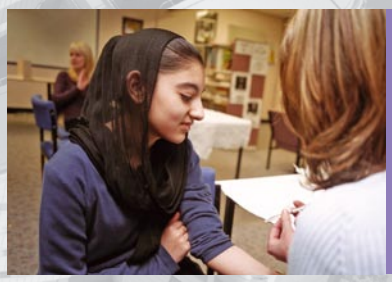
University Hospital Birmingham
NHS Foundation Trust

Annual Report and Accounts **2006/07**



This annual report covers the period
1 April 2006 to 31 March 2007

University Hospital Birmingham NHS Foundation Trust

Annual Report and Accounts

This annual report covers the period
1 April 2006 to 31 March 2007

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

CONTENTS

1. CHAIRMAN'S STATEMENT

I am pleased to contribute this statement to the Annual Report of University Hospital Birmingham NHS Foundation Trust (UHB) 2006/07. UHB has had a very successful year thanks to the continued commitment and hard work of its staff, governors, members, volunteers and key partners.

We have met or exceeded some very challenging targets and have also achieved a breakeven financial position for the twelfth successive year.

The Healthcare Commission performance ratings for 2005/06 were published in October 2006. UHB scored "good" for service quality and "excellent" for use of resources. These scores mean that the Trust was the highest performing in the West Midlands. Nationally, only two Trusts achieved higher ratings.

We reached financial close on the £545 million privately funded initiative to build Birmingham's first new hospital in 70 years and provided the best possible care and treatment to over 500,000 patients from South Birmingham and beyond.

Our direction continues to be shaped by our Board of Governors and our membership, with an increase in their active involvement in the Trust. They provide us with insight and welcome feedback into the organisation, its services and environment, as well as helping us to shape our priorities now and into the future.

In 2006/07, there were significant changes to the senior management team and the Board of Directors. I took on the role of Chairman in December. The Trust now has a new Chief Executive, two new Non-Executive Directors, and four new Executive Directors (two of whom are acting). A new project director for the new hospital took up post in December 2006.

The Trust expects that the external healthcare environment will continue to become more testing as a result of a number of factors. The challenges include: the reduction in funding growth for the NHS after March 2008; the development of practice-based commissioning; the policy of providing more services in community setting and greater competition from other FTs and the independent sector. However we have robust measures in place to mitigate key risks.

The new Executive and Non-Executive team is looking forward to leading UHB into the new hospital and into a new era. We know we have some challenges ahead as we strive to deliver best care to our all patients, while managing our finances expertly and ensuring the new hospital project is on time and on budget.

However I am confident we have the skills, strategy and desire to achieve them.

I would like to thank everyone once again for their contribution over the last 12 months and look forward to working with you in the future.

Sir Albert Bore
Chairman

2. CHIEF EXECUTIVE'S STATEMENT

This is my first Annual Report as Chief Executive. However, I have worked at UHB for five years and am well aware of the enormous dedication and talent of its staff, Governors, members and volunteers. 2006/07 was another very successful year for the Trust and it would not have been possible without the efforts of each and every one of them.

Over 98% of our patients have been treated, admitted, or discharged from accident and emergency within four hours throughout the year; we have met our cancer waiting time targets and sustained some of the lowest inpatient and outpatient waiting times in the NHS. We have also achieved dramatic reductions in diagnostic waiting times and we were successful in a bid to secure funding for technological support, such as scanning, for research projects.

Through prudent stewardship, we have also achieved financial balance for the twelfth successive year.

We have made a number of important investments in new consultant posts in stroke services, anaesthetics, spinal surgery, ENT, trauma, and neurosurgery. We have also invested in an additional CT/MRI scanner and a New Linear Accelerator, fully opened the West Midlands Leukaemia Centre and extended the Liver Outpatients Department to improve patient care.

While UHB can be proud of its achievements over the last year, we acknowledge that more needs to be done in some areas. We need to improve further the experience of patients and continue our fight to reduce infection rates. Each member of staff will have a personal objective to reduce and prevent infection.

2006/07 was a year of change and strategic positioning. 2007/08 will be a year of three key priorities:

1. To increase the number of patients choosing to be treated at our hospitals.

2. To increase our productivity, while carefully managing costs.

3. To continue to deliver the new hospital for our half a million patients ensuring it is on time and on budget.

It will not be easy. However I am confident that through the support, enthusiasm and hard work of everyone who has an interest in this organisation we will deliver the challenges and ultimately deliver best care for our patients.

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

Julie Moore
Chief Executive

June 7, 2007
Date

3. BACKGROUND INFORMATION

3.1 University Hospital Birmingham NHS Foundation Trust (UHB)

UHB runs two hospitals, the Queen Elizabeth and Selly Oak, which are situated 1.5 miles apart in South Birmingham.

On July 1, 2004 we achieved Foundation Trust 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 those of a NHS trust.

UHB has around 86,000 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.

The annual budget in 2006/07 was £394 million and by the end of the year more than 6,900 people were working for UHB across more than 40 disciplines. Our staff provide traditional district general hospital services for the adult population of South Birmingham and specialist acute treatments for people in the West Midlands and beyond.

In June 2006, UHB reached financial close on the £545 million PFI project to build Birmingham's first new hospital in 70 years. The commencement of the construction work for the new hospital was officially commemorated by the Prime Minister Tony Blair MP on September 14 and the building work is currently on time and on budget. The first phase of transition into the new hospital starts in 2010, with it becoming fully operational by June 2012.

Over 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 this year received 'excellent' for its financial management and 'good' for the quality of its clinical and non-clinical services in the Healthcare Commission's first Annual Health Check. UHB was the top performing trust in the West Midlands and in the top 20 in the country.

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).

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. UHB is one of only a small number of hospitals that can provide the full range of medical specialties – trauma, burns, plastics, orthopaedics, neurosurgery, critical care - needed to treat the complex nature of conflict injuries, all under one roof.

Medical military staff also gain valuable experience working in an NHS hospital equipping them with the skills needed to take with them to theatre in war zones.

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 UHB and the University of Birmingham Medical School.

4. OPERATING AND FINANCIAL REVIEW

4.1 Operational reporting

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

4.2 Key aims and objectives

UHB is the leading teaching Trust in the West Midlands. We have very close links to the University of Birmingham and so our aims are not simply to provide the best possible care but also to make sure that we fulfil our leading role in teaching medical and nursing students and in providing a base for excellent research. Complementing our role as a centre of excellence, we also aim to be an asset to the communities of Birmingham and the West Midlands.

These ambitions are incorporated into our strategic aims, which also form the framework for annual and medium term planning. Our Annual Plan is available on the Trust's website: www.uhb.nhs.uk

We regularly monitor the progress we are making in meeting our objectives and we do this by producing a twice yearly update to the Board of Directors on the extent to which medium term plan objectives have been fully or partially met, and by providing a suite of monthly performance indicators that measure both operational performance and longer term goals.

4.3 Main trends and factors underlying the development, performance and position of the business

2006/07 was an eventful year for the Trust.

4.31 Internal developments

The Trust reached financial close on the New Hospitals Project. This means that the Trust has to deliver its contractual obligations to be ready to move by certain dates and to pay the Unitary Payment as it begins to occupy the new buildings. It also means that the Trust has obligations to upgrade and must refer to its joint venture partner if it wishes to alter its existing retained estate in any way. UHB has put in place robust arrangements for ensuring that the Trust is fully prepared for the move to new facilities commencing in 2010.

There were significant changes to the senior management team and the Board of Directors. The Trust now has a new Chairman, a new Chief Executive, two new Non-Executive Directors and four new Executive Directors (two of whom are acting). A project director for the new hospital took up post in December 2006. Full details of the changes are outlined in Section 6 – Board of Directors.

The Trust met its objectives in 2006/07, showing strong performances against most national targets including A&E, cancer and other waiting times. The reduction during 2006/07 in waiting times for diagnostic tests has been particularly pleasing and places the Trust in a good position to meet further challenging waiting time reductions during 2007/08. The Trust was also successful in a bid to secure funding for technological support, such as scanning, for research projects.

The Healthcare Commission performance ratings for 2005/06 were published in October 2006. UHB scored "good" for service quality and "excellent" for use of resources. Nationally, only two Trusts achieved higher ratings.

While infection rates were slightly down on last year, we have not made the progress we would have liked in this area. In December 2006 the Trust invited the Department of Health to review our practice to see if there were any improvements we could make on infection control. The DH report was generally very complimentary about the action we are taking to reduce infection rates. Infection rates in the second half of the year were lower than in the first half.

The results of the 2005/06 Patient Survey were received in June 2006 and showed that there were areas for improvement. These are being addressed and the Trust has also begun to undertake more detailed surveys of patients to provide information on the performance of specific areas within the Trust.

The Staff Survey results were, again, good, showing significantly higher than average levels of staff satisfaction. Some 86% of staff said they were proud to work for the Trust.

The Trust also undertook extensive survey work of its members as a basis for developing its membership strategy. This work again highlighted the strong reputation of the Trust for delivering clinical services of high quality. More detail is outlined in Section 7 - Membership.

In September 2006 the Trust also entered into a contractual arrangement with a commercial company, Xchanging, to provide the Trust with HR administrative services and to further commercialise and market the Trust's existing payroll service which pays around 110,000 NHS staff.

After an OJEU tendering process Xchanging were also appointed to support the Trust in developing process redesign or "lean" projects that will improve patient care and satisfaction and contribute to reducing unit costs.

The Government Office European Regional Development Fund and the regional development agency, Advantage West Midlands (in June and September 2006 respectively) approved capital contributions totalling £1.1m to support the building of a Learning Hub on the UHB site to support hard-to-reach groups to access health and building employment opportunities as well as to provide a training venue for low-skilled Trust employees.

The Trust has faced a significant challenge over the last 12 months in its efforts to care for the military personnel who are being treated at our hospitals following injuries sustained in Iraq and Afghanistan.

Selly Oak Hospital has received high profile media coverage which in the main has been inaccurate, unsubstantiated and ill-informed as well as extremely demotivating for both military and civilian staff.

However, despite the challenging times, the Trust has continued to work closely with the Ministry of Defence to ensure that military personnel receive the best possible care that recognises their specific needs, at all times.

During the last 12 months we have received over 110 VIP visitors to the military patients including the Prince of Wales, the Prime Minister Tony Blair MP, leader of the Opposition David Cameron and Under Secretary for State for Defence Derek Twigg. Every one of them has supported the quality of treatment and care being offered at UHB. General Richard Dannatt, Chief of Staff of the Army, told the national press that the treatment at Selly Oak was 'world-class'.

Since 2001 we have treated over 6,000 military inpatients and nearly 30,000 military outpatients. The number of complaints we have received is very small and we have worked hard with the military to resolve any issues that have arisen.

4.32 Other Trust initiatives

During the year the Trust established a number of initiatives to improve the service it provides to patients:

- The Trust won a contract with the Ministry of Defence to provide a fast-track Trauma service for domestic military patients
- The Trust opened an Automated Bacteriological Laboratory Track service in June 2006 which will meet the 6% annual growth in demand
- A Diabetic Research Centre was established on the Selly Oak site in collaboration with Novo-Nordisk
- UHB Medicines received its production licence for the manufacture of Sterile Fluids in August 2006. The manufacturing unit, which incorporates state of the art facilities, will provide sterile fluids to the NHS and private companies
- The Trust has expanded its Neurosurgical coiling service for sub-arachnoid haemorrhage to the whole of the West Midlands Region

- The Trust E-prescribing system (known as PICS) has been extended to all inpatient specialties within the Trust and a pilot is also underway in haematology outpatients to further develop the service
- The Trust introduced a Hospital at Night service on the Queen Elizabeth site. The service provides a much improved and timely response to patients' needs out of hours and maximises the efficient use of clinical staff via work prioritisation backed by an IT Communication system. The service will be extended to Selly Oak in 2007/08
- An 'Early Donor Assessment and Management Service for Heart & Lung Transplantation' is being established to increase the number of organs available for transplantation
- Initial pilots have been undertaken to electronically book outpatient appointments from GP surgeries. It is hoped to roll out this service to all GPs during 2007/08

4.33 External developments

Working relationships with South Birmingham PCT have been strengthened following the substantive appointment of a Chief Executive and senior management team in that organisation.

The Trust's initial contracts expired in 2006/07. Discussions with South Birmingham PCT over a new contract, based on the national model contract have been held in a constructive atmosphere and the contract is now agreed.

Practice-based commissioners in South Birmingham selected cluster leads during 2006/07 and the Trust has begun to meet with these leads on a quarterly basis. A GP Services Manager has also been appointed to assist in communications with GP practices.

Work is also underway with local GPs and the PCT to manage outpatient demand in ophthalmology, plastic surgery, urology, rheumatology and trauma.

Relationships with other key stakeholders continued to be strong. As well as reaching agreements with Advantage West Midlands (AWM) and the Government Office West Midlands (GOWM), the Trust continued to work effectively with its PFI partner Consort, Birmingham and Solihull Mental Health Trust and Birmingham City Council to ensure the smooth delivery of the Birmingham New Hospitals Project.

Sandwell and West Birmingham Trust began public consultation on short term reconfiguring of paediatric and surgical services, likely to result in some increase in emergency surgical activity at UHB.

Heart of Birmingham Primary Care Trust began consultation on moving Sandwell and West Birmingham services onto a single site on the Birmingham/Smethwick border. Associated with this move they are proposing a significant change to the way in which they commission hospital services. The results for UHB could be an increased inpatient workload as a result of the move and downsizing of SWBH, although this is likely to be offset by the need to provide outpatient services in different settings and in different ways.

The West Midlands Strategic Health Authority awarded a contract for diagnostic work to the independent sector. It is too early to predict the effect of this contract on UHB diagnostic activity. There is a short term need to reduce diagnostic waiting times and the act of doing this may increase the underlying demand for diagnostic activity. The Trust is in regular dialogue with South Birmingham PCT to identify and take early action in the event of any shifts in referral patterns.

