University Hospital Birmingham
NHS Foundation Trust

2007 › 2008
Annual Report & Accounts

This annual report covers the period
1 April 2007 to 31 March 2008

Presented to Parliament pursuant to Schedule 7, paragraph 25(4) of the National Health Service Act 2006

University Hospital Birmingham NHS Foundation Trust
Annual Report and Accounts 2007/08

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Section 1
Chair's Statement

2007/08 has, I am proud to say, been a year of successes.

- We have received 'Excellent' for Use of Resources and 'Good' for Quality of Services in the Healthcare Commission's Annual Health Check for the second year running
- We have achieved financial balance for the 12th year in succession
- We have broadly hit our operational targets
- We have launched the Birmingham Clinical Research Academy with our academic partners – its aim is to turn science into new treatments for patients
- We have been successful in our bid to become one of country's seven National Institute for Health Research (NIHR) Collaborations For Leadership in Applied Health Research and Care centres, a £10million funding prize
- We have won a £3.75 million NIHR bid for research into liver disease
- Some 89% of our staff have said they are proud to work for our Trust
- Patient satisfaction has improved
- We have significantly reduced our infection rates
- Our £545million PFI project to build Birmingham's first new acute hospital in 70 years is ahead of time and on budget

2007/08 has also been a year of change.

- We have complemented our very strong operational performance with a more strategic focus developing a vision, purpose and set of values to help define our objectives for the coming years
- We have formed closer partnerships with key stakeholders in order to provide appropriate patient services in the community
- The roles of our governors have, with their help, been clearly defined, enhanced and implemented
- Our Governors are playing a much more strategic role in our organisation helping to develop our plans for the future
- We have defined the role of our members as well as developed and implemented a Members' Strategy with the help of our governors and key stakeholders

But there is still more to do in 2008/09.

- We need to further reduce our rates of infection
- We need to further improve the patient experience in our hospitals
- We need to ensure the construction of the new hospital remains on schedule and on budget
- We need to be prudent with costs while improving quality of our service

And there are other external factors likely to influence future development, performance and position of our Trust. We expect that the health 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 World-Class 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 and which can result in fines for missing targets
- The development of practice-based commissioning which provides incentives for GPs to reduce expenditure in secondary care
- The Darzi Review which is likely to encourage the provision of more services in a community setting
- Increased competition from other NHS Trusts, and, to a lesser degree, the private 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

One of the greatest challenges is to ensure that the new hospital remains affordable and delivered on time. The Trust Board continues to review the detailed assumptions and affordability of the business case for the new hospital. Detailed progress reports and plans are presented to the Board on a regular basis.

The Trust is well-placed to meet these challenges, having delivered very strong service quality and financial performance over a number of years.

It will be another exciting year.

Sir Albert Bore
Chairman

Section 2
Directors' Report

2.1 Names of persons who were Directors of the Trust

Throughout the year, the Board of Directors comprised the Chairman, six executive and seven non-executive directors. The Chairman has been appointed 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 1 December 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
Medical Director: David Rosser
Director of Organisation Development: Caroline Wigley
Chief Nurse: Kay Fawcett
Chief Operating Officer: Tim Jones

Non-executive directors:
Professor David Bailey
Stewart Dobson
Tony Huq
David Ritchie
Clare Robinson
Rt Revd Mark Santer
Professor David Westbury (retired 30 November 2007)
Professor Michael Sheppard (from 5 December 2007)

Kay Fawcett was appointed Chief Nurse from 14 January 2008. Trisha Curran filled this post in an acting capacity from 1 April 2007-26 September 2007 and then this was filled by Michele Morris again in an acting capacity, from 27 September 2007 to 13 January 2008.

Tim Jones was appointed Chief Operating Officer from 13 June 2007. Prior to this he was Acting Chief Operating Officer.

Professor David Westbury retired as a non-executive director on 30 November 2007. Professor Michael Sheppard was appointed as a non-executive director on 5 December 2007.

The board considers Mark Santer, Tony Huq, Clare Robinson, Stewart Dobson, David Bailey, David Ritchie and Professor David Westbury (retired 30 November 2007) to be independent.

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 1 December 2006 and Professor Michael Sheppard who was appointed for a term of three years commencing 5 December 2007.

2.2 Principal activities of the Trust

The principal activities of the Trust are to provide healthcare for the local population of South Birmingham, to provide general and specialist healthcare for a local, regional and, in certain specialities, a national population. It is also to provide an environment for teaching medical, nursing and allied health professionals and for clinical research.

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

The Trust's total income for 2007/08 was £424.5m, which represented an increase of £23.4m (5.9%) from £401.1m in 2006/07. Earnings before Interest, Tax, Depreciation and Amortisation (a measure of profitability) increased from 5.0% of turnover in 2006/07 to 6.7% of turnover in 2007/08.

2.3 Description of the Trust's services

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.

As a specialist teaching Trust, UHB provides a wide 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 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

Over 525,000 patients came to UHB for their care in the last 12 months, 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 Annual Health Check.

UHB has very close links to the University of Birmingham and Birmingham City University and therefore its aims are not simply to provide the best possible care but also to make sure that it fulfils its leading role in teaching medical and nursing students and in providing a base for excellent research.

Complementing its role as a centre of excellence, it also aims to be an asset to the communities of Birmingham and the West Midlands.

UHB 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.

The Trust has around 82,000 members and a Board of Governors which includes 24 members of the public (local people, patients and staff), who have been elected as representatives. It serves an ethnically diverse community and this is reflected in its membership and in its Board of Governors.

UHB's ambitions are incorporated into its 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

The results of the 2006/07 Patient Survey were received in June 2007 and showed a small improvement over the previous year, although there were still 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 89% 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 November 2007 the Birmingham Clinical Research Academy (BCRA) was launched. The Academy, which is led by UHB and the University of Birmingham, is working with Aston and Birmingham City universities to establish a world-class medical, technology research and training centre in the region. It is hoped that other healthcare organisations will get involved in the Academy in the near future.

One of the first roles of Professor Richard Lilford, Director of BCRA, was to bid to

become one of only seven Collaboration for Leadership in Applied Health Research and Care centres in the country. The Birmingham and Black Country Collaboration, led by UHB and University of Birmingham, was successful in its bid, announced at the end of May by the Health Minister Dawn Primarolo.

To be successful in securing the £10million funding, the partnership had to demonstrate an excellent record in undertaking applied health research - particularly targeted at chronic disease and ways of improving public health - and to put forward very strong proposals for new research and for implementing research findings, which were very likely to generate a step change in the way that research is done and research evidence is implemented into practice.

The University of Birmingham and the UHB NHS Foundation Trust (UHBFT) already enjoy a strong working partnership, and both organisations have benefited from a physical campus co-location for more than 50 years, with the University's Medical School and the Queen Elizabeth Hospital sited next door to each other.

This partnership is being taken to new levels through the formation of the BCRA, where together, it can deliver the best in medical care, taking cutting edge research from the laboratory bench to patient bedside.

2.4 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 World-Class 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 and which can result in fines for missing targets
- The development of practice-based commissioning which provides incentives for GPs to reduce expenditure in secondary care
- The Darzi Review which is likely to encourage the provision of more services in a community setting
- Increased competition from other NHS Trusts, and, to a lesser degree, the private 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. 2008/09 will be the final year of operation for the Healthcare Commission. The extent of changes in the national performance framework that will be developed by its successor is not yet known.

One of the greatest challenges is to ensure that the new hospital remains affordable and is delivered on time. The Trust Board continues to review the detailed assumptions and affordability of the business case for the new hospital. Detailed progress reports and plans are presented to the Board on a regular basis.

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.

We will continue to improve patient satisfaction 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.

Many of UHB's services are provided from outdated estate split across two sites. 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 UHB from achieving the levels of patient satisfaction it would like for inpatients on a number of privacy and dignity indicators. Whilst it make every effort to maximise patient dignity and comfort, it will not be in a position to fully address these issues until we transfer into the new hospital.

2.5 Principal risks and uncertainties facing the Trust

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 has strengthened the identification and reporting of key risks.

The main uncertainties facing the Trust concern the operation of the new national contract and revisions to the external performance assessment system.

The new national contract allows for Trusts to be fined for not meeting the target to reduce Clostridium difficile (c-diff) infection rates and some work, if not specifically approved by a commissioner, not being paid for. Both of these factors present risks to future income. However, the extent of the financial risk is difficult to gauge in advance and will depend partly on the approach adopted by individual commissioners.

The external performance assessment framework has recently been the subject of consultation by the Healthcare Commission. Some targets will become more challenging, such as infection control targets and the need to treat 90% of all inpatients and 95% of all outpatients within 18 weeks. UHB has a high proportion of referrals from other Trusts who may refer patients late to UHB, making this target more challenging.

2.6 Finance and Performance

With total income of £424.5m for the 2007/08 financial year, UHB is established within the top 10% of Foundation Trusts when ranked by size of turnover. The Trust has achieved a surplus of £12.5m for 2007/08, equivalent to 2.9% of turnover. This strong financial performance has resulted in the Trust receiving an overall Financial Risk Rating of 4 from Monitor.

The Trust's income and expenditure for 2007/08 is set out in the table below. This shows that the outturn position is significantly ahead of the planned surplus of £5.7m (before exceptional items) that was forecast in the 2007/08 Annual Plan. This reflects a combination of additional healthcare income and strong control of costs including delivery of additional efficiency savings to prepare for the future increase in costs associated with the new hospital. Further detail of income and expenditure is included below the table.

It had been intended that the Trust would recognise a provision in its 2007/08 accounts, as an exceptional item, for the unavoidable transition costs associated with moving into and making operational the new hospital. However, it has subsequently been determined that these costs will not be recognised in 2007/08. This delay in recognising costs does not impact on the Trust's cash flow or operating performance for 2007/08.

2.7 Income and expenditure

The table below compares the original planned income and expenditure with the outturn position for 2007/08.

Summary income and expenditure – plan v. outturn

UHB Summarised Income and Expenditure (£M's)		
	Plan 2007/08	**Outturn Position 2007/08**
Income	411.6	424.5
Expenditure	-391.0	-396.1
EBITDA	**20.6**	**28.4**
Depreciation	-8.0	-9.7
Dividend	-7.7	-7.7
Loss on asset disposal	0	-0.9
Interest	0.8	2.4
I&E before exceptional items	**5.7**	**12.5**
Exceptional items	-5.7	0
I&E after exceptional items	**0.0**	**12.5**

The provision of healthcare accounts for £353m of total income.

The Trust has a number of other 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 £32.5m in 2007/08, equivalent to 7.7% of the Trust's total income.

The education and research funding is comprised of three main elements. These are 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 2007/08 are £14.5m and £13.1m respectively. Finally, the Trust receives £4.9m from the Department of Health to support Research and Development activities including a contribution to the costs of operating the Wellcome Trust Clinical Research Facility.

The largest item of expenditure is salaries and wages, accounting for £241m, equivalent to 60% of total expenditure. Other significant components include £40m on drugs (10%) and £57m on Clinical Supplies and Services (14%).

The Trust has had a strong cash position during 2007/08 and therefore, in line with the business plan, there has been no requirement to exercise the Prudential Borrowing Limit or to use its overdraft facility.

2.8 Capital Expenditure Plans

UHB's capital expenditure plans, which run alongside the development of the new hospital, come to a total of circa £69m over the next three years (08/09 to 10/11). Currently it is not anticipated that it will be necessary to borrow against the Prudential Borrowing Limit during these years.

Of the £69m capital programme, £13m is being spent on protected buildings which will be retained under the existing estate. All expenditure on the non-retained estate is now funded from revenue.

The Trust is carrying all land at the District Valuer's valuation in 2007 for the Selly Oak site and 2008 for the QE site. The Selly Oak Hospital land is owned freehold and Queen Elizabeth Hospital is on a long-term lease from Birmingham City Council due to expire 29 September 2932.

