lung disease and how this influences patient management and treatment. He also plays a major international role in the education of doctors in chronic lung disease and has prepared guidelines for the management of genetic lung disease.

Professor Stockley was appointed to his post in September 2005 with responsibility for training and education, research and development, clinical governance and medical manpower.

6.1.7 Caroline Wigley, Director of Organisation Development

Caroline became a law graduate before joining the NHS as a National Management Trainee. After an early role in Planning, she developed a career in Human Resources. She has worked in a variety of health authorities and hospitals in the North of England and moved to Birmingham in 1987. She had a brief spell working for Ernst & Young, accountancy management consultants before re-joining the NHS in 1998 as Director of Personnel for Birmingham Health Authority and has since undertaken a variety of posts in Birmingham's health services.

She then moved into mainstream general management in 1996 and moved to City Hospital NHS Trust as Executive Director of Operations. She then became Chief Executive of Birmingham Women's Health Care Trust in 2000.

In June 2005, she moved to UHB to take up the role of Executive Director of Organisation Development. She will continue to have the HR portfolio but in addition will oversee the whole transformation process.

Non-Executive Directors

6.18 Rt Rev Mark Santer, Vice-Chairman

The Rt Rev Mark Santer has been Bishop of Birmingham since 1987. He was previously Principal of Westcott House, Cambridge (1973-80) and Bishop of Kensington (1981-87).

He was a member of Birmingham Health Authority's Advisory Panel which reviewed the future of healthcare in Birmingham under the Chairmanship of Lord Hunt of Kings Heath and was instrumental in providing a supportive environment for the Birmingham New Hospitals Project throughout the city.

He was appointed as a Non-Executive Director of UHB NHS Trust on December 1, 2002. His term for UHB NHS Trust was rolled over upon attainment of Foundation Trust status on July 1, 2004 and runs to November 30, 2006.

6.1.9 Stewart Dobson

Stewart Dobson was appointed as a Non-Executive Director on September 10, 2004 for a four-year period.

Stewart worked for some 32 years as a lawyer for various large local authorities. This included over 13 years working for Birmingham City Council, mainly as the Director of Legal Services but finishing up as Acting Chief Executive. He retired from the City Council's employment in November 2002 and was the Chief Executive of Millennium Point and Thinktank, within the Eastside area of Birmingham, from 2003 to 2005. He now works as a local government consultant.

6.1.10 Tozammel (Tony) Huq MBE

Tony Huq was appointed a Non-Executive Director to the UHB NHS Trust on July 1, 2002. His term for the NHS trust rolled over upon attainment of Foundation Trust status on July 1, 2004. He was re-appointed for four years by the Board of Governors on June 28, 2005.

Mr Huq has had a long and distinguished career both in education and with UNESCO. He was a Senior Special Adviser to the Director General of UNESCO and has represented the organisation at many summits, UN and international meetings and conferences. He was the Government of Bangladesh's Ambassador to France, Spain and UNESCO in the 1980s.

He is currently a visiting Lecturer in International Relations at the University of Birmingham; an Honorary Research Fellow at the University of Warwick and was awarded an Honorary Doctorate by the University of Birmingham for services to Community Development and Education.

6.1.11 Clare Robinson

Clare Robinson is a highly experienced Chartered accountant with a wide-ranging background in finance and operations. She brings with her seven years experience as a non-executive director at the Royal Orthopaedic Hospital NHS Trust where she was also Chair of the Audit Committee. Currently, Ms Robinson is working as an independent Business Consultant on a variety of assignments including change management, strategic and operational reviews and management services.

She was appointed as a Non-Executive Director on September 10, 2004 for a term of four years which runs to September 9, 2008.

6.1.12 Mary Thomas

Mary Thomas is a highly skilled health promotion specialist combining NHS, local authority and private sector experience. She has also worked in the community for the Birmingham Settlement, a voluntary sector organisation.

She was a Non-Executive Director of the NHS Trust in 1999 and has long been committed to public involvement and improving the patient experience. She undertook the role of Complaints Convenor for UHB for many years and she is also a NED of SIFA (Supporting Independence from Alcohol, previously known as HARP).

She chairs UHB's committees for Improving Working Lives and NSF for Older People. As a health promotion specialist, she chairs the Choosing Health Committee.

Mary's term as Non-Executive Director for UHB NHS Trust rolled over upon attainment of Foundation Trust status on July 1, 2004 and runs to November 30, 2006.

6.1.13 Professor David Westbury OBE

Professor David Westbury became an independent consultant in October 2002. Before that, he was Vice-Principal of the University of Birmingham (1992-2002). Prior to that he was Executive Dean of the Faculty of Medicine and Dentistry in Birmingham (1984-1992).

He is chair of the Joint Costing and Pricing Steering Group, working on behalf of the Funding Councils and the representative bodies of the Higher Education sector to encourage the adoption of formal costing and pricing methods and the integration of financial and academic management.

David chairs the Board of Directors' Annual Plan and Strategy Committee and is Chairman of U. M. Association Ltd., which provides mutual insurance services for higher education institutions.

David's term as Non-Executive Director for UHB NHS Trust rolled over upon attainment of Foundation Trust status on July 1, 2004 and runs to 30 November 2007.

6.2 Performance appraisal

The Chair carries out annual performance appraisals for each NED, but the Board of Governors has the responsibility for appointing and terminating individuals, i.e. as a result of poor performance, misconduct, etc. Appointment and termination has to be approved by the Board of Governors.

6.3 Board of Directors Interests

UHB's Constitution and Standing Orders of the Board of Directors requires UHB to maintain a Register of Interests for Directors. Directors are required to declare interests that are relevant and material to the Board. These details are kept up-to-date by an annual review of the Register, during which any changes to interests declared during the preceding 12 months are incorporated. The Register is available to the public on request to the Foundation Secretary, University Hospital Birmingham NHS Foundation Trust, Trust Headquarters, PO Box 9551, Main Drive, Queen Elizabeth Medical Centre, Edgbaston, Birmingham B15 2PR.

7. Membership

The Trust has three membership constituencies: public, staff and a patients' constituency.

- **Public constituency**

The public constituencies correspond to the Parliamentary constituencies of Birmingham. Public members are those individuals who are aged 16 or over and:
(a) who live in the Area of the Trust; and
(b) who are not eligible to become Members of the staff constituency and are not Members of any other constituency

- **Staff Constituency**

The staff constituency is divided into four classes:
(a) medical staff
(b) nursing staff
(c) clinical scientist or allied health professional staff
(d) ancillary, administrative and other staff

- **Patient Constituency**

Patient members are individuals who are:-
(a) Patients or Carers who are aged 16 or over; and
(b) not eligible to become Members of the staff constituency and are not Members of any other constituency.

(N.B. A Patient who lives in the Area of the Trust will not be invited to be a Member of the Patients' constituency. Such Patient will be invited to be a Member of a public constituency but this does not affect his/her ability to be a Patient Member by making an application for that membership.)

7.1 Membership Overview by Constituency

Constituency	Level 1	Level 2	Level 3	Total (31/03/06)
Public members	56,457	1,092	1,135	**58,684**
Patient members	25,069	734	399	**26,202**
Staff members	6,778	148	149	**7,075**
Totals	88,304	1,974	1,683	**91,961**

* Numbers correct up to March 31, 2006

7.2 Membership development

UHB has adopted the following strategy to develop the involvement of Foundation Trust Governors, members, patients and the public as well as develop mechanisms to demonstrate actions resulting from the views expressed by the above stakeholder groups.

7.3 Membership Strategy

The membership of UHB was stratified in early 2005 to offer members the opportunity to state the level of involvement they would like with UHB. Of the 96,000 members at the time, 1,500 opted to become Level 3 members and be more actively involved. During the past year an effort has been made to encourage more members to become more actively involved. The result is that we now have almost 1,700 Level 3 members. We aim to increase this number to 2,000 in the next 12 months.

It is not our plan to significantly increase our membership numbers overall but our strategy seeks to broadly maintain our membership numbers at the current level. In 2006/7 we are anticipating that our total membership numbers may reduce in size slightly.

We will therefore actively recruit members through a range of initiatives to minimise the net loss of numbers and increase activity levels of members. We will put a particular emphasis on refreshing via attracting what are generally considered to be under-represented groups in FT membership.

Recruitment initiatives will include:

- Information and recruitment drives through our patient magazine
- Utilisation of our patient bedside television system, which has a Trust channel and will provide information on membership.
- Posters and leaflets displayed around the trust
- Involvement of our patient and carer councils
- Local media events

We will engage a market research company to undertake an opinion poll of our membership to provide feedback on the perceptions of our membership about UHB's performance. Our large membership base will enable a meaningful randomised sample to be identified. The membership survey will better inform us of the demographics of our current membership.

We will be working with Public Governors and other members to encourage participation from people within their communities.