4.34 Main trends and factors likely to influence future development, performance and position

The Trust expects that the external environment will continue to become more challenging as a result of:

- The reduction in funding growth for the NHS after March 2008
- The development of Commissioning in the NHS as a vehicle to shape the pattern of service provision
- The new national contract which provides opportunities for PCTs to exert a greater degree of control over Trusts
- The development of practice-based commissioning which provides incentives for GPs to reduce expenditure in secondary care
- The policy of providing more services in community setting
- Greater competition from other FTs and the independent sector
- The need to ensure that all patients are treated within 18 weeks by December 2008
- The impact of Modernising Medical Careers and European Working Time Regulations

The framework for assessing the Trust's performance will continue to become more sophisticated with an increasing focus on both the experience of patients and the outcome of clinical activities.

Additionally the Trust must ensure that the new hospital remains affordable and delivered on time.

The Trust is well placed to meet these challenges, having delivered very strong service quality and financial performance over a number of years. Some services that may be vulnerable to large shifts in commissioning patterns, such as elective orthopaedics, are not provided at UHB.

The Trust will continue to improve patient satisfaction with its services by listening carefully to patients and acting upon that feedback. We will also continue to reduce infection rates. The new hospital, when it is built, will assist in achieving these aims.

4.35 Key constraints

4.35.1 Facilities

Many of UHB's services are provided from outdated estate split across two sites a mile and a half 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 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. The quality of the estate prevents 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.

4.35.2 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 single rooms also hinders UHB's response to Infection Control issues. UHB has made more progress during 2006/07 in reducing MRSA and holding clostridium difficile (C-diff) levels to last year's 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.

Selly Oak Hospital has also launched an 18-month clinical trial to establish whether the installation of copper surfaces will reduce surface contamination and other organisms coming into the hospital, leading to a decrease in cross contamination. If the trial, which is run in conjunction with the Copper Development Agency, is successful, the results will be investigated further.

4.36 Relevant Risks and Directors' approach to managing these risks

The main risks faced by the Trust can be grouped under the following headings:

- Risks to income – for whatever reason income will be lower than planned
- Risks to costs – for whatever reason costs will be higher than planned
- Risks to activity – differ from planned levels
- Risks to clinical quality – the Trust does not achieve the required standards and benchmarks for clinical quality that the Trust sets, or that are set by external bodies such as the Healthcare Commission
- Risks to reputation – perceptions of the Trust are adversely affected by the experience of patients, staff and stakeholders or by media coverage
- Risks presented by the new hospital – the Trust does not manage the contract with Consort effectively, the change programme required to move safely into the new hospital is not delivered and risk that the new hospital is not affordable

The Trust maintains corporate, divisional and departmental risk registers and these are kept under regular review. In addition the Trust is undertaking a review of its approach to risk management and the structures and processes that support this.

4.37 Developments of organisation-wide quality issues

The Trust is committed to improving the experience of patients and has developed comprehensive action plans, including piloting the use of local surveys on bedside televisions.

In 2006/07 an additional 130 volunteers were recruited to support patient care.

The Trust is also committed to implementing a programme of service and process redesign to make services more responsive to the needs of patients. The MRI services piloted a "lean" process redesign and this approach will be rolled out across the Trust with each Division undertaking a number of specific projects.

These projects will sit within new models of care developed as part of the Transformation programme to the new hospital.

The transformation programme is a structured programme based on six work streams. These are:

- Clinical Redesign
- Clinical Information and Automation
- Workforce development
- New hospital physical move
- Patient and public involvement
- Soft facilities management

The programme is overseen by a programme board chaired by an Executive Director of the Trust.

4.38 Regeneration, environmental and social issues

In 2006/07 the Trust completed the final year of the ACTIVATE project that provides jobs and skills training through a three-week induction programme followed by a three-week placement. The programme has been financed by European Social Fund and has met all of its targets. See 4.59 for more details.

The Learning Hub has been functioning from temporary facilities but will move into permanent purpose-built accommodation

at UHB in June 2007. It targets unemployed people and people from BME communities and also has targets to provide training, support and place people in employment. See 4.59 for more details.

The Trust is also in the process of completing the Sustainable Development Commission's Corporate Social Responsibility self assessment.

4.4 Operational Performance 2006/07

Overall operating performance in 2006/07 remained strong with the Trust treating more patients, more quickly, than in 2005/06. Diagnostic waiting times were reduced dramatically from over 40 weeks in some cases to under 13 weeks for all diagnostic tests. Inpatient maximum waiting times also fell from 26 weeks to 20, and outpatient waiting times reduced from 13 weeks to 11 weeks. The A&E department maintained its performance of over 98% of patients waiting less than four hours to be treated for the year despite an increase in attendances of 2.75%.

4.41 Information on key operational performance

More patients have been treated and both the numbers waiting and the time taken to receive treatment have reduced during 2006/07.

Table 1 activity 2005/6-2006/7

	2005/6	2006/7	% Increase
Inpatient Finished Consultant Episodes	68,114	67,174	-1.38
Day-cases (excluding renal dialysis regular day attenders)	28,128	29,841	6.09
Outpatient attendances	316,733	337,539	6.57
A&E Attendances	80,010	81,242	1.54
Total treatments	492,985	515,796	4.63

During 2006/07 the Trust met all of its targets except MRSA bacteraemia reduction. The Trust is meeting its trajectory to reduce emergency bed days by 5% between 03/04 and 07/08. However the Healthcare Commission is measuring progress only between 2005/06 and 2006/07. The Trust is underperforming against this measure.

1. NATIONAL TARGETS/STANDARDS 2006/07

No	Type	Indicator	National/Internal Target	Data Period	Trust	
1	1M	Cancer - 31 days from decision to treat to treatment	98%	Apr 06 - Mar 07	100.0%	
2	1M	Cancer - 62 days from urgent referral to treatment	95%	Apr 06 - Mar 07	98.0%	
3	1M	Inpatient 26 weeks waits (20 weeks from March 2007)	0% (Mar 07- Green above target, amber below target, red below Mar 06 figure)	As at Mar 07	0%	0%
4	1M	Outpatient 13 week waits (11 weeks from March 2007)	0% (Internal - Green above target, amber below target, red below Mar 06 figure)	As at Mar 07	0%	0%
5	1M	Diagnostic 13 week waits from March 2007	Green all 16 tests on target, amber 14 to 15 on target, red <14 on target	As at Mar 07		
6	1M	Bookings for inpatient, outpatient and daycase	100%	Apr 06 - Mar 07	100%	
7	1M	MRSA 60% reduction from 03/04 to 07/08. 20% yr on yr reduction from 05/06	Green in line with target, amber up to 10% above target, red >10% above target	Apr 06 - Mar 07	101 (74)	
8	1M	A&E 4 hour waits	98% average over the year	Apr 06 - Mar 07	98.2%	
9	1M	Cancer 2 week waits	100%	Apr 06 - Mar 07	100%	
10	1M	Rapid access chest pain clinic 2 week waits	Green 98% - 100%, amber 80% - 97%, red < 80%	Apr 06 - Mar 07	100%	
11	1M	Revascularisation 3 month waits	Green <=0.10%, amber 0.2%, red > 0.2%	Apr 06 - Mar 07	0%	
12	1M	Cancelled operations and those not admitted within 28 days	Green 0.8%/5%, amber 1.5%/15%, red >1.5%/>15%	Apr 06 - Mar 07	0.2%	0
13	1M	Thrombolysis 60 minute call to needle	68%	Apr 06 - Mar 07	69%	
14	1M	Delayed transfers of care	Green <= 3.5%, amber 4%, red >4%	Apr 06 - Mar 07	2.1%	
15	1M	Emergency bed days	5% reduction by 2008 from 2003/04 baseline - 06/07 should show no increase from 05/06.	Apr 06 - Dec 06	3.50%	
16	1M	Data quality on ethnic group for patients	Green 80%, amber 60%, red <60%	Apr 06 - Mar 07	89.5%	
17	3M	Monitor Finance risk rating (also HC Use of Resources rating)	3 or above	Q4 06/07	4	
18	3M	Monitor Governance risk rating	Green	Q4 06/07	Amber	

1. NATIONAL TARGETS/STANDARDS 2006/07 (cont.)

19	3M	Monitor Mandatory Services risk rating	Green	Q4 06/07	Green
20	12M	Experience of patients	Secure sustained improvements in NHS patient experience by 2008	2006	TBC
21	3M	Drug misusers - information , screening and referral	Increase participation of problem users in treatment progs by 100% by 2008. 5 Y/N Q's.	Mar-07	4 Y, 1 N/A
22	3M	Compliance with NICE self harm guidelines in emergency depts (Reduce mortality by 2010 from suicide & undetermined injury by 20%+)	Green - 5 yes, amber 3 or 4 yes, red <3 yes	Mar-07	5 Y
23	3M	Smoke-free NHS - record smoking status & reduce smoking (Reduce smoking rates to <=21% by 2010, routine/manual groups to <=26%)	Green - 3 yes, amber - 2 yes, red <2 yes	Mar-07	3 Y
24	3M	Participation in audits - MINAP, Cardiac Audit and Stroke Audit	Reduce mortality by 2010 from heart disease, stroke and related disease	Mar-07	4 Y
25	3M	Percentage of stroke pts reported in National Sentinel Audit of Stroke (2006) to have spent > 50% of their stay on a stroke unit	Reduce mortality by 2010 from stroke and related diseases	Mar-07	66%

4.5 Patient Care

4.51 Complaints Handling

UHB's complaints policy is in line with the 2004 and 2006 NHS Complaints Regulations. During 2006/07, 98% of complainants received an acknowledgement letter within two working days and 86% received a full response from the Chief Executive within 20/25 days. As from September 1, 2006 the 2006 NHS (Complaints) Amendment Regulations gave the NHS 25 working days to provide a full response to complainants thus giving more time for complaints to be thoroughly investigated.

Complaints meetings are offered to complainants. These meetings are tape recorded and a copy of the tape is given to the complainant/family. Complainants are advised of sources of support in making a complaint via the Independent Complaints Advisory Service (ICAS) and of the Trust's Patient Advice and Liaison Service.

Where complainants are dissatisfied with the Trust's response, every effort is made to resolve the complaint within the Trust. If a complainant remains dissatisfied, he/she is advised of their right to an independent review of their complaint. The Healthcare Commission manages the second stage or independent review of complaints. From September 2006, the Healthcare Commission advised the NHS that every effort should be made at local resolution before advising the complainant of their right to escalate their complaint.

During the year 488 new complaints were received. As the 2006/07 year closed, 15 new complaints were referred to the Healthcare Commission with 27 still awaiting decisions by the HCC and 30 cases were closed. One unresolved complaint was received by the Ombudsman.

4.52 Patient Advice and Liaison Service (PALS)

PALS continues to be an "on the spot" focal service for patients relatives and carers when they need help or advice. Regular reports are produced ensuring that patients' and relatives' views are heard and considered for the purpose of continuous improvement and involvement.

This year PALS received approximately 1,650 contacts from patients and visitors. This is an increase of 6.5% compared to last year. Approximately 30% of contacts to PALS were general enquiries for information. The remainder of contacts revealed issues with the following top five themes:

1. Clinical treatment
2. Communication and information
3. Attitude of staff
4. Outpatient appointment delayed or cancelled
5. Inpatient appointment delayed or cancelled

Improvements have been made to services as a direct result of issues or comments presented to PALS. Examples include the raising of staff awareness of the bereavement care policy following the experience of a relative. PALS also suggested (on behalf of patients) a waiting times information board in the Burns & Plastics Outpatients. The catering department changed the mealtime delivery route in the west ward area of the Queen Elizabeth Hospital following comments from patients about the temperature of the hot meals.

4.53 Patient & Carer Councils

Patients, Governors and Foundation members are all represented on UHB's four clinical Divisional Patient & Carer Councils (DPCC). 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.

The councils were collaboratively involved in a hand washing campaign in 2006. As part of the campaign council members audited the understanding of patients and visitors of the need to wash their hands and raised awareness of how and when to wash hands.

A Patient & Carer Council for the Facilities Division was established in 2006 with representatives from each of the four clinical DPCCs. The council has enabled a joint approach to addressing some of the key issues raised at individual council meetings for improvements within hotel services and hospital facilities.

Over the next 12 months, UHB plans to increase the number of patients and the public involved in the councils by increasing awareness through publicity, and to involve Patient and Public Governors to encourage participation from people within their diverse communities. We also plan to continue the hand washing campaign throughout 2007.

4.54 Patient & Carer Information

UHB's policy for written information has been in place for two years and is working efficiently. The patient information database (where all approved patient information is stored until its review date) has grown significantly and is now home to many

approved leaflets, written in plain English and in a clear and concise format. We provide leaflets in varying Asian languages in some specialties. The patient information steering group meets monthly to review patient information that has been submitted through the system.

An essential part of this policy has been for clinical governance to review 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. All patient information has to be submitted electronically for approval.

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 through a checklist of good practice in producing patient information is available on the intranet and it is based on the Department of Health toolkit for patient information.

4.55 Patient Information Development Group

The Information Development Group meets monthly and is chaired by a Senior Manager and attended by the Associate Director of Patient Affairs, representatives from UHB's Board of Governors, Patient & Carer Councils and Foundation Membership. This forum has enabled patients, governors and members to feedback comments and suggestions that relate to patient and public information materials for example, patient letters, site signage, maps, leaflets, posters and internet content. This forum has enabled us to address inconsistencies and ensure that signage and leaflets are produced in a clear and uniform way.

4.56 UHB Patient and Public Involvement Forum (PPIF)

A range of Trust staff attended the PPIF meetings over the last year to present on various topics, as requested by Forum members. PPIF members also visited a variety of clinical and non-clinical areas of the Trust to gain a better understanding of how the Trust works and what services it provides.