In 2007/08 UHB invested £14.5m capital financial resources in new facilities and improving old environments. A summary of the major investments is provided below:

Category	Capital Invested £m
IT Strategy and Infrastructure	1.5
Expenditure on the retained estate to maintain statutory standards	0.5
Modernisation:	
• Picture Archiving and Communication System	4.4
• Critical Care Expansion	0.4
• Equipment	0.3
• Other	0.8
Learning Hub Centre	0.7

2.9 Value for Money

The Trust's Financial Plan for 2007/08 required the delivery of cash releasing efficiency savings of 4.0% against relevant budgets. In order to achieve this, a formal cost improvement programme (CIP) totalling £9.7m was agreed for 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 ongoing tendering and procurement rationalisation and a review of all requests to recruit to both new and existing posts via the Workforce Approval Committee.

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 2007 the Trust achieved a rating of 'excellent' for the

use of resources (based on 2006/07 outturn data).

2.10 Private Patient Income (PPI)

PPI was £2.9m which is within the authorised limit of 1.23%.

2.11 University Hospital Birmingham Charities

The charitable funds for UHB are administered by UHB Charities, a separate legal entity from the Trust. In 2007/08 the Trust received grants of £0.75m from UHB Charities.

2.12 Audit Information

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

2.13 Policies in relation to disabled employees and equal opportunities

This year UHB has consolidated its policies into a Single Equality Scheme which went to the Board of Directors in December 2007. This is now out for consultation with an extensive range of groups. The Healthcare Commission's audit of websites demonstrated that UHB were one of only 35 Trusts to meet its publishing requirements under the Race Equalities 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.

Impact Assessments have been carried out on various Trust policies and procedures with a remit to ensure they do not restrict or discriminate against any of the six equality groups, including staff with disabilities. Awareness on disability issues is provided for managers via a national online training package, which is also open to all staff, as well as during Corporate Induction Training days for new employees. All staff currently have an appraisal every six months which identifies any training needs or requirements they may have around disability issues. Occupational Health provides support for workplace assistance as a result of a long-term or a recently-acquired disability. A Single Equality Scheme has been drafted and is currently under review with its aim to support current and future initiatives on Disability objectives and information about this can be accessed on the Trust's website. Access audits have been carried out on all aspects of the New Hospital Project.

2.14 Consultation

UHB believes 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. This year the Trust has set up a new Corporate Consultative Committee in addition to the four Clinical Divisions. Staff are also encouraged to attend Foundation Trust membership meetings.

Each month the Chief Executive personally briefs the Trust’s senior managers, who then cascade the information to their teams through department heads. Staff can also contact the Chief Executive through her hotline if they have issues or concerns they wish to be addressed.

Divisional Performance Reviews for each clinical division are held bi-annually. This gives the division an opportunity to formally update the executive team on the past six months’ performance, their development plans for the coming six months and gives the executive the opportunity to talk through the Trust’s long-term strategic plans.

..... 12 June 2008

Julie Moore **Date**
Chief Executive

Section 3
Background Information

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

On July 1, 2004 UHB 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.

3.1 Changes in accounting policies by UHB in the 2007/08

UHB in the preparation of its accounts has complied for the first time in 2007/08 with UK GAAP Financial Reporting Standards 25, 26 and 29 on Financial Instruments. Further details are found in note 25.1 of the Accounts.

3.2 External Auditors

UHB's external auditors are KPMG LLP. The audit cost for the year is £68,000 for statutory audit services, none of which relates to non-audit work. Following a competitive tendering exercise from the 1 April 2006, KPMG has also provided taxation advice to the Trust.

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

3.3 Pensions

The accounting policy for pensions and other retirement benefits are set out in note 1.15 to the accounts and details of senior employees' remuneration can be found in page 47 in the remuneration report.

Section 4
Management Commentary

4.1 The development and performance of the Trust during the financial year

UHB has broadly met or exceeded its planned activity assumptions and generally showed an increase in activity compared with the previous year.

Table 1 activity 2006/7-2007/8

	2006/7	2007/8	% change
Inpatient Finished Consultant Episodes	67,174	65,259	-2.85
Day-cases (excluding renal dialysis regular day attenders)	29,841	28,611	-4.12
Outpatient attendances	337,337	350,299	3.8
A&E Attendances	81,748	81,770	0.0147
Total treatments	516,110	525,939	1.9

UHB met nearly all of its objectives in 2007/08, showing strong performance against most national targets including A&E, cancer and all waiting times. It assessed itself as being compliant with core standards at all times during the year.

The Healthcare Commission performance ratings for 2006/07 were published in October 2007. UHB scored "good" for service quality and "excellent" for use of resources, putting the Trust in the top quartile of national performance.

The Trust met its target for reducing c-diff infections. The overall Trust rate reduced by some 13%. The Trust's MRSA bacteraemia rate reduced by 25%. However, the target reduction for 2007/08 was missed. In June 2007 the Healthcare Commission visited the Trust to audit the Trust's compliance with the Hygiene Code. The conclusion of the audit was that the Trust was compliant with the Code. In addition the Department of Health visited the Trust in July 2007 and again in January 2008 to assist the Trust in reducing infections. Revised action plans to reduce infections were put into place following these visits.

4.2 Main trends and factors underlying the development, performance and position of the Trust at the end of the financial year

The Trust started the year with a new executive team, most of whom came into post in late 2006. In addition, in 2007/08 substantive appointments were made to the Chief Operating Officer and Chief Nurse/ Director of Infection Prevention and Control posts. A new non-Executive Director was appointed in December 2007 and Governor elections were held.

Infection control has been and continues to be the highest priority for the Trust. It engaged with the Department of Health's Cleaner Hospitals' team to help reduce infections. During the year it made significant investment in cleaning, training and audit. The Trust revised its infection control procedures, its infection control team and its antibiotic prescribing policy. It also introduced new and more visible hand washing signs. Executive and Non-Executive Directors of the Trust made, and continue to make unannounced hand washing visits to all wards.

The Trust also invested resources in an externally supported leadership development programme for senior clinical and managerial staff with the aim of improving skills and developing succession planning.

In addition it continued to progress its Lean management and Make It Count operation improvement programmes resulting in improved efficiency and patient-focussed care in a number of areas such as Plastic Surgery.

UHB improved its ability to learn from patient feedback, introducing regular reports on patient complaints, lessons learned from those complaints and action taken.

4.3 The position of the Trust at the end of the year

The Trust ended the year in a strong financial position and having met all but one of its operational targets.

Progress on the new hospital project has also been significant, the Trust's position as the leading teaching hospital in the West Midlands has been strengthened and relationships with key stakeholders have been improved. The competitive position of the Trust remains strong.

As UHB moves forward into 2008/09 it is well placed to enjoy another successful year and to make progress on both strategic and operational goals.

The Trust now has a full substantive Board and senior management team in place and has embarked on a programme to develop senior clinical and managerial talent.

The key priorities for the Trust in the coming year will be to reduce infection rates still further, to improve the experience and satisfaction of patients, to ensure progress on all aspects of the new hospital project, to develop the Birmingham Clinical Research Academy and to continue to play a leading role in the wider Birmingham community.

4.4 New hospital progress

The £545m privately-funded initiative (PFI) to build Birmingham's first new acute hospital in 70 years has made significant progress. Construction work is ahead of schedule and the Trust has continued to make progress in a number of other key areas. These include:

- Developing clinical models of care for the new hospital
- Determining what the workforce will look like in the new hospital
- The physical move of services
- Purchasing of major medical equipment
- The future use of the Selly Oak site
- The use of existing buildings on the Queen Elizabeth site

The Trust began a series of open meetings for staff to provide more detail on the new hospital and how it will operate. Some 500 staff have already attended.

During the year UHB set up an Investment Committee as a sub committee of the Board of Directors. This Committee will help the Trust to evaluate investment opportunities more swiftly and with greater diligence.

4.5 Patient care and stakeholder relations

4.5.1 Improving patient services

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

- The creation of a dedicated MRSA cohort ward to ensure the most effective treatment of MRSA patients and to reduce the risk of cross infection
- Improved isolation facilities for patients with c-diff
- The development of a GP web page which gives GPs real-time patient specific information on discharge summaries, scheduled outpatient appointments, inpatient admission dates and diagnostic test results. This is now being rolled out across the Trust's key primary care trusts.
- Winning a tender to provide an Orthopaedic Treatment and Assessment service for Heart of Birmingham Teaching PCT
- Setting up an outreach service for Ear, Nose and Throat in a GP practice in Sutton Coldfield, which has enjoyed very high levels of patient satisfaction

4.5.2 Performance against key patient targets

The following table sets out performance against UHB's main targets:

1a. NATIONAL TARGETS/STANDARDS FOR 2007/08

No	Type	Indicator	National/Internal Target	Data Period	Trust	
1	1M	Cancer - 31 days from decision to treat to treatment	98%	Apr 07 - Feb 08	99.8%	
2	1M	Cancer - 62 days from urgent referral to treatment	95%	Apr 07 - Feb 08	98.1%	
3	1M	18 week referral to treatment	Admitted pts 85% by March 2008 Non-admitted pts 90% by March 2008	Mar-08	AP 86.6%	NAP 91.3%
4	1M	Inpatient waits (26 weeks by March 2008)	Green on target, amber off target but <=3% waiting over, red off target or >3% waiting over	Mar-08	0%	
5	1M	Outpatient waits (11 weeks by March 2008)	Green on target, amber off target but <=3% waiting over, red off target or >3% waiting over	Mar-08	0%	
6	1M	Diagnostic waits (6 weeks by March 2008)	Green all tests on target, amber 1 or 2 tests off target, red >2 tests off target	Mar-08		
7	1M	MRSA 60% reduction from 03/04 baseline (full year target is 49 cases)	Green in line with target, amber up to 10% above target, red >10% above target	Apr 07 - Mar 08	76 (49)	
8	1M	A&E 4 hour waits	98% average over the year	Apr 07 - Mar 08	98.3%	
9	1M	Cancer 2 week waits	100%	Apr 07 - Feb 08	100%	
10	1M	Rapid access chest pain clinic 2 week waits	Green 98% - 100%, amber 900% - 97%, red < 90%	Apr 07 - Mar 08	99.8%	
11	1M	Revascularisation 13 week waits	Green <=0.10%, amber 0.2%, red > 0.2%	Feb-08	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 07 - Feb 08	0.29%	0
13	1M	Thrombolysis 60 minute call to needle	68%	Apr 07 - Mar 08	70%	
14	1M	Delayed transfers of care	Green <= 3.5%, amber 4%, red >4%	Apr 07 - Mar 08	2.3%	
15	1M	C-Diff - 10% reduction in >65s from 2006 (2006 outturn was 622 so full yr target for 07/08 is 560 for >65s)	Green on target, amber upto 5% increase from target, red >5% increase from target	Jan 07 - Mar 08	692 (700)	
16	1M	Emergency bed days - target for April to December 07	Green 3% increase, amber 4% increase, red >4% increase	Apr 07 - Dec 07	-1.53%	
17	1M	Data quality on ethnic group for patients - target for April to December 07	Green 80%, amber 60%, red <60%	Apr 07 - Dec 07	94.1%	

Key for Type

1M - monthly reporting
3M - 3 monthly reporting
6M - 6 monthly reporting
12M - 12 monthly reporting
INT - Internal UHBFT target
HCS - Healthcare Commission surveillance data standards

Monitor Priority Targets

Target weighted 1.0

Target weighted 0.4

4.5.3 Complaints Handling

The Trust received 569 complaints in 2007/08, which was 7% higher than the number received in 2006/07. It responded fully to 92.8% of complaints within the national standard of 25 days. The main areas of complaints were:

- Communication and information
- Outpatient appointments
- Perceptions of clinical treatment

Some of the actions taken as a result of complaints feedback include:

- Improvements to clinical care pathways
- Better information to patients
- More responsive patient administration systems
- Initiatives to improve patients' privacy and dignity

The Trust also runs a Patient Advice and Liaison Service (PALS). There were 1,417 PALS contacts in 2007/08. This compares with 1,485 the year before. This equates to a 4.57% reduction.

