Heart of England
Annual Report
and Accounts

2008/09

NHS

HEART of ENGLAND
NHS Foundation Trust

Annual Report and Accounts 2008/09

Heart of England NHS Foundation Trust

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

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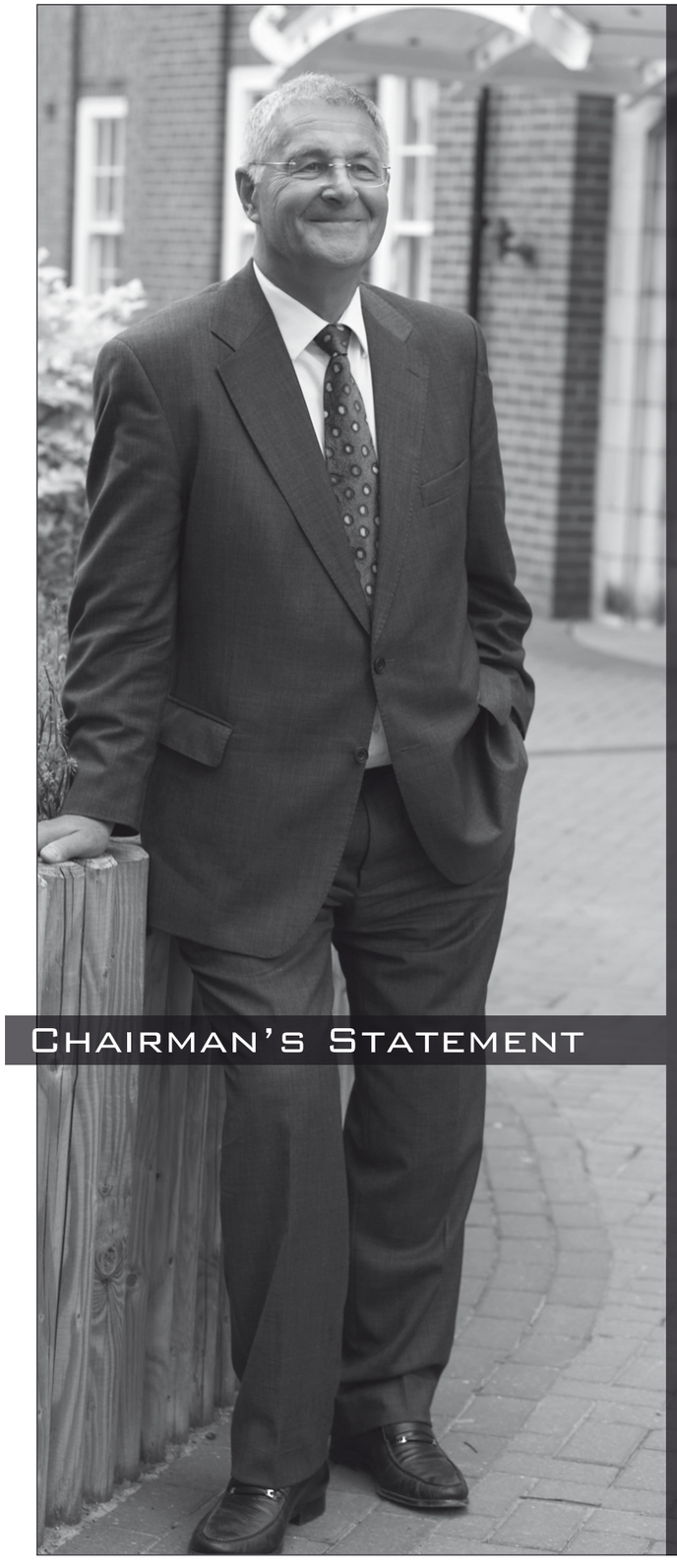


Chairman's Statement

It has been a tough year for the Trust with the demand for our services growing markedly from the contractual arrangements set out with our PCTs back in April 2008. A significant proportion of this additional activity came through the winter period and presented staff with major challenges which they met with vigour and focus.

Whilst disappointingly we just missed our target of 98% patients being seen, treated and discharged or admitted within four hours during the last two quarters of the year, we did meet all of our other statutory targets. This was a strong achievement for the Trust set against a challenging environment.

The investment required both in terms of staff and buildings to meet the added demand and our commitment to quality and safety has meant that our projected surplus reduced from a budgeted £23m to an actual £19m.

We have developed a strong programme of information for our members and provide opportunities for them to attend health information seminars ranging from obesity and diabetes to bowel cancer.

Over the year the Trust's Governors have become involved in health checks and patient feedback sessions, gaining greater exposure within the organisation and holding us to account. Five new Governors were appointed during the year ensuring that we have wide representation on the Council from the many communities we serve. In addition to induction sessions and Council meetings, the Governors and Trust Board held a joint away day to determine the Trust's exciting site strategy for the next 10 years.

The Trust Board has continued to work as an effective team and during the year commissioned an independent review of its effectiveness to build an ongoing programme of Board development. This will ensure that we have a Board which can continue to drive the success of the organisation in what is a very difficult economic environment. During the year Mr Richard Harris was appointed as a non executive director on 1 May 2008 completing our complement of eight Non-Executive Directors.

Finally, I would like to thank my Board colleagues and congratulate the executive team and the staff for their professionalism and commitment demonstrated over the last 12 months.

Chief Executive's Statement

This year was both busy and challenging, bringing continued success and growth in many areas, and providing us with learning and focus in others.

Early in the year, we announced plans for a 10-year £190m investment of refurbishment and redevelopment across the organisation which can be reviewed given the rather unstable national economic situation. Wards will be modernised and existing clinical areas upgraded to improve and expand our services for patients. There is no reliance on PFI - the investment comes from our own resources.

This year also saw the completion of the modular ward at Good Hope. From concept to first patient took just five months, an incredible achievement for all those involved. During this period, we introduced a new emergency flow pathway, streamlining how A&E cases are admitted.

Innovation is something that we pride ourselves on, and the opening of the Hollier Simulation Pilot Centre at Good Hope last autumn led the way in developing an exciting way of training medical staff. Feedback so far has been extremely positive. Once complete, this centre will provide training for doctors, dentists, nurses, allied health professionals and medical teams across the region.