4.57 Volunteers

Over the last year voluntary services have gone from strength to strength supported by the implementation of the strategy and policy for volunteers which was agreed by the Board of Directors in May 2006. The emphasis of the strategy was to support the corporate aim of becoming a community asset by supporting citizenship. A successful partnership with the Birmingham Voluntary Services Council and Community Services Volunteers has been developed with the result that UHB supported two local companies in their Corporate Citizenship endeavours, providing 90 individuals the opportunity to contribute through one-day volunteering events.

The policy provides a framework for the recruitment, placement, induction, training and ongoing support for volunteers. This has supported the recruitment of a further 130 regular volunteers over the last year to give us a total of 310.

A recognition and award scheme for volunteers, introduced in 2005 has continued, supported by a local celebrity and TV presenter, Nick Owen. 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.

4.58 Key influential 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, West Midlands 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, Xchanging
- 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.

4.59 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.

4.59.1 ACTIVATE

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.

4.59.2 The Learning Hub

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 Summer 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.

4.6 Finance and Performance

With a turnover in 2006/07 of £401m, 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 surplus of £2.8m before exceptional items on March 31, 2007.

UHB has posted an audited overall net deficit. This is wholly due to a £87.6m charge for the write off of buildings now the new hospital is being built. 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 financial position of the Trust has been relatively steady throughout the year. Cost pressures have been absorbed through strong activity performance and full delivery of efficiency savings.

4.6.1 Income and expenditure

The table on page 22 compares the original planned income and expenditure with the outturn position for a full 12 months.

4.6.2 Summary income and expenditure – plan v. outturn

UHB Summarised Income and Expenditure (£M's)		
	Plan 2006/07	Outturn Position 2006/07
Income	393.7	401.1
Expenditure	(373.9)	(381.0)
EBITDA	19.8	20.1
Depreciation	(12.6)	(10.2)
Dividend	(7.9)	(7.9)
Interest	0.7	0.8
I&E before exceptional items	0	2.8
Exceptional items	(15.8)	(87.6)

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 £329m 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 £29.5m in 2006/07, equivalent to 7.4% 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 2006/07 are £13.6m and £10.3m respectively. Finally the Trust receives £5.6m to support Research and Development activities including a contribution to the costs of operating the Wellcome Trust Clinical Research Facility.

4.6.3 Impairment of Buildings

The University Hospital Birmingham NHS Foundation Trust reported a deficit of £84.8m for the year to March 31, 2007. As shown in Note 7 to the accounts, this deficit was after charging a one-off impairment charge of £87.6m to the Income and Expenditure Account.

This impairment charge arises due to the signing of the PFI agreement for the new hospital. In our case, these assets were classified as impaired because they were valued by a professional valuer at a lower amount than we had recorded it in our accounting records.

Under the accounting rules for NHS Foundation Trusts, which in relation to this issue are the same as for commercial entities, the difference between the valuation and the amount recorded in our accounting records needed to be charged to our Income and Expenditure Account. This changed our result for the year as follows:

	£m
Result for the year	2.8
Impairment charged to the Income and Expenditure Account	(87.6)
	(84.8)

The impairment charge and the resultant change in the reported Income and Expenditure Account is the result of following FRS11 and professional valuation rules, rather than as a result of the operational decisions of the Board. The impairment does not have a cash impact on the Trust. This impairment accounting treatment for NHS Foundation Trusts moves University Hospital Birmingham closer to full UK GAAP compliance and promotes greater transparency and comparability with the accounting treatment adopted by commercial sector organisations in the UK.

Previously, under NHS Trust accounting

rules this charge would have been made to the revaluation reserve and would not have had any impact on the Income and Expenditure Account.

Monitor, the Independent Regulator of NHS Foundation Trusts' recognises that the impairment loss is not caused by operational decisions of the Board and has confirmed that the element of the deficit caused as a result of fixed asset impairments will be excluded from the calculations of the financial risk rating assigned to the Trust as part of its Compliance Framework.

4.6.4 Capital Expenditure Plans

UHB's capital expenditure plans, which run alongside the development of the new hospital, come to a total of circa £53million 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 until 2009/10.

Of the £53 million capital programme, £8m is being spent on protected buildings which will be retained under the existing estate. All expenditure on the non-retained estate will now be funded from revenue.

The Trust is carrying all land at the District Valuer's valuation of March 31, 2007. 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 September 29, 2932.

In 2006/07 UHB invested £13.0m 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:	2.6
Equipment Replacement	0.9
IT Strategy and Infrastructure	0.6
Expenditure on the non retained estate to maintain statutory standards	1.5
Expenditure on the retained estate to maintain statutory standards	0.2
Modernisation:	
• *Additional/replacement Linear Accelerator*	1.9
• *Diabetics facility*	0.1
• *Learning Hub Centre*	0.9
• *Leukaemia Centre*	0.2
• *Other*	1.2

4.6.5 Value for Money

Agreement of a balanced financial plan for 2006/07 required UHB to deliver cash releasing efficiency savings of 2.5%. 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.

In addition to the agreed annual cost improvement programme, further efficiency savings have been realised in the year through initiatives such as the Product Evaluation Group which reviews non-pay expenditure and the Workforce Approval Committee which considers requests to recruit to both new and existing posts.

The Trust's use of resources is also assessed by the Healthcare Commission

as part of the Annual Health Check based on the Financial Risk Ratings assigned by Monitor. In the latest results published in October 2006 the Trust achieved a rating of 'excellent' for the use of resources (based on 2005/06 outturn data).

4.6.6 Changes in accounting policies by UHB in the 2006/07

The signing of the Private Finance Initiative (PFI) contracts for the building of the new hospital has resulted in changes to the Trust's accounting policies with the addition of a note on how these PFI transactions are reflected in the Annual Accounts. Note 24 of the Accounts, gives more details.

4.6.7 Private Patient Income (PPI)

PPI was £3.1m which is within the authorised limit of 1.23%.

4.6.8 External Auditors

UHB's external auditors are KPMG LLP. The audit cost for the year is £88,000 for statutory audit services, none of which relates to non-audit work. Following a competitive tendering exercise from the April 1, 2006, KPMG has also provided taxation advice to the Trust.

During the year the reappointment of external audit services from 2007/08 onwards was made by the Board of Governors, following a competitive tender exercise.

4.6.9 University Hospital Birmingham Charities

The charitable funds for UHB are administered by UHB Charities, a separate legal entity from the Trust. In 2006/07 the Trust received grants of £1.0m from UHB Charities.

4.7 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 Boards

The Board of Governors is responsible for representing the interests of members, and partner organisations in the local health economy as well as in the governance of the Trust. It regularly feeds back information about the Trust, its vision and its performance to the constituencies and the stakeholder organisations.

The Board of Directors' role is to exercise the powers of the Trust, set the Trust's strategic aims and to be responsible for the operational management of the Trust's facilities, ensuring compliance by the Trust with its terms of authorisation, its constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations.

The Trust has a formal scheme of delegation which reserves certain matters to the Board of Governors or the Board of Directors and delegates certain types of decision to individual executive directors.

The Board of Directors has reserved to itself matters concerning regulation and control, senior level appointments, policy determination, strategic matters, approval of major capital expenditure projects and consideration of significant finance matters, significant operational decisions and the establishment of external relationships.

The Board of Governors appoints and determines the remuneration and terms of office of the Chairman and non-executive directors and the external auditors.
The Board of Governors approves any appointment of a Chief Executive made by the non-executive directors.

5.2 Board of Governors

UHB's Board of Governors was established in July 2004, with 24 representatives (increased to 25 on 13 March 2007 due to future Parliamentary constituency boundary changes) each elected for an initial term of three years. This required a change in the constitution.

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, 13 stakeholder Governors were appointed by 12 of our key stakeholders, again for an initial term of three years.

The Board of Governors consists of:

- 13 public Governors elected from the Parliamentary Constituencies in Birmingham (this figure was increased to 14 by a resolution of the Board of Governors made on 13 March 2007, to take account of future changes to the Parliamentary Constituency boundaries.

- 6 patient Governors elected by Patient members, who are members of UHB's four Patient & Carer Councils

- 5 staff Governors elected by the following staff groups:
  - Medical
  - Nursing (2)
  - Clinical Scientist/Allied Health Professional
  - Ancillary, Administrative and Other Staff

- 13 stakeholder Governors

During this year, the Governors have been:

5.2.1 Patient

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

5.2.2 Public (by Parliamentary Constituency)

Northfield
Margaret Burdett
Roy Green

Selly Oak
David Spilsbury
Gwyneth Harbun

Hall Green
Brian Hanson
Derek Hickson (deceased March 20, 2007)

Edgbaston
Geoffrey Oates
Sir Richard Knowles

Ladywood
Anne Griffin

Sparkbrook & Small Heath
Abul Hassan

Perry Barr
Shazad Zaman (elected unopposed June 27, 2006, seat previously vacant)

Yardley & Hodge Hill
Kadeer Arif

Erdington & Sutton Coldfield
Alan Corr

5.2.3 Staff

Professor John Buckels (Medical Class)
Paul Brettle (Clinical Scientist/Allied Health Professional)
Carol Rawlings (Nursing Class)
Barbara Tassa (Nursing Class)
Anne Waller (Ancillary, Administrative and Other Staff)

5.2.4 Stakeholder

The Most Revd Vincent Nichols (Archbishop of Birmingham), appointed by the Birmingham Faith Leaders' Group

Professor David Cox and Ms Moira Dumma (replaced Mr Graham Urwin on October 20, 2006), both appointed by South Birmingham Primary Care Trust

Mr Norman Cave, appointed by South West Birmingham Partnership for Further Education

Professor Michael Clarke, appointed by the University of Birmingham

Lieutenant General Lillywhite MBE QHS MB BCh MSc psc (replaced Surgeon Vice Admiral IL Jenkins on October 27, 2006), appointed by the Ministry of Defence

Ms Nikki Walker (replaced Ms Sue Battle on June 27, 2006), appointed by the Birmingham Chamber of Commerce and Industry

Ms Gill Howland (replaced Mr David Cragg on July 26, 2006), appointed by the Birmingham and Solihull Learning and Skills Council

Professor David Tidmarsh (replaced Dr Peter Knight on January 1, 2007), appointed by University of Central England in Birmingham

Cllr James Hutchings, appointed by Birmingham City Council

Ms Gisela Stuart MP, appointed by UHB South Birmingham MPs Liaison Group

Ms Marie Greer (replaced Ms Karen Yeomans on November 3, 2006), appointed by Advantage West Midlands

Ms Ruth Harker, appointed by the South West Area Network of the Secondary Education Sector in Birmingham

During the year ending March 31, 2007, the vacant seat of Governor for Perry Barr was filled by Mr Shazad Zaman who was elected unopposed. An election was held for the seat of staff Governor for the Medical Class as there were two candidates nominated, and Prof. John Buckels was elected.

The Board of Governors met regularly throughout the year, holding four meetings in total.

Name of Governor	No. of meetings attended*
Rita Bayley	All
Rosanna Penn	All
David Spilsbury	All
Brian Hanson	All
Geoffrey Oates	All
Sir Richard Knowles	All
Abul Hassan	All
Kadeer Arif	All
Prof. John Buckels	All
Paul Brettle	All
Lieutenant General Lillywhite	All
Prof. David Tidmarsh	All
James Hutchings	All
Marie Greer	All
Derek Hickson	All
Margaret Burdett	3 out of 4
Gwyneth Harbun	3 out of 4
Barbara Tassa	3 out of 4
The Most Revd Vincent Nichols	3 out of 4
Prof. Norman Cave	3 out of 4
Nikki Walker	3 out of 4
Ruth Harker	3 out of 4
Nazir Ahmed	2 out of 4
Alan Bailey	2 out of 4
Roy Green	2 out of 4
Anne Griffin	2 out of 4
Anne Waller	2 out of 4
Prof. Michael Clarke	2 out of 4
Valerie Jones	2 out of 4
Wynford Morgan	1 out of 4
Alan Corr	1 out of 4
Gisela Stuart, MP	1 out of 4
Prof. David Cox	1 out of 4
Dr Peter Knight	1 out of 4
Shazad Zaman	0 out of 4
Gill Howland	1 out of 2
Karen Yeomans	1 out of 2
Graham Urwin	0 out of 2

*Whilst a member of the Board of Governors.

5.3 Understanding the views of governors and members

In the first three months of 2007 the Chairman invited all the governors, from each of the constituencies, to meet with him to discuss their role and experiences as governors – what has worked, what hasn't worked – to understand how they can increase their activity and contribution to the Trust. Three key themes have emerged – developing communication channels with their constituents, defining their role more specifically and having more of an input into the strategic direction of the Trust. A detailed communication plan addressing these issues will be presented to the Board of Governors meeting in June 2007. Governors sit on various operational groups chaired by Executive Directors. The non-executive directors attend joint seminars with the governors.

In October last year the Board of Directors commissioned a Members' Survey to better understand the views of our members. A proposed Membership Strategy will be brought to the Board of Directors' meeting in July 2007.

5.4 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 Composition

Throughout the year, the Board of Directors comprised the Chairman, five executive and either six or seven non-executive directors.

John Charlton retired as Chairman on November 30, 2006 and Sir Albert Bore was appointed in his place on December 1, 2006 for a period of four years.

Mark Santer is the deputy chairman and senior independent director. He was reappointed as a Non-Executive Director on December 1, 2006 for a further period of two years. The senior independent director is always available to meet stakeholders on request and to ensure that the Board is aware of member concerns not resolved through existing mechanisms for member communications.

The Board is currently comprised as follows:
Chairman: Sir Albert Bore
Chief Executive: Julie Moore
Director of Finance: Mike Sexton
Executive Medical Director: Dr David Rosser
Director of Organisation Development: Caroline Wigley
Executive Chief Nurse (Acting): Trisha Curran
Chief Operating Officer (Acting): Tim Jones

Non-executive directors:
Professor David Bailey
Stewart Dobson
Tony Huq
David Ritchie
Clare Robinson
Rt Revd Mark Santer
Professor David Westbury

Mark Britnell held the post of Chief Executive until June 30, 2006. Julie Moore held the post in an acting capacity from July 1, 2006 until November 20, 2006, when she was appointed as substantive Chief Executive.