The main areas of PALS' contacts were similar to complaints – communication, information, outpatients and perceptions around treatment.

4.5.4 Patient and Public Involvement activities

a. Patient and Carer Councils

There are four Patient and Carer Councils covering all the clinical areas within the Trust's two hospitals. The purpose is for patients and the public to work in partnership with staff to improve the services provided to patients. All councils have been active in seeking patients' views to influence the improvements in care. Councils have introduced an 'Adopt-A-Ward' scheme to facilitate partnership working with ward staff. The aim of the scheme is to represent the patient's view and influence action to be taken to improve the patient's experience.

b. Hand Washing Awareness Campaign led by Patient and Carer Councils

For the second year running, the councils led and co-ordinated a campaign to raise awareness amongst patients, visitors and staff of the need to wash or clean their hands. The campaign included displays of hand washing information, posters and a selection of freebies - e.g. mini hand gels and pens - to 'encourage' participation. Participants from staff, patient and visitor groups were asked to complete a brief questionnaire to assess their awareness of hand washing. Staff and Patient and Carer Council members also visited ward areas armed with ultraviolet light hand washing boxes, information leaflets and questionnaires. During these visits, patients, visitors and staff had the opportunity to use the light boxes to check their hand washing technique. An observational review was conducted of hand washing during the visits which included the availability of hand gel at each bedside and visibility of staff hand washing prior to, and after, patient contact.

c. Patient Experience Matrices

Patients and members have been involved in the development of patient experience measures which will be used by the West Midlands Strategic Health Authority (SHA) during the commissioning of services by PCTs. Workshops have taken place within the Trust and with the SHA to develop the measures which include infection control, privacy and dignity, nutrition and communication.

d. Models of Care

Models of Care have been developed to help map out all of the different processes that patients will go through during their visit or stay in the new hospital. Patients, public and members have been working with key Trust Clinical Redesign staff, to provide a 'sense check' for the emerging models of care. They have had the opportunity to comment on, or suggest, improvements that the Trust may need to undertake to ensure that the patient has the best possible experience during their visit or stay in the hospital. They have also identified some of the communication needs of patients and the public.

e. Information Group

The group was established two years ago and provides a forum for involving patients and the public in reviewing and influencing the way in which information is provided in all formats. This ensures that all information within UHB is produced in a way that is useful to patients, carers and the public, has a consistent style, is in a non-jargonised language, that falls in line with national NHS guidelines. This year the group has specifically been involved with:

- Information points: assessment of the usefulness of telephone information points around the hospital site
- Hospital Information Channel: development of a hospital information channel. The group was involved in producing and editing the information to be included on the channel. This work has been done in partnership with Premier Telesolutions, the providers of the bedside entertainment system used at UHB. The information has also been produced in a booklet format for those patients who cannot access the television
- Introductory video: The group has been involved in writing the script for an introductory video that will be shown to patients on admission. Some of the group also appear in the video

f. PPI Forum liaison and visits

A good relationship has continued this year with the PPI Forum. The forum has visited various services within UHB including HIV, diabetes and palliative care.

g. Consultation on Single Equality Scheme

Members of the Trust's Patient and Carer Councils have been invited to comment on the Single Equality Scheme.

h. Increase in volunteers from the local community

The profile of volunteers has changed from the traditional, retired, white, middle class female, to better represent the local community and the patients we care for. Of all the volunteers placed in 2007:

- 38% were from Black or Ethnic Minority sections of the community
- 16% were over 65 years of age
- 42% were under 25 years of age
- 38% were students
- 15% were employed, either full or part-time

Relationships have been fostered with the Birmingham Voluntary Services Council, other voluntary organisations, Birmingham City Council, local universities and colleges and community groups. This has enhanced the development of the voluntary services at UHB and added to the infrastructure that will ensure the continuation of the service for years to come. All volunteers will become members of the Trust.

i. Mystery patient

Improving the patient experience of the services at UHB is of paramount importance in its aspiration to deliver the best in care. In a bid to better understand the patient experience, in May 2007, a project was

launched inviting individuals to become 'Mystery Patients'. The respondents would not be assessing the quality of the clinical care provided, but would be providing feedback about the environment in which they were cared for. For example, giving their opinions on cleanliness, food, administrative processes, staff attitude and wayfinding.

The information is formulated into a report to the executive management team to help inform improvements in the patient experience.

j. Foundation members' healthcare seminars

Each month UHB holds healthcare seminars to which all members of the Foundation Trust are invited to attend. The seminars cover many different topics from healthcare issues such as diabetes, eye conditions and looking after your heart, MRSA, infection control and rheumatology, to information about new technology and developments in medical treatment.

The monthly events feature an hour-long presentation and a 30-minute question and answer session to enable members to air their views and ask our experts that all-important question that they've always wanted to know the answer to. The sessions are also a great opportunity for our governors to meet people from our membership.

Seminars are informal and feedback has shown that people welcome the chance to talk to staff, patient and public governors about their experiences and queries.

k. Service improvements following patient surveys or comments and healthcare commission reports:

- Introduction of new pricing system for the bedside patient entertainment system
- Increased portion size for food and raised awareness of snack boxes
- Changes to food delivery to patients on wards so that meals are at the correct temperature when served
- Reconfiguration of mixed sex wards to single sex areas. All toilet facilities are clearly marked for male or female use
- All curtains around bed areas have privacy signs available and are used effectively to maintain the privacy and dignity of patients
- Reduction in the number of letters sent to patients prior to an outpatient appointment
- Improvement in the content of letters to highlight the important information for patients
- Introduction of a Welcomer Service to support patients in finding their destination within the hospital
- Reduction in the noise at night time within wards
- Improvements in the cleaning and preparation of commodes
- Introduction of a 'Standards of Behaviour' for staff to improve patient and customer care and staff attitude
- Clutter removed from ward corridors and dayrooms to improve the environment for patients
- Hand gel dispensers available at each bed space for use by patients, visitors and staff

l. Improvements in patient/carer information

- Infection control – produced a leaflet for patients and visitors about c-diff
- 'Mythbuster' articles in the Trust newspaper InsideOut
- Information on bedside entertainment system provided to wards so that staff are better informed to advise patients about use of the system

4.5.5 Partnerships and alliances

The Trust held a number of Board-to-Board meetings with key stakeholders with the aim of deepening relationships. These stakeholders included South Birmingham PCT, Heart of Birmingham Teaching PCT, West Midlands Ambulance Trust and Aston University.

Further Board-to-Board meetings are planned with other stakeholders as are repeat meetings with South Birmingham and Heart of Birmingham.

UHB developed a community engagement strategy with the aim of achieving better engagement with the diverse communities that it serves.

The Trust undertook a self assessment against the Sustainability Development Commission's self assessment toolkit. This showed that the Trust has performed well against most of the criteria for assessment. For example the new hospital will meet future energy efficiency targets and the Trust has taken active steps to promote local employment opportunities as the hospital is being built.

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.

To address these issues UHB has developed a Learning Hub. This has been functioning from temporary facilities but will move into permanent purpose-built accommodation at UHB in Summer 2008. It targets unemployed people and people from Black and Minority Ethnic communities and also has targets to provide training, support and place people in employment.

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.

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.

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.

In February 2008 the Defence Select Committee released its report into medical

care of the armed forces. Its report found that the care provided by UHB was "world class" and paid tribute to all our staff caring for military patients. The Committee also condemned the inaccurate reporting by the media and urged editors to ensure reports were based on fact rather than hearsay. The report further acknowledged that the model of basing care for military patients in a centre of excellence, with the full range of all specialties, was the correct one and did not support the call for a return to military hospitals.

In September 2006 the Trust also entered into a contractual partnership with a commercial company, Xchanging, to provide the Trust with HR administrative and payroll services.

The performance of the partnership is subject to review on an ongoing basis.

Relationships with main commissioners continued to be positive and constructive. The GP Services Manager visited all of the Trust's main referrers and gained valuable insight into the perceptions of the Trust by GPs.

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.

Externally, Heart of Birmingham PCT completed consultation on moving Sandwell and West Birmingham services onto a single site on the Birmingham/Smethwick border. Associated with this move a significant change to the way in which they commission hospital services is proposed. They began discussions with acute trusts to provide some existing outpatient work in community settings.

The West Midlands Strategic Health Authority published its strategy 'Investing for Health' which sets out clear priorities and direction for local NHS organisations.

Nationally the interim report of Lord Darzi signalled a strengthening of the impetus to move work from hospitals into community settings and to ensure that complex hospital work is only done in places that can demonstrate sufficient skills and experience to undertake the work.

UHB, in common with many other Trusts enjoyed a year of strong financial performance, reflecting in part the continuing significant increases in NHS funding. The Trust has begun to build reserves to ensure that expected increases in costs as we move into the new hospital are affordable.

Locally the Birmingham Women's Trust and Birmingham and Solihull Mental Health Trust were approved as Foundation Trusts.

4.5.6 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.

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 Constitution, Regulation and Control; Values and Standards; Strategy, Business Plans and Budgets; Statutory Reporting Requirements; Policy Determination; Major Operational Decisions; Performance Management; Capital Expenditure and Major Contracts; Finance and Activity; Risk Management Oversight; Audit Arrangements; and External Relationships.

The Board of Directors remains accountable for all of its functions; even those delegated to the Chairman, individual directors or officers, and therefore it expects to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

All powers which are neither reserved to the Board of Directors or the Board of Governors nor directly delegated to an Executive Director, a committee or sub-committee, are exercisable by the Chief Executive or as delegated by her under the Scheme of Delegation or otherwise.

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.

Section 5
Board of Governors

5.1 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 Parliamentary constituency boundary changes - this required a change in the constitution) each elected for an initial term of three years. Governor elections were held in May and June for all elected governors in this reporting year. Three by-elections were also held to fill seats that were vacant after the initial elections. Governors appointed to public and patient seats at these elections (and subsequent by-elections) were appointed for terms of either two or three years.

UHB opted to have elected Governors representing patients, staff and the wider public, in order to capture the views of those who have direct experience of our services, those who work for us, and those that have no direct relationship with UHB, but have an interest in contributing their skills and experience to help shape our future. In addition, 13 stakeholder Governors are appointed by 12 of its key stakeholders.