Control of infection continues to remain high on the agenda for the NHS and we had a huge breakthrough in our own efforts to end the year well ahead of trajectory for MRSA bacteraemia. Our improvements with C Diff rates have been even more dramatic.

This winter there was a steep rise in emergencies to our A&E departments and high levels of activity across every area of the organisation. Staff responded in an exemplary way, and we have learnt from this to ensure we are even better prepared for next winter.

As we step into a new financial year, we will focus our efforts on patient safety which continues to remain our priority. The progress we have made on control of infection over recent years gives me much encouragement that we can make similar headway on patient safety.

To make steady improvements year on year, while maintaining stability, is a huge challenge for any organisation.At Heart of England, that ambition exists here and I am proud to lead an organisation whose Board and staff have the desire to strive for excellence and great ambitions for the future.

Directors' Report

The Board of Directors is chaired by Mr Clive Wilkinson, who was appointed for a four year term commencing 1 April 2006. The Chief Executive is Dr Mark Goldman. Other than the Chairman, there are seven Executive Directors and seven Non-Executive Directors. The Directors do not have material interests in organisations where those organisations or related parties are likely to do business, or are possibly seeking to do business, with Heart of England.

Executive Board Directors
The voting Executive Directors on the Trust Board are:

Dr Mark Goldman - Chief Executive
Dr Sarah Woolley - Director of Governance and Standards
Dr Hugh Rayner - Medical Director for Medicine
Mr Ian Cunliffe - Medical Director for Surgery
Ms Mandy Coalter - Director of Human Resources and Organisational Development
Mr Adrian Stokes - Director of Finance, Chief Finance Officer (appointed 1 July 2008)
Ms Mandie Sunderland – Chief Nurse (appointed 1 December 2008)

The non-voting Executive Directors who support the Trust Board are:

Mrs Fay Baillie - Acting Director of Nursing (resigned 30 November 2008)
Ms Lisa Dunn - Director of Corporate Affairs
Mrs Beccy Fenton - Deputy Chief Executive (resigned as a voting member of the Board 30 June 2008)
Mr Alan Gurney - Operations Director for Surgery
Mrs Kath Kelly - Operations Director for Medicine
Mr Andrew Laverick - Director of Information and Communications Technology
Ms Ellen Ryabov – Acting Chief Operating Officer (appointed 1 April 2009)
Mr John Sellars - Director of Asset Management
Mr Simon Hackwell - Commercial Director

Changes in Executive Board Membership
In addition to being the Trust's Deputy Chief Executive, Beccy Fenton became the Trust's Director of Transformation on 1 July 2008. As a result she stood down as Managing Director and as a voting member of the Board.

Adrian Stokes, Finance Director expanded his role and became the accountable Trust Board Director for Finance and Chief Finance Officer and became a voting member of the Board on 1 July 2008.

Non-Executive Board Directors
Non-Executive Directors are appointed for four years and are terminable with one month's notice on either side. The Non-Executive Directors are:

Mr Clive Wilkinson - Chairman
Ms Anna East
Mr David Bucknall
Ms Najma Hafeez
Professor Christopher Ham
Mr Paul Hensel
Mr Richard Samuda
Mr Richard Harris (appointed 1 May 2008)

Anna East took over the role of Deputy Chairman with effect from 1 April 2008. Further details of the Directors, their remuneration and how they operate are disclosed in Remuneration Report on page 35.

Background Information
Heart of England is one of the leading foundation trusts in the country, providing general and specialist hospital care for the people of East Birmingham, Solihull, Sutton Coldfield, Tamworth and South Staffordshire.

We pride ourselves on having services local to our communities. The Hospitals include Birmingham Heartlands Hospital, Solihull Hospital, Good Hope Hospital and Birmingham Chest Clinic. There are also a number of smaller satellite units so people can be treated as close to home as possible.

Heartlands Hospital originally developed from Little Bromwich Hospital, a fever hospital and sanatorium on the outskirts of Birmingham. As East Birmingham District General Hospital, it acquired the Marston Green Maternity Hospital and became the first acute trust in Birmingham in 1992. The following year, it merged with nearby Yardley Green Hospital and acquired Birmingham Chest Clinic in the city centre.

Solihull Hospital first opened its doors as a workhouse in 1839 for the poor, including the homeless, sick, aged and those with smallpox and TB. Until 1939 there was no hospital in Solihull but the circumstances of war turned it become a hospital. The opening of Solihull District General Hospital in 1994 was an important event in Solihull's history as it was the first time the people in the area had a modern purpose-built hospital where all types of treatment, including the care of children, the elderly, and the mentally ill was provided on one site.

Good Hope Hospital began life as a large Victorian house, which was purchased in the spring of 1943 for £5,000 for use as a convalescent home for patients from the Sutton Cottage Hospital. In the early 1950s, during the Cold War, two single storey wards were built as a place to evacuate people from Birmingham in the event of a nuclear attack.

Following the merger between Birmingham Heartlands NHS Trust and Solihull Hospital in 1995, Birmingham Heartlands and Solihull NHS Trust was formed. This became Heart of England NHS Foundation Trust in April 2005 when the Trust achieved foundation status. In April 2007, Good Hope Hospital became part of Heart of England, in the first acquisition of its kind in the NHS.

We offer national and regional clinical services, as well as secondary care, emergency and elective practice. As the second largest employer in Birmingham with 10,500 staff, the Hospitals play an important part in the local community. The Trust has a reputation for pushing the boundaries, transforming the way care is delivered and shaping healthcare of the future.

Principal Activities of the Trust
The principal activity of the Trust is the provision of free healthcare to eligible patients. We also provide a very small amount of healthcare to private patients in accordance with our terms of authorisation. As part of our principal activity, we also train clinical staff including doctors. Other activities of the Trust include:

Management Consultancy
HEFT Consulting completed its first full year in March 2008. It was formally established in November 2007 following approval by the Trust Board of the Consulting Gameplan and in the financial year 2008/09 HEFT Consulting was set up as a trading unit within the Trust with a part-time Chief Executive, Beccy Fenton.