The position of Chief Finance Officer and Deputy Chief Executive was held by Peter Shanahan until his departure on November 30, 2006.

Mike Sexton was appointed as Director of Finance on December 1, 2006. Professor Rob Stockley held the post of Executive Medical Director up until November 30, 2006. Dr David Rosser was appointed to this post on December 1, 2006.

Dame Catherine Elcoat resigned from the post of Executive Chief Nurse on November 19, 2006. This position has been filled by Trisha Curran in an acting capacity from November 20, 2006.

Tim Jones has filled the post of Chief Operating Officer (made vacant by the appointment of Julie Moore as Chief Executive) from July 1, 2006 in an acting capacity.

Mary Thomas retired as a non-executive director on November 30, 2006. David Bailey

and David Ritchie were appointed as non-executive directors on December 1, 2006.

6.2 Independent non-executive directors

The board considers Mark Santer, David Westbury, Tony Huq, Clare Robinson, Stewart Dobson, David Bailey, David Ritchie and Mary Thomas (retired 30 November 2006) to be independent.

6.3 Board meetings

The board met regularly throughout the year, holding 11 meetings in total.

Directors	No. of meetings attended*
John Charlton	All
Sir Albert Bore	All
Julie Moore	All
Mike Sexton	All
Caroline Wigley	All
Prof Rob Stockley	All
Prof David Westbury	All
Trisha Curran	All
Tim Jones	All
Mary Thomas	All
Stewart Dobson	All
Clare Robinson	All
David Ritchie	All
Rt Revd Mark Santer	8 out of 11
Mark Britnell	2 out of 3
Dame Catherine Elcoat	5 out of 7
Tony Huq	9 out of 11
Peter Shanahan	7 out of 8
Dr David Rosser	3 out of 4
Prof David Bailey	3 out of 4

*Whilst a member of the Board of Directors

The non-executive directors have been appointed for terms of four years, with the exception of Mark Santer who was reappointed for a further term of two years commencing December 1, 2006.

6.4 The Board of Directors

6.4.1 Sir Albert Bore, Chairman

Sir Albert Bore was elected Chairman of UHB on December 1, 2006. He is the former leader of Birmingham City Council and the current leader of council's principal opposition group (Labour). During his five years at the helm, Sir Albert was responsible for an annual budget of over £2.5billion and for shaping the strategic policy of the council. He also spearheaded key regeneration projects including Eastside and the Bullring. He holds a number of non-executive director positions including Symphony Hall, Optima Community Housing Association, Marketing Birmingham, National Exhibition Centre Limited and Birmingham Technology Ltd, the joint venture company developing and managing Aston Science Park.

6.4.2 Julie Moore, Chief Executive

Julie is a graduate nurse who spent ten years in clinical practice before entering nurse management. During her time as nurse manager and later director, she undertook an MA in Health Services Studies at Leeds University and was seconded to work at the Department of Health on developing nursing roles. After a year in general management, in 1998 Julie became a director in the newly merged Leeds Teaching Hospitals' Trust. She became the Executive Director of Operations at UHB in 2002, where she was responsible for the day-to-day running of two acute hospital sites. When UHB became a foundation trust in July 2004, Julie's post became Chief Operating Officer as her role was extended to include all Operations, Clinical Service Development, infection control and the clinical transformation programme. She became Chief Executive (Acting) on July 1, 2006 and the position was made substantive in November 2006.

6.4.3 Trisha Curran, Executive Chief Nurse (Acting)

Trisha trained as a nurse and was a sister,

then senior sister in Neurosciences at the Queen Elizabeth. She then held various senior positions in the South Birmingham Acute Unit before becoming Directorate Manager, Cardiovascular and Respiratory Services in 1994. After a short spell in the private sector, Trisha returned to UHB as Director of Operations, Division Two. Earlier this year she became Deputy Chief Operating Officer (Acting) and Director of Infection Control and Prevention. She took up the role of Chief Nurse (Acting) on November 20.

6.4.4 Tim Jones, Chief Operating Officer (Acting)

After graduating from the University College, Cardiff, with a joint honours degree in History and Economics, Tim joined the District Management Training scheme at City and Hackney Health Authority based at St Bartholomew's Hospital in London. He joined The Royal Wolverhampton NHS Trust in 1992 as Business Manager for Medicine before taking up his first post at UHB in 1995 as the Directorate Manager for Medicine. In 1999 he became the first Divisional General Manager (now Directors of Operations) for Division Three and was then appointed as the Head of Service Improvement before being becoming Deputy Chief Operating Officer in 2004. He became Chief Operating Officer (Acting) in November 2006.

6.4.5 Dr David Rosser, Executive Medical Director

David trained at University of Wales College of Medicine and did his basic specialist training in medicine and anaesthesia in South Wales before becoming a research fellow and lecturer in Clinical Pharmacology at University College London Hospital. He joined UHB in 1996, became lead clinician for the Queen Elizabeth Intensive Care unit in December 1997 before becoming Group Director and then Divisional Director of Division One in 2002. Dr Rosser is also Senior Responsible Owner for Connecting for Health's e-prescribing programme, providing national guidance on e-prescribing to the Department of Health. Dr Rosser took up the role in December 2006.

6.4.6 Mike Sexton, Director of Finance

Mike, who started his new role in December 2006, spent five years in the private sector working for the accountancy firm KPMG and had a brief spell at the Regional Specialities Agency (RSA) before joining UHB in 1995. Over the last 11 years he has held numerous positions including Finance Manager – Clinical Services, Acting General Manager – Neurosciences and Opthalmology, Head of Operational Finance and Business Planning, Director of Operational Finance and Performance and Acting Director of Finance.

6.4.7 Caroline Wigley, Director of Organisation Development

Caroline became a law graduate before joining the NHS as a National Management Trainee. 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. 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, moving to UHB in 2005.

Non-executive directors

6.4.8 Rt Rev Mark Santer, Vice-Chairman

Mark, who retired as Bishop of Birmingham in 2002, joined the UHB NHS Trust board in 1998. 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 that 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.

6.4.9 Professor David Bailey

David Bailey is reader in Economic Policy and International business and Head of the Industrial and Labour Economic (ILE) Group at the Birmingham Business School. David has responsibility for staff development, teaching allocations and programme development and has led a strategic programme redesign in undergraduate retention.

6.4.10 Stewart Dobson

Stewart, who worked for 32 years as a lawyer for various large local authorities, joined the board in 2004. His work 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 in 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.

6.4.11 Tozammel (Tony) Huq MBE

Tony Huq was appointed as a non-executive director on July 1, 2002. His terms for the NHS trust rolled over upon attainment of FT status on July 1, 2004. He was reappointed for four years by the Board of Governors on June 28, 2005.

Tony 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 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.

6.4.12 David Ritchie CB

David Ritchie worked at a senior level in Government for a number of years most recently as Regional Director, Government Office for the West Midlands – the most senior official in the region. He was responsible for an annual budget approaching £1billion and about 300 staff, mostly engaged on the physical and industrial development of the region. He was also Chair of the Oldham Independent Review into the causes of the Oldham Race Riots in 2001.

6.4.13 Clare Robinson

Clare Robinson, who joined the board in 2004, is a highly experienced Chartered accountant. 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 she is working as an independent Business Consultant including change management, strategic and operational reviews and management services.

6.4.14 Professor David Westbury OBE

The Professor became an independent consultant in October 2002 after serving as 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 from 1984. David 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. David is Chairman of UM Association Ltd, which provides mutual insurance services for higher education institutions.

6.5 Balance of the Board

The balance, completeness and appropriateness of the membership of the Board of Directors were reviewed throughout the year by the Executive Appointments and Remuneration Committee. As a result of this review process, it was decided to increase the number of non-executive directors by one to a total of seven (not including the Chairman). The Trust decided to seek candidates for this new vacancy, and the vacancy created by the retirement of Mary Thomas, with experience in operating at a strategic level and/or in a commercial environment, finance, property management or regeneration and development.

6.6 Evaluation of the Board

As mentioned in the Chairman's Statement there were significant changes to the Board of Directors throughout 2006/07, starting in July, with the new board holding its first meeting in December 2006. In 2007/08 the board will undertake a formal evaluation of its performance and the performance of its committees and the individual directors.

6.7 Performance appraisal

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

6.8 Board of Directors Interests

Whilst the previous Chairman, John Charlton did not have any other significant commitments, the current Chair Sir Albert Bore is the leader of the Labour Party Group on Birmingham City Council and holds the following non-executive directorships.

Birmingham Marketing Partnership
Birmingham Technology (Venture Capital) Limited
Birmingham Technology (Property) Limited
Birmingham Technology (Services) Limited
Birmingham Technology Limited
National Exhibition Centre Limited (The)
National Exhibition Centre (Finance) plc
Optima Community Association Limited
West Midlands Regional Assembly Limited
Symphony Hall (Birmingham) Limited
Colliers CRE
Broad Street Partnership Limited
Jewellery Quarter Regeneration Partnership Board

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.

6.9 Audit Committee

The Audit and Financial Risk Committee was re-constituted as the Audit Committee on February 22, 2007. The Audit Committee is a sub-committee of the board whose purpose is to assist the board in the effective discharge of its responsibilities for financial reporting and corporate control.

The Committee meets regularly and is chaired by Clare Robinson. It now comprises all the independent non-executive directors of the Trust, with the external and internal auditors and other executive directors attending by invitation. Prior to February 22, 2007, it comprised the chair and Stewart Dobson and David Westbury, with David Bailey joining on December 21, 2006. Mark Santer, Mary Thomas and Tony Huq were also members of the committee until May 18, 2006.

The Committee met regularly throughout the year, holding five meetings in total.

Directors	No. of meetings attended*
Clare Robinson	All
David Westbury	All
David Bailey	All
David Ritchie	All
Stewart Dobson	2 out of 5
Mary Thomas	1 out of 2
Mark Santer	1 out of 2
Tony Huq	1 out of 2

*Whilst a member of the Audit Committee

The Audit Committee is responsible for the relationship with the group's auditors, and its duties include providing an independent and objective review of the Trust's systems of internal control, including financial systems, financial information, governance arrangements, approach to risk management and compliance with legislation and other regulatory requirements, monitoring the integrity of the financial statements of the Trust and reviewing the probity of all Trust communications relating to these systems.

The Audit Committee undertakes a formal assessment of the auditors' independence each year, which includes a review of non-audit services provided to the Trust and the related fees. The Audit Committee also holds discussions with the auditors about any relationships with the Trust or its directors that could affect auditor independence, or the perception of independence. Parts of selected meetings of the Audit Committee are held between the non-executive directors and external auditors in private.

The Audit Committee has reviewed the Group's system of internal controls and reviews the performance of the internal audit function annually.

6.9.1 Independence of External Auditors

To ensure that the independence of the External Auditors is not compromised where work outside the audit code has been purchased from the Trust's external auditors, the Trust has a policy for the Engagement of External Audit Services, which identifies three categories of work as applying to the professional services from external audit, being:

a) Statutory and audit-related work - certain projects where work is clearly audit-related and the external auditors are best-placed to do the work (e.g. regulatory work, e.g. acting as agents to Monitor, the Audit Commission, the Healthcare Commission, for specified assignments

b) Audit-related and advisory services - projects and engagements where the auditors may be best-placed to perform the work, due to:
   - Their network within and knowledge of the business (e.g. taxation advice, due diligence and accounting advice) or
   - Their previous experience or market leadership

c) Projects that are not permitted - projects that are not to be performed by the external auditors because they represent a real threat to the independence of the external auditor.

Under the policy:
- Prior approval for statutory and audit-related work must be sought from the Audit and Financial Control Committee and the Board of Governors, for each discrete piece of additional work awarded to the external auditors for a value in excess of £10,000; and
- For audit-related and advisory services, the Trust's Standing Financial Instructions (SFIs) Procurement of Services should be followed and the prior approval of the Audit and Financial Control Committee be obtained prior to commencement of the work.

Additionally, the policy and Standing Financial Instructions limit the fees payable to the external Auditor to no more than 25% of the audit fee.

6.9.2 Auditors' reporting responsibilities

KPMG LLP, our independent auditors, report to the Board of Governors through the Audit and Financial Control Committee. KPMG LLP's accompanying report on our financial statements is based on its examination conducted in accordance with UK Generally Accepted Accounting Practices and the Financial Reporting Manual issued by the independent regulator Monitor. Their work includes a review of our internal control structure for the purposes of designing their audit procedures.

6.10 Nomination Committee

The Nomination Committee for Non-Executive Directors comprises four Governors of the Trust. The Chairman of the committee is Sir Richard Knowles. The other members of the committee for the year ended March 31, 2007 were Barbara Tassa, David Cox and Derek Hickson (deceased March 20, 2007).

The Committee met twice during the year. All Committee members in office at the relevant times attended all Committee meetings.

The Nomination Committee for Non-Executive Directors is a sub-committee of the Board of Governors responsible for advising that board and making recommendations on the appointment of new non-executive directors, including the Chairman of the Trust. Its terms of reference, role and delegated authority have all been agreed by the full Board of Governors. The committee meets on an as required basis.

During the year, the Committee oversaw the appointment of a new Chairman, two new non-executive directors and the re-appointment of an existing non-executive director. Several candidates were considered for the posts of Chairman and the two new non-executive directors. To ensure that there were a sufficient number of appropriate candidates to be considered for these posts, they were openly advertised.

7. MEMBERSHIP

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

7.1 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

7.2 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

7.3 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.)