7.4 Foundation Member monthly health seminars

Since May 2005, Level 3 foundation members have been invited to attend monthly health seminars. Ten sessions have been held to date with positive comments received from both governors and members. The events are split into two sections, presentation and a Q&A. Following feedback from members in January 2006, both morning and evening sessions are run to enable more people to attend. This forum also gives Public and Patient Governors the opportunity to speak to members who prefer to voice their concerns/queries to someone face-to-face.

Members were also invited to attend a Healthcare Scientist Seminar as part of National Healthcare Scientist week in November. This evaluated very well and informed members of some of the many roles our healthcare scientists have.

7.5 Readership panel

Level 3 foundation members have been invited to form a readership panel to review UHB publications and electronic and printed patient information. This will ensure that the information we print is in a clear format and written in a non-technical language that our patients understand.

7.6 Consultation

Patients, governors and the public have been asked to comment on a number of developments, polices and UHB strategies to ensure that they reflect the need of the community we serve. These have included:

- Development of the UHB's Annual Plan and divisional objectives
- The development of a Volunteer Strategy and policy
- Impact assessments for the Race Relations Act
- Revision of the Patient and Public Partnership Strategy
- Outpatient letters
- Visiting arrangements
- Standards for cleaning and the environment

7.7 Website

Member and governor information on the website has been revised and people are encouraged to feedback their comments. All governor correspondence is logged by the Communications team and forwarded to the relevant governor for feedback.

7.8 Trust in the Future

In July 2005 we launched a dedicated members' newsletter to inform members of key events and raise awareness of key health issues within UHB. We welcome feedback and encourage members to put forward ideas for future issues. From April 2006, this will be sent twice yearly to our full membership of 92,000 people. We have been keen to encourage as many people as possible to opt for the Level 3 membership and are pleased to report that recent campaigns have resulted in an increased number.

7.9 Governors

Governors' development seminars have continued throughout the year providing governors with an insight into the many clinical and non-clinical services at UHB as well as some of the regulatory frameworks that UHB operates within.

Patient Governors were invited to become members of the Divisional Patient and Carer Councils to enable them to have closer contact with patients and carers and therefore to gain feedback. Two governors were elected by council members to chair councils.

Governors were invited to take part in an audit of the extent to which UHB implements Corporate Social Responsibility. The outcome of the audit will be one of the factors that influence the development of the medium term plan for the next three years.

8. Public interest disclosures

8.1 Disability policies

UHB has incorporated legislation, responsibilities and issues relating to disability into its equal opportunities training programme which is offered to all staff and publicised on the UHB Training Directory.

A recent review of mandatory training requirements has led to the development of a draft policy and the piloting of a second induction day covering a range of mandatory inputs applicable to all staff. These inputs include equal opportunities/diversity issues and incorporate disability.

UHB has commenced piloting an e-learning approach to equal opportunities and diversity which provides a further means of raising awareness of disability legislation and responsibilities.

If successful, a business case will be produced to roll out the pilot.

The intention during 2006/07 is to take the relevant core Knowledge and Skills Framework Dimension to training opportunities and establish the requirement for a minimum competence standard for all staff.

8.2 Equal Opportunities

UHB is an equal opportunities employer and has policies and procedures in place to ensure equality of opportunity. A significant proportion of Birmingham residents are from minority ethnic groups. In particular, the Pakistani and Bangladeshi groups will increase significantly during the next five years. Much of the work we are developing on the new role of support worker will aim to attract this group. UHB is also actively contributing to the 'Fair Cities' groundbreaking initiative which is designed by the National Employment Panel, to help disadvantaged members of ethnic minorities get, stay and advance in work.

8.3 Provision of information and consultation with employees and stakeholders

- We regularly provide information through our monthly newsletter and through the monthly team brief sessions with staff. This is reinforced by a new weekly news bulletin. In particular the delay surrounding a decision on the PFI has necessitated regular updates to staff. The above communication tools have been supplemented by a weekly electronic update from the Chief Executive.

- The trade unions have raised with us that there has been some lack of clarity on arrangements for consultation on change within UHB and this is currently being reviewed.

- There has been ongoing consultation on ward, departmental and workforce changes on an operational basis. Agenda for Change implementation has been the subject of regular consultation and communication with staff and in particular our decision to slow down the implementation timescale to ensure the project is completed properly.

- The proposed HR and payroll joint venture has been subject to consultation.

- As a requirement of the Trust's self-assessment against the Healthcare Commission's Core Standards for Better Health, UHB has consulted with the relevant Overview and Scrutiny Committee, PPI Forum and its Board of Governors.

8.4 Health and safety performance

There are no major issues to report. UHB has not been served with any improvement notices and there are no impending prosecutions for incidents.

There have been two incidents relating to a contractor working on our premises and the discovery of asbestos and partly incinerated clinical waste in ground being cleared as part of the advanced works for the new hospital.

Priority issues include slips/trips/falls and manual handling. We have an ageing stock of patient hoists which needs to be replaced. An option appraisal has been undertaken.

Trials are taking place to find a latex-free glove which gives surgeons the appropriate degree of dexterity that they need to operate. We are also costing some needle-safe devices following a year-long trial.

8.5 Occupational health development

Activity levels continue to rise and processes have been reorganised to improving waiting times. Musculo-skeletal and mental health problems remain the major cause of absence.

Sickness absence has risen for in some areas and measures are being taken to review our sickness absence procedures. There was a significant increase in the take-up of influenza immunisation this year

8.6 Countering fraud and corruption

UHB policy is to apply best practice regarding fraud and corruption and at the moment we comply fully with the Secretary of State directions. Our local counter fraud service is provided by our internal auditors (under a separate tender) and the counter fraud plan follows these directions. UHB does not tolerate fraud and the plan is designed to make all staff aware of what they should do if they suspect fraud

8.7 Better Payment Practice Code

Better Payment Practice Code – measure of compliance

	Number	£000
Total bills paid in the period	90,023	265,411
Total bills paid within target	78,635	252,456
Percentage of bills paid within target	87.3%	95.1%

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

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

Interest of £666.71 was charged to UHB in the year for late payment of commercial debts.

8.9 Management costs

Management costs, calculated in accordance with the Department of Health's definitions, are 4%.

9. Remuneration Report

The Remuneration Committee of the Board of Directors comprises all the non-executive directors of the Trust, and is chaired by the Trust Chairman, as set out on page 37.

The Committee's terms of reference are to determine on behalf of the Board of Directors competitive remuneration for the executive directors, which recognises their individual contributions to the Trust's overall performance. The Committee believes strongly that the remuneration policy should be completely aligned with the Trust's interests. In addition the Committee assists the Board of Directors in ensuring that the senior management of the Trust are recruited, developed and remunerated in an appropriate fashion.

9.1 Executive Remuneration Policy

The Committee recognises that, in order to ensure optimum performance, it is necessary to have a competitive pay and benefits structure. The Committee also recognises that there is a highly competitive market for successful executives and that the provision of appropriate rewards for superior performance is vital to the continued growth of the business.

From April 2005 a single payment has been introduced that consolidates performance, pay and benefits in to a base salary. Salaries are based on median market rates.

The remuneration policy was reviewed by the Committee in June 2005.

Executive Directors are on full contracts with a notice period of six months. Each Director has annual objectives which are agreed by the Chief Executive. Reviews on performance are quarterly. The Chairman agrees the objectives of the CEO and associated performance measures.

Executive Directors are on a continuing contract, and have a six-month notice period each way. There were no termination payments to Senior Managers and the Contracts do not stipulate that there is any entitlement to them. No significant awards and no compensation for loss of office were made to Senior Managers during 2005/06.

9.2 Pensions

All the executive directors are members of the NHS Pensions Scheme. Under this scheme, members are entitled to a pension based on their service and final pensionable salary subject to Inland Revenue limits. The scheme also provides life assurance cover of twice the annual salary. The normal pension age for directors is 60. None of the non-executive directors are members of the schemes. Details of the individual arrangements for executive directors are given in Note 5.2 of the Annual Accounts and UHB's policy on pension is given in Note 1.14.

9.3 Other benefits

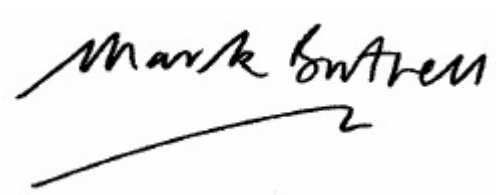
Where there were a number of months still under contract on their lease car, Directors were able to continue with the lease. Their annual salary entitlement has been reduced in line with the cost of providing this car.

9.4 Non-Executive Directors' remuneration

Non-executive directors' remuneration consists of fees which are set by the Board of Governors following advice taken from independent consultants. NED fees are reviewed each year.