The Board of Governors consists of:

- 14 public Governors elected from the Parliamentary Constituencies in Birmingham
- 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:

5.1.1 Patient

Up to 30 June 2007	From 1 July 2007 (with term shown in brackets, all (commencing 1 July 2007)
Rita Bayley	Rita Bayley (3 years)
Rosanna Penn	Rosanna Penn (2 years)
Valerie Jones	Valerie Jones (2 years)
Wynford Morgan	Paul Darby (3 years)
Nazir Ahmed	Bridget Pearce (3 years)
Alan Bailey	Alan Bailey (2 years)

5.1.2 Public (by Parliamentary Constituency)

Up to 30 June 2007	From 1 July 2007
Northfield	**Northfield**
Margaret Burdett	Margaret Burdett (3 years)
Roy Green	Roy Green (2 years - resigned February 2008)
Selly Oak	**Selly Oak**
David Spilsbury	Brian Hanson (2 years)
Gwyneth Harbun	Gwyneth Harbun (3 years)
Hall Green	**Hall Green**
Brian Hanson	David Spilsbury (3 years)
Vacant (following death of incumbent)	Martin Straker-Welds (2years)
Edgbaston	**Edgbaston**
Geoffrey Oates	Geoffrey Oates (2 years)
Sir Richard Knowles	Caroline Badley (3 years)
Ladywood	**Ladywood**
Anne Griffin	Shazad Zaman (2 years)
Perry Barr	**Perry Barr**
Shazad Zaman	Hazel Flinn (Vacant until by-election on 4 March 2008) (3 years)
Sparkbrook & Small Heath	**Constituency area absorbed into others**
Abul Hassan	
Yardley & Hodge Hill	**Yardley**
Kadeer Arif	Kadeer Arif (3 years)
	Hodge Hill
	Anne Griffin (3 years)
Erdington & Sutton Coldfield	**Erdington**
Alan Corr (resigned June 2007)	David Ward (Vacant until by-election on 2 October 2007) (2 years)
	Sutton Coldfield
	Joan Walker (Vacant until by-election on 4 March 2008) (2 years)

5.1.3 Staff

Up to 30 June 2007	From 1 July 2007
Professor John Buckels (Medical Class	Professor John Buckels (3 years)
Paul Brettle (Clinical Scientist/Allied Health Professional)	Paul Brettle (3 years)
Carol Rawlings (Nursing Class)	Erica Perkins (3 years)
Barbara Tassa (Nursing Class)	Barbara Tassa (3 years)
Anne Waller (Ancillary, Administrative and Other Staff)	Anne Waller (3 years)

5.1.4 Stakeholder

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

Professor David Cox and Ms Moira Dumma, 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, appointed by the Ministry of Defence

Ms Nikki Walker, appointed by the Birmingham Chamber of Commerce and Industry

Ms Gill Howland, appointed by the Birmingham and Solihull Learning and Skills Council (resigned July 12, 2007)

Professor David Tidmarsh, 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, 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 31 March 2008, elections were held for all public, patient and staff governor seats. Public Governors for all but two of the public governor seats were elected unopposed. All six patient Governors were elected unopposed. Save for the Nursing class, all staff governors were elected unopposed. An election was held for the two seats of staff Governor for the Nursing Class as there were three candidates nominated, and Erica Perkins and Barbara Tassa were elected.

By-elections were held for the two unfilled seats of Perry Barr and Erdington, and also for Sutton Coldfield which became vacant in June 2007 following the resignation of Alan Corr. Following contested elections, these seats were filled by David Ward (Erdington), Joan Walker (Sutton Coldfield) and Hazel Flinn (Perry Barr).

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

Name of Governor	No. of meetings attended*
Patient Governors	
Paul Darby	4 out of 4
Rosanna Penn	5 out of 5
Nazir Ahmed	1 out of 1
Wynford Morgan	1 out of 1
Alan Bailey	3 out of 5
Rita Bayley	3 out of 5
Bridget Pearce	2 out of 4
Valerie Jones	2 out of 5
Public Governors	
Gwyneth Harbun	5 out of 5
Martin Straker-Welds	4 out of 4
Brian Hanson	5 out of 5
Sir Richard Knowles	1 out of 1
David Ward	3 out of 3
Margaret Burdett	5 out of 5
Roy Green	4 out of 4
Hazel Flinn	1 out of 1
David Spilsbury	4 out of 5
Geoffrey Oates	4 out of 5
Kadeer Arif	3 out of 5
Caroline Badley	2 out of 4
Shazad Zaman	1 out of 5
Abul Hassan	0 out of 1
Joan Walker	0 out of 1
Anne Griffin	0 out of 5
Alan Corr	0 out of 1
Stakeholder Governors	
Cllr James Hutchings	4 out of 5

Prof. David Cox	4 out of 5
Prof. David Tidmarsh	3 out of 5
Marie Greer	3 out of 5
Lieutenant General Lillywhite	2 out of 5
Ruth Harker	2 out of 5
The Most Revd Vincent Nichols	1 out of 5
Prof. Norman Cave	1 out of 5
Nikki Walker	0 out of 5
Prof. Michael Clarke	0 out of 5
Gisela Stuart, MP	0 out of 5
Moira Dumma	0 out of 5
Gill Howland	0 out of 2
Staff Governors	
Barbara Tassa	4 out of 4
Carol Rawlings	1 out of 1
Prof. John Buckels	3 out of 5
Paul Brettle	3 out of 5
Anne Waller	3 out of 5
Erica Perkins	1 out of 4

*While a member of the Board of Governors.

5.2 Understanding the views of governors and members

A large amount of work has been undertaken in the last 12 months to ensure that our governors and members play an active role in the Trust.

- Clear, definitive roles for our Governors have been introduced
- A communications plan to raise the profile of Trust Governors and to increase their communication channels with their constituents has been introduced
- Governors attend monthly briefing seminars led by the Trust Chairman where key strategic developments of the Trust are discussed and debated at a very early stage to get Governors input
- Joint Board of Directors/Board of Governor meetings are held on a bi-annual basis to look forward and back on the achievements of the Trust
- Governors have their own Trust email address and have access to the Trust's intranet
- Governors also sit on strategic internal and external forums ie Trust Task & Finish Groups, The King's Fund
- 4,800 members took part in a comprehensive Members' Survey conducted in 2006/07
- The results of this work have formed the basis of a Members' Strategy which was implemented in July 2007
- The results have also led to improvements in the communication channels with members – changes to the members' newsletter and access to Chief Executive's Hotline

5.3 Board of Governors Nomination Committee for Non-Executive Directors

The Nomination Committee for Non-Executive Directors is a sub-committee of the Board of Governors responsible for advising the Board of Governors 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.

The Nomination Committee for Non-Executive Directors comprises the Chairman and four Governors of the Trust. The Chairman chairs the committee, save when the post of chairman is the subject of nominations, in which case the committee is chaired by Brian Hanson, Governor Vice-Chair. The other members of the committee for the year ended 31 March 2008 were Erica Perkins, Ruth Harker and Margaret Burdett.

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

During the year, the Committee oversaw the appointment of a new non-executive director. The Committee approved the recommendation of the Executive Appointments and Remuneration Committee that an appointee should be sought from a senior level of the University of Birmingham with experience of the Medical School. The University was asked to seek nominations from candidates. The Committee met to discuss the single application, interview the candidate and determine whether a recommendation should be made to the Board of Governors and decided to recommend to the Board of Governors that Professor Michael Sheppard be appointed as a Non-Executive Director of the Trust for an initial period of three years.

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.

Section 6
Board of Directors

6.1 Composition

Throughout the year, the Board of Directors comprised the Chairman, six executive and seven non-executive directors. The Chairman has been appointed for four years.

Mark Santer is the deputy chairman and senior independent director. He was reappointed as a Non-Executive Director on 1 December 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

Medical Director: David Rosser

Director of Organisation Development: Caroline Wigley

Chief Nurse: Kay Fawcett

Chief Operating Officer: Tim Jones

Non-Executive Directors:

Professor David Bailey

Stewart Dobson

Tony Huq

David Ritchie

Clare Robinson

Rt Revd Mark Santer

Professor David Westbury (retired 30 November 2007)

Professor Michael Sheppard

Kay Fawcett was appointed Chief Nurse from 14 January 2008. Trisha Curran filled this post in an acting capacity from 1 April 2007-26 September 2007 and then this was filled by Michele Morris again in an acting capacity, from 27 September 2007 to 13 January 2008.

Tim Jones was appointed Chief Operating Officer from 13 June 2007. Prior to this he was Acting Chief Operating Officer.

Professor David Westbury retired as a non-executive director on 30 November 2007. Professor Michael Sheppard was appointed as a non-executive director on 5 December 2007.

6.2 Independent non-executive directors

The board considers Mark Santer, Tony Huq, Clare Robinson, Stewart Dobson, David Bailey, David Ritchie and Professor David Westbury (retired 30 November 2007) to be independent.

6.3 Board meetings

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

Directors	No. of meetings attended*
Sir Albert Bore	10 out of 11
Julie Moore	All
Mike Sexton	10 out of 11
Caroline Wigley	10 out of 11
Prof David Westbury	All
Trisha Curran	3 out of 4
Tim Jones	All
Michele Morris	4 out of 4
Stewart Dobson	All
Clare Robinson	9 out of 11
David Ritchie	9 out of 11
Rt Revd Mark Santer	All
Prof Michael Sheppard	2 out of 3
David Rosser	8 out of 11
Tony Huq	All
Prof David Bailey	8 out of 11
Kay Fawcett	3 out of 3

*While 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 1 December 2006 and Professor Michael Sheppard who was appointed for a term of three years commencing 5 December 2007.

6.4 The Board of Directors

Sir Albert Bore, Chairman

Sir Albert Bore was elected Chairman of UHB on 1 December 2006 and appointed for a period of four years. 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.

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 prevention and control and the clinical transformation programme. She became Chief Executive (Acting) on July 1, 2006 and the position was made substantive in November 2006.

Kay Fawcett, Chief Nurse

Kay qualified as a Registered General Nurse in 1980 and held a series of clinical posts before moving on to be a Clinical Teacher and then Nurse Tutor, before returning to clinical work as a Lecturer Practitioner and Emergency Care manager in 1995. In 1998, Kay became an Operational Manager at the George Eliot Hospital NHS Trust before joining UHB NHS Trust in 2000 as Head of Nursing. She became Deputy Chief Nurse in 2002, took a part-time secondment to work with the Director of Nursing at Birmingham and Black Country Strategic Health Authority and in July 2005 took up post as Executive Director of Nursing for Derby Hospitals NHS Foundation Trust. She had responsibility for Nursing and Allied Health Professionals, Infection Prevention and Control, Clinical Governance and Quality, Risk Management and Emergency Planning. In January 2008 Kay was appointed as Chief Nurse at UHB.

Tim Jones, Chief Operating Officer

After graduating from 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 becoming Deputy Chief Operating Officer in 2004. He became Chief Operating Officer in June 2007.

David Rosser, 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 was 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 of Medical Director in December 2006.

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 13 years he has held numerous positions including Finance Manager – Clinical Services, Acting General Manager – Neurosciences and Ophthalmology, Head of Operational Finance and Business Planning, Director of Operational Finance and Performance and Acting Director of Finance.

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

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.

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.

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.

Tozammel (Tony) Huq MBE

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

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 around 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.

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.

Professor Michael Sheppard

Professor Sheppard was appointed a non-executive director of UHB in December 2007. Prof Sheppard is Pro-Vice-Chancellor for Resources at University of Birmingham, and will become Vice-Principal of the University at the end of September 2008. He graduated from the University of Cape

Town with MBChB (Hons), and was later awarded a PHD in Endocrinology. His career at Birmingham began in 1982, when he was appointed as a Wellcome Trust Senior Lecturer in the Medical School. He then subsequently held the roles of the William Withering Professor of Medicine, Head of the Division of Medical Sciences, Vice-Dean and Dean of the Medical School. Michael's main clinical and research interests are in thyroid diseases and pituitary disorders. He holds honorary consultant status at University Hospital Birmingham NHS Foundation Trust has published over 230 papers in peer reviewed journals and has lectured at national and international meetings, particularly the UK, Europe and the USA Endocrine Societies.

6.5 Balance of the Board

The balance, completeness and appropriateness of the membership of the Board of Directors were reviewed during the year by the Executive Appointments and Remuneration Committee. Following the confirmation by Professor David Westbury of his intention to retire on 30 November 2007, it was decided to seek a replacement candidate who is a member of the executive of the University of Birmingham, with experience of the medical school.

6.6 Evaluation of the Board

Appraisals for all Executive and Non-Executive Directors (including the Chairman) have been undertaken and the outcomes of these have been reported to the Board of Governors or the Board of Directors as appropriate. The Board of Directors and the Audit Committee have each evaluated their performance.

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

The Chairman, 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 Committee is a committee of the Board of Directors whose principal purpose is to assist the Board in ensuring that it receives proper assurance as to the effective discharge of its full range of responsibilities.

The Committee meets regularly and was chaired by Clare Robinson up to and including 31 December 2007. Stewart Dobson became Chair from 1 January 2008. It comprises all the independent non-executive directors of the Trust, with the external and internal auditors and other executive directors attending by invitation.