7.4 Membership Overview by Constituency

Constituency	Total at 31/03/07	%	% change from previous year
Public	55,920	64.4	-4.7
Patient	23,888	27.5	-8.8
Staff	7,054	8.1	-0.3
Total Membership	86,862	100%	91,961

Numbers correct up to March 31, 2007

The table above shows there has been an overall decline in membership during 2006/07 of members largely as a result of data cleansing and the removal of duplicate registrations.

The ethnic profile of the Trust's membership is broadly representative of the population served. BME communities make up around 20% of the Trust's local catchment area. However the Trust serves a much wider community for its specialist services which comprise a significant proportion of the Trust's workload. BME groups make up a smaller proportion of this wider community.

Therefore we conclude that our membership is broadly representative of the population we serve, with, perhaps, a slight under-representation of minority communities. We will focus on growing this sector of our membership in 2007/08.

7.5 Membership Strategy

In October 2006 UHB commissioned a Members' Survey. Its key objectives were to:

- Inform a review of UHB membership strategy
- Inform the future size and level of engagement with members
- Inform the way UHB communicates with members
- Explore brand reputation, services and factors influencing choice of hospital for treatment
- Inform its Marketing Strategy for 2007-11

In order to carry out the survey UHB first had to contact the full membership with a data capture questionnaire asking members to provide details on age, ethnicity, gender, socio-economic status. The original membership database does not contain comprehensive demographic data. Just over 10,000 were returned.

One of the early conclusions is that over a third of the members surveyed are not clear about why they are a member and suggest that reducing the number of members will enable the Trust to communicate more effectively with a smaller, more committed membership and involve them more fully in their contribution to the Trust.

A full report and Membership Strategy will be recommended to the Board of Directors in July 2007.

7.6 Contact procedures for members who wish to communicate with governors and/or directors

There are several ways for members to communicate with governors and/or directors. The principal ones are as follows:

- Face-to-face interaction at our monthly Members' Seminars. Governors attend these meetings and use them as a 'surgery' for members

- Public part of the monthly Board of Directors' meeting

- Telephone, written or electronic communications co-ordinated through the Communications office who then steer members to the appropriate Governor/ Director

- Trust in the Future magazine – highlights a Governor each issue and offers contact details

- Direct email and helpline number to the Members' Register management company who take any kind of membership query and then feed back into the Trust to action

- Chief Executive hotline – phone communication for queries, comments and ideas

7.7 Communications plan for 2007/08

A Governors' Communications Task & Finish Group, comprised of patients, public and staff governors as well as the Director of Communications has been set up.

It has the following key objectives:

- To improve communications and engagement with the constituency members Governors represent
- To raise the profile of Governors and members with staff, patients and carers in the hospital and externally to the general public, key stakeholders and potential patients
- To improve communications from governor-to-governor
- To improve communications between Governors and directors/the Trust

A Governors' Communications Strategy will then be presented to the June 2007 Board of Governors' meeting for approval and will be implemented from July 2007 following the Governor elections.

8. PUBLIC INTEREST DISCLOSURES

8.1 Consultation

We believe that communication is vital to ensure that all employees are involved and informed about what is happening within the Trust. The Trust conducts an annual staff survey in which a random sample of staff participates. Feedback from the survey results in an action plan each year to address areas of concern. Inside Out, the Trust newspaper, is produced on a monthly basis and staff are encouraged to contribute stories to the paper. Each week there is a global email entitled "In the Loop" which informs staff of activities happening within the Trust, for example training courses, work-life balance seminars etc.

Each division has monthly consultative meetings and the Trust has regular monthly meetings with Trade Union Representatives to ensure partnership working. Staff are also encouraged to attend Foundation Trust membership meetings.

8.2 Policies in relation to disabled employees and equal opportunities

We are an equal opportunities employer and believe in treating all staff equally and with respect. We have an Equal Opportunities Policy and also a Rehabilitation Policy. A Race Equality Scheme, Disability Equality Scheme and Gender Equality Scheme have been launched in line with the new legislation.

Staff who have a disability have their work area assessed and adapted to meet their needs to allow them to carry out their roles to the best of their ability. If a member of staff becomes disabled during the course of their career at the Trust they are actively encouraged to return to work in a different capacity if necessary. The Rehabilitation Policy allows for a staged return to work and retraining as required.

The Trust has a Disability Equality Group which was established as part of the Disability Equality Scheme. This group looks at areas of the Trust which could be improved to help disabled employees and works towards making the improvements.

8.3 Health and Safety

There have been no Improvement Notices issued by the HSE to the Trust in the last 12 months. The staff incident rate for the year 2006/07 was 5.8 incidents per 100 staff, with the most common types of incidents being violence and aggression and inoculation injuries. In order to reduce these incidents various initiatives have been implemented over the last five years, for example, close working with local police, restricting access to buildings out of hours and training staff to recognise and de-fuse potential aggression. A trial of needle safe devices has also been undertaken to reduce the incidence of inoculation incidents.

Overall, by far the most frequent incident type for patients and staff combined is slips, trips and falls, and this year the Trust launched its slips, trips, and falls prevention policy, which introduces clear standards and guidance and will be used to inform the new hospital project.

A wide range of health and safety initiatives are being progressed, for example health and safety e-learning for managers and monitoring/audit of compliance with health and safety policy.

Musculo-skeletal disorders (MSDs) and stress are the main causes of work-related sickness absence for staff and this is reflected nationally. Ergonomic assessment of workplaces, audit of manual handling practices and provision of training are ongoing interventions to prevent and reduce MSDs. A stress audit is planned for 2007/08 to identify the action required to reduce the incidence of work related stress.

8.4 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

8.5 Better Payment Practice Code

Better Payment Practice Code – measure of compliance

	Number	£000
Total bills paid in the period	82,070	205,512
Total bills paid within target	80,863	201,578
Percentage of bills paid within target	98.5%	98.1%

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.

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

Nil interest was charged to UHB in the year for late payment of commercial debts.

8.7 Management costs

Management costs, calculated in accordance with the Department of Health's definitions, are 4.2%.

9. REMUNERATION REPORT

9.1 Executive Appointments and Remuneration Committee

The Executive Appointments Committee and the Remuneration and Review Committee were re-constituted as a single committee, the Executive Appointments and Remuneration Committee, in February 2006. The Committee comprises the Chairman, all other non-executive directors and, for appointments of executive directors other than the Chief Executive, the Chief Executive. The chairman of the Committee is the Chairman of the Trust.

The Executive Appointments and Remuneration Committee and its predecessor committees met regularly throughout the year, holding eight meetings in total.

Directors	No. of meetings attended*
Mark Santer	7 out of 8
David Westbury	7 out of 8
Clare Robinson	7 out of 8
Tony Huq	6 out of 8
Mary Thomas	6 out of 7
Stewart Dobson	5 out of 8

*Whilst a member of the Remuneration Committee

The Executive Appointments and Remuneration Committee is a sub-committee of the Board of Directors responsible for reviewing and advising the Board of Directors on the composition of the Board of Directors and appointing and setting the remuneration of executive directors. Its terms of reference, role and delegated authority have all been agreed by the full Board of Directors. The committee meets on an as required basis.

The Executive Appointments and Remuneration Committee's terms of reference empower it to constitute a sub-committee to act as a Nominations Committee to undertake the recruitment and selection process, including the preparation of a description of the role and capabilities required and appropriate remuneration packages, for the appointment of the Executive Director posts on the Board of Directors.

During the year, the Committee, assisted by the Nominations Committee, oversaw the appointment of a new Chief Executive, an Executive Medical Director and a Director of Finance.

To ensure that there were a sufficient number of appropriate candidates to be considered for each of these posts, each of the posts was openly advertised and, in the case of the post of Chief Executive, the services of an external search consultancy were engaged.

9.2 Executive Remuneration Policy

The Committee recognises that, in order to ensure optimum performance, it is necessary to have a competitive pay and benefits structure.

From April 2005 a new salary structure was introduced which consolidated previous bonus and benefits into baseline salary.

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

Executive Directors are on substantive 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.

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 2006/07.

9.3 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 of the Annual Accounts and UHB's policy on pension is given in Note 1.15.

9.4 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.

9.5 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.

NAME	Date of Appointment/ Latest Renewal	Term	Date of end of term
Sir Albert Bore	1 December 2006	4 years	30 November 2010
Rt Rev Mark Santer	1 December 2006	2 years	30 November 2008
Prof David Westbury	1 December 2003	4 years	30 November 2007
Tony Huq	1 July 2005	4 years	30 June 2009
Clare Robinson	10 September 2004	4 years	9 September 2008
Stewart Dobson	10 September 2004	4 years	9 September 2008
David Bailey	1 December 2006	4 years	30 November 2010
David Ritchie	1 December 2006	4 years	30 November 2010
John Charlton	1 December 2002	4 years	30 November 2006
Mary Thomas	1 December 2002	4 years	30 November 2006

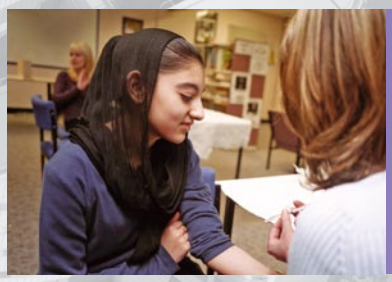
June 7, 2007

Julie Moore
Chief Executive

Date

University Hospital Birmingham
NHS Foundation Trust

Accounts
2006/07



Accounts for the year ended
31 March 2007

University Hospital Birmingham NHS Foundation Trust
Accounts for the year ended 31 March 2007

Contents

FOREWORD TO THE ACCOUNTS

UNIVERSITY HOSPITAL BIRMINGHAM NHS FOUNDATION TRUST

These accounts for the period ended 31 March 2007 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 2003 in the form which Monitor has, with the approval of the Treasury, directed.

Signed.....Date.....7/6/07.....
J Moore
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 7/6/07

J Moore
Chief Executive

STATEMENT OF DIRECTORS' RESPONSIBILITIES 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 17 to 24, 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.

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

By order of the Board

Signed ..... Date 7/6/07
J Moore
Chief Executive

Signed ..... Date 7/6/2007
Mike Sexton
Director of Finance

KPMG

Independent Auditor's Report to the Board of Governors of University Hospital Birmingham NHS Foundation Trust

We have audited the financial statements of University Hospital Birmingham NHS Foundation Trust for the year ended 31 March 2007 under the Health and Social Care (Community Health and Standards) Act 2003. These comprise the Income and Expenditure Account, the Balance Sheet, the Cashflow Statement, the Statement of Total Recognised Gains and Losses and the related notes. These financial statements have been prepared under the accounting policies relevant to NHS Foundation Trusts set out therein.

This report is made solely to the Board of Governors of University Hospital Birmingham NHS Foundation Trust ('the Trust'), as a body, in accordance with the Health and Social Care (Community Health and Standards) Act 2003. Our audit work has been undertaken so that we might state to the Board of Governors of the Trust, as a body, those matters we are required to state to it in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Governors as a body, for our audit work, for this report, or for the opinions we have formed.

Respective Responsibilities of the Directors and Auditors

As described on page 2 the Accounting Officer is responsible for the preparation of the financial statements in accordance with directions issued by Monitor. Our responsibilities, as independent auditors, are established by statute, the Code of Audit Practice issued by Monitor and our profession's ethical guidance.

We report to you our opinion as to whether the financial statements give a true and fair view of the state of affairs of the Trust and its income and expenditure for the year ended 31 March 2007.

We review whether the statement on internal control on pages 6 to 12 reflects compliance with Monitor's guidance issued in the NHS Foundation Trust Financial Reporting Manual. We report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information we are aware of from our audit of the financial statements. We are not required to consider, nor have we considered, whether the directors' statement on internal control covers all risks and controls. We are also not required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures. Our review was not performed for any purpose connected with any specific transaction and should not be relied upon for any such purpose.

We read the information contained in the Annual Report and consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the statement of accounts.

Basis of audit opinion

We conducted our audit in accordance with the Health and Social Care (Community Health and Standards) Act 2003 and the Code of Audit Practice issued by Monitor, which requires compliance with relevant auditing standards issued by the Auditing Practices Board.

An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements. It also includes an assessment of the significant estimates and judgements made by the Directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give

reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error. In forming our opinion we also evaluated the overall adequacy of the presentation of information in the financial statements.

Opinion

In our opinion the financial statements give a true and fair view of the state of affairs of University Hospital Birmingham NHS Foundation Trust as at 31 March 2007 and of its income and expenditure for the year then ended.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of the Health and Social Care (Community Health and Standards) Act 2003 and the NHS Foundation Trust Audit Code of Practice issued by Monitor.

KPMG LLP

KPMG LLP
Chartered Accountants
Birmingham
8 June 2007

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 acknowledge 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 2007 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

Overall responsibility for the management of risk within the Trust rests with the Board of Directors. Reporting mechanisms are in place to ensure that the Board of Directors receives timely, accurate and sufficient information regarding the management of risks.

The composition of the Board of Directors was reviewed during 2006/07 and it was decided to increase the number of non-executive directors by one. As a result of this and the retirement of the existing Chairman and one existing non-executive director, a new Chairman and two new non-executive directors were appointed to strengthen the Board of Directors in the areas of strategic commercial operations, finance, property management and regeneration and development.

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

STATEMENT ON INTERNAL CONTROL (continued)

The Audit and Financial Control Committee (renamed the Audit Committee in February 2007) monitors and assesses both internal control issues and the process for risk management. Bentley Jennison (internal audit) and KPMG (external audit) attend all Audit Committee meetings. The Audit Committee receives all the reports of the Internal Auditors. Reports that impact on clinical risks were reported to the Clinical Governance Committee until February 2007 and are now reported directly to the Board of Directors.

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' that 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 local 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. Until February 2007, it was supported by three committees which provided assurance on risk management issues:

a. the Audit and Financial Control Committee;
b. the Risk and Compliance Committee; and
c. the Clinical Governance Committee

Following a review of the roles and interaction of these committees, the Board of Directors resolved to dissolve the Risk, Compliance and Assurance Committee and the Clinical Governance Committee and enlarge the role of the re-named Audit Committee to that of an overview and scrutiny committee across all appropriate areas of the Trust.