Details of the salary, pensions and benefits are shown in Note 5 of the accounts. Details on the non-executives are given below:

Name	Date Appointed	End of term of office
Mr John Charlton	01.12.2002	30.11.2006
Mr Tony Huq	28.07.2005	30.06.2009
Ms Clare Robinson	10.09.2004	09.09.2008
Rt Rev Mark Santer	01.12.2002	30.11.2006
Ms Mary Thomas	01.12.2002	30.11.2006
Professor David Westbury	01.12.2003	30.11.2007
Mr Stewart Dobson	10.09.2004	09.09.2008



Mark Britnell
Chief Executive

June 15, 2006
Date

Data entered below will be used throughout the workbook:

Trust name:	University Hospital Birmingham NHS Foundation Trust
This period	2005/06
Last period	2004/05
This period ended	31 March 2006
Last period ended	31 March 2005
This period beginning	1 April 2005

University Hospital Birmingham NHS Foundation Trust
Accounts for the year ended 31 March 2006

Contents

FOREWORD TO THE ACCOUNTS

UNIVERSITY HOSPITAL BIRMINGHAM NHS FOUNDATION TRUST

These accounts for the period ended 31 March 2006 have been prepared by the University Hospital Birmingham NHS Foundation Trust in accordance with paragraph 24 and 25 of Schedule 1 to the Health and Social Care (Community Health and Standards) Act 20 03 in the form which Monitor has, with the approval of the Treasury, directed.

Signed  Date 13th June 2006

M Britnell
Chief Executive

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF UNIVERSITY HOSPITAL BIRMINGHAM NHS FOUNDATION TRUST

The Health and Social Care (Community Health and Standards) Act 2003 states that the Chief Executive is the accounting officer the Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts are set out in the the Accounting Officer's Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the Health and Social Care (Community Health and Standards) Act 2003, Monitor has directed the University Hospital Birmingham NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of University Hospital Birmingham NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the aaccounts, The Accounting Officer is required to comply with the requirements of the NHS foundation trust Financial 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 Financial 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 Trust and to enable him to ensure that the accounts comply with the requirements outlined in the above mentioned Act. The Accounting Officer is 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.

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…….. Date 13th June 2006

M Britnell
Chief Executive

STATEMENT OF DIRECTORS' RESPONSIBILTIES IN RESPECT OF THE ACCOUNTS

The Directors are required under the Health and Social Care (Community Health and Standards) Act 2003 to prepare accounts for each financial year Monitor, 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 of the Trust for that period. In preparing those accounts, the Directors are required to;

- select suitable accounting policies, as described on pages 15 to 21, and then apply them consistently;

- 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 ;

- prepare accounts on the going concern basis unless it is inappropriate to presume that the Trust will continue in business.

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 Monitor. The Directors 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 that they have complied with the above requirements in preparing the accounts.

By order of the Board

Signed…….. Date…13th June 2006…

M Britnell
Chief Executive

Signed…….. Date…13th June 2006…

P Shanahan
Chief Financial Officer

INDEPENDENT AUDITORS' REPORT TO THE GOVERNORS OF THE BOARD OF UNIVERSITY HOSPITAL BIRMINGHAM NHS FOUNDATION TRUST

INDEPENDENT AUDITORS' REPORT TO THE GOVERNORS OF THE BOARD OF UNIVERSITY HOSPITAL BIRMINGHAM NHS FOUNDATION TRUST

STATEMENT ON INTERNAL CONTROL

1. Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the University Hospital Birmingham 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 University Hospital Birmingham NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also aknowledge my responsibilities as set out in the NHS Accounting Officer Memorandum.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of University Hospital Birmingham 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 University Hospital Birmingham NHS Foundation Trust for the year ended 31 March 2006 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

Risk issues are reported through the Clinical Governance Reporting Framework and the Divisional Management Structures. Management and ownership of risk is delegated to the appropriate level from Director to local management teams through the Divisional Management Structure.

The Audit and Financial Control Committee monitors and assesses both internal control issues and financial risk. Audit managers from both Bentley Jennison (internal audit) and KPMG (external audit) attend all Audit and Financial Control Committee meetings and are responsible for the development of the audit reports and findings and the Annual Management Letter. The Committee approves the Internal Audit Plan. This Plan is based on the Trust's Assurance Framework. The Audit and Financial Control Committee receives all of the reports of the Internal Auditors. Reports that impact on clinical risks are reported to the Clinical Governance Committee. The main purposes of the audit reports are to provide Management, the Audit and Financial Control Committee and the Board of Directors with:

STATEMENT ON INTERNAL CONTROL (continued)

- An opinion of the adequacy of internal control;

- Information on significant audit findings and recommendations

The Internal Audit Plan covers both financial and non financial areas and includes a number of operational and support systems.

For the Trust's key systems, positive opinions have been issued by Internal Audit.

All new staff to the Trust are required to attend the Corporate Induction which covers all key elements of risk management. Existing members of staff are trained in the specific elements of risk management dependent on their level within the organisation. Managers attend the 'Managing Risks' course that covers the principles of risk assessment and Risk Registers. There is a guidance document 'Guidance on the Implementation and Management of Risk Registers' which details the risk register process. Risk Management is taught on all Trust and Divisional development programmes. Learning from incidents and good practice is discussed at the Professional Leads Forum and with loacl departments and wards. Senior staff are trained in Root Cause Analysis. The training is being expanded to Divisional Director level and local managers.

4. The risk and control framework

The Board of Directors is responsible for the strategic direction of the Trust in relation to Clinical Governance and Risk Management. It is supported by three committees which provide assurance on risk management issues: the Audit and Financial Control Committee, the Risk and Compliance Committee and the Clincal Governance Committee. The new Trust Foundation Secretary is currently reviewing the interaction, ways of working, Terms of Reference and membership of these committees.

In order to assess internal control, the Trust carried out a self assessment exercise against compliance with the Healthcare Commission Standards for Better Health.

The declaration to the Commission is that the Trust is fully compliant with all standards. This has been approved by the Board of Directors. Internal audit has reviewed the process that the Trust undertook to reach this decision and has given the Trust a positive comment that the process is robust.

The Trust was assessed at level 2 against the Clinical Negligence Standards for Trusts (CNST) in December 2005. It was successful in maintaining CNST level 2 with improved scores in comparison to the last assessment in 2003.

STATEMENT ON INTERNAL CONTROL (continued)

A risk management strategy is in place which has been endorsed by the Board of Directors and clearly defines risk management structures, accountability and responsibilities and incorporates consideration of stakeholders. All serious untoward incidents are reported to the South Birmingham PCT.

There are elements of risk management where public stakeholders are closely involved. Infection control is a high profile risk. Members of the public are encouraged to participate through the 'Clean your hands' campaign and patients are involved with all aspects of their care. There are representatives on the Trust Cleaning groups and aspects of risk, including infection control are discussed at all Divisional Patient Council meetings.

4.1 Risk identification and evaluation

Risks are identified via a variety of mechanisms:

All areas within the Trust report incidents and near misses in line with the Trust's Incident Reporting Policy. Details of incidents are reported through the Divisional Governance structure and quarterly to the Clinical Governance Committee.

Risk Assessments, including Health and Safety and Infection Control Audits are undertaken throughout the Trust. All identified risks at all levels are evaluated using a common methodology based on the risk matrix contained in the Risk Management Standard AS/NZ 43360:1999.

Risk Registers are generated through the assessment process and reviewed on a quarterly basis to ensure that action plans are being carried out and those risks can be added or deleted, as necessary. The high level risks, as identified by the Divisional Management Teams, are reported through Performance Review. There are plans in place to change the process to reporting the Risk Registers to the Chief Operating Officers Advisory Group on a quarterly basis and to the Risk and Compliance Committee every 6 months. This committee will assess if the level of assurance is sufficient for the Board of Directors to accept.

Other methods of identifying risks are:

Complaints and Healthcare Commission Independent Review Panel Reports and recommendations;
Inquest findings and HM Coroners recommendations;
Health and Safety visits undertaken by Director of Operations of each Division;
Medico-legal claims and litigation;
Ad hoc risk issues brought to either the Divisional Clinical Governance Team meetings, Health, Safety and Environment Committee or the Clinical Governance Committee;
Incident reports and trend analysis;
Internally generated reports from Health Informatics Team;
Internal and external financial audit reports;
Performance reviews.

STATEMENT ON INTERNAL CONTROL (continued)

4.2 Risk Control

Risks are reported to the Clinical Governance Committtee and the Risk, Compliance and Assurance Committee, which have fully delegated authority from the Board of Directors. Compliance with the HealthCare Commissions Standards for Better Health is reported to the Clinical Governance Committee and to the Board of Directors. The assurance on this process was provided by Internal Audit to the Clinical Governance Committee.

Risks are reported locally at divisional level through the Clinical Governance structure.

The Infection Control Committee, chaired by the Director of Infection Control (who is also the Chief Operating Officer), meets on a monthly basis. In addition, key infection control indicators (MRSA/*Clostridium difficile*) are reported on a quarterly basis as part of the Trust's Performance Review process. This data is also reported to Divisional Clinical Governance teams for local follow up action.