HEFT Consulting was established to meet three objectives (in order of priority):
1. To stimulate **organisational learning** – consultancy involves engaging intellectually with another organisation's business and its problems. This in turn provides learning for the Trust both in terms of the journey so far and for future direction.
2. To **enable personal development** – working in different environments enhances individuals' learning, self reflection and expertise;
3. To **generate income** – turning knowledge into value to re-invest in the core business.

The year has been extremely successful in terms of meeting these original aspirations. The key highlights include:

- Delivery of a large scale and complex piece of work for the East Midlands Strategic Health Authority.
- Development of a strong proposition to support NHS trusts in achieving Foundation Trust status.
- Examples of learning from other organisations bought back into the Trust.
- Personal development and skills development of the Trust's staff
- Excellent financial growth with strong margins.
- Success in open competition against other large consulting brands.

Research and Development (R&D)
There have been significant developments in our research and innovation development over the last 12 months. The new MIDRU (Medical Innovation, Development and Research Unit) building opens in July 2009 and the MIDRU services have expanded to include regional roles such as industry support role for the Birmingham and Black Country Research Network and undertaking research management for three other NHS trusts. Our research portfolio has started to grow as anticipated and the R&D Directorate approved over 50% more clinical trials than the previous year. Academic collaborations have strengthened considerably and a number of new professorships and senior lecturers are in development and are being co-funded between the Trust and the Universities of Birmingham and Aston. As part of our ongoing investment in research and development a number of new clinical academic posts have been created with Aston University. These are in metabolic medicine, sleep research and a new professor and clinical director of Aston's Research

Centre for Healthy Ageing. These posts will also play an important in our new £1.5m Bio-Medical Research Unit which will focus on research into obesity and lifestyle factors, which will be based in the new MIDRU building.

We were a key player in Birmingham's application to become an Academic Health Science Centre (AHSC), however, despite being shortlisted the application was unsuccessful. Notwithstanding this, the vision for clinical research across Birmingham remains and we are working closely with the Universities of Birmingham and Aston and University Hospital Birmingham to develop an alternative model to the AHSC. This will be a key development for the year ahead.

Training, Teaching and Development
As a major teaching hospital, we are committed to training, teaching and development. We have strong capabilities for this including dedicated staff and on site facilities, for example, we are developing a regional Simulation Centre at Good Hope to support clinical development of junior doctors. We have also created a central Learning and Development team and a Board, chaired by a Medical Director, responsible for Workforce Planning and Education. A new learning and development strategy is currently being developed with broad engagement of all stakeholders. In the last two years, the Trust has developed 500 leaders and managers through its Leadership Academy. In addition, we have piloted a 'talent management' approach that supports succession planning in to senior posts. A group of 20 leaders will be assessed and developed this year as a result .

We have also developed the HEFT Academy, the vision for which is: *"To become recognised as an influential contributor both nationally and internationally in the debate around the future delivery and management of healthcare."* To do this the Academy will commission research, develop networks, gather learning from others and look to develop new solutions and approaches that can be shared both within the Trust and with others. In 2009/10 the Academy will receive a contribution from HEFT Consulting to enable it to begin its work. This is likely to take the form of commissioning a small number of research projects and building further relationships with some key external and influential individuals and organisations.

Review of the Trust's business.
The purpose of this Review is to set out how the Directors have performed their duty to promote the success of the company. The major headlines over the past year are as follows:

- Achievement of all of the 18 week Referral to Treatment targets ahead of the Government target of December 2008.
- Significant improvement in the delivery of infection control targets with 41 MRSA cases in the year against a target of 54 and 337 cases of C.Difficile in the year.
- In Financial Performance our income has exceeded £0.5bn for the first time, demonstrating an income growth level of 8% on the previous year's delivered income. The majority of the growth in income came from clinical services, which exceeded plan by £30m due to clinical activity across the four sites which continues to increase year on year. Although slightly behind our plan for the year we are reporting a high level of surplus (£19.8m) and our cashflow is £6.7m in excess of the planned figure at £77.5m.
- We have maintained Level 3 CNST (Clinical Negligence Scheme for Trusts) across all three sites in obstetrics.
- £30m capital investment including the development of the prestigious £11m MIDRU centre which is due to open in July 2009, a new ward at Good Hope, a state of the art CT scanner and a rolling replacement programme of estates and IT and medical equipment.
- Emergency care pathway improved at Good Hope following the opening of the AMU facility in February 2009 and redesigned systems and processes.
- £8m revenue investment in quality schemes.
- Development and Board approval of a new 10 year Safety Strategy for the Trust. Delivery and realisation of the year one plan of this Strategy will be the focus of the Governance and Standards Directorate over the 2009/2010.
- 76% of our staff who were surveyed said they experienced job satisfaction.
- IT developments including ward census and handover.

Risks and uncertainties
The Trust operates in an uncertain

world and the NHS is changing rapidly, giving rise to many opportunities and a number of risks and uncertainties. The healthcare market is an increasingly competitive one with growing patient choice about where and how they want to be treated. Against this backdrop, the Governance and Risk Committee continually identify the strategic and operational risks facing the Trust. There are currently seven strategic risks the Trust must understand and mitigate against.

Staff Capacity - Workforce planning, recruitment, sickness management, retention and succession planning is not fully adequate to meet the needs of services.

Workforce Capability - Continuous action is required to ensure a fully competent trained workforce delivering high quality safe services.

Patient Flow & Capacity- Capacity model and operational arrangements for managing emergency admissions can result in delayed admissions and discharges.

Workforce Redesign - Future requirements for workforce and staffing need to meet requirements of service strategy and national policy (eg EWTD).

Patient Satisfaction - The use of patient satisfaction information is not consistently aligned and focused on accommodating patient needs, excellent clinical outcomes and reputation.

Responsiveness of Services
Access/Waiting Times - Patient and customer needs are not fully met in accessing services.

Site Strategy - Failure to effectively implement the site strategy plan will lead to a hospital that does not meet the needs of the population.

Risks are reviewed regularly and actions are taken to mitigate and manage risks. The Risk Register for 2009/10 will be presented:

- Quarterly to the Governance and Risk Committee and Trust Board.
- Six monthly to the Audit Committee.