A Task and Finish Group has been constituted by the Board of Directors to consider the establishment of an Investment Committee to develop an investment policy and provide the Board of Directors with assurance over investments, borrowings, performance benchmarks and compliance with Trust treasury policies and procedures.

Clinical governance is now overseen directly by the Board of Directors and a Risk Assurance Task and Finish Group has been established to consider how the Board of Directors will obtain assurance that risks within the Trust are being appropriately managed and monitored following the dissolution of the Risk, Compliance and Assurance Committee.

STATEMENT ON INTERNAL CONTROL (continued)

The Trust's Foundation Secretary has also been charged with preparing a report to the Board on the Trust's Assurance Framework, identifying the role of the Compliance Unit within this framework and how the revised committee structure will bring greater clarity to the flow of assurances to the Board.

In order to confirm its compliance with the Healthcare Commission Standards for Better Health, the Trust carried out a self assessment exercise against those standards. Following the dissolution of the Risk, Compliance and Assurance Committee, the Risk Task and Finish Group received the information supporting the declaration.

The declaration to the Commission is that the Trust is fully compliant with all core standards, save for a lapse in assurance for core standard C11b between 12 October 2006 and 23 January 2007, which was corrected by 31 March 2007. This was approved by the Board of Directors meeting of 22 March 2007. 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. During the year ended 31 March 2007 the Trust participated in the pilot phase for the new NHSLA Risk Management Standards as a pre pilot and pilot site. This, although not a formal assessment, resulted in confirmation that the Trust would be a level 2 trust under the accreditation process for the new standards. This is equivalent to our current CNST level, level 2.

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.

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.

All serious untoward incidents are reported to South Birmingham PCT.

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, up to that Committee's dissolution. Following that dissolution, incidents form part of the Clinical Quarterly Monitoring Report which is made to the Board of Directors each month.

STATEMENT ON INTERNAL CONTROL (continued)

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. High level risks identified by the Divisional Management Teams and corporate risks were reported regularly through Performance Review and, up until its dissolution, the Risk, Compliance and Assurance Committee. Following that dissolution, high level risks will be reported to the Audit Committee. Risk Registers are reported to the Audit 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 Audit Committee;

Incident reports and trend analysis;

Internally generated reports from Health Informatics Team;
Internal and external audit reports; and

Performance Reviews.

4.2 Risk Control

Until February 2007, risks were reported to the Clinical Governance Committee and the Risk, Compliance and Assurance Committee, which had fully delegated authority from the Board of Directors. Following the dissolution of those two committees, clinical risks are now reported directly to the Board of Directors through the Clinical Governance Reporting Framework. Non-clinical risks are reported to the Board of Directors through the responsible Executive Directors and the Risk Management Structure. The process of reporting of risks is overseen by the Audit Committee.

Compliance with the Health Care Commissions Standards for Better Health is reported to the Board of Directors. The assurance on this process is provided by Internal Audit.

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

STATEMENT ON INTERNAL CONTROL (continued)

The Infection Control Committee, chaired by the Director of Infection Control (who is also the Chief Nurse), 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 its strategic objectives and, through its Assurance Framework, assesses 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 this process and all members are aware of the Assurance Framework.

The Trust is progressing with its Joint PFI scheme with the South Birmingham and Solihull Mental Health Trust and the New Hospital Programme has been identified as a major risk to the Trust. A Programme Board is in place which is chaired by the Chief Executive of University Hospital Birmingham NHS Foundation Trust. The New Hospital Programme has an integrated risk log and a robust risk management structure to ensure that all programme risks are appropriately managed.

There is a regular report on the main Programme risks to both Programme Board and Board of Directors. A programme of audits is being agreed with the Trust internal auditors to provide assurance to the Board of Directors on the management of the Programme. In addition, a Health Gateway stage 0 will take place in summer 2007, which will provide further external assurance to the Trust Board of Directors.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with.

5. Review of Economy, Efficiency and Effective Use of Resources

The Trust's Financial Plan for 2006/07 was approved by the Board of Directors in May 2006 which forecast a breakeven income and expenditure position at 31 March 2007 before exceptional costs associated with the New Hospital Project. Achievement of the financial plan relied on delivery of cash releasing efficiency savings of over £7m during the financial year. This has been accomplished through a 2.5% cost improvement programme across Divisions and Corporate Departments. Progress on delivery of cost improvement targets is monitored throughout the year and quarterly progress updates are included in the Finance and Activity Performance Report presented to the Board on a monthly basis.

STATEMENT ON INTERNAL CONTROL (continued)

In addition to the agreed annual cost improvement programme, further efficiency savings are realised in year through initiatives such as the Product Evaluation Group which reviews non-pay expenditure and the Workforce Approval Committee which considers all requests to recruit to both new and existing posts. During 2006/07 the Trust has introduced "Lean Thinking" methodologies within its MRI department, resulting in significant improvements in productivity and throughput which have helped to reduce waiting times for this service. It is intended that "Lean Thinking" will be rolled out to other departments during 2007/08.

During 2006/07 the Board of Directors have also received a monthly report on Key Performance Indicators. This includes trend data on a number of measures of efficiency and use of resources such as the average length of stay, day case rates, theatre utilisation and sickness absence. Performance is measured against national benchmarks where available, for example the Audit Commission basket of day case procedures.

The objectives set out in the Trust's Internal Audit Plan include ensuring the economical, effective and efficient use of resources and this consideration is applied across all of the work-streams carried out. The findings of internal audit are reported to the Board through the Audit Committee.

As part of the annual health check, the Trust's use of resources is also assessed by the Healthcare Commission, based on the Financial Risk Ratings assigned by Monitor. In the latest results published in October 2006 the Trust achieved a rating of 'excellent for the use of resources' (based on 2005/06 outturn data).

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 2006/07 to develop the monitoring and reporting of the control framework. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, Internal Audit, the Foundation Secretary, the Compliance Unit, the Risk, Compliance and Assurance Committee (prior to its dissolution in February 2007) and External Audit. The system of internal control is regularly reviewed and plans to address any identified weaknesses and ensure continuous improvement of the system are put in place.

STATEMENT ON INTERNAL CONTROL (continued)

The processes applied in maintaining control include:

a. the maintenance of a view of the overall position with regard to internal control by the Board of Directors through its routine reporting processes and its work on Corporate risks maintained a view of the overall position;

b. review of the Assurance Framework and the receipt of Internal and External Audit reports on the Trust's internal control processes by the Audit Committee;

c. personal input into the controls and risk management processes from all Executive Directors and Senior Managers and individual clinicians; and

d. the provision of comment by Internal Audit, through their annual report, on the Trust's system of Internal Control. The Board's review of the Trust's risk and internal control framework is supported by the Head of Internal Audit's annual opinion which states that significant assurance can be given that there is a sound system of internal control, designed to meet the organisation's objectives and that controls are generally being applied consistently.

As set out above, the Trust declared a lapse in assurance for core standard C11b (mandatory training) between 12 October 2006 and 23 January 2007. An audit of mandatory training was undertaken by the Trust's Internal Auditors, who reported their draft findings on 12 October 2006 and made two key recommendations. The Trust addressed these recommendations through modification of the draft Mandatory and Statutory Training Policy, which was then formally approved and implemented in January 2007. This was confirmed at the Board of Directors meeting of 22 /march 2007.

Other than as disclosed in the preceding paragraph, there are no significant internal control issues I wish to report. I am satisfied that all internal control issues raised have been, or are being, addressed by action plans and that these action plans are subject to appropriate monitoring.

Signed..... Date 7/6/07

J Moore
Chief Executive

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31 MARCH 2007

	NOTE	31 March 2007 £000	31 March 2006 £000
Income from activities	2	**328,931**	305,153
Other operating income	3	**72,168**	73,387
Operating expenses	4 - 6	**(391,165)**	(370,756)
OPERATING SURPLUS		**9,934**	7,784
Exceptional items	7	**(87,577)**	(3,564)
Loss on disposal of fixed assets	8	**(79)**	(77)
(DEFICIT)/SURPLUS BEFORE INTEREST		**(77,722)**	4,143
Interest receivable	9.1	**847**	753
Interest payable	9.2	**0**	(1)
Other finance costs - unwinding of discount		**(26)**	(26)
Other finance costs - change in discount rate on provisions		**0**	(142)
(DEFICIT)/SURPLUS BEFORE TAXATION		**(76,901)**	4,727
Taxation	10	**0**	0
(DEFICIT)/SURPLUS AFTER TAXATION		**(76,901)**	4,727
Public Dividend Capital dividends payable		**(7,922)**	(8,253)
RETAINED (DEFICIT)/SURPLUS FOR THE YEAR *		**(84,823)**	(3,526)

The notes on pages 17 to 45 form part of these accounts.
All income and expenditure is derived from continuing operations.

* The retained surplus for the year was £2,754,000 (2006 - £38,000) prior to the exceptional item as detailed above. For further information on exceptional item see note 7 on page 31.

BALANCE SHEET AS AT 31 MARCH 2007

	NOTE	31 March 2005 £000	31 March 2005 £000
FIXED ASSETS			
Tangible assets	11.2	**173,555**	241,346
CURRENT ASSETS			
Stocks and work in progress	12	**9,583**	8,790
Debtors	13	**28,827**	26,947
Cash at bank and in hand	18.3	**20,420**	14,653
		58,830	50,390
CREDITORS: Amounts falling due within one year	14	**(46,240)**	(42,747)
NET CURRENT ASSETS		**12,590**	7,643
TOTAL ASSETS LESS CURRENT LIABILITIES		**186,145**	248,989
PROVISIONS FOR LIABILITIES AND CHARGES	15	**(8,652)**	(5,817)
TOTAL ASSETS EMPLOYED		**177,493**	243,172
FINANCED BY:			
TAXPAYERS' EQUITY			
Public dividend capital		**160,695**	157,707
Revaluation reserve	17	**68,597**	68,530
Donated asset reserve	17	**9,304**	10,188
Income and expenditure reserve	17	**(61,103)**	6,747
TOTAL TAXPAYERS EQUITY		**177,493**	243,172

Signed..... Date 7/6/07
J Moore
Chief Executive

STATEMENT OF TOTAL RECOGNISED GAINS AND LOSSES FOR THE YEAR ENDED 31 MARCH 2007

	NOTE	31 March 2007 £000	31 March 2006 £000
(Deficit)/Surplus for the financial year before dividend payments		(76,901)	4,727
Disposal of donated assets	17	(2)	(1,183)
Impact of disposals on revaluation reserve	17	(71)	(2,379)
Unrealised surplus on fixed asset and current asset investments and revaluations		17,111	0
Increases in the donated asset reserve due to receipt of donated assets		43	414
Reductions in the donated asset reserve due to the depreciation, impairment and disposal of donated assets		(925)	(1,045)
TOTAL RECOGNISED (LOSSES)/GAINS FOR THE FINANCIAL YEAR		(60,745)	534

CASH FLOW STATEMENT FOR THE YEAR ENDED 31 MARCH 2007

	NOTE	Year to 31 March 2007 £000	Year to 31 March 2006 £000
OPERATING ACTIVITIES			
Net cash inflow from operating activities	18.1	**23,830**	25,919
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:			
Interest received		**810**	763
Interest paid		**0**	(1)
Net cash inflow from returns on investments and servicing of finance		**810**	762
CAPITAL EXPENDITURE			
(Payments) to acquire tangible fixed assets		**(13,982)**	(17,176)
Receipts from sale of tangible fixed assets		**0**	25
Net cash (outflow) from capital expenditure		**(13,982)**	(17,151)
DIVIDENDS PAID		**(7,922)**	(8,253)
Net cash inflow before management of liquid resources and financing		**2,736**	1,277
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 before financing		**2,736**	1,277
FINANCING			
Public dividend capital received		**2,988**	4,005
Other capital receipts		**43**	414
Net cash inflow from financing		**3,031**	4,419
Increase in cash		**5,767**	5,696

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 2006/07 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 FRS3 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.

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

NOTES TO THE ACCOUNTS (continued)

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 revalued using professional valuations in accordance with FRS15 every five years with an interim valuation carried out in year three. The last full valuation was carried out in 2004 and accounted for on 31 March 2005. During the year, a valuation was carried out on land and buildings scheduled for demolition/disposal under the New Hospital PFI. The building revaluation has resulted in an impairment, the details of which can be found in Note 7 on page 31 of the accounts. A further professional interim valuation will be carried out in 2007/08 and accounted for at 31 March 2008.

NOTES TO THE ACCOUNTS (continued)

Assets in the course of construction are valued at cost.

Depreciation and Amortisation and Impairments

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. No depreciation is provided on freehold land.

Buildings scheduled for disposal/demolition under the new hospital PFI scheme have undergone a valuation in year. This has given rise to an impairment which has been reflected in these financial statements. This impairment constitutes a loss of economic benefit and as such, has been charged to the income and expenditure account. The corresponding balance in the revaluation reserve relating to these buildings was transferred to the income and expenditure account as a reserve movement, the details of which can be found in Note 17 to the accounts on page 37.

Buildings, installations and fittings not scheduled for disposal/demolition, are depreciated on their current value over the estimated remaining life of the asset as assessed by the Trust's professional valuer.

Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust respectively.

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.

NOTES TO THE ACCOUNTS (continued)

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 are accounted for as Government grants. Where the Government grant is used to fund revenue expenditure it is taken 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.

1.7 Private Finance Initiatives (PFI) Transactions

Where existing Trust Buildings are to be retained as part of the PFI scheme, a deferred asset will be created at the point that the Trust transfers those buildings to the PFI partner. The deferred asset will be written off through the income and expenditure account over the life of the concession.

Where current estate will be retained in use and maintained by the PFI provider but the risks and rewards will not pass to the provider, that part of the estate will remain on balance sheet and refurbishment costs which are included in the PFI will also be capitalised.