Risk Management is embedded into the organisation in many ways. The culture of the organisation aids the confident use of the incident reporting procedures throughout the Trust.

The Trust has undertaken an exercise to determine the strategic objectives and developed an Assurance Framework to assess the potential risks that threaten the achievement of the organisational objectives, the existing control measures that are in place and where assurances are gained. Corporate Risk Assessments provide supportive evidence to the Assurance Framework. The Board of Directors has been involved in its process and all members are aware of the Assurance Framework.

The Trust is progressing to financial close on its Joint PFI scheme with the South Birmingham and Solihull Mental Health Trust. This has been identified as a major risk to the Trust. A Project Board is in place which is chaired by the Chair of the Foundation Trust. The Chief Executive and Deputy Chief Executive are also members. The Project Plan is a working document. The minutes of this group are presented to the Board of Directors. A risk register has been produced and is actively managed.

To provide assurance to the Board of Directors, an independent review of the assumptions included in the New Hospital Business Case has been commissioned. This concluded that the assumptions, as reported to the Board of Directors have been accurately stated in the financial model.

STATEMENT ON INTERNAL CONTROL (continued)

5. Review of economy, efficiency and effective use of resources

Agreement of a balanced financial plan for 2005/06 required the Trust to deliver cash releasing efficiency savings of 1.7%. In order to achieve this, a formal cost improvement programme was agreed across all divisions and corporate areas.

In addition to the agreed cost improvement programme, further efficiency savings were targeted through a Corporate Review. This focused on Trust wide initiatives including a review of all vacancies prior to advert and delivery of further non-pay savings through the establishment of a Product Evaluation Group.

During 2005/06 benchmarking has been carried out in a number of areas across the Trust including theatre utilisation and commercially outsourced contracts which are reviewed against similar service provision in comparable Acute Teaching Trusts outside of London. Data shows that the Trust can demonstrate national best value in terms of price, quality and the management of demand in the vast majority of the commercial services contracts.

Further evidence of value for money is provided through the publication of reference costs, which confirmed that in overall terms services were provided at the national average cost (ie an index of 100) based on the latest full year cost and activity data (2004/05).

6. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the Internal Auditors and the executive managers within the Trust who have responsibility for the development and maintenance of the internal control framework and comments made by the External Auditors in their management letter and other reports. The Board of Directors recognises the importance of internal control and has invested in resources during 2005/06 to develop both the monitoring and reporting of the control framework. I have been advised on the implications of the result of my review on the effectiveness of the system of internal control by the Board, the Audit and Financial Control Committee, Internal Audit, Risk, Compliance and Assurance Committee and External Audit. A plan to address weaknesses and ensure continuous improvement of the system is in place.

Signed…… Date…13th June 2006…

M Britnell
Chief Executive

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31 MARCH 2006

	NOTE	12 Months to 31 March 2006 £000	9 Months to 31 March 2005 £000
Income from activities	2	**305,153**	211,428
Other operating income	3	**73,387**	57,114
Operating expenses	4 - 6	**(370,756)**	(262,785)
OPERATING SURPLUS		**7,784**	5,757
Exceptional items	7	**(3,564)**	0
Loss on disposal of fixed assets	8	**(77)**	(10)
SURPLUS BEFORE INTEREST		**4,143**	5,747
Interest receivable	9.1	**753**	633
Interest payable	9.2	**(1)**	0
Other finance costs - unwinding of discount		**(26)**	(22)
Other finance costs - change in discount rate on provisions		**(142)**	0
SURPLUS BEFORE TAXATION		**4,727**	6,358
Taxation	10	**0**	0
SURPLUS AFTER TAXATION		**4,727**	6,358
Public Dividend Capital dividends payable		**(8,253)**	(5,269)
RETAINED (DEFICIT)/SURPLUS FOR THE YEAR *		**(3,526)**	1,089

The notes on pages 15 to 41 form part of these accounts.
All income and expenditure is derived from continuing operations.

* The retained surplus for the year was £38,000 prior to the exceptional item as detailed above.

BALANCE SHEET AS AT 31 MARCH 2006

	NOTE	31 March 2006 £000	31 March 2005 £000
FIXED ASSETS			
Tangible assets	11.2	**241,346**	242,245
CURRENT ASSETS			
Stocks and work in progress	12	**8,790**	7,982
Debtors	13	**26,947**	29,750
Cash at bank and in hand	18.3	**14,653**	8,957
		50,390	46,689
CREDITORS: Amounts falling due within one year	14	**(42,161)**	(34,803)
NET CURRENT ASSETS		**8,229**	11,886
TOTAL ASSETS LESS CURRENT LIABILITIES		**249,575**	254,131
PROVISIONS FOR LIABILITIES AND CHARGES	15	**(5,817)**	(6,586)
TOTAL ASSETS EMPLOYED		**243,758**	247,545
FINANCED BY:			
TAXPAYERS' EQUITY			
Public dividend capital		**157,707**	153,702
Revaluation reserve	17	**68,530**	70,996
Donated asset reserve	17	**10,774**	12,661
Income and expenditure reserve	17	**6,747**	10,186
TOTAL TAXPAYERS EQUITY		**243,758**	247,545

Signed…….. Date 13th June 2006

M Britnell
Chief Executive

STATEMENT OF TOTAL RECOGNISED GAINS AND LOSSES FOR THE YEAR ENDED 31 MARCH 2006

	NOTE	12 Months to 31 March 2006 £000	9 Months to 31 March 2005 £000
Surplus for the financial year before dividend payments		4,727	6,358
Disposal of donated assets	17	(1,183)	0
Impact of disposals on revaluation reserve	17	(2,379)	0
Unrealised surplus on fixed asset and current asset investments and revaluations		0	5,201
Increases in the donated asset reserve due to receipt of donated ssets		414	299
Reductions in the donated asset and government grant reserve due to the depreciation, impairment and disposal of donated and government grant financed assets		(1,118)	(1,192)
TOTAL RECOGNISED GAINS AND LOSSES FOR THE FINANCIAL YEAR		461	10,666

The nine month comparatives are as restated following two prior year adjustments.

A prior period adjustment to the income and expenditure reserve occurred due to the requirement to comply with FRS 5 Reporting the Substance of Transactions and UITF 40 Revenue Recognition and Service Contracts. This resulted in an increase in the surplus for the 9 month financial period to 31 March 2005 before dividend payments of £1.063m. For further details see note 17 to the accounts.

CASH FLOW STATEMENT FOR THE YEAR ENDED 31 MARCH 2006

	NOTE	12 Months to 31 March 2006 £000	9 Months to 31 March 2005 £000
OPERATING ACTIVITIES			
Net cash inflow from operating activities	**18.1**	**25,919**	15,795
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:			
Interest received		**763**	636
Interest paid		**(1)**	0
Net cash inflow from returns on investments and servicing of finance		**762**	636
CAPITAL EXPENDITURE			
(Payments) to acquire tangible fixed assets		**(17,176)**	(13,051)
Receipts from sale of tangible fixed assets		**25**	0
Net cash (outflow) from capital expenditure		**(17,151)**	(13,051)
DIVIDENDS PAID		**(8,253)**	(5,269)
Net cash inflow/(outflow) before management of liquid resources and financing		**1,277**	(1,889)
MANAGEMENT OF LIQUID RESOURCES			
(Purchase) of current asset investments		0	0
Sale of current asset investments		0	0
Net cash inflow/(outflow) from management of liquid resources		**0**	0
Net cash inflow/(outflow) before financing		**1,277**	(1,889)
FINANCING			
Public dividend capital received		**4,005**	9,479
Other capital receipts		**414**	460
Net cash inflow from financing		**4,419**	9,939
Increase in cash		**5,696**	8,050

NOTES TO THE ACCOUNTS

1 Accounting policies

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2005/06 NHS Foundation Trust Financial Reporting Manual issued by Monitor. The accounting policies contained in that manual follow UK generally accepted accounting practice for companies (UK GAAP) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of tangible fixed assets at five yearly intervals. NHS foundation trusts, in compliance with HM Treasury's Financial Reporting Manual, are not required to comply with the FRS 3 requirements to report "earnings per share" or historical profits and losses.

1.2 Income recognition

Income is accounted for applying the accruals convention. The main source of income for the Trust is under contracts from commissioners in respect of healthcare services. Income is recognised in the period in which services are provided.

When a patient is admitted and treatment begins, then the income for that treatment or spell can start to be recognised. Income relating to those spells which are partially completed at the financial year end is therefore accrued for.

Partially completed spells of patient care relate to Finished Consultant Episodes (FCEs). An income value is attributed to these spells by reference to episode type (elective, non-elective etc), the relevant HRG, and any local or national tariff.

The accrual of income relating to partially completed patient spells represents a change in accounting policy because in previous years, income was only recognised when patient spells were complete. As such, this results in the requirement for a Prior Period Adjustment, the details of which can be found in note 17 to the accounts.