The Board conducts reviews of the Trust's system of internal controls. Full details of this is incorporated in the Chief Executive's Statement of Internal Control (SIC) starting on page 47.

Performance and Development of the Trust
Details of the development and performance of the Trust's business allied to the Trust's six strategic objectives are set out more fully in the Operational and Financial Review (OFR) on page 37. In summary we have had a good year from a financial viewpoint, reporting a surplus of £19.8m. Whilst this is £3.7m behind plan it is against a backdrop of an exceptionally busy winter, especially in emergency care, and additional costs being incurred as part of our commitment to meet infection control and treatment time targets. Our income is £34m above plan, in the main due to increases in clinical income primarily driven by additional activity.

The Trust has a very strong balance sheet with cash balances well ahead of plan so we remain in a strong position to deliver our ambitious 10-year financial strategy and investment plan. The capital plan for 2009/10 is £30m in addition to the slippage of 2008/09 schemes of £7.2m which will deliver better equipment to treat patients and improved or new buildings in which the care will be delivered. The 10- year investment plan has begun its first tranche of work and significant building works are planned to start by the end of 2009.

The Trust has scored a four for its financial risk assessed by Monitor. This good score is a result of a high cash balance, a healthy balance sheet and a healthy surplus being made. In line with Monitor's compliance framework, we recently submitted our three year plan which forecasts continued strong financial performance despite a number of challenges to the Trust, such as the transfer of clinical activity into the primary care setting and macro-economic predictions surrounding future NHS funding. We are developing plans on how to react to these challenges to ensure we are able to be flexible and maintain a strong financial footing.

Performance against Key Operational Targets
The Trust operates sophisticated performance reporting systems which highlight achievements as well as focusing on ambitious targets which are not being reached. Details of these targets are disclosed in the OFR on page 37

Other Information
The Trust has employed a Diversity Manager to provide proactive advice and guidance to us on all equality matters including disability and progress. This is monitored through the Diversity Steering group. We have published our equality schemes which include our approach to disability and support for people with disabilities. We monitor the workforce disability profile and publish the results. We seek feedback from disabled employees through our local staff survey.

The Trust proactively involves, consults and engages with the workforce on all matters and has in place formal consultation mechanisms to consult the recognised Trade Unions. A monthly team brief system operates across all three of the Trust's major sites which is delivered by the Chief Executive and includes all key corporate matters. We publish our own in house magazine 'Heartbeat' and surveys have demonstrated that the vast majority of staff receive and read this. We also run communication events at key times for staff to attend; for example on site sessions for staff about the Trust's new group structure which have been well attended. Our local staff survey is completed annually and 3000 staff responded this year. We also run regular topic based surveys of staff.

We are committed to minimising the environmental impact of our activities and have introduced a range of specific measures and initiatives which are set out on page 41 of the OFR.

The Trust is charged with achieving the Public Sector Payment Policy target of paying at least 90% of invoices within 30 days. Monitor has issued guidance recommending that foundation trusts adopt the commitment to paying non-public sector suppliers as soon as possible, with an expectation of within 10 days. We continue to pay invoices when they are ready for payment. In addition, there may be some supplier payments that are fast tracked where there is an important supplier relationship to establish or maintain.

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

Directors' Responsibilities for preparing the financial statements
The following statements, which should be read in conjunction with the Statement of Auditor's Responsibilities included in the Independent Auditor's Reports, are made to distinguish the respective responsibilities of the Directors and the Auditors in relation to the financial statements for 2008/09.

The Directors are responsible for preparing the Annual Report and Accounts 2008/09. The Directors are required by the Trust's terms of authorisation to prepare financial statements for each financial year, giving a true and fair view of the state of affairs of the Trust at the end of the financial year, and of the surplus or deficit for the financial year. Our financial statements must be prepared in accordance with UK Generally Accepted Accounting Practice (GAAP), the NHS Foundation Trust Financial Reporting Manual 2008/09 and the Companies Acts 1985 and 2006.

The Directors consider that, in preparing the financial statements on a Going Concern basis, the Trust has used appropriate accounting policies, that these have been consistently applied and supported by reasonable and prudent judgements and estimates, and that all applicable accounting standards have been followed.

The Directors have responsibility for ensuring the maintenance of proper accounting records that disclose, with reasonable accuracy at any time, the financial position of the Trust and to enable them to ensure that the financial statements and the Directors' Remuneration Report comply with the NHS Foundation Trust Financial Reporting Manual 2008/09 and the Companies Acts 1985 and 2006. They are also responsible for safeguarding the assets of the Trust and for taking reasonable steps to prevent and detect fraud and other irregularities.

The Directors are responsible for the maintenance and integrity of the Trust's website.

Directors' Responsibility Statement
We confirm to the best of our knowledge that:

- The financial statements, prepared in accordance with UK Generally Accepted Accounting Practice (GAAP), give a true and fair view of the assets, liabilities, financial position and surplus of the Trust.



- The Business review, which is incorporated into the Directors' report, includes the information required by the NHS Foundation Trust Financial Reporting Manual 2008/09, namely a fair review of the development and performance of the business and the position of the Trust, together with a description of the principal risks and uncertainties they face.

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

By order of the Board

Clive Wilkinson
Chairman
3 June 2009

Mark Goldman
Chief Executive Officer
3 June 2009

A fuller and more detailed review of the Trust's business is incorporated in the Operational and Financial Review (OFR) on page 37 of the Annual Report.

Quality Report

"The requirement to publish quality accounts has come at a good time for us as a Trust. The last few years have seen us move steadily away from an agenda focused purely on year-on-year financial stability towards one entirely focused on quality and patient safety, all delivered within our financial capability. Over the year the Board has reaffirmed the Trust's vision and strategy to deliver quality improvements through meeting our obligations to the local community. The aim is to improve health and wellbeing by collaborating with other public and private sector organisations. By developing links and working together, we can have a greater impact on the community and each individual patient journey. We recognise that in an era of choice, we need to fully understand patients' perceptions and priorities, and allow these to guide the decisions we make.

I would like to say a huge "thank you" to all those who have worked with us on this journey. As we commit to further developing quality as a business strategy we look forward to a greater sense of satisfaction and fulfilment in our work in the knowledge that patients and their families will have appreciated a compassionate, dignified and clinically excellent service."