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

Directors	No. of meetings attended*
Clare Robinson	All
David Westbury	3 out of 4
David Bailey	2 out of 5
David Ritchie	All
Stewart Dobson	All
Mark Santer	2 out of 5
Tony Huq	All
Michael Sheppard	1 out of 1

*While 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 internal 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 Approval of Additional Services by the Trust's External Auditors, 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:

- Statutory and audit-related work assignments do not require further approval from the Audit Committee or the Board of Governors. However, recognising that the level of non-audit fees may also be a threat to independence, a limit of £25,000 will be applied for each discrete piece of additional work, above which limit prior approval must be sought from the Board of Governors, following a recommendation by the Audit Committee.
- For advisory services assignments, the Trust's Standing Financial Instructions (SFIs) Procurement of Services should be followed and the prior approval of the Board of Governors, following a recommendation by the Audit Committee, must be obtained prior to commencement of the work. Neither approval of the Board of Governors nor a recommendation from the Audit Committee will be required for discrete pieces of work within this category with a value of less than £10,000, subject to a cumulative limit of £25,000 per annum.

6.9.2 Auditors' reporting responsibilities

KPMG LLP, our independent auditors, report to the Board of Governors through the Audit 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 Executive Appointments & Remuneration Committee appointed two nominations committees during the year, the first, comprising of Mark Santer (chair) and Tony Huq, to deal with the appointment of a Chief Operating Officer and the second, comprising Clare Robinson (chair), David Westbury and David Ritchie, the appointment of a Chief Nurse. Each of these nomination committees met once and all members were in attendance.

Section 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 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 31/03/08	%	% change from previous year
Public	51,545	63.9	-7.8
Patient	22,190	27.5	-7.1
Staff	6,990	8.6	-0.7
Total Membership	80,725	100%	-7.1

*Numbers correct up to 31 March 2008

The table above shows there has been an overall decline in membership during 2006/07 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 2008/09.

7.5 Membership Strategy

UHB's Membership Strategy was approved by the Board of Directors in July 2007. The Strategy was developed by a specific Task & Finish Group which comprised the Trust's

Director of Corporate Affairs, Director of Communications and a staff, public and patient governor. The strategy was based on a comprehensive Members' Survey which was carried out by the Trust from October 2006-March 2007.

The strategy outlined the role of a member at UHB. The role is:

- To receive information from the Trust to ensure members are well informed about its services
- To act as a sounding board for the Trust in its development of services, new initiatives etc
- To relay ideas, issues, concerns etc to their appropriate (public, patient or staff) Governor which will then be passed on to the Trust
- To elect Trust Governors, which is their statutory role

Ultimately, the Trust believes that if the above is delivered, its members will become ambassadors for the Trust.

The Trust has a three-point plan to help members fulfil their role:

- Identify
- Inform
- Involve

During the last 12 months there have been several key pieces of work which have been undertaken to ensure that going forward UHB's membership is active, engaged, cost-effective and plays an integral part in the organisation.

The biggest piece of work has been the membership database audit. In October 2007 the Trust reminded all of its circa 86,000 members that they were members of the Trust and asked them to fill in and return a data capture form. The Trust also gave each member an opportunity to no longer be a member, should they so wish. This was a repeat of a similar exercise in May 2007. Just over 10,000 responses were received on the first occasion. The third and final exercise was carried out in February 2008 and the response is currently being analysed from the three data capture exercises. Developing a more active, engaged and value-for-money membership may result in a smaller number of members.

Once a clean, core membership database has been established, an analysis will be carried out to test whether it is a representative membership. Based on current feedback it is believed the membership will be broadly representative of the constituencies the Trust represents.

A recruitment strategy will be worked up to ensure that the Trust's our membership reflects the breakdown of our patient, public and staff populations by age, gender, disability, demographic split and cultural diversity. An annual recruitment strategy will then be worked up to maintain and grow, the number of members.

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 monthly Members' Seminars. Governors attend these meetings and use them as a 'surgery' for members
- The Annual General Meeting
- Telephone, written or electronic communications co-ordinated through the Communications office which then steers members to the appropriate Governor/ Director
- 'Trust in the Future' magazine – highlights a Governor each issue
- 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

Section 8
Public Interest Disclosures

8.1 Consultation

The Trust's policy on consultation is outlined in point 2.14 on page 15.

8.2 Policies in relation to disabled employees and equal opportunities

These policies are outlined in point 2.13 on page 15.

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 20.5 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 defuse potential aggression. A trial of needle safe devices has also been undertaken to reduce the incidence of inoculation incidents.

The Trust has been visited by the Health and Safety Executive this year to look at what it is doing with regards to stress management. This is a key priority for the NHS and UHB was selected as an organisation that they thought might be able to assist others because it's a large employer with a consultant-led occupational health service. In essence, the HSE are pleased with the work the Trust is doing. They will come back later in the year to see how our Action Plan is developing.

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. Its local counter fraud service is provided by its 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	85,428	275,530
Total bills paid within target	83,648	270,464
Percentage of bills paid within target	97.9	98.2

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%.

Section 9
Remuneration Report

9.1 Executive Appointments and Remuneration Committee

The Executive Appointments and Remuneration 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 met regularly throughout the year, holding five meetings in total.

Directors	No. of meetings attended*
Albert Bore	4 out of 5
Julie Moore	5 out of 5
Mark Santer	5 out of 5
David Westbury	4 out of 4
Clare Robinson	5 out of 5
Tony Huq	5 out of 5
Stewart Dobson	5 out of 5
David Bailey	2 out of 5
David Ritchie	5 out of 5
Michael Sheppard	1 out of 1

*While a member of the Executive Appointments and 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 Operating Officer and Chief Nurse.

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 Executive Chief Nurse, 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.

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 2007/08.

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 benefits for executive directors are given in the tables provided on page 53.

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.

Salary and Pension Entitlements of Senior Managers

Remuneration:

Name and Title	Year Ended 31 March 2008			Year Ended 31 March 2007		
	Salary	Other Remuneration	Benefits in Kind	Salary	Other Remuneration	Benefits in Kind
	(bands of £5000)	(bands of £5000)	Rounded to the Nearest £100	(bands of £5000)	(bands of £5000)	Rounded to the Nearest £100
	£000	£000		£000	£000	
SENIOR MANAGERS						
Julie Moore, Chief Executive (commenced office 01/07/2006)	200-205	0	0	145-150	0	0
Mike Sexton, Director of Finance (commenced office 30/06/2006)	130-135	0-5	0	40-45	0-5	0
Trisha Curran, Acting Chief Nurse (left office 26/09/2007)	40-45	0	0	40-45	0	0
Tim Jones, Chief Operating Officer (appointed substantively 13/06/2007)	130-135	0	0	100-105	0	0
Caroline Wigley, Director of Organisation Development	125-130	0	0	110-115	0	0
David Rosser, Medical Director (commenced office 01/12/2006)	80-85	90-95	0	10-15	90-95	3,300
Mike Sharon, Director of Policy, Planning and Performance Management	95-100	0	0	95-100	0	0
Fiona Alexander, Director of Communications	95-100	0	0	85-90	0	0
Morag Jackson, New Hospital Director (commenced office 11/12/2006)	105-110	0	0	30-35	0	0
David Burbridge, Director of Corporate Affairs (commenced office 07/05/2007)	75-80	0	0	0	0	0
Michele Morris, Acting Chief Nursing Officer (commenced 27/09/2007 and left 13/01/2008)	20-25	0	0	0	0	0
Kay Fawcett, Chief Nursing Officer (commenced 14/1/2008)	25-30	0	0	0	0	0
NON EXECUTIVE DIRECTORS						
Sir Albert Bore, Chairman (appointed 01/12/2006)	45-50	0	0	15-20	0	100
David Bailey (commenced 01/12/2006)	10-15	0	0	0-5	0	0
Stewart Dobson	10-15	0	0	10-15	0	100
Tony Huq	10-15	0	0	10-15	0	100
David Ritchie (commenced 01/12/2006)	10-15	0	0	0-5	0	0
Clare Robinson	10-15	0	0	10-15	0	0
Rev Mark Santer	10-15	0	0	10-15	0	0
Professor David R Westbury (retired 30/11/2007)	5-10	0	0	10-15	0	0
Professor Michael Sheppard (commenced 5/12/2007)	0-5	0	0	0	0	0

Pension Benefits:

Name and Title	Real increase in pension at age 60	Real increase in pension related lump sum at age 60	Total accrued pension at age 60 at 31 March 2008	Total accrued pension related lump sum at age 60 at 31 March 2008	Cash Equivalent Transfer Value at 31 March 2007	Cash Equivalent Transfer Value at 31 March 2008	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
	(bands of £2500)	(bands of £2500)	(bands of £5000)	(bands of £5000)				To nearest £100
	£000	£000	£000	£000	£000	£000	£000	
Julie Moore, Chief Executive	7.5-10	27.5-30	65-70	205-210	862	1,032	170	N/A
Mike Sexton, Director of Finance	2.5-5	7.5-10	35-40	115-120	529	588	59	N/A
Trisha Curran, Acting Chief Nurse (commenced 1/4/2007-left 26/9/2007)	2-2.5	5-7.5	30-35	90-95	424	461	37	N/A
Michelle Morris, Acting Chief Nurse (commenced 27/9/2007 left 13/1/2008)	5-7.5	17.5-20	20-25	65-70	191	277	86	N/A
David Burbridge, Director of Corporate Affairs (commenced 7/5/2007)	0-2.5	0-2.5	0-5	0-5	0	13	13	N/A
Kay Fawcett, Chief Nursing Officer (commenced 14/1/2008)	5-7.5	20-22.5	35-40	115-120	464	587	123	N/A
Tim Jones, Chief Operating Officer	0-5	0-5	20-25	70-75	273	293	20	N/A
Caroline Wigley, Director of Organisation Development	5-7.5	17.5-20	45-50	140-145	669	810	141	N/A
David Rosser, Medical Director	7.5-10	25-27.5	35-40	115-120	381	501	120	N/A
Mike Sharon, Director of Policy, Planning and Performance Management	5-7.5	15-17.5	25-30	85-90	345	431	86	N/A
Fiona Alexander, Director of Communications	0-2.5	2.5-5	0-5	5-10	14	31	17	N/A
Morag Jackson, New Hospital Director	2.5-5	7.5-10	25-30	80-85	319	364	45	N/A

9.5 Non-Executive Directors' remuneration

Non-Executive directors' remuneration consists of fees which are set by the Board of Governors. The Board of Governors has established a committee, the Board of Governors Remuneration Committee for Non-Executive Directors, to advise the Board of Governors as to the levels of remuneration for the Non-Executive Directors. NED fees are reviewed each year with advice taken from independent consultants where appropriate. During this year, an increase to the Chairman's and Non-Executive Directors' fees was approved in line with the NHS inflationary pay award.

The Committee comprises Brian Hanson (chair), Barbara Tassa, David Spilsbury and James Hutchings. It met on two occasions during the year and all members attended both meetings with the exception of James Hutchings who attended one meeting.

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
Michael Sheppard	5 December 2007	3 years	4 December 2010

..... 12 June 2008

Julie Moore **Date**
Chief Executive

Section 10
Annual Accounts

University Hospital Birmingham NHS Foundation Trust
Accounts for the year ended 31 March 2008

Contents

Foreword to the Accounts

University Hospital Birmingham NHS Foundation Trust

These accounts for the year ended 31 March 2008 have been prepared by the University Hospital Birmingham NHS Foundation Trust in accordance with paragraph 25 of Schedule 7 to the National Health Service Act 2006 in the form which Monitor has, with the approval of the Treasury, directed.

..... 12 June 2008

Julie Moore **Date**
Chief Executive

Statement of the Chief Executive's responsibilities as the accounting officer of University Hospital Birmingham NHS Foundation Trust

The National Health Service Act 2006 states that the Chief Executive is the accounting officer of 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 National Health Service Act 2006, 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 accounts, 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.