At the end of the concession period all buildings included within the PFI scheme will pass to the Trust at nil consideration. These buildings will have a remaining useful economic life which will constitute as asset which the Trust will have paid for during the concession period. In accordance with the guidance set out in Lane and Buildings in PFI Deals (version 2) and Treasury Technical Note 1 the residual value will be built up over the concession period.

PFI transactions include an injection of cash to the private partner in exchange for a reduction in future payment rentals. Where this has occurred, the value of the reduction in future payment is recorded in long term debtors if there is any delay in the realisation of benefits beyond one year, or included as a prepayment in debtors whereby reduced charges begin to crystallise within one year.

Deferred assets are written off to the income and expenditure account over the period of the service payment reductions.

Details of the impact of the PFI on the Trust's Financial Statements in the year to 31 March 2007 can be found in Note 24 to the accounts on page 41.

NOTES TO THE ACCOUNTS (continued)

1.8 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.

1.9 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.

1.10 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 separated from patient care activity and is therefore not separately disclosed.

1.11 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.

1.12 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:

NOTES TO THE ACCOUNTS (continued)

Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

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

1.13 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.

1.14 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 £1million.

1.15 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 FRS17.

NOTES TO THE ACCOUNTS (continued)

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.

1.16 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.

1.17 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.

1.18 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.

1.19 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.

NOTES TO THE ACCOUNTS (continued)

1.20 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.

1.21 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.

1.22 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 25. To date the Trust has not utilised any of its available prudential borrowing.

1.23 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

	Year Ended 31 March 2007 £000	Year Ended 31 March 2006 £000
Foundation Trusts	23	35
NHS Trusts	720	755
Strategic Health Authorities	0	16
Primary Care Trusts	285,000	280,069
Department of Health - other	31,675	13,794
NHS Other	3,158	2,522
Non NHS:		
- Private Patients	3,095	2,906
- Overseas patients (non-reciprocal)	179	90
- Road Traffic Act	1,224	1,611
- Other*	3,857	3,355
	328,931	305,153

* Included within 'Non NHS Other' is £3,659,000 relating to the Trust contract with the Royal Centre fo Defence Medicine (2006 - £3,250,000).

Road Traffic Act income is subject to a provision for doubtful debts of 7.7% to reflect expected rates of collection.

2.1 Private Patient Income

	2006/07 £000	Base Year 2002/03 £000
Private patient income	3,095	2,773
Total patient related income	328,931	225,193
Proportion (as percentage)	0.94%	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

	Year Ended 31 March 2007 £000	Year Ended 31 March 2006 £000
Research and development	8,434	9,879
Education and training	25,771	26,644
Charitable and other contributions to expenditure	811	1,072
Transfers from donated asset reserve	925	1,045
Non-patient care services to other bodies	13,665	12,588
Other income	22,562	22,159
	72,168	73,387

Other income of £22.6m includes £5.4m Section 106 monies relating to the New Hospital, £1.9m from Clinical Excellence Awards, £1.5m from the National Quality Assurance Service with £13.8m arising from other sources.

4. Operating Expenses

4.1 Operating expenses comprise:

	Year Ended to 31 March 2007 £000	Year Ended to 31 March 2006 £000
Services from Foundation Trusts	212	75
Services from other NHS Trusts	8,961	7,296
Services from other NHS bodies	1,725	2,419
Purchase of healthcare from non NHS bodies	7,746	5,792
Executive directors' costs	1,381	1,376
Non-executive directors' costs	138	116
Staff costs	226,510	217,435
Drug costs	38,049	34,502
Supplies and services - clinical	50,616	49,952
Supplies and services - general	5,213	5,237
Establishment	4,132	4,484
Transport	1,101	598
Premises	15,289	15,839
Bad debts	233	356
Depreciation and amortisation	10,219	12,783
Audit fees	88	117
Clinical negligence	1,780	1,726
Other	17,772	10,653
	391,165	370,756

4.2 Operating leases

4.2/1 Operating expenses include:

	Year Ended 31 March 2007 £000	Year Ended 31 March 2006 £000
Hire of plant and machinery	146	228
Other operating lease rentals	246	85
	392	313

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

	Land and Buildings		Other leases	
	31 March 2007 £000	31 March 2006 £000	31 March 2007 £000	31 March 2006 £000
Operating leases which expire:				
Within 1 year	0	0	163	62
Between 1 and 5 years	0	0	151	166
After 5 years	704	460	0	0
	704	460	314	228

5 Salary and Pension entitlements of senior managers

5.1 Remuneration

Name and Title	Year Ended 31 March 2007			Year Ended 31 March 2006		
	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						
Julie Moore, Chief Executive (commenced office 1/7/2006)	145-150	0	0	0	0	0
Mark Britnell, Chief Executive (left office 30/6/2006)	45-50	0	8,900	195-200	0	13,600
Mike Sexton, Executive Director of Finance (commenced office 1/12/2006)	40-45	0	0	35-40	0	0
Peter Shanahan, Deputy chief Executive and Chief Financial Officer (left office 30/11/2006	85-90	0	4,600	135-140	0	8,400
Trisha Curran, Acting Chief Nurse (commenced office 20/11/2006)	40-45	0	0	0	0	0
Dame Catherine Elcoat, Chief Nursing Officer (left office 19/11/2006)	75-80	0	0	110-115	0	10,500
Tim Jones, Acting Chief Operating Officer (commenced office 1/7/2006)	100-105	0	0	0	0	0
Julie Moore, Chief Operating Officer (became CE 1/7/2006)	30-35	0	0	135-140	0	0
Caroline Wigley, Director of Organisation Development	110-115	0	0	90-95	0	0
Dr David Rosser, Medical Director (commenced office 1/12/2006)	10-15	50-55	3,300	0	0	0
Professor Rob Stockley, Medical Director and Director of Clinical Standards (left office 30/11/2006)	70-75	40-45	0	50-55	30-35	0
Mike Sharon, Director of Policy, Planning and Performance Management	100-105	0	0	90-95	0	0
Fiona Alexander, Director of Communications	85-90	0	0	10-15	0	0
Morag Jackson, New Hospital Director (commenced office 11/12/2006)	30-35	0	0	0	0	0
NON EXECUTIVE DIRECTORS						
Sir Albert Bore, Chairman (commenced office 1/12/2006)	15-20	0	100	0	0	0
John Charlton, Chairman (left office 30/11/2006)	30-35	0	0	30-35	0	0
David Bailey (commenced office 1/12/2006)	0-5	0	0	0	0	0
Stuart Dobson	10-15	0	100	10-15	0	0
Tony Huq	10-15	0	100	10-15	0	0
David Ritchie (commenced office 1/12/2006)	0-5	0	0	0	0	0
Clare Robinson	10-15	0	0	10-15	0	0
Rev Mark Santer	10-15	0	0	10-15	0	0
David R Westbury	10-15	0	0	10-15	0	0
Mary Thomas (left office 30/11/2006)	5-10	0	100	10-15	0	0

Benefits in kind relate to the provision of lease cars and business mileage.

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 2007 (bands of £5000) £000	Total accrued pension related lump sum at age 60 at 31 March 2007 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2006 £000	Cash Equivalent Transfer Value at 31 March 2007 £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension To nearest £100
Julie Moore, Chief Executive (commenced office 1/7/2006 - previously COO)	17.5-20	55-57.5	60-65	180-185	565	862	198	N/A
Mark Britnell, Chief Executive (left office 30/6/2006)	0-2.5	2.5-5	20-25	70-75	251	271	2	N/A
Mike Sexton, Executive Director of Finance (commenced office 1/12/2006)	10-12.5	35-37.5	35-40	105-110	337	529	128	N/A
Peter Shanahan, Deputy chief Executive and Chief financial Officer (left office 30/11/2006)	0-2.5	2.5-5	15-20	50-55	187	214	10	N/A
Trisha Curran, Acting Chief Nurse (commenced office 20/11/2006)	2.5-3	7.5-10	25-30	80-85	303	424	30	N/A
Dame Catherine Elcoat, Chief Nursing Officer (left office 19/11/2006)	0-2.5	10-12.5	35-40	110-115	536	627	35	N/A
Tim Jones, Acting Chief Operating Officer (commenced office 1/7/2006)	5-7.5	17.5-20	20-25	65-70	163	273	56	N/A
Caroline Wigley, Director of Organisation Development	5-7.5	17.5-20	40-45	125-130	539	669	82	N/A
Dr David Rosser, Medical Director (commenced office 1/12/2006)	0-2.5	0-2.5	30-35	90-95	336	381	8	N/A
Professor Rob Stockley, Medical Director and Director of Clinical Standards (left office 30/11/2006)	25-27.5	80-82.5	75-80	230-235	662	1,447	360	N/A
Mike Sharon, Director of Policy, Planning and Performance Management	0-2.5	2.5-5	20-25	70-75	315	345	15	N/A
Fiona Alexander, Director of Communications	0-2.5	2.5-5	0-5	0-5	1	14	9	N/A
Morag Jackson, New Hospital Director (commenced office 11/12/2006)	0-2.5	0-2.5	0-5	0-5	0	5	1	N/A

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

	31 March 2007 Total	Permanently Employed	Other	31 March 2006 Total
	£000	£000	£000	£000
Salaries and wages	**184,176**	172,664	11,512	175,057
Social Security Costs	**15,184**	15,184	0	15,576
Employer contributions to NHSPA	**20,472**	20,472	0	19,405
Agency/contract staff	**8,059**	0	8,059	8,742
	227,891	**208,320**	**19,571**	218,780

6.2 Average number of persons employed

	2007 Total	Permanently Employed	Other	2006 Total
	Number	Number	Number	Number
Medical and dental	**736**	736	0	716
Administration and estates	**1,468**	1,468	0	1,496
Healthcare assistants and other support staff	**558**	558	0	538
Nursing, midwifery and health visiting staff	**2,570**	2,570	0	2,536
Scientific, therapeutic and technical staff	**804**	804	0	791
Bank and agency staff	**91**	0	91	114
Total	**6,227**	**6,136**	**91**	6,191

6.3 Retirements due to ill-health

During the year to 31 March 2007 there were 15 early retirements from the Trust agreed on the grounds of ill-health (31 March 2006 - 6). The estimated additional pension liabilities of these ill-health retirements will be £840,240 (31 March 2006 - £206,109). The cost of these ill-health retirements will be borne by the NHS Pensions Agency.

7. Exceptional Items

The impairment arises due to the revaluation of buildings scheduled for disposal/demolition under the new hospital PFI scheme.

The Trust has applied an impairment charge to these buildings to follow the accounting treatment required in the NHS Foundation Trust Manual (FReM) in line with Financial Reporting Standard 11: Impairment of Fixed Assets and Goodwill.

	Year ended 31 March 2007 £000	Year ended 31 March 2006 £000
Retained surplus for the year prior to exceptional items	2,754	38
Impairment of buildings	(87,577)	(3,564)
Deficit for the financial year	(84,823)	(3,526)

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

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

	Year ended 31 March 2007 £000	Year ended 31 March 2006 £000
Profit on disposal of plant and equipment	0	25
Loss on disposal of plant and equipment	(79)	0
Loss on disposal of land and buildings	0	(102)
	(79)	(77)

9. Interest

9.1 Interest Receivable	31 March 2007 £000	31 March 2006 £000
Bank interest receivable	856	731
Loan interest receivable	(9)	22
	847	753

9.2 Financing Costs

Interest paid in year	0	1

10. Taxation

10.1 Corporation Tax Payable

The activities of the Trust have not given rise to any corporation tax liability in the year (year ended 31 March 2006 - £nil).

11. Fixed Assets

11.1 The net book value of land, buildings and dwellings at 31 March 2007 comprises:

	31 March 2007 £000	31 March 2006 £000
Freehold	140,736	208,420
Long leasehold	0	0
Short leasehold	0	0
TOTAL	140,736	208,420

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 2006	72,652	129,483	6,285	3,800	68,578	119	4,162	5,141	290,220
Additions purchased	2,178	1,574	0	4,967	4,103	0	181	0	13,003
Additions donated	0	0	0	3	40	0	0	0	43
Impairments	0	(88,352)	(4,788)	(896)	(113)	0	0	0	(94,149)
Reclassifications	687	1,266	1	(3,940)	1,110	0	855	21	0
Other in year revaluation	17,111	0	0	0	0	0	0	0	17,111
Disposals	0	0	0	0	(7,231)	0	(106)	0	(7,337)
At 31 March 2007	**92,628**	**43,971**	**1,498**	**3,934**	**66,487**	**119**	**5,092**	**5,162**	**218,891**
Depreciation at 1 April 2006	0	0	0	0	43,595	119	1,670	3,490	48,874
Provided during the year	0	3,807	126	0	5,283	0	563	440	10,219
Impairments	0	(6,318)	(254)	0	0	0	0	0	(6,572)
Disposals	0	0	0	0	(7,079)	0	(106)	0	(7,185)
Depreciation at 31 March 2007	**0**	**(2,511)**	**(128)**	**0**	**41,799**	**119**	**2,127**	**3,930**	**45,336**
Net book value									
- Purchased at 1 April 2006	72,652	123,578	6,252	3,791	20,877	0	2,463	1,545	231,158
- Donated at 1 April 2006	0	5,905	33	9	4,106	0	29	106	10,188
Total at 1 April 2006	**72,652**	**129,483**	**6,285**	**3,800**	**24,983**	**0**	**2,492**	**1,651**	**241,346**
- Purchased at 31 March 2007	92,628	40,826	1,595	3,923	21,185	0	2,946	1,148	164,251
- Donated at 31 March 2007	0	5,656	31	11	3,503	0	19	84	9,304
Total at 31 March 2007	**92,628**	**46,482**	**1,626**	**3,934**	**24,688**	**0**	**2,965**	**1,232**	**173,555**

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 2007	0	22,270	0	0	0	0	0	0	**22,270**
- Unprotected assets at 31 March 2007	92,628	24,212	1,626	3,934	24,688	0	2,965	1,232	**151,285**
Total at 31 March 2007	**92,628**	**46,482**	**1,626**	**3,934**	**24,688**	**0**	**2,965**	**1,232**	**173,555**

12. Stocks and Work in Progress

	31 March 2007 £000	31 March 2006 £000
Raw materials and consumables	9,395	8,609
Work-in-progress	12	17
Finished goods	176	164
TOTAL	9,583	8,790

13. Debtors

	31 March 2007 £000	31 March 2006 £000
Amounts falling due within one year:		
NHS debtors	11,739	10,723
Non NHS trade debtors	6,202	5,281
Provision for irrecoverable debts	(337)	(210)
Loan to NHS Trust	0	103
Other prepayments and accrued income	5,398	5,369
Deferred asset	41	0
Other debtors	2,925	3,469
Sub Total	25,968	24,735
Amounts falling due after more than one year:		
NHS debtors	618	720
Provision for irrecoverable debts	(152)	(84)
Loan to NHS Trust	0	176
Deferred asset	416	0
Other debtors	1,977	1,400
Sub Total	2,859	2,212
TOTAL	28,827	26,947

The deferred asset of £41,000 falling due within one year and £416,000 falling due after one year is a bullet payment made in relation to the New Hospital PFI (see note 24).