Mark Goldman
Chief Executive Officer
3 June 2009

Our Quality Story So Far

Vision

The Trust has focused its performance management framework to deliver its vision and key strategic objectives:

Corporate Vision
"To be the most exciting and influential healthcare business worldwide"

Corporate Mission Statement
"To be a centre of excellence in the provision of healthcare and education"

Corporate Strategy
"Quality as a Business Strategy"

Strategic Objectives

We provide the highest quality patient care.
We are the recognised employer of choice.
We are the local provider of choice.
We continually learn and innovate.
We grow the business for own and the region's prosperity.
We are financially secure.

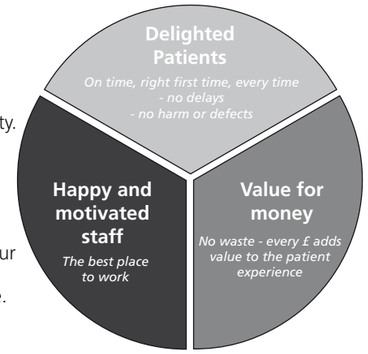
The requirement to produce Quality Accounts has followed on quite naturally from our strategy, 'Quality as a Business Strategy', which we set out in December 2007. This strategy set out the Trust's mission to drive up quality across three key areas of the business: Acute Hospital Healthcare, Integrated Community Healthcare and the HEFT Academy (a dedicated learning and research centre).

To support the delivery of our quality programme the Board approved a Trustwide Transformation Strategy in July 2008 and agreed a 'True North' to guide and focus redesign projects that enable continuously improvement in our overall total quality. Our guiding True North is shown in the pie chart to the right.



The Corporate Business Plan for 2009/10 identifies three key areas for improvement during the year. In line with our True North these will be Patient Quality, People and Productivity.

In order to assess improvements in Patient Quality we will be focusing on the three measures set out by Lord Darzi. Improving safety, patient experience and the effectiveness of our patient care will enable us to provide the best quality acute care worldwide.

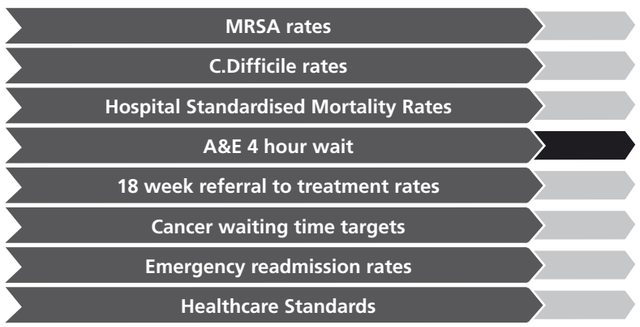


Quality Objectives

Of the Trust's six overarching strategic objectives, two of these focus directly on the delivery of patient care, namely:

- We provide the highest quality patient care.
- We are the local provider of choice.

A number of board approved performance measures to monitor these have been in place for a number of years and include both national and local priorities. Our success in achieving these targets can be seen in the diagram below (a grey flag denotes achieved in 2008/09, black denotes not achieved).



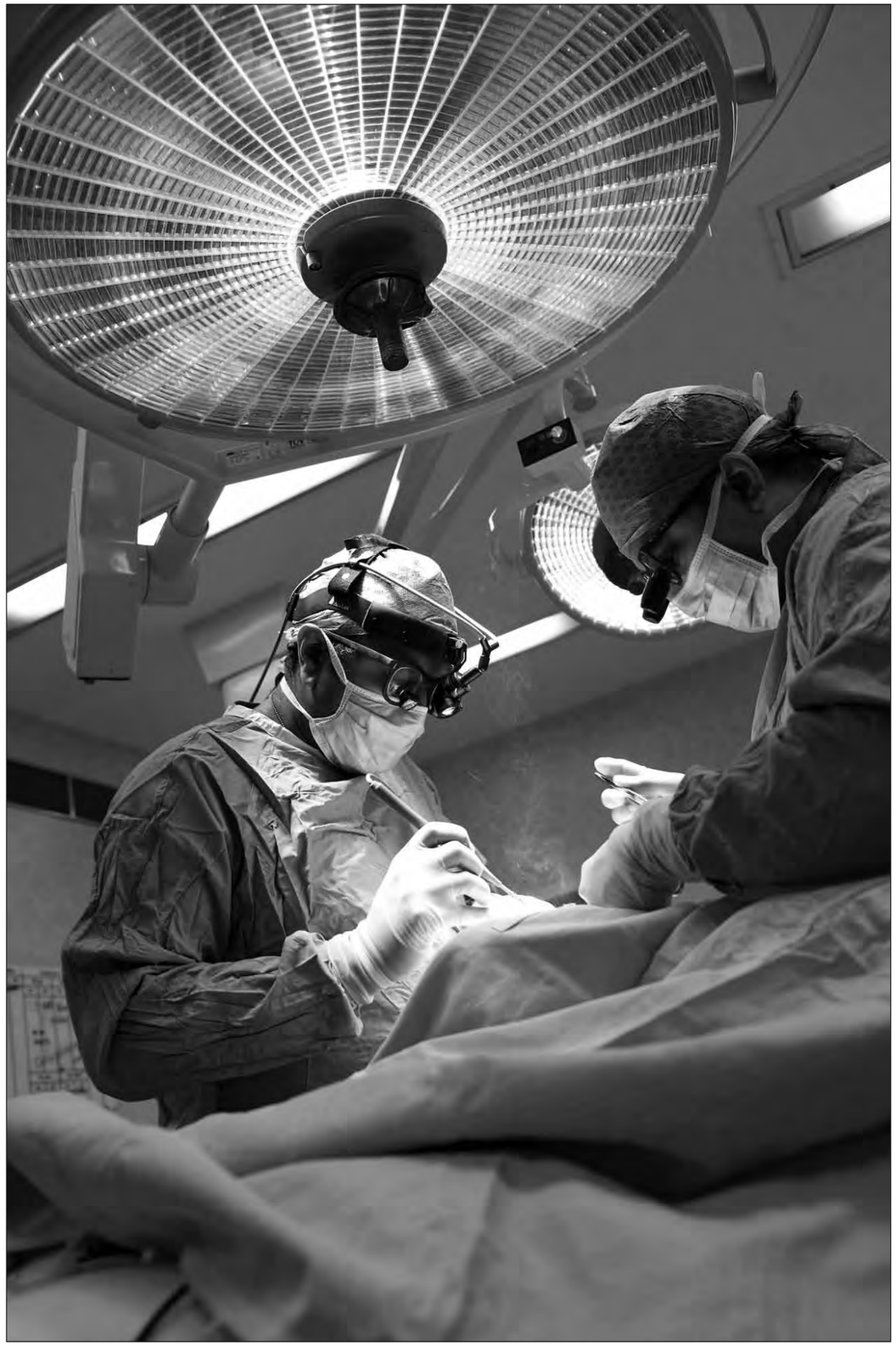
Every year we are required to make a declaration against 43 national core standards, and at the end of 2007/08 we declared compliance against 42 of these. The one area of non-compliance related to mandatory training. During the last year work has been undertaken to address the shortfalls and at the end of 2008/09, the Trust was fully compliant with all the national core standards.