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

1.3 Expenditure

Expenditure is accounted for by applying the accruals convention.

1.4 Tangible fixed assets

Capitalisation

Tangible assets are capitalised if they are capable of being used for a period which exceeds one year and they:

- individually have a cost of at least £5,000; or

- form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

- form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Valuation

Tangible fixed assets are stated at the lower of depreciated replacement cost and net realisable value. On initial recognition they are measured at cost including any costs directly attributable to bringing them into working condition. The carrying values of tangible fixed assets are reviewed for impairments in period if events or changes in circumstances indicate the carrying value may not be recoverable.

Land and buildings are valued in the accounts in accordance with a formal valuation carried out by the by the District Valuer in March 2005. This valuation will be reconsidered in March 2008, with a professional revaluation being done in March 2010. This marks a change in accounting policy from the annual application of indexation to arrive at the carrying value.

Operational equipment assets are initially valued at cost less depreciation but will also be subject to review in 2008.

Assets in the course of construction are valued at cost.

Depreciation and amortisation

Tangible fixed assets are depreciated at rates calculated to write them down to estimated residual value on a straight-line basis over their useful lives.

Assets in the course of construction are not depreciated until the asset is brought into use.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as assessed by the Trust's professional valuers.

Equipment is depreciated on current cost evenly over the estimated life;

Short life medical equipment	5 years
Medium life medical equipment	10 years
Long life medical equipment	15 years
IT assets	5 years

1.5 Donated fixed assets

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

1.6 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. Where the Government grant is used to fund revenue expenditure it was taken to to the income and expenditure account to match that expenditure. Where the grant is used to fund capital expenditure the grant is held as a creditor and released to the income and expenditure account over the life of the asset on a basis consistent with the depreciation charge for that asset. This represents a change in accounting policy, because in 2004/05 a government grant reserve was maintained. The change in accounting policy results in the requirement for a Prior Period Adjustment, the details of which can be found in note 17 to the accounts.

1.7 Stocks and work-in-progress

Stocks and work-in-progress, except pharmacy and warehouse stock, are valued at the lower of cost and net realisable value. Pharmacy and warehouse stocks are valued at average cost. This is considered to be a reasonable approximation to current cost due to the high turnover of stocks. Work-in-progress comprises goods and services in intermediate stages of production.

1.8 Cash, bank and overdrafts

Cash, bank and overdrafts are recorded at the current values of these balances in the Trust's cash book. These balances exclude monies held in the Trust's bank account belonging to patients (see third party assets below). Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases overdrafts are disclosed within creditors. Interest earned on bank accounts and interest charged on overdrafts are recorded as, respectively, "interest receivable" and interest payable" in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

1.9 Research and development

Expenditure on research is not capitalised, it is treated as an operating cost in the year in which it is incurred.

Research and development activity cannot be seperated from patient care activity and is therefore not seperately disclosed.

1.10 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet 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.

1.11 Contingencies

Contingent liabilities are provided for where a transfer of economic benefits is probable. Otherwise, they 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 confimed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.12 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 15.

1.13 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises. The Trust has also taken out additional insurance cover claims in excess of £1 million.

1.14 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. As a consequence it is not possible for the Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme under FRS 17.

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 income and expenditure account at the time the Trust commits itself to the retirement, regardless of the method of payment. No such payments have been made in this or the comparative financial year.

1.15 Value Added Tax

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

1.16 Corporation tax

The Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to disapply the exemption in relation to specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities which are not related to, or ancillary to, the provision of healthcare, and where the profits there from exceed £50,000 per annum.

1.17 Foreign exchange

Transactions that are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the income and expenditure account.

1.18 Third party assets

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

1.19 Leases

Operating leases rental charges are charged to the income and expenditure account on a straight line basis over the term of the lease. The Trust does not have any finance leases.

1.20 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities ie the net assets of a public benefit corporation.

A charge, reflecting the forecast cost of capital utilised by the Trust, is paid over as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5% on the average relevant net assets of the Trust). Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and cash held with the Office of the Paymaster General. Average relevant net assets are calculated as a simple mean of opening and closing relevant net assets.

1.21 Financial Instruments

All financial instruments are held for the sole purpose of a managing the cash flow of the Trust on a day to day basis or arise from the operating activities of the Trust. The management of risks around these financial instruments therefore relates primarily to the Trust's overall arrangements for managing risks to their financial position.

The Trust can borrow within the limits set by Monitor's Prudential Borrowing Code. The Trust's position against its prudential borrowing limit is disclosed in note 14.2. To date Trust has not utilised any of its available prudential borrowing.

1.22 Losses and Special Payments

Losses and special payments are charged to the relevant functional headings on a cash 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.)

2. Income from Activities	**12 Months to 31 March 2006 £000**	9 Months to 31 March 2005 £000
Foundation Trusts	**35**	0
NHS Trusts	**755**	327
Strategic Health Authorities	**16**	0
Primary Care Trusts	**280,069**	192,768
Department of Health - other	**13,794**	9,418
NHS Other	**2,522**	2,189
Non NHS:		
- Private Patients	**2,906**	2,408
- Overseas patients (non-reciprocal)	**90**	95
- Road Traffic Act	**1,611**	1,278
- Other*	**3,355**	2,945
	305,153	211,428

* Included within 'Non NHS Other' is £3,250,000 relating to the Trust contract with the Royal Centre for Defence Medicine.

Road Traffic Act income is subject to a provision for doubtful debts of 6.0% to reflect expected rates of collection. Although the rate advised by Monitor is 8.7%, an analysis of the historic data of the Trust indicates that a rate of 6% is more appropriate.

2.1 Private Patient Income

	2005/06 £000	Base Year 2002/03 £000
Private patient income	**2,996**	2,773
Total patient related income	**305,153**	225,193
Proportion (as percentage)	**0.98%**	1.23%

The note above confirms that the Trust has complied with the condition imposed at the time of receiving Foundation status with regard to Private Patients Income.

3 Other Operating Income

4. Operating Expenses

4.1 Operating expenses comprise:

	12 Months to 31 March 2006 £000	9 Months to 31 March 2005 £000
Services from Foundation Trusts	**75**	23
Services from other NHS Trusts	**7,296**	6,077
Services from other NHS bodies	**2,419**	1,009
Purchase of healthcare from non NHS bodies	**5,792**	4,032
Executive directors' costs	**1,376**	929
Non-executive directors' costs	**116**	78
Staff costs	**217,435**	155,959
Drug costs	**48,199**	31,826
Supplies and services - clinical	**36,255**	25,582
Supplies and services - general	**5,237**	3,856
Establishment	**4,484**	3,598
Transport	**598**	393
Premises	**15,839**	10,180
Bad debts	**356**	(70)
Depreciation and amortisation	**12,783**	10,523
Audit fees	**117**	170
Clinical negligence	**1,726**	997
Other	**10,653**	7,623
	370,756	262,785

4.2 Operating leases

4.2/1 Operating expenses include:

	12 Months to 31 March 2006 £000	9 Months to 31 March 2005 £000
Hire of plant and machinery	**228**	198
Other operating lease rentals	**85**	69
	313	267

4.2/2 Annual commitments under non - cancellable operating leases are:

	Land and Buildings		Other leases	
	12 Months to 31 March 2006 £000	9 Months to 31 March 2005 £000	12 Months to 31 March 2006 £000	9 Months to 31 March 2005 £000
Operating leases which expire:				
Within 1 year	**0**	0	**62**	82
Between 1 and 5 years	**0**	0	**166**	238
After 5 years	**460**	457	**0**	0
	460	457	**228**	320

5 Salary and Pension entitlements of senior managers

5.1 Remuneration

Name and Title	Year Ended 31 March 2006			9 Months to 31 March 2005		
	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100
SENIOR MANAGERS						
Mark Britnell, Chief Executive	195 - 200	0	13,600	130 - 135	0	10,200
Peter Shanahan, Deputy Chief Executive and Chief Financial Officer	135 - 140	0	8,400	75 - 80	0	5,000
Dame Catherine Elcoat, Chief Nursing Officer	110 - 115	0	10,500	65 - 70	0	6,800
Professor William Littler, Executive Medical Director *Consent to disclose other remuneration withheld (left office 30/9/2005)	20 - 25	*	0	30 - 35	*	0
Julie Moore, Chief Operating Officer	135 - 140	0	0	80 - 85	0	0
Melvyn Morris, New Hospital Project Director (left office 31/12/05)	85 - 90	0	0	75 - 80	0	0
Mike Sexton, Acting Director of Finance (commenced office 26/10/2005)	35 - 40	0	0	N/A	N/A	N/A
Mike Sharon, Director of Policy, Planning and Performance Management	90 - 95	0	0	25 - 30	0	0
Professor Rob Stockley, Medical Director and Director of Clinical Standards (commenced office 3/10/2005)	50 - 55	30 - 35	0	N/A	N/A	N/A
Caroline Wigley, Director of Organisation Development (commenced office 6/6/2005)	90 - 95	0	0	N/A	N/A	N/A
Robert White, Director of Finance (left office 23/10/2005)	50 - 55	0	0	65 - 70	0	0
NON EXECUTIVE DIRECTORS						
John Charlton, Chairman	30 - 35	0	0	25 - 30	0	0
S Dobson	10 - 15	0	0	5 - 10	0	0
T Huq	10 - 15	0	0	5 - 10	0	0
C Robinson	10 - 15	0	0	5 - 10	0	0
Rev M Santer	10 - 15	0	0	5 - 10	0	0