14. Creditors

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

	31 March 2007 £000	31 March 2006 £000
Amounts falling due within one year:		
Payments received on account	333	54
NHS creditors	7,098	5,828
Non - NHS trade creditors - revenue	10,939	9,756
Non - NHS trade creditors - capital	2,311	3,247
Other tax and social security costs	5,368	4,990
Other creditors	3,080	3,378
Accruals and deferred income	17,111	15,494
Sub Total	46,240	42,747
Amounts falling due after more than one year:	0	0

NHS creditors include pension contributions of £2,506,106 outstanding at the 31 March 2007 (31 March 2006: £2,416,894).

14.2 Prudential borrowing limit:

	31 March 2007 £000	31 March 2006 £000
Prudential borrowing limit set by Monitor	77,100	77,100
Working capital facility	28,500	19,500
Actual borrowing in year - long term	0	0
Actual borrowing in year - working capital	0	0
Minimum dividend cover	2.7	2.2
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

There has been no necessity to exercise the Trust's Prudential Borrowing Limit or to use it's overdraft facility.

15. Provisions for liabilities and charges

	Pensions relating to other staff	Legal claims	Other	**Total**
	£000	£000	£000	**£000**
At 1 April 2006	269	1,317	4,231	**5,817**
Arising during the year	0	929	4,696	**5,625**
Utilised during the year	(31)	(194)	(2,500)	**(2,725)**
Reversed unused	(12)	(57)	(22)	**(91)**
Unwinding of discount	26	0	0	**26**
At 31 March 2007	**252**	**1,995**	**6,405**	**8,652**
Expected timing of cashflows:	£'000	£'000	£'000	**£'000**
Within one year	31	592	5,291	**5,914**
Between one and five years	113	276	1,114	**1,503**
After five years	108	1,127	0	**1,235**

The provisions included under 'legal claims' are for personal injury (£1,475,402), employers and public liability (£253,225) and other claims notified by the Trusts solicitors (£266,000). The provisions for employers and public liability have been calculated based on information received from the NHS Litigation Authority (NHSLA) taking into account indications of uncertainty and timing of payments. Injury benefit has been calculated based on guidance received from the NHS Pensions Agency.

Provisions with in the annual accounts of the NHS Litigation Authority at 31 March 2007 include £7,567,574 in respect of clinical negligence liabilities of the Trust (31 March 2006 - £5,672,027).

16.1 Movement in taxpayers' equity

	31 March 2007	31 March 2006
	£000	£000
Taxpayers' equity at start of period	**243,758**	247,052
Prior period adjustments	**(586)**	(166)
Taxpayers equity at start of period, as restated	**243,172**	246,886
Surplus/(deficit) for the financial year	**(76,901)**	4,727
Public dividend capital dividends	**(7,922)**	(8,253)
Surplus/(deficit) from revaluations of fixed assets	**17,040**	(2,379)
New public dividend capital received	**2,988**	4,005
Additions/(reductions) in donated asset reserve	**(884)**	(1,814)
Taxpayers equity at 31 March 2007	**177,493**	243,172

17. Movements on Reserves

Movements on reserves in the year comprised the following:

	Revaluation Reserve	Donated Asset Reserve	Income and Expenditure Reserve	**Total**
	£000	£000	£000	**£000**
At 1 April 2006	68,530	10,774	6,747	**86,051**
Prior Period Adjustments	0	(586)	0	**(586)**
At 1 April 2006 as restated	68,530	10,188	6,747	**85,465**
Transfer from the income and expenditure account	0	0	(84,823)	**(84,823)**
Fixed asset impairments	(16,792)	0	16,792	**0**
Surplus on the revaluation of land	17,111	0	0	**17,111**
Impact of disposals on revaluation reserve	(71)			**(71)**
Receipt of donated assets	0	43	0	**43**
Transfers to the Income and Expenditure Account for depreciation on donated assets		(925)		**(925)**
Other transfers between reserves (see below)	(181)	0	181	**0**
Transfer to Income and Expenditure Account for disposal of donated assets	0	(2)	0	**(2)**
At 31 March 2007	**68,597**	**9,304**	**(61,103)**	**16,798**

Other transfers relate to 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 donated asset reserve occurred due to the requirement of the FREM to account for assets funded by the Big Lottery Fund and its predecessor body the New Opportunities Fund (NoFF), as deferred income in the same way as government granted assets.

18. Notes to the cash flow Statement

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

	31 March 2007 £000	31 March 2006 £000
Total operating surplus	9,934	7,784
Depreciation and amortisation charge	10,219	12,783
Transfer from donated asset reserve	(925)	(1,118)
(Increase)/decrease in stocks	(793)	(808)
Decrease in debtors	(1,843)	2,793
Increase/(decrease) in creditors	4,429	5,422
Increase in provisions	2,809	(937)
Net cash inflow from operating activities	23,830	25,919

18.2 Reconciliation of net cash flow to movement in net debt

	£000	£000
Increase in cash in the period	5,767	5,696
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	5,767	5,696
Non - cash changes in debt	0	0
Net debt at 1 April 2006	14,653	8,957
Net debt at 31 March 2007	20,420	14,653

18.3 Analysis of changes in net debt

	At 1 April 2006 £000	Cash changes in year £000	At 31 March 2007 £000
OPG cash at bank	519	9,246	9,765
Commercial cash at bank and in hand	14,134	(3,479)	10,655
	14,653	5,767	20,420

19. Capital Commitments

Commitments under capital expenditure contracts at the balance sheet date were £2,908,398 (31 March 2006 - £2,109,457).

20. Post Balance Sheet Events

The Trust does not have any post balance sheet events.

21. Contingencies

There are £92,969 (31 March 2006 - £nil) 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 £7,922,000 (31 March 2006 - 8,253,000) bears to the average relevant net assets of £195,444,000 (31 March 2006 - £226,705,00 that is 4.05% (31 March 2006 - 3.6%).

The rate of 4.05% reflects the fact that the Trusts relevant net assets have been reduced in 2006/07 by the revaluations carried out as a result of the signing the PFI agreement in June 2006. The PDC payment is calculated based on known events in December 2005 before the signing of the PFI was a certainty.

23. Related Party Transactions

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

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. The main local commissioners are South Birmingham PCT, Pan Birmingham Specialised Services, Heart of Birmingham PCT and West Midlands South LSG from whom the Trust received £186.5m for health care contracts. Additionally the Trust has transacted with a large number of other PCTs and NHS Trusts including Birmingham East and North PCT, Worcestershire PCT, South Staffordshire PCT, Sandwell PCT, Telford and Wrekin PCT, Birmingham Women's Health Care NHS Trust, Solihull PCT, Dudley PCTand Sandwell and West Birmingham PCT as well as NHS Logistics and the National Blood Service.

The Trust considers other NHS Foundation Trusts to be related parties, as they and the Trust are under the common performance management of Monitor. During the year the Trust contracted with certain other Foundation Trusts for the provision of clinical and non clinical support services. The value of activity undertaken with these organisations was not material to the accounts.

The debtors balance for NHS bodies as at 31 March 2007 stood at £11.7m. The creditors balance for NHS bodies as at 31 March 2007 stood at £6.4m.

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies, in particular the Ministry of Defence. The Trust also had a significant level of transactions with The University of Birmingham.

The Trust has also received revenue and capital payments from a number of charitable funds, certain of the Trustees for which are also members of the NHS Foundation Trust Board. John Charlton and Brian Hanson who were both Trustees of UHB Charities throughout 2006/07 were respectively Chairman and a Governor of University Hospital Birmingham NHS Foundation Trust. Brian Hanson was a Governor throughout 2006/07 and John Charlton resigned as Chairman of University Hospital Birmingham NHS Foundation Trust on 30 November 2006.

24. Private Finance Transactions

24.1 New Hospital Project

PFI schemes deemed to be off-balance sheet - New Hospital

A contract for the development of the new hospital was signed by the Trust and its PFI partner on 14 June 2006. The purpose of the scheme is to deliver a modern, state of the art acute hospital facility on the QE site which is due to open in 2012. This is part of a wider PFI deal in partnership with Birmingham and Solihull Mental Health Trust. The scheme is in conjunction with Birmingham New Hospitals Project (BNHP) a consortium consisting of Balfour Beatty, Royal Bank of Scotland and HSBC.

The scheme is contracted to end on 14 June 2046 at which time the building will revert to the ownership of the Trust.

The new building will open in 3 phases. Phase 1 will open in June 2010, phase 2 in November 2010 and phase 3 by October 2011. Work on the retained estate is set for completion in August 2012. Over the period, the Trust and its partners will have invested £545m in building the new hospital. A number of the Trust properties will be sold and most of the income invested in the scheme.

Impact On Accounts

	2006/07 £000	2005/06 £000
Amounts included within operating expenses in respect of PFI transactions deemed to be off-balance sheet - gross	1,254	0
Amortisation of PFI deferred asset	30	0
Net charge to operating expenses	1,284	0

The Trust is committed to make the following payments during the next year ended 31 March 2008.

	£000	£000
PFI scheme which expires; 36th to 40th years (inclusive)	1,395	0

The estimated annual payments in future years are expected to be materially different from those which the Trust is committed to make during the next year. In the second to fifth years of the scheme, the Trust is committed to make payments of £19.7m with the annual committment rising to £46.7m in the remaining years of the PFI scheme.

	£000
Estimated capital value of the PFI scheme	484,889
Contract Start date:	14 June 2006
Contract End date:	14 August 2046

PFI schemes deemed to be off-balance sheet - New Hospital (cont'd)

In the accounts there are a number of balances relating to the PFI scheme as follows;

Within debtors falling due over one year £416,458 relates to the deferred asset of a bullet payment to the PFI partner. This will reduce payments made to the PFI partner over the next 12 years and will be amortised over that period.

Within debtors falling due within one year £40,630 relates to the element of the bullet payment to the PFI partner for which the benefit will be realised within one year of the balance sheet date.

As at the balance sheet date there was one formal contract variation which has not resulted in any cost to the Trust.

Service' element of PFI schemes deemed to be on-balance sheet

The Trust does not have any PFI schemes which are deemed to be on-balance sheet.

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	Fixed rate	Non-interest bearing	Fixed rate Weighted average interest rate
	£000	£000	£000	%
At 31 March 2007				
Sterling	20,420	0	20,420	0.0%
Other	416	416	0	2.2%
Gross financial assets	**20,836**	**416**	**20,420**	
At 31 March 2006				
Sterling	14,653	0	14,653	0.0%
Other	896	896	0	3.1%
Gross financial assets	**15,549**	**896**	**14,653**	

25.2 Financial Liabilities

Currency	Total	Fixed rate	Non-interest bearing	Fixed rate Weighted average interest rate
	£000	£000	£000	%
At 31 March 2007				
Sterling	0	0	0	0.0%
Other	169,347	8,652	160,695	0.5%
Gross financial liabilities	**169,347**	**8,652**	**160,695**	
At 31 March 2006				
Sterling	0	0	0	0.0%
Other	163,524	5,817	157,707	2.2%
Gross financial liabilities	**163,524**	**5,817**	**157,707**	

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 2007.

	Book Value £000	Fair Value £000	
Financial assets			
Cash	20,420	20,420	
Debtors over 1 year:			
Agreements with commissioners to cover creditors and provisions	416	416	a
Total	20,836	20,836	
Financial liabilities			
Working capital facility	28,500	28,500	
Provisions under contract	8,652	8,652	b
Public dividend capital	160,695	160,695	c
Total	197,847	197,847	

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 note c below, fair value is not significantly different from book value.

b 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.

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

26 Third Party Assets

The Trust held £2,646 cash at bank and in hand at 31 March 2007 (£2,508 - at 31 March 2006) 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.

The Trust also held £609,379 cash at bank and in hand at the 31 March 2007 (£nil - 31 March 2006) for Midtech Inovations Ltd. This has been excluded from cash at bank and in hand figure reported in the accounts.

27 Losses and Special Payments

There were 341 cases of losses and special payments (31 March 2006 - 167 cases) totalling £355,089 (31 March 2006 - £427,427) approved in the year.

There were no clinical negligence cases where the net payment exceeded £100,000 (prior year: no cases).

There were no fraud cases where the net payment exceeded £100,000 (prior year: no cases).

There were no personal injury cases where the net payment exceeded £100,000 (prior year: no cases).

There were no compensation under legal obligation cases where the net payment exceeded £100,000 (prior year: no cases).

There were no fruitless payment cases where the net payment exceeded £100,000 (prior year: no 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.

University Hospital Birmingham NHS Foundation Trust
Accounts for the year ended 31 March 2007

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: 22 December 2006