..... 12 June 2008

Julie Moore **Date**
Chief Executive

Statement of Directors' responsibilities in respect of the Accounts

The Directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. 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 23, 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

..... 12 June 2008

Julie Moore **Date**
Chief Executive

..... 12 June 2008

Mike Sexton **Date**
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 2008 under the National Health Service Act 2006. These comprise the Income and Expenditure Account, the Balance Sheet, the Cash flow 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 National Health Service Act 2006. 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 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 2008. We also report to you whether in our opinion the information given in the Directors' Report is consistent with the financial statements.

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 the Directors' 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 National Health Service Act 2006 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 2008 and of its income and expenditure for the year then ended; and
- the information given in the Directors' Report is consistent with the financial statements.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of the National Health Service Act 2006 and the NHS Foundation Trust Audit Code of Practice issued by Monitor.

KPMG LLP

2, Cornwall Street,
Birmingham
B3 2DL
12 June 2008

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 other 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 2008 and up to the date of approval of the annual report and accounts.

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

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.

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.

The Audit Committee monitors and assesses both internal control issues and the process for risk management. RSM 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 are reported directly to the Board of Directors.

All new staff joining the Trust are required to attend 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 Clinical Quality Group, reporting monthly to the Board of Directors and with local departments and wards. Senior staff are trained in Root Cause Analysis. A programme for risk management training for Directors is being developed.

4. The risk and control framework

The Board of Directors is responsible for the strategic direction of the Trust in relation to Clinical Governance and Risk Management. It is supported by the Audit Committee which provided assurance on risk management issues.

The Board of Directors has established 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 overseen directly by the Board of Directors. The Clinical Quality Group was established in April 2007.

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. The Audit Committee reviewed the process for validating the information supporting the declaration.

The declaration to the Commission is that the Trust is fully compliant with all core standards. This was approved at the Board of Directors meeting of the 27th March 2008. The Audit Committee has reviewed the process that the Trust undertook before arriving at this declaration and has assured the Board of Directors that the process was appropriately robust. (Internal audit have also reviewed the process 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. The Trust is preparing for an assessment in December 2008.

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.

The Board of Directors has reviewed, revised and enhanced its arrangements for ensuring that it is compliant with the Code of Practice on Healthcare Associated Infections and is assured that suitable systems and arrangements are in place to ensure that the code is being observed in this Trust, and that no significant lapses have been identified.

There are clear policies and escalation procedures for the management of Hospital Acquired Infections (HAI), which form part of the Infection Prevention and Control Plan for the Trust. The Trust Action Plan makes clear reference to the Code of Practice and there are plans in place to maintain and continue to improve the performance within the Trust.

The Trust received an unannounced visit from the Health Care Commission on 13 June 2007 which found no material breaches of the Hygiene Code. Two recommendations were made, both of which have been implemented. The Trust invited the Department of Health to review its practices on infection prevention and control and as a result drew up a comprehensive action plan which has formed part of the longer term strategy. The Department of Health continues to be engaged in this work and is supportive of the Trust's approach.

The Infection Prevention and Control report is a standing item on the agenda for meetings of the Board of Governors, the Board of Directors and the Chief Executive's Advisory Group.

All serious untoward incidents are reported to the South Birmingham PCT, including MRSA bacteraemia and Clostridium difficile deaths.

Risks to information are managed and controlled through the Information Governance Working Group, chaired by the Director of Corporate Affairs. The Executive Medical Director, as Caldicott Guardian, is responsible for the protection of patient information, although all information governance issues are integrated through the Working Group. The Board of Directors has received a report regarding its systems of control for information governance, which were reviewed in the latter part of the year. These include satisfactory completion of its annual self-assessment against the Information Governance Toolkit, mapping of data flows, monitoring of access to data and reviews of incidents. The Trust has not experienced any Serious Untoward Incidents involving data loss or confidentiality breach. During 2008/09, further work will be undertaken to strengthen the Information Governance Framework, supported by appropriate training for all staff.

The Trust's internal audit team reported on the controls within the Trust's payroll bureaux joint venture with Xchanging plc and identified several issues, which, although not considered by them to be significant, were of concern. The Trust has worked with its internal auditors, the managers of the bureaux and Xchanging plc to address the issues, with formal monitoring of these actions being reported to the Chief Executive. The Audit Committee has been regularly appraised of progress in this area.

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 to the Clinical Quality Group.

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 the Audit Committee. Risk Registers are reported to the Audit Committee every quarter, where detailed examination of identified high risk elements takes place. 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 Coroner's recommendations;
- Health and Safety visits undertaken by Director of Operations of each Division;
- Medico-legal claims and litigation;
- Ad hoc risk issues brought to either the Divisional Clinical Governance Team meetings, Health, Safety and Environment Committee or the Clinical Quality Group;
- Incident reports and trend analysis;
- Internally generated reports from Health Informatics Team;
- Internal and external audit reports; and
- Performance Reviews.

4.2 Risk Control

Clinical risks are 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 monitored and 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 was provided by Internal Audit.

Risks Management is well embedded throughout the organisation. The culture of the organisation aids the confident use of the incident reporting procedures throughout the Trust. Risks are reported locally at divisional level through the Clinical Governance structure.

The Infection Control Committee, chaired by the Executive Chief Nurse, meets on a monthly basis. In addition, key infection

control indicators (MRSA / Clostridium difficile) are reported to the Board of Directors on a monthly basis. This data is also reported to Divisional Clinical Governance teams for local follow up action.

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. Further improvements to the assurance framework and the high level assurance reporting to the Audit Committee are planned for 08/09, focussing on the use of technology to manage risks, controls and assurance.

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 potential risk to the Trust. As the part of the project that provided new buildings for Birmingham & Solihull NHS Mental Health Trust neared completion, the joint Programme Board was dissolved and the Trust has set up a Strategic Clinical Redesign Group, chaired by the Chief Executive, to oversee the risks associated with the impending move to the new hospital. 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 are regular reports on the main Programme risks to the Strategic Clinical Redesign Group, the Board of Directors and the Audit Committee. A programme of audits is being agreed with the Trust's internal auditors to provide assurance to the Board of Directors on the management of the Programme. In addition, the Trust has agreed that a Department of Health Gateway Project Review at stage 0 (Strategic assessment) will take place in summer 2008, which will provide further external assurance to the Trust Board of Directors.

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

The Trust's Financial Plan for 2007/08 was approved by the Board of Directors in May 2007. Achievement of the financial plan relied on delivery of cash releasing efficiency savings of over £9.7m during the financial year. This has been accomplished through the establishment of a 4.0% cost improvement programme applied to all relevant budgets across Divisions and Corporate Departments. Progress against delivery of cost improvements is monitored throughout the year and quarterly updates are included in the Finance and Activity Performance Report presented to the Board of Directors each month.

In addition to the agreed annual cost improvement programme, further efficiency savings are realised in year through initiatives, such as ongoing tendering and procurement rationalisation and review of all requests to recruit to both new and existing posts via the Workforce Approval Committee. During 2007/08 the Trust has introduced "Lean Thinking" methodologies within a number of key areas, resulting in significant improvements in productivity and throughput. It is intended that "Lean Thinking" will be

rolled out to other departments across the Trust during 2008/09.

During 2007/08 the Board of Directors have continued to receive 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 Oct 2007 the Trust achieved a rating of 'excellent for the use of resources' (based on 2006/07 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 2007/08 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 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.

The processes applied in maintaining control include:

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

Conclusion

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.

..... June 12, 2008

Julie Moore **Date**
Chief Executive

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31 MARCH 2008

	NOTE	31 March 2008 £000	31 March 2007 £000
Income from activities	2	**352,856**	328,931
Other operating income	3	**71,610**	72,168
Operating expenses	4 - 5	**(405,792)**	(391,165)
OPERATING SURPLUS		**18,674**	9,934
Exceptional items	6	**0**	(87,577)
Loss on disposal of fixed assets	7	**(886)**	(79)
SURPLUS/(DEFICIT) BEFORE INTEREST		**17,788**	(77,722)
Interest receivable	8.1	**2,446**	847
Interest payable	8.2	**0**	0
Other net gains/(losses) on financial instruments		**0**	0
Other finance costs - unwinding of discount		**(27)**	(26)
Other finance costs - change in discount rate on provisions		**0**	0
SURPLUS/(DEFICIT) BEFORE TAXATION		**20,207**	(76,901)
Taxation	9	**0**	0
SURPLUS/(DEFICIT) AFTER TAXATION		**20,207**	(76,901)
Public Dividend Capital dividends payable		**(7,721)**	(7,922)
RETAINED SURPLUS/(DEFICIT) FOR THE YEAR		**12,486**	(84,823)

The notes on pages 17 to 43 form part of these accounts.
All income and expenditure is derived from continuing operations.

BALANCE SHEET AS AT 31 MARCH 2008

	NOTE	31 March 2008 £000	31 March 2007 £000
FIXED ASSETS			
Tangible assets	10.2	**182,135**	173,555
		182,135	173,555
CURRENT ASSETS			
Stocks and work in progress	11	**9,741**	9,583
Debtors	12	**25,440**	28,827
Cash at bank and in hand	17.3	**71,434**	20,420
		106,615	58,830
CREDITORS: Amounts falling due within one year	13	**(77,366)**	(46,240)
NET CURRENT ASSETS		**29,249**	12,590
TOTAL ASSETS LESS CURRENT LIABILITIES		**211,384**	186,145
CREDITORS: Amounts falling due after more than one year	13	**0**	0
PROVISIONS FOR LIABILITIES AND CHARGES	14	**(8,580)**	(8,652)
TOTAL ASSETS EMPLOYED		**202,804**	177,493
FINANCED BY:			
TAXPAYERS' EQUITY			
Public dividend capital	21	**168,612**	160,695
Revaluation reserve	16	**72,445**	68,597
Donated asset reserve	16	**8,942**	9,304
Income and expenditure reserve	16	**(47,195)**	(61,103)
TOTAL TAXPAYERS EQUITY		**202,804**	177,493

..... June 12, 2008

Julie Moore **Date**
Chief Executive

STATEMENT OF TOTAL RECOGNISED GAINS AND LOSSES FOR THE YEAR ENDED 31 MARCH 2008

	31 March 2008 £000	31 March 2007 £000
Surplus/(Deficit) for the financial year before dividend payments	**20,207**	(76,901)
Disposal of donated assets	**(140)**	(2)
Impact of disposals on revaluation reserve	**(182)**	(71)
Unrealised surplus/(deficit) on fixed asset and current asset investments and revaluations	**5,618**	17,111
Increases in the donated asset reserve due to receipt of donated assets	**392**	43
Reductions in the donated asset reserve due to the depreciation, impairment and disposal of donated assets	**(920)**	(925)
TOTAL RECOGNISED GAINS/(LOSSES) FOR THE FINANCIAL YEAR	**24,975**	(60,745)

CASH FLOW STATEMENT FOR THE YEAR ENDED 31 MARCH 2008

	NOTE	Year to 31 March 2008 £000	Year to 31 March 2007 £000
OPERATING ACTIVITIES			
Net cash inflow from operating activities	17.1	**61,871**	23,830
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:			
Interest received		**2,602**	810
Net cash inflow from returns on investments and servicing of finance		**2,602**	810
CAPITAL EXPENDITURE			
(Payments) to acquire tangible fixed assets		**(14,047)**	(13,982)
Net cash (outflow) from capital expenditure		**(14,047)**	(13,982)
DIVIDENDS PAID		**(7,721)**	(7,922)
Net cash inflow before management of liquid resources and financing		**42,705**	2,736
MANAGEMENT OF LIQUID RESOURCES		**0**	0
Net cash inflow before financing		**42,705**	2,736
FINANCING			
Public dividend capital received		**13,917**	2,988
Public dividend capital repaid (not previously accrued)		**(6,000)**	0
Other capital receipts		**392**	43
Net cash inflow from financing		**8,309**	3,031
Increase/(decrease) in cash		**51,014**	5,767

1 Accounting Policies

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Reporting Manual which shall be agreed with HM Treasury. Consequently, the financial statements and notes to the accounts have been prepared in accordance with the 2007/08 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 by 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.