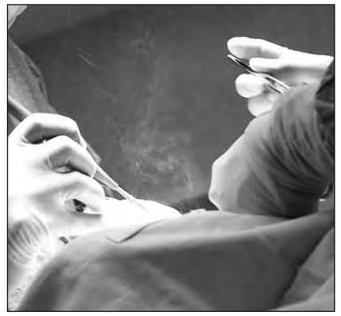
Shifting our focus to quality and building capacity to deliver

We have developed a series of ongoing initiatives to increase organisational effectiveness around quality and to embed quality in the Trust through the development of internal structures and processes. All of this work strengthens our capability and builds a quality focused culture. Examples of our work in this area are:

- Patient Safety First: The Trust has signed up to the National Patient Safety First Campaign which aims to change the culture within the NHS to one that puts the safety of patients as the highest priority, and makes all avoidable death and harm unacceptable. As part of this campaign the Trust is trialling the effectiveness of the Global Trigger tool as a way to measure the safety and safety culture of the organisation. A rolling programme of Patient Safety walk rounds has also been established to give front line staff the opportunity to identify and discuss safety issues with the senior management team and identify areas for improvement or areas of best practice that could be shared with other areas.

- NHSLA level 2 – 2008/09 is the first year following the merger with Good Hope in 2007 that the Trust has been assessed against the challenging new Risk Management Standards for Acute Trusts. Aside from the financial benefits of this successful accreditation, this is a huge achievement from a safety perspective and demonstrates





"that the organisation's processes for managing risks, as described in the approved documentation, are in use and have been implemented throughout the organisation."
NHSLA Risk Management Standards 2008

- Development and approval of a new 10 year Safety Strategy for the Trust.

- At Good Hope a new modular ward was completed within a five-month period from decision to build to opening. The new 28-bed ward was built of a modular construction and provides excellent quality space standards and control of infection features.

- Over the last 12 months, the HR team has prioritised managing areas of organisational risk, particularly workforce capacity, capability and redesign. As a result, sickness absence levels and costs have significantly reduced. Recruitment time to hire has improved with boosted staffing levels and the plans to secure European Working Time Directive compliance for trainee doctors are well rolled out.

- Following 12 months of joint working between the Human Resources and Governance Directorates, we have completely reviewed our approach to mandatory training. The Human Resources team and the mandatory trainers now provide mandatory training programmes, targeted at specific staff groups. Development of a central process to record and analyse attendance now allows the Mandatory Training Committee to oversee the take up and effectiveness of the training provided. As a direct result of this the Trust achieved 10/10 and level 2 for NHSLA Mandatory Training.

Our priorities for quality improvement in 2008/09

Three key priority areas for improvement were identified:

To substantially reduce our MRSA and C.Difficile rates.

To reduce our hospital standardised mortality rates (HSMR).

To improve our levels of patient satisfaction feedback.

Priority 1: To substantially reduce our MRSA and C.Diff rates

Why we chose this priority
At the end of 2007/08 the Trust was recognised as having some of the worst MRSA and C.Difficile rates nationally, and failed to achieve our external target for MRSA. It was clear that a significant amount of work was required to improve these rates.

Our Aim/Goal: As a minimum to achieve the national targets set for 2008/09:

MRSA – 54 cases
C.Difficile – 690 cases

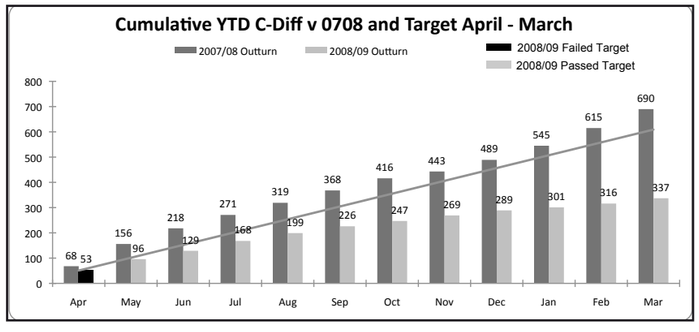
What we did
Following the Good Hope merger and subsequent failure to achieve sustained reductions in infections at all hospital sites a series of meetings chaired by the CEO led to the formulation of a new multi-disiplinary Trust-wide plan in late 2007. Many of the initiatives were advised and led by the Infection Prevention and Control Team (IPCT) and were delivered in a short timescale in early 2008. The IPCT embraced the principles of evidence-based practice in developing service changes by using learning from Root Cause Analysis (RCA) investigations as well as scientific evidence to target interventions.