5.2 Pension Benefits

Name and title	Real increase in pension at age 60 (bands of £2500) £000	Real increase in pension related lump sum at age 60 (bands of £2500) £000	Total accrued pension at age 60 at 31 March 2005 (bands of £5000) £000	Total accrued pension related lump sum at age 60 at 31 March 2005 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2005 £000	Cash Equivalent Transfer Value at 31 March 2006 £000	Real Increase in Cash Equivalent Transfer Value £000	Employ Contribut Stakeh Pensi To neare
Mark Britnell, Chief Executive	0 - 2.5	5 -7.5	*	65 - 70	251	222	29	N/A
Peter Shanahan, Deputy Chief Executive and Chief Financial Officer	*	10 - 15	*	45 - 50	187	132	55	N/A
Dame Catherine Elcoat, Chief Nursing Officer	*	25 - 30	*	95 - 100	536	356	180	N/A
Professor William Littler, Executive Medical Director (left office 30/9/2005)	*	0	*	310 - 315	0	0	0	N/A
Julie Moore, Chief Operating Officer	2.5 - 5	10 - 15	*	100 - 105	470	395	75	N/A
Melvyn Morris, New Hospital Project Director (left office 31/12/2005)	*	5 - 7.5	*	135 -140	0	0	0	N/A
Mike Sexton, Acting Director of Finance (commenced office 26/10/2005)	0	0	20 -25	70 - 75	337	0	0	N/A
Mike Sharon, Director of Policy, Planning and Performance Management	0 - 2.5	2.5 - 5	20 - 25	65 - 70	315	289	26	N/A
Professor Rob Stockley, Medical Director and Director of Clinical Standards (commenced office 3/10/2005)	0	0	35 - 40	105 - 110	662	0	0	N/A
Caroline Wigley, Director of Organisation Development (commenced office 6/6/2005)	0	0	30 - 35	100 - 105	539	0	0	N/A
Robert White, Director of Finance (left office 23/10/2005)	*	7.5 - 10	*	40 - 45	179	140	39	N/A

* Consent to disclose withheld

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

5.2a Pension Benefits (continued)

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 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 described 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.

6. Staff costs and numbers

6.1 Staff costs

	12 Months to 31 March 2006 Total	Permanently Employed	Other	9 Months to 31 March 2005 Total
	£000	£000	£000	£000
Salaries and wages	**175,057**	163,660	11,397	114,557
Social Security Costs	**15,576**	15,576	0	10,591
Employer contributions to NHSPA	**19,405**	19,405	0	13,267
Agency/contract staff	**8,742**	0	8,742	18,470
	218,780	**198,641**	**20,139**	156,885

6.2 Average number of persons employed

	2006 Total	Permanently Employed	Other	2005 Total
	Number	Number	Number	Number
Medical and dental	**716**	716	0	642
Administration and estates	**1,496**	1,496	0	1,501
Healthcare assistants and other support staff	**538**	538	0	503
Nursing, midwifery and health visiting staff	**2,536**	2,536	0	2,263
Scientific, therapeutic and technical staff	**791**	791	0	928
Bank and agency staff	**114**	0	114	101
Total	**6,191**	**6,077**	**114**	5,938

6.3 Retirements due to ill-health

During the year to 31 March 2006 there were 6 early retirements from the Trust agreed on the grounds of ill-health (9 months to 31 March 2005 - 9). The estimated additional pension liabilities of these ill-health retirements will be £206,109 (9 months to 31 March 2005 - £328,183). The cost of these ill-health retirements will be borne by the NHS Pensions Agency.

7. Exceptional Items

	12 Months to 31 March 2006 £000	9 Months to 31 March 2005 £000
Accelerated depreciation	3,564	0

The exceptional item of £3,564,000 relates to additional depreciation charges as a result of the new hospital. Although financial close had not been reached by 31 March 2006 this reflects the write off of buildings that have been demolished during 2005/06 as part of the enabling works.

8. Profit/(Loss) on Disposal of Fixed Assets

Profit/loss on the disposal of fixed assets is made up as follows:

	12 Months to 31 March 2006 £000	9 Months to 31 March 2005 £000
Profit/(loss) on disposal of plant and equipment	25	(10)
Loss on disposal of land and buildings	(102)	0
	(77)	(10)

9. Interest

9.1 Interest Receivable

Bank interest receivable	731	633
Loan interest receivable	22	0
	753	633

9.2 Interest payable

Interest paid in year	1	0

10. Taxation

10.1 Corporation Tax Payable

The activities of the Trust have not given rise to any corporation tax liability in the year (9 months to 2005 - not applicable).

11. Fixed Assets

11.1 The net book value of land, buildings and dwellings at 31 March 2006 comprises:

	31 March 2006 £000	31 March 2005 £000
Freehold	208,420	203,023
Long leasehold	0	0
Short leasehold	0	0
TOTAL	208,420	203,023

11.2 Tangible Fixed Assets

Tangible fixed assets at the balance sheet date comprise the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and poa	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2005	72,298	126,565	6,408	10,264	63,217	128	3,596	4,975	287,451
Additions purchased	354	8,562	0	4,624	5,158	0	0	0	18,698
Additions donated	0	27	0	109	278	0	0	0	414
Reclassifications	0	7,702	85	(11,197)	2,678	0	566	166	0
Disposals	0	(7,358)	0	0	(2,753)	(9)	0	0	(10,120)
At 31 March 2006	**72,652**	**135,498**	**6,493**	**3,800**	**68,578**	**119**	**4,162**	**5,141**	**296,443**
Depreciation at 1 April 2005	0	0	0	0	40,965	128	1,240	2,873	45,206
Provided during the year	0	6,299	208	0	5,229	0	430	617	12,783
Disposals	0	(284)	0	0	(2,599)	(9)	0	0	(2,892)
Depreciation at 31 March 2006	**0**	**6,015**	**208**	**0**	**43,595**	**119**	**1,670**	**3,490**	**55,097**
Net book value									
- Purchased at 1 April 2005	72,298	119,248	6,373	10,254	17,122	0	2,316	1,973	229,584
- Donated at 1 April 2005	0	7,317	35	10	5,130	0	40	129	12,661
Total at 1 April 2005	**72,298**	**126,565**	**6,408**	**10,264**	**22,252**	**0**	**2,356**	**2,102**	**242,245**
- Purchased at 31 March 2006	72,652	123,578	6,252	3,791	20,291	0	2,463	1,545	230,572
- Donated at 31 March 2006	0	5,905	33	9	4,692	0	29	106	10,774
Total at 31 March 2006	**72,652**	**129,483**	**6,285**	**3,800**	**24,983**	**0**	**2,492**	**1,651**	**241,346**

11.3 Analysis of tangible fixed assets

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and poa	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
Net book value									
- Protected assets at 31 March 2006	0	67,924	0	0	0	0	0	0	**67,924**
- Unprotected assets at 31 March 2006	72,652	61,559	6,285	3,800	24,983	0	2,492	1,651	**173,422**
Total at 31 March 2006	**72,652**	**129,483**	**6,285**	**3,800**	**24,983**	**0**	**2,492**	**1,651**	**241,346**

12. Stocks and Work in Progress

	31 March 2006 £000	31 March 2005 £000
Raw materials and consumables	7,760	7,545
Work-in-progress	17	5
Finished goods	1,013	432
TOTAL	8,790	7,982

13. Debtors

	31 March 2006 £000	31 March 2005 £000
Amounts falling due within one year:		
NHS debtors	10,723	12,940
Non NHS trade debtors	5,281	5,583
Provision for irrecoverable debts	(210)	(137)
Loan to NHS Trust	103	0
Other prepayments and accrued income	5,369	5,827
Other debtors	3,469	3,449
Sub Total	24,735	27,662
Amounts falling due after more than one year:		
NHS debtors	720	713
Provision for irrecoverable debts	(84)	(88)
Loan to NHS Trust	176	0
Other debtors	1,400	1,463
Sub Total	2,212	2,088
TOTAL	26,947	29,750

14. Creditors

14.1 Creditors at the balance sheet date are made up of:

	31 March 2006 £000	31 March 2005 £000
Amounts falling due within one year:		
Payments received on account	**54**	195
NHS creditors	**5,828**	2,725
Non - NHS trade creditors - revenue - other	**9,756**	10,343
Non - NHS trade creditors - capital	**3,247**	1,311
Tax and social security costs	**4,990**	4,589
Other creditors	**3,378**	3,187
Accruals and deferred income	**14,908**	12,453
Sub Total	**42,161**	34,803
Amounts falling due after more than one year:	**0**	0
TOTAL	**42,161**	34,803

NHS creditors include;

£2,416,894 outstanding pensions contributions at 31 March 2006 (31 March 2005 £2,224,338).