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; or
- Are not part of any land or buildings scheduled for demolition or disposal under the new hospital PFI.

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. A professional interim valuation was carried out in 2007/08 and accounted for at 31 March 2008.

During the previous financial year, a valuation was carried out on land and buildings scheduled for demolition/disposal under the new hospital PFI. The building revaluation resulted in an impairment in the prior year. The details of the impairment charges can be found in Note 6 on page 28.

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 underwent a valuation in the last financial year. This gave rise to an impairment which has been reflected in the prior year financial statements. This impairment constituted a loss of economic benefit and as such, was charged to the income and expenditure account in the prior year.

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.

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 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 Land 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 2008 can be found in Note 23 to the accounts on page 39.

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 20 on page 38 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

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

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 14 on page 34.

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 to 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. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying Scheme assets and liabilities. Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

The Scheme is subject to a full actuarial investigation every four years. The main purpose of which is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such investigation, on the conclusions of which scheme contribution rates are currently based, had an effective date of 31 March 2004 and covered the period from 1 April 1999 to that date. Between the full actuarial valuations, the Government Actuary provides an annual update of the scheme liabilities for FRS17 purposes. The latest assessment of the liabilities of the Scheme is contained in the Scheme Actuary report, which forms part of the NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the Business Service Authority - Pensions Division website at www.nhspa.gov.uk. Copies can also be obtained from The Stationery Office.

The conclusion of the 2004 investigation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. This is after making some allowance for the one-off effects of pay modernisation, but before taking into account any of the scheme changes which come into effect on 1 April 2008. Taking into account the changes in the benefit and contribution structure effective from 1 April 2008, employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008 employees paid contributions at the rate of 6% (manual staff 5%) of their pensionable pay. From 1 April 2008, employees will pay contributions according to a tiered scale from 5% up to 8.5% of their pensionable pay.

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.

1.20 Leases

Operating lease rental costs 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 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.

Financial assets and liabilities have been reviewed upon adoption of FRS 25 and 26 in line with FReM. PDC is not considered to be a financial instrument.

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 13.2 on page 33. 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 2008	Year Ended 31 March 2007
	£000	£000
Foundation Trusts	**64**	23
NHS Trusts	**154**	720
Strategic Health Authorities	**13,982**	0
Primary Care Trusts	**305,555**	285,000
Department of Health - other	**19,979**	31,675
NHS Other	**2,318**	3,158
Private Patients	**2,903**	3,274
NHS Injury Scheme	**1,916**	1,224
Other*	**5,985**	3,857
	352,856	328,931

* Included within 'Non NHS Other' is £5,707,634 relating to the Trust contract with the Royal Centre for Defence Medicine (2007 - £3,659,000).

The £13,981,923 of Income from Strategic Health Authorities is from the National Commissioning Group (Liver and Cardiac specialities), which in 2007/08 were paid by the London Strategic Health Authority. In 2006/07 and prior years this income stream was received directly from the Department of Health (£13,381,000 in 2006/07) which was disclosed within the 'Department of Health - other' line.

NHS Injury Scheme income is subject to a provision for doubtful debts of 7.8% to reflect expected rates of collection.

2.1 Private Patient Income

	2007/8	Base Year 2002/3
	£000	£000
Private patient income	**2,903**	2,773
Total patient related income	**352,856**	225,193
Proportion (as percentage)	**0.82%**	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 Patient Income.

3. Other Operating Income

	Year ended 31 March 2008 £000	Year Ended 31 March 2007 £000
Research and development	**7,402**	8,434
Education and training	**27,774**	25,771
Charitable and other contributions to expenditure	**1,082**	811
Transfers from donated asset reserve	**920**	925
Non-patient care services to other bodies	**13,986**	13,665
Other income	**20,446**	22,562
	71,610	72,168

Other income includes £3.9m from Clinical Excellence Awards, £2.9m recharges to the Ministry of Defence to fund the training expenditure of Nurses along with catering and car parking costs associated with the military contract, £1.6m from the National Quality Assurance Service and £12.0m arising from other sources.

4. Operating Expenses

4.1 Operating expenses comprise:	Year Ended to 31 March 2008 £000	Year Ended to 31 March 2007 £000
Services from Foundation Trusts	**783**	212
Services from other NHS Trusts	**4,684**	8,961
Services from other NHS bodies	**1,977**	1,725
Purchase of healthcare from non NHS bodies	**10,580**	7,746
Executive directors' costs	**1,387**	1,381
Non-executive directors' costs	**149**	138
Staff costs	**239,417**	226,510
Drug costs	**39,556**	38,049
Supplies and services - clinical	**56,828**	50,616
Supplies and services - general	**5,446**	5,213
Establishment	**4,046**	4,132
Transport	**975**	1,101
Premises	**17,333**	15,289
Bad debts	**135**	233
Depreciation and amortisation	**9,706**	10,219
Audit fees	**68**	88
Other auditors remuneration	**0**	0
Clinical negligence	**560**	1,780
Other	**12,188**	17,772
Fixed asset reversal of impairments	**(26)**	0
	405,792	391,165

4.2 Operating leases

4.2/1 Operating expenses include:	**Year Ended 31 March 2008**	Year Ended 31 March 2007
	£000	£000
Hire of plant and machinery	**112**	146
Other operating lease rentals	**853**	950
	965	1,096

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

	Land and Buildings		Other leases	
	31 March 2008	31 March 2007	**31 March 2008**	31 March 2007
	£000	£000	**£000**	£000
Operating leases which expire:				
Within 1 year	**83**	83	**73**	163
Between 1 and 5 years	**91**	90	**133**	151
After 5 years	**553**	531	**0**	0
	727	704	**206**	314

5. Staff costs and numbers

5.1 Staff costs

	31 March 2008			31 March 2007
	Total	**Permanently Employed**	**Other**	Total
	£000	**£000**	**£000**	£000
Salaries and wages	**194,958**	182,007	12,951	184,176
Social Security Costs	**15,806**	15,806	0	15,184
Employer contributions to NHSPA	**21,618**	21,618	0	20,472
Other pension costs	**0**	0	0	0
Agency/contract staff	**8,422**	0	8,422	8,059
	240,804	219,431	21,373	227,891

5.2 Average number of persons employed

	2008			2007
	Total	**Permanently Employed**	**Other**	Total
	Number	**Number**	**Number**	Number
Medical and dental	**769**	769	0	736
Administration and estates	**1,362**	1,362	0	1,468
Healthcare assistants and other support staff	**586**	586	0	558
Nursing, midwifery and health visiting staff	**2,588**	2,588	0	2,570
Scientific, therapeutic and technical staff	**830**	830	0	804
Bank and agency staff	**147**	0	147	91
Total	**6,282**	**6,135**	**147**	6,227

5.3 Retirements due to ill-health

During the year to 31 March 2008 there were 13 early retirements from the Trust agreed on the grounds of ill-health (31 March 2007 -15). The estimated additional pension liabilities of these ill-health retirements will be £426,811 (31 March 2007 - £840,240). The cost of these ill-health retirements will be borne by the NHS Pensions Agency.

6. Exceptional Items

The impairment in 2006/07 arose 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 2008	Year ended 31 March 2007
	£000	£000
Retained surplus for the year prior to exceptional items	**12,486**	2,754
Impairment of buildings	**0**	(87,577)
Surplus/(Deficit) for the financial year	**12,486**	(84,823)

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

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

	Year ended 31 March 2008	Year ended 31 March 2007
	£000	£000
Loss on disposal of plant and equipment	**(886)**	(79)
	(886)	(79)

8. Interest

8.1 Interest Receivable

	31 March 2008	31 March 2007
	£000	£000
Bank interest receivable	**2,446**	847
	2,446	847

8.2 Financing Costs

Interest paid in year	**0**	0

9. Taxation

9.1 Corporation Tax Payable

The activities of the Trust have not given rise to any corporation tax liability in the year (year ended 31 March 2007- £nil).

10. Fixed Assets

10.1 The net book value of land, buildings and dwellings at 31 March 2008 comprises:

	31 March 2008	31 March 2007
	£000	£000
Freehold	**142,506**	140,736
Long leasehold	**0**	0
Short leasehold	**0**	0
TOTAL	**142,506**	140,736

10.2 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 2007	92,628	84,992	2,839	3,931	66,486	119	5,093	5,163	261,251
Additions purchased	4,914	92	0	3,589	5,323	0	5,519	21	19,458
Additions donated	0	0	0	125	267	0	0	0	392
Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	1	70	0	(2,520)	2,248	0	217	(16)	0
Other in year revaluation	956	3,906	756	0	0	0	0	0	5,618
Disposals	(6,000)	(174)	0	0	(13,295)	0	(72)	(73)	(19,614)
At 31 March 2008	**92,499**	**88,886**	**3,595**	**5,125**	**61,029**	**119**	**10,757**	**5,095**	**267,105**
Depreciation at 1 April 2007	0	38,510	1,212	0	41,797	119	2,128	3,930	87,696
Provided during the year	0	2,755	98	0	5,691	0	920	242	9,706
Impairments	0	0	0	0	0	0	0	0	0
Reversal of Impairments	0	(26)	0	0	0	0	0	0	(26)
Reclassifications	0	0	0	0	0	0	0	0	0
Other in year revaluation	0	0	0	0	0	0	0	0	0
Disposals	0	(75)	0	0	(12,201)	0	(61)	(69)	(12,406)
Depreciation at 31 March 2008	**0**	**41,164**	**1,310**	**0**	**35,287**	**119**	**2,987**	**4,103**	**84,970**
Net book value									
- Purchased at 1 April 2007	92,628	40,826	1,595	3,920	21,185	0	2,946	1,148	164,248
- Donated at 1 April 2007	0	5,656	32	11	3,504	0	19	85	9,307
Total at 1 April 2007	**92,628**	**46,482**	**1,627**	**3,931**	**24,689**	**0**	**2,965**	**1,233**	**173,555**
- Purchased at 31 March 2008	92,499	42,296	1,725	6,450	22,149	0	7,150	924	173,193
- Donated at 31 March 2008	0	5,426	560	(1,325)	3,593	0	620	68	8,942
Total at 31 March 2008	**92,499**	**47,722**	**2,285**	**5,125**	**25,742**	**0**	**7,770**	**992**	**182,135**

10.3 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 2008	0	25,054	0	0	0	0	0	0	25,054
- Unprotected assets at 31 March 2008	92,499	22,668	2,285	5,125	25,742	0	7,770	992	157,081
Total at 31 March 2008	**92,499**	**47,722**	**2,285**	**5,125**	**25,742**	**0**	**7,770**	**992**	**182,135**

11. Stocks and Work in Progress

	31 March 2008	31 March 2007
	£000	£000
Raw materials and consumables	**9,378**	9,250
Work-in-progress	**0**	12
Finished goods	**363**	321
TOTAL	**9,741**	**9,583**

12. Debtors

	31 March 2008	31 March 2007
	£000	£000
Amounts falling due within one year:		
NHS debtors	**13,226**	11,739
Non NHS trade debtors	**3,760**	6,202
Provision for irrecoverable debts	**(318)**	(337)
Other prepayments and accrued income	**2,926**	5,398
Deferred asset	**41**	41
Other debtors	**2,944**	2,925
Sub Total	**22,579**	**25,968**
Amounts falling due after more than one year:		
NHS debtors	**541**	618
Provision for irrecoverable debts	**(163)**	(152)
Other prepayments and accrued income	**0**	0
Deferred asset	**375**	416
Other debtors	**2,108**	1,977
Sub Total	**2,861**	**2,859**
TOTAL	**25,440**	**28,827**

The deferred asset of £41,000 falling due within one year (2007- £41,000) and £375,000 falling due after one year (2007-£416,000) is a bullet payment made in relation to the New Hospital PFI (see note 23).