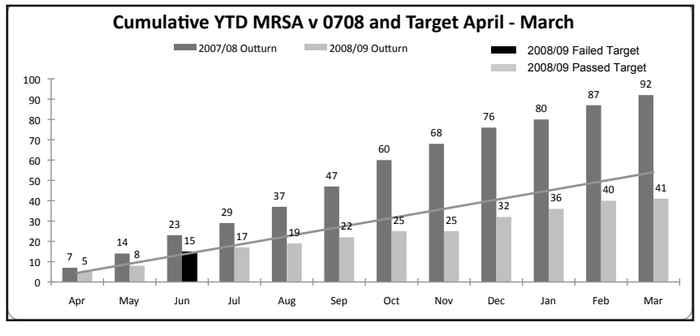
These included:
- Introduction of MRSA screening of all elective surgical patients at pread-mission in January 2008 ahead of national target.
- MRSA screening of all emergency admissions from June 2008.
- Provision of blood culture packs designed to reduce contaminated cultures.
- Use of bespoke Peripheral cannula packs with Chlorasepp®
- On-line RCA tool for MRSA bacteraemia.
- Re-launch of high impact interventions using web-based on-line reporting.
- Dedicated cleaning team for infections and outbreaks and the use of hydrogen peroxide vapour.
- Early investigation of episodes of increased incidence of C.Difficile on wards.
- Antibiotic improvement notices for doctors.
- Development of a lead Infection Control Consultant for all wards and departments in addition to our established link worker system.

Where we are now
2008/09 was a landmark year for the IPCT demonstrating sustained commitment to reducing healthcare

associated infections. Their hard work and perseverance and a co-ordinated Trust-wide approach resulted in significant improvements in the quality of care delivered to patients with a 55% reduction in MRSA bacteraemia (41 cases) and 51% reduction in C.Difficile infections (337 cases) in 2008/09 compared to 2007/08. This was an extremely successful year culminating in an unannounced visit by the Healthcare Commission to assess compliance against the Hygiene Code with no breaches found.

This improvement is demonstrated in the graphs below:





Ongoing commitment

Continued improvement against these infection control targets remains one of our top priorities for 2009/10. We will continue to monitor our performance against new and tougher targets. Alongside this we are committed to achieving 100% compliance with emergency and elective screening for MRSA.

Reduction in our Hospital Standardised Mortality Rates

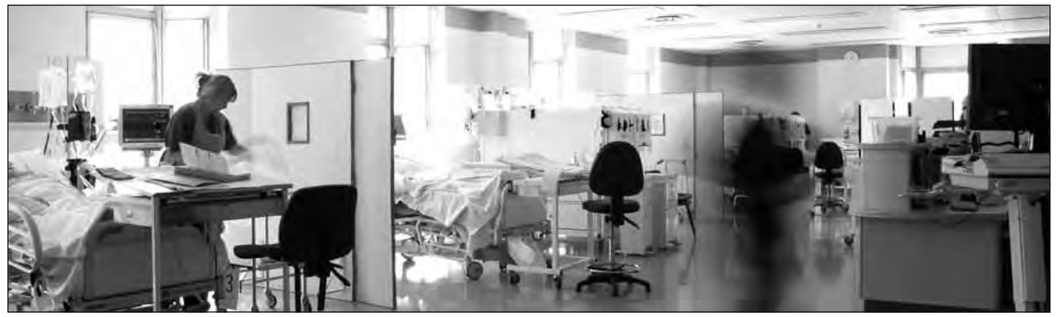
Why we chose this priority

For the two previous years, the Hospital Standardised Mortality Rate (HSMR) for the Trust was above the national average. In the Dr. Foster Hospital Guide for 2008 the Trust was categorised as having a significantly higher than expected HSMR.

Our Aim/Goal: To reduce the Trust's HSMR rate to at least 100

What we did

Throughout 2008/2009 improving HSMR has been a priority for the Trust. A Mortality and Morbidity Group was established with a remit for monitoring and investigating specialties where mortality was at its highest. The group includes the Trust's Director of Safety, Consultant representatives and, when required, representation from Dr. Foster. Improvement programmes were instigated across two of the Trust's three hospital sites to look at deaths related to fractured neck of femur, an area where there was a particular cause for concern.



Where we are now

In the 11 months from March 2008 to February 2009 the Trust has experienced a fall in its HSMR from 107.1 to 95.7 representing a significant improvement on the previous year's performance.

	2008/09	2007/08	2006/07
Hospital Standardised Mortality Rates	95.8 (Mar 09)	107.1	112.7

Ongoing Commitment

Continued improvement against the HSMR target is required and we will continue to monitor our performance in this area to ensure that the Trust's HSMR remains below 100.

To improve our levels of patient satisfaction feedback

Why we chose this priority

Findings from the inpatients surveys show that year-on-year the Trust has made improvement in many areas of patient satisfaction and the results have been largely positive. Whilst this was the case we wanted to obtain better quality, real-time feedback from patients.

Our Aim/Goal: To improve our response rate on patient surveys and feedback.

What we did

The CQC National Inpatient Survey of 2008/09 raised some issues for the Trust to consider, notably around discharge, certain information being provided to patients, staff behaviours and cancellations of procedures. Performance against the national survey is monitored through mailing out a weekly scaled down version of the inpatient survey. This proactive way of delivering a picture of satisfaction informs the Trust Executives and Board whilst enabling challenges and issues to be tackled as they arise.

Patient satisfaction is continually measured using a range of methods such as self completion questionnaire, patient interviews and drop in sessions. More recently, electronic patient diaries in appropriate areas have also complemented the portfolio. The Nursing Directorate and the Engagement (PPI) team have worked in partnership introducing a trial of hand held computers to obtain patient satisfaction data.

The Net Recommender Index had been piloted during the year but had received very erratic response rates. As a result we invested in an in-house electronic system for capturing rapid feedback directly from clinical areas called the Patient Experience Tracker which had been developed by Dr Foster Intelligence. These were hand held electronic units which had been preloaded with 5 questions on the patient's experience of care. The devices had been handed to patients or carers at the bedside and had then been used to rate the clinical area on the questions asked. In due course this system would integrate into the nurse handover. The system has been trialled on 6 pilot ward sites and will be rolled out Trust wide during 2009/10. Trained volunteers will conduct these electronic surveys at the bed side providing real time patient satisfaction data from across the organisation's three sites.

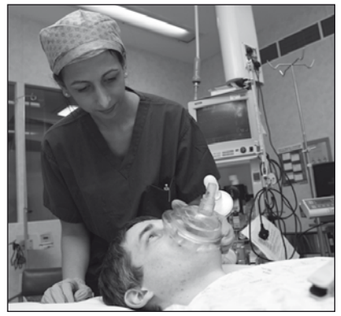
In addition the Patient Experience Survey, which measures patient experience against five key drivers, has also been devised and distributed since December 2008.