14.2 Prudential borrowing limit:

	31 March 2006 £000	31 March 2005 £000
Prudential borrowing limit set by Monitor	**77,100**	11,000
Working capital facility	**19,500**	8,000
Actual borrowing in year	**0**	0
Minimum dividend cover	**2.2%**	3.1%
Minimum interest cover	**0.0%**	0.0%
Minimum debt service cover	**0.0%**	0.0%
Maximum debt/capital ratio	**0.0%**	0.0%
Maximum debt service to revenue	**0.0%**	0.0%

15. Provisions for liabilities and charges

	Pensions relating to other staff	Legal claims	Other	**Total**
	£000	£000	£000	**£000**
At 1 April 2005	257	1,029	5,300	**6,586**
Change in discount rate	16	126	0	**142**
Arising during the year	0	421	3,452	**3,873**
Utilised during the year	(30)	(166)	(4,269)	**(4,465)**
Reversed unused	0	(93)	(252)	**(345)**
Unwinding of discount	26	0	0	**26**
At 31 March 2006	**269**	**1,317**	**4,231**	**5,817**

Expected timing of cashflows:	£'000	£'000	£'000	**£'000**
Within one year	31	291	4,231	**4,553**
Between one and five years	117	197	0	**314**
After five years	121	829	0	**950**

The provisions included under 'legal claims' are for personal injury (£1,078,337) and employers and public liability (£238,780). The provision for public liability has been calculated based on information received from the Trust's legal advisors, taking into account indications of uncertainty and timing of payments. Injury benefit has been calculated based on guidance received from the NHS Pensions

16.1 Movement in taxpayers' equity	31 March 2006 £000	31 March 2005 £000
Taxpayers' equity at start of period	247,711	232,604
Prior period adjustments	(166)	0
Taxpayers equity at start of period, as restated	247,545	232,604
Surplus/(deficit) for the financial year	4,727	6,358
Public dividend capital dividends	(8,253)	(5,269)
Surplus/(deficit) from revaluations of fixed assets and current asset investments	(2,379)	12,987
New public dividend capital received	4,005	9,479
Additions/(reductions) in donated asset reserve	(1,887)	(8,614)
Taxpayers equity at 31 March 2006	243,758	247,545

17. Movements on Reserves

Movements on reserves in the year comprised the following:

	Revaluation Reserve	Donated Asset Reserve	Government Grant Reserve	Income and Expenditure Reserve	**Total**
	£000	£000	£000	£000	**£000**
At 1 April 2005	70,996	12,661	1,229	9,123	**94,009**
Prior Period Adjustments	0	0	(1,229)	1,063	**(166)**
At 1 April 2005 as restated	70,996	12,661	0	10,186	**93,843**
Transfer from the income and expenditure account	0	0	0	(3,526)	**(3,526)**
Impact of disposals on revaluation reserve	(2,379)	0	0	0	**(2,379)**
Donated assets disposed of in year		(1,183)	0	0	**(1,183)**
Receipt of donated assets	0	414	0	0	**414**
Transfers to the Income and Expenditure Account for depreciation on donated assets	0	(1,118)	0	0	**(1,118)**
Other transfers between reserves	(87)	0	0	87	**0**
At 31 March 2006	**68,530**	**10,774**	**0**	**6,747**	**86,051**

The release from the revaluation reserve to the income and expenditure reserve is in respect of the depreciation charge applied to fixed assets in excess of historic cost. The transfer avoids the anomaly of the revaluation reserve remaining in perpetuity after an asset has become fully depreciated.

Prior Period Adjustments

The prior period adjustment to the government grant reserve occurred due to the requirement to fully comply with SSAP 4 Accounting for Government Grants which states that government grants should be treated as deferred income. This represents a change in accounting policy from 2005 in that previously, such grants were accounted for as a reserve under tax payer's equity.

The prior period adjustment to the income and expenditure reserve occurred due to the requirement to comply with FRS 5 Reporting the Substance of Transactions and UITF 40 Revenue Recognition and Service Contracts, under which, income relating partially completed patient treatments at the end of the financial year are accrued for.

18. Notes to the cash flow Statement

18.1 Reconciliation of operating surplus to net cash flow from operating activities:

	31 March 2006 £000	31 March 2005 £000
Total operating surplus	7,784	5,757
Depreciation and amortisation charge	12,783	10,523
Transfer from donated asset reserve	(1,118)	(1,121)
Transfer from the government grant reserve	0	0
(Increase)/decrease in stocks	(808)	268
Decrease in debtors	2,793	2,175
Increase/(decrease) in creditors	5,422	(3,764)
Increase in provisions	(937)	1,957
Net cash inflow from operating activities	25,919	15,795

18.2 Reconciliation of net cash flow to movement in net debt

	£000	£000
Increase in cash in the period	5,696	8,050
Cash inflow from new debt	0	0
Cash outflow from debt repaid and finance lease capital payments	0	0
Cash (inflow)/outflow from (decrease)/increase in liquid resources	0	0
Change in net debt resulting from cashflows	5,696	8,050
Non - cash changes in debt	0	0
Net debt at 1 April 2005	8,957	907
Net debt at 31 March 2006	14,653	8,957

18.3 Analysis of changes in net debt

	At 1 April 2005 £000	Cash changes in year £000	At 31 March 2006 £000
OPG cash at bank	42	477	519
Commercial cash at bank and in hand	8,915	5,219	14,134
	8,957	5,696	14,653

19. Capital Commitments

Commitments under capital expenditure contracts at the balance sheet date were £2,109,457 (31 March 2005 - £8,493,000).

20. Post Balance Sheet Events

On 14 June 2006, the Trust received financial close on the Birmingham New Hospital Project. This project will provide a facility which will support the transformation and modernisation of acute and mental health services in South Birmingham during the first part of this century. The £545 million project is being developed by University Hospital Birmingham NHS Foundation Trust in partnership with Birmingham and Solihull Mental Health NHS Trust.

As it will be the first new hospital to be built in Birmingham for 70 years, there is an unprecedented level of support for the project within the City. The new secondary and tertiary care hospital, which has capacity for over 1,200 beds, will be built on the Queen Elizabeth site in Edgbaston. Construction work has commenced and the project is due for completion in 2011.

21. Contingencies

New Hospital Contingent Liability:

At 31st March 2006 there was a contingent liability of £43.5m (31 March 2005 - £15.0m). This contingency ceased on 14th June 2006 following financial close.

University Hospital Birmingham NHS Foundation Trust, together with its partner Birmingham and Solihull Mental Health Trust entered into an advanced Works agreement with Balfour Beatty Limited. The essence of this agreement was that Balfour Beatty will, during the period from appointment of a preferred bidder to financial close, carry out a series of works and progress (such as construction of car parks) and progress the construction designs to a level which will enable the main construction programme to commence immediately after financial close. This arrangement reduced the overall construction period hence reducing the unitary payment for both Trusts.

Balfour Beatty funded these works from their internal resources prior to financial close with the intent that as soon as financial close was reached they are funded as part of the PFI in the normal way and the Advanced Works agreement fell away.

Further detail of the New Hospital development can be found in note 24.

Other Contingent Liability:

There are nil (31 March 2005 - £119, 000) included above which relates to amounts notified by the NHSLA for potential employer and public liability claims over and above the amounts provided for in note 16.

22. Public Dividend Capital dividend

The Trust is required to absorb the cost of capital at a rate of 3.5% of average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital, totalling £8,253,000 (9 months to 31 March 2005 - 5,269,000) bears to the average relevant net assets of £226,705,000 (9 months to 31 March £216,187,000) that is 3.6% (9 months to 31 March 2005 - 2.44%).

23. Related Party Transactions

University Hospital Birmingham NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

Mr M Britnell, Chief Executive of the Trust is also a Non-Executive Director of Dr Foster LLP. The Trust paid a total of £53110 for the services of Dr Foster Limited during the year to 31 March 2006 (9 Months to 31 March 2005 - £22,208). The amount owed to this company was £7403 at the balance sheet date (31 March 2005 - nil) .