13. Creditors

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

	31 March 2008 £000	31 March 2007 £000
Amounts falling due within one year:		
NHS creditors	**9,332**	7,098
Non - NHS trade creditors - revenue	**17,339**	10,939
Non - NHS trade creditors - capital	**2,142**	2,311
Other tax and social security costs	**5,667**	5,368
Other creditors	**2,993**	3,080
Accruals and deferred income	**39,893**	17,444
Sub Total	**77,366**	46,240
Amounts falling due after more than one year:	**0**	0

NHS creditors include pension contributions of £2,660,178 outstanding at the 31 March 2008 (31 March 2007: £2,506,106).

13.2 Prudential borrowing limit:

	31 March 2008 £000	31 March 2007 £000
Prudential borrowing limit set by Monitor	**77,100**	77,100
Working capital facility	**32,000**	28,500
Actual borrowing in year - long term	**0**	0
Actual borrowing in year - working capital	**0**	0
Minimum dividend cover	**4.2**	2.7
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 its overdraft facility.

14. Provisions for liabilities and charges

	Pensions relating to former directors	Pensions relating to other staff	Legal claims	Other	**Total**
	£000	£000	£000	£000	**£000**
At 1 April 2007	0	252	1,995	6,405	**8,652**
Change in discount rate	0	0	0	0	**0**
Arising during the year	0	0	1,694	3,432	**5,126**
Utilised during the year	0	(33)	(182)	(4,898)	**(5,113)**
Reversed unused	0	(12)	(67)	(33)	**(112)**
Unwinding of discount	0	27	0	0	**27**
At 31 March 2008	**0**	**234**	**3,440**	**4,906**	**8,580**
Expected timing of cash flows:	£'000	£'000	£'000	£'000	**£'000**
Within one year	0	31	338	3,792	**4,161**
Between one and five years	0	117	2,017	1,114	**3,248**
After five years	0	86	1,085	0	**1,171**

The provisions included under 'legal claims' are for personal injury (£1,433,460), employers and public liability (£256,807) and other claims notified by the Trust's solicitors (£1,749,676). 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 within the annual accounts of the NHS Litigation Authority at 31 March 2008 include £9,853,630 in respect of clinical negligence liabilities of the Trust (31 March 2007 - £7,567,574).

15 Movement in taxpayers' equity

	31 March 2008	31 March 2007
	£000	£000
Taxpayers' equity at start of period	**177,493**	243,758
Prior period adjustments	**0**	(586)
Taxpayers equity at start of period, as restated	**177,493**	243,172
Surplus/(deficit) for the financial year	**20,207**	(76,901)
Public dividend capital dividends	**(7,721)**	(7,922)
Fixed asset impairments	**0**	0
Surplus/(deficit) from revaluations of fixed assets	**4,240**	17,040
New public dividend capital received	**13,917**	2,988
Public dividend capital repaid in year	**(6,000)**	0
Public dividend capital repayable (creditor)	**0**	0
Public dividend capital written off	**0**	0
Other movements in public dividend capital in year	**0**	0
Additions/(reductions) in donated asset reserve	**668**	(884)
Net gains/(losses) on available for sale investments	**0**	0
Additions/(reductions) in other reserves	**0**	0
Taxpayers equity at 31 March 2008	**202,804**	177,493

16. 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 2007	68,597	9,304	(61,103)	**16,798**
Prior Period Adjustments	0	0	0	**0**
At 1 April 2007 as restated	68,597	9,304	(61,103)	**16,798**
Transfer from the income and expenditure account	0	0	12,486	**12,486**
Fixed asset impairments	0	0	0	**0**
Surplus/(deficit) on the revaluation of fixed assets and current asset investments	4,422	1,196	0	**5,618**
Revaluations of available for sale investments - gross	0	0	0	**0**
Revaluations of available for sale investments - tax	0	0	0	**0**
Net gains/(losses) on available for sale investments through the Income and Expenditure account	0	0	0	**0**
Receipt of donated assets	0	392	0	**392**
Transfers to the Income and Expenditure Account for depreciation, impairment and disposal of donated assets	0	(920)	0	**(920)**
Other transfers between reserves (see below)	(574)	(1,030)	1,422	**(182)**
Other movements on reserves	0	0	0	**0**
Transfer of realised profits/(losses) to Income and Expenditure Account reserve	0	0	0	**0**
At 31 March 2008	**72,445**	**8,942**	**(47,195)**	**34,192**

Other transfers relate to the release from the revaluation reserve to the income and expenditure reserve 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.

17. Notes to the Cash Flow Statement

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

	31 March 2008	31 March 2007
	£000	£000
Total operating surplus	**18,674**	9,934
Depreciation and amortisation charge	**9,706**	10,219
Fixed asset impairments	**0**	0
Fixed asset reversal of impairments	**(26)**	0
Transfer from donated asset reserve	**(920)**	(925)
(Increase)/decrease in stocks	**(158)**	(793)
Increase/ (Decrease) in debtors	**3,375**	(1,843)
Increase/(decrease) in creditors	**31,293**	4,429
Increase/ (decrease) in provisions	**(73)**	2,809
Other movements	**0**	0
Net cash inflow from operating activities	**61,871**	23,830

17.2 Reconciliation of net cash flow to movement in net debt

	£000	£000
Increase in cash in the period	**51,014**	5,767
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 cash flows	**51,014**	5,767
Non - cash changes in debt	**0**	0
Net debt at 1 April 2007	**20,420**	14,653
Net debt at 31 March 2008	**71,434**	20,420

17.3 Analysis of changes in net debt

	As 1 April 2007	Cash changes in year	**At 31 March 2008**
	£000	£000	**£000**
OPG cash at bank	9,765	59,833	**69,598**
Commercial cash at bank and in hand	10,655	(8,819)	**1,836**
Bank overdrafts	0	0	**0**
Debt due within one year	0	0	**0**
Debt due after one year	0	0	**0**
Finance leases	0	0	**0**
Current asset investments	0	0	**0**
	20,420	51,014	**71,434**

18. Capital Commitments

Commitments under capital expenditure contracts at the balance sheet date were £2,513,019, (31 March 2007 - £2,908,398).

19. Post Balance Sheet Events

The Trust does not have any post balance sheet events.

20. Contingencies

There are £88,395 (31 March 2007 - £92,969) which relates to amounts notified by the NHSLA for potential employer and public liability claims over and above the amounts provided for in note 14.

21. 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 £7,721,000 (31 March 2007 - £7,922,000) bears to the average relevant net assets of £141,345,000 (31 March 2007 - £195,444,000) that is 5.5% (31 March 2007 - 4.05%).

The rate of 5.5% reflects the fact that the Trust's relevant net assets have been reduced in 2007/08 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 2006 before the signing of the PFI was a certainty.

Movements in public dividend capital:	**2007/08**	2006/07
	£000	£000
Public dividend capital at 1 April	**160,695**	157,707
New public dividend capital received	**13,917**	2,988
Public dividend capital repaid in year	**(6,000)**	0
Public dividend capital at 31 March	**168,612**	160,695

22. Related Party Transactions

University Hospital Birmingham NHS Foundation Trust is a corporate body 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, Black Country PCT and West Midlands South LSG from whom the Trust received £250m for health care contracts.

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 2008 stood at £13.2m. The creditors balance for NHS bodies as at 31 March 2008 stood at £9.3m.

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. Brian Hanson, who was a Trustee of UHB Charities throughout 2007/08, was also a Governor of University Hospital Birmingham NHS Foundation Trust.

23. Private Finance Transactions

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

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 be fully operational in 2012. This is part of a wider PFI deal between the Trust, Birmingham & Solihull Mental Health Trust and a consortium led by Consort Healthcare.

The scheme is contracted to end on 14 August 2046 at which time the building will revert to the ownership of the Trust. Good progress is being made on the construction of the new building with all programme deadlines being met on time or delivered ahead of schedule.

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

Impact On Accounts

	31 March 2008	31 March 2007
	£000	£000
Amounts included within operating expenses in respect of PFI transactions deemed to be off-balance sheet - gross	**2,052**	1,254
Amortisation of PFI deferred asset	**41**	30
Net charge to operating expenses	**2,093**	1,284

The Trust is committed to make the following payments during the next year ended 31 March 2009:

	£000	£000
PFI scheme which expires;		
36th to 40th years (inclusive)	**2,263**	1,395

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 third to fifth years of the scheme, the Trust is committed to make average payments of £28.7m with the annual commitment rising to £48.7m 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

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

Within debtors falling due over one year, £375,828 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 11 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 were 12 formal contract variations which relate to the Trust. The cost of the approved variations have been included in the accounts where the work has been completed.

23.2 PFI schemes deemed to be on-balance sheet

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

24. Derivatives and Financial Instruments

24.1 FRS 29 Financial Instruments Disclosures

FRS 29 requires that entities quantify and disclose the role financial instruments have played in creating or changing their exposure to risk. A Financial Instrument is any contract that gives rise to a financial asset of one company and a financial liability or equity instrument in another company. Examples of financial assets are cash, deposits in other companies, trade receivables, loans to other companies, investments in debt instruments, investments in shares and other equity instruments. Examples of financial liabilities are trade payables, loans from other companies and debt instruments issued by the company. The Standard also applies to more complex derivative financial instruments such as call options, put options, forwards, futures and swaps. Due to the Trust's terms of authorisation and our use of public funds, our activities to deal in instruments are limited. A derivative is a financial asset or liability that requires no initial investment, will be settled at a future date and whose value changes in relation to a specified interest rate, index or other variable.

Derivatives can be found within PFI contracts and contracts for the supply of goods and services. To this end we have reviewed our contracts and found that the although they contain derivatives in relation to price increases over the life of contracts, the price increases are in line with UK Retail price index which is deemed to be a closely related economic market and therefore does not require separate disclosure.

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 29. 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.

24.2 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.

24.3 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.

24.4 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 2008.

	Book Value £000	Fair Value £000	
Financial assets			
Other	93,920	93,920	
Agreements with commissioners to cover creditors and provisions	28	28	a
Total	**93,948**	**93,948**	
Financial liabilities			
Creditors :	(47,565)	(47,565)	
Creditors over 1 year:			
Provisions under contract	(8,580)	(8,580)	b
Total	**(56,145)**	**(56,145)**	

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.

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 2.2% in real terms.

25 Third Party Assets

The Trust held £5,430 cash at bank and in hand at 31 March 2008 (£2,646 - at 31 March 2007) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

The Trust held £nil cash at bank and in hand for other third parties at the 31 March 2008 (£609,379 - 31 March 2007).

26 Losses and Special Payments

There were 408 cases of losses and special payments (31 March 2007 - 341 cases) totalling £557,268 (31 March 2007 - £355,089) approved in the year.

There were no clinical negligence cases where the net payment exceeded £100,000 (2006/07: no cases).

There were no fraud cases where the net loss exceeded £100,000 (2006/07: no cases).

There were no personal injury cases where the net payment exceeded £100,000 (2006/07: no cases).

There were no compensation under legal obligation cases where the net payment exceeded £100,000 (2006/07: no cases).

There were no fruitless payment cases where the net payment exceeded £100,000 (2006/07: no cases).

National Health Service Act 2006

Directions by Monitor, independent regulator of NHS Foundation Trusts in respect of the keeping of accounts and the preparation of 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 24 and 25 of schedule 7 to the National Health Service Act 2006, hereby directs that the keeping of accounts and the annual report and accounts of each NHS foundation trust shall be in the form as laid down in the annual reporting guidance for NHS foundation trusts with the NHS Foundation Trust Financial Reporting Manual, known as the NHS foundation trust FReM, that is in force for the relevant financial year.

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

Signed:

Name: Dr William Moyes (Chairman)

Dated: 17 January 2008

National Health Service Act 2006

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 7 to the National Health Service Act 2006, (the 2006 Act) 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.

"the NHS foundation trust" means the NHS foundation trust in question.

2. Form of accounts

(1) The Annual Accounts submitted under paragraph 25 of Schedule 7 to the 2006 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

Signed:

Name: Dr. William Moyes (Chairman)

Dated: 17 January 2008