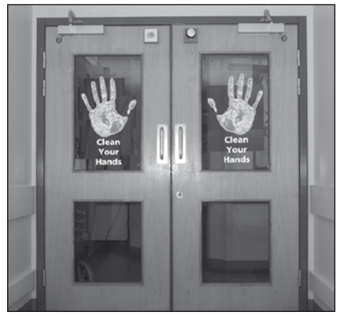
Where we are now

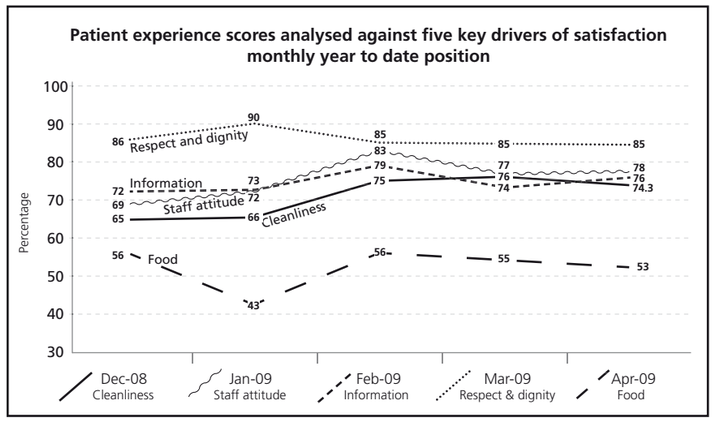
Since December 2008, 3,400 postal patient experience surveys have been sent out with 815 completed and returned, giving a response rate at 25%. The key findings were :

- The standard of food dipped sharply in January 2009, however it showed a recovery in February / March 2009. This dipped again by two points in April 09.
- Information and staff attitude showed a slight improvement over the March / April 2009 period.
- Respect and dignity remained constant over the last three months.
- Cleanliness dipped slightly in April 2009.

The full findings are sent out in the chart on the next page:







Ongoing commitment

Over 2009/10 the Patient Experience Tracker (PET) will be introduced across the Trust. The Trust is also looking at developing a user group or forum to represent each clinical discipline. This will provide the Trust with reliable qualitative user experience across the organisation on a regular basis. The results from the Patient Experience Survey for 2009/10 will be benchmarked against the results from the national 2008/09 Inpatients Survey.

Our relationships with external bodies during 2008/09

We are required to report quarterly to Monitor against a number of key national targets and a quarterly compliance framework has been developed to support this. The table shows our performance for 2008/09 against our 2007/08 performance for these indicators.

We achieved all of the Monitor targets, with the exception of the A&E 4 hour target which we failed to achieve for 3 out of the 4 quarters for last year. As a result of this we have been working closely with Monitor on the development of action plans to deliver the target in 2009/10.

In 2008/09 we received an amber governance risk rating from Monitor.

National targets and regulatory requirements	2008-09	2007-08	Target
The Trust has fully met the HCC core standards, and national targets.	44/44	43/44	44
C.Difficile year-on -year reduction	337	690	609
MRSA – maintaining the annual number of MRSA bloodstream infections at less than half the 2003/04 level	41	92	54
Maximum waiting time of 31 days from decision to treat to start of treatment extended to cover all cancer treatments	99.37%	n/a	None available
Maximum waiting time of 62 days from all referrals to treatment for all cancers	94.43%	n/a	None available
18 week maximum wait from point of referral to treatment (admitted patients)	90.7%	85.8%	90%
18 week maximum wait from point of referral to treatment (non-admitted patients)	96%	93.8%	95%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	97.63%	98.12%	98%
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	99%	99%	98%
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	98%	99%	95%
People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack)	76.92%	80.7%	68%
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	93.09%	n/a	None available

Looking ahead to 2009/10

In the light of our achievements in 2008/09 the Board and Governors Consultative Council have considered the quality priorities for 2009/10. These have been largely based on the Commissioning for Quality and Innovation Framework agreed with the PCTs.

Priority 1: To further reduce our MRSA and C.Difficile rates

Infection control and reduction of MRSA and C.Difficile rates is important to staff, patients and members of the public.

In 2009/10 we will continue to build on the work we have undertaken in the last 12 months and will aim to have had fewer cases of both MRSA and C.Difficile than we had in 2008/09.

We will also work to deliver 100% compliance with the emergency and elective screening targets.

We have agreed further stretched targets with our commissioners which will be monitored through a health economy Quality Review Group.

Priority 2: To introduce a nursing quality measurement system

The pilot phase has already begun for the implementation of a Trust-wide system which will measure and monitor nursing care standards and quality. This data will be cross checked against user views and outcome measures, to provide live performance information on nursing care for senior nurses and the Trust Board. This work is already attracting interest both locally and nationally. The system will also link in with the Productive Ward programme and will be part of our aim of working towards 'Heart of England

World Class Wards'.
The key areas of focus for improvement will be cleanliness and dignity and privacy.

Priority 3: To improve stroke management care
There is clear evidence that rapid diagnosis, admission to a specialist stroke unit, and prompt brain imaging and use of thrombolysis (treatment to dissolve blood clots) where indicated can all contribute to better outcomes for patients.

In line with NICE guidance issued in July 2008, the Trust will work towards improving stroke management care for all patients with a suspected stroke and patients with a high risk of TIA.

Improvements will be measured using performance indicators that relate to thrombolysis within three hours and access times to CT scans. Alongside this we will undertake a bi-annual patient survey of patients treated at the Trust within stroke services to inform us of the identified service and quality improvements we can make.

Priority 4: To speed the process of hospital discharge
Remaining in hospital when medically fit can, especially among older people, result in disruption to social networks and disorientation and could may lead to a higher risk of a hospital acquired infection. Our work this year with Berwood Court Nursing Home has demonstrated better health outcomes for patients who have been transferred to a non-acute setting. It is vitally important for patients and for the Trust to reduce the number of patients in hospital beds for whom their medical care does not need to be given in hospital.