	Payments to Related Party by the Trust	Receipts from Related Party to the Trust	Amounts owed to Related Party	Amounts due from Related Party
	£	£	£	£
Dr Foster LLP	53,110	16,690	7,403	0

The Department of Health is regarded as a related party. During the year University Hospital Birmingham NHS Foundation 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:

Anthony Nolan Bonemarrow Trust
Avon Ambulance Service NHS Trust
Birmingham & Black Country StHA
Birmingham & Solihull Mental Health Trust
Birmingham Childrens NHS Trust
Birmingham Women's Health Care NHS Trust
Burntwood, Lichfield & Tamworth PCT
Cannock Chase PCT
Coventry Teaching PCT
Dudley, Beacon & Castle PCT
Dudley South PCT
Eastern Birmingham PCT
East Leicestershire PCT
East Staffordshire PCT
Good Hope Hospital NHS Trust
Health Commission Wales
Health and Community Ambulance NHS Trust
Health Protection Agency
Heart of Birmingham PCT
Heart of England NHS Foundation Trust
Herefordshire PCT
North Birmingham PCT
North Wales Health Authority
North Warwickshire PCT
Oldbury & Smethwick PCT
Oxford Radcliffe Hospital NHS Trust
Prescription Pricing Authority
Redditch & Bromsgrove PCT
Rowley Regis & Tipton PCT
Royal Orthopaedic Hospital NHS Trust
Sandwell & West Birmingham NHS Trust
Shropshire County PCT
Solihull PCT
South Birmingham PCT
South Worcestershire PCT
South Warwickshire PCT
South Western Staffordshire PCT
Telford & Wrekin PCT
University Hospital Coventry & Warwickshire NHS Trust
Walsall PCT
Warwickshire Ambulance Service NHS Trust

24. Private Finance Transactions

24.1 New Hospital Project

On 12 April 2006, HM Treasury approved the Business Case for the New Hospital under the PFI Initiative and on 14 June 2006, the Trust achieved financial close.

24.2 Pan Birmingham Decontamination Project

The Pan Birmingham Decontamination Project has involved 8 of the trusts in the city working together to find an optimal, state of the art solution to improve both the quality and facilities for decontamination across the city. An initial option appraisal carried out by the project team indicated a preferred solution that reduced the existing seven processing units down to no more than two sites.

The Full Business Case (FBC) was approved by the Strategic Health Authority Review Group on 25 May 2006. The project is expected to reach financial close in July 2006.

25 Derivatives and Financial Instruments

FRS 13, Derivatives and Other Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with local Primary Care Trusts and the way those Primary Care Trusts 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 the listed companies to which FRS 13 mainly applies. 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.

As allowed by FRS 13, debtors and creditors that are due to mature or become payable within 12 months from the balance sheet date have been omitted from all disclosures other than the currency profile. Provisions are shown gross. Any amount expected in reimbursement against a provision (and included in debtors) should be separately disclosed.

The Trust is required to be a member of the EU Carbon Emissions Trading Scheme due to the Trust's level of emissions. The scheme meets the definition of a derivative financial instrument under FRS 13. However as Treasury rules prohibit government bodies from trading in carbon allowances solely for the purposes of trading in the financial markets, this means that the Trust cannot speculate on the future value of carbon allowances.

Liquidity risk

The NHS Trust's net operating costs are incurred under annual service agreements with local Primary Care Trusts, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from funds made available from Government under an agreed borrowing limit. University Hospital Birmingham NHS Foundation Trust is not, therefore, exposed to significant liquidity risks.

Interest-Rate Risk

100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. University Hospital Birmingham NHS Foundation Trust is not, therefore, exposed to significant interest-rate risk. The following two tables show the interest rate profiles of the Trust's financial assets and liabilities:

25.1 Financial Assets

Currency	Total	Floating rate	Fixed rate	Non-interest bearing	Fixed rate: Weighted average interest rate	Fixed rate: Weighted average period for which fixed	Non-interest bearing: Weighted average term
	£000	£000	£000	£000	%	Years	Years
At 31 March 2006							
Sterling	14,653	0	0	14,653	0.0%	0	0
Other	896	0	896	0	3.1%	0	0
Gross financial assets	**15,549**	**0**	**896**	**14,653**			
At 31 March 2005							
Sterling	8,957	0	0	8,957	0.0%	0	0
Other	713	0	713	0	3.5%	0	0
Gross financial assets	**9,670**	**0**	**713**	**8,957**			

25.2 Financial Liabilities

Currency	Total	Floating rate	Fixed rate	Non-interest bearing	Fixed rate: Weighted average interest rate	Fixed rate: Weighted average period for which fixed	Non-interest bearing: Weighted average term
	£000	£000	£000	£000	%	Years	Years
At 31 March 2005							
Sterling	0	0	0	0	0.0%	0	0
Other	163,524	0	5,817	157,707	2.2%	0	0
Gross financial liabilities	**163,524**	**0**	**5,817**	**157,707**			
At 31 March 2005							
Sterling	0	0	0	0	0.0%	0	0
Other	160,288	0	6,586	153,702	3.5%	0	0
Gross financial liabilities	**160,288**	**0**	**6,586**	**153,702**			

Note: The public dividend capital is of unlimited term.

25.3 Fair Values

Set out below is a comparison, by category, of book values and fair values of the Trust's financial assets and liabilities as at 31 March 2006.

	Book Value	Fair Value	Basis of fair valuation
	£000	£000	
Financial assets			
Cash	14,653	14,653	
Debtors over 1 year:			
- Agreements with commissioners to cover creditors and provisions	720	720	Note a
- Loan to NHS Trust	176	176	Note b
Total	15,549	15,549	
Financial liabilities			
Working capital facility	(19,500)	(19,500)	
Provisions under contract	(5,817)	(5,817)	Note c
Public dividend capital	(157,707)	(157,707)	Note d
Total	(183,024)	(183,024)	

Notes

a These debtors reflect agreements with commissioners to cover creditors over 1 year for early retirements and provisions under contract, and their related interest charge/unwinding of discount. In line with notes c and e, below, fair value is not significantly different from book value.

b This debtor reflects the element of a loan made to another NHS Trust which is due to be repaid to University Hospital Birmingham NHS Foundation Trust in more than one year.

c Fair value is not significantly different from book value since, in the calculation of book value, the expected cash flows have been discounted by the Treasury discount rate of 3.5% in real terms.

d This figure is the full value of PDC in the balance sheet.

26 Third Party Assets

The Trust held £2,508 cash at bank and in hand at 31/03/06 (£17,124 - at 31/03/05) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts.

27 Losses and Special Payments

There were 167 cases of losses and special payments (9 months to 31 March 2005 - 139 cases) totalling £427,427 (9 months to 31 March 2005 - £278,940) approved in the year.

There were nil clinical negligence cases where the net payment exceeded £100,000 (prior 9 month period: nil cases).

There were nil fraud cases where the net payment exceeded £100,000 (prior 9 month period nil cases).

There were nil personal injury cases where the net payment exceeded £100,000 (prior 9 month period nil cases).

There were nil compensation under legal obligation cases where the net payment exceeded £100,000 (prior 9 month period nil cases).

There were nil fruitless payment cases where the net payment exceeded £100,000 (prior 9 month period nil cases.

Note: The total costs included in this note are on a cash basis and will not reconcile to the amounts in the notes to the accounts which are prepared on an accruals basis.

HEALTH AND SOCIAL CARE (COMMUNITY HEALTH STANDARDS) ACT 2003

DIRECTIONS BY MONITOR IN RESPECT OF NATIONAL HEALTH SERVICE FOUNDATION TRUSTS' ANNUAL ACCOUNTS

Monitor, the Independent Regulator of NHS Foundation Trusts, with the approval of HM Treasury, in exercise of powers conferred on it by paragraph 25(1) of schedule 1 of the Health and Social Care (Community Health Standards) Act 2003, hereby gives the following Directions:

1. Application and interpretation

(1) These Directions apply to NHS foundation trusts in England.

(2) In these direction "The Accounts" means:

for an NHS foundation trust in its first operating period since authorisation, the accounts of an NHS foundation trust for the period from authorisation until 31 March; or

for an NHS foundation trust in its second or subsequent operating period following authorisation, the accounts of an NHS foundation trust for the period from 1 April until 31 March.

2. Form of accounts

(1) The Annual Accounts submitted under paragraph 25 of Schedule 1 of the 2003 Act shall show, and give a true and fair view of, the NHS foundation trust's gains and losses, cash flows and financial state at the end of the financial period.

(2) The annual Accounts shall meet the accounting requirements of the NHS Foundation Trust Financial Reporting Manual (FT FReM) as agreed with HM Treasury, in force for the relevant financial year.

(3) The Balance Sheet shall be signed and dated by the chief executive of the NHS foundation trust.

(4) The Statement on Internal Control shall be signed and dated by the chief executive of the NHS foundation trust.

3. Statement of accounting officer's responsibilities

(1) The statement of accounting officer's responsibilities in respect of the accounts shall be signed and dated by the chief executive of the NHS foundation trust.

4. Approval on behalf of HM Treasury

(1) These Directions have been approved on behalf of HM Treasury

Signed by the authority of Monitor, the Independent Regulator of NHS foundation trusts

Name: Dr. William Moyes (Chairman)

Dated: 8 November 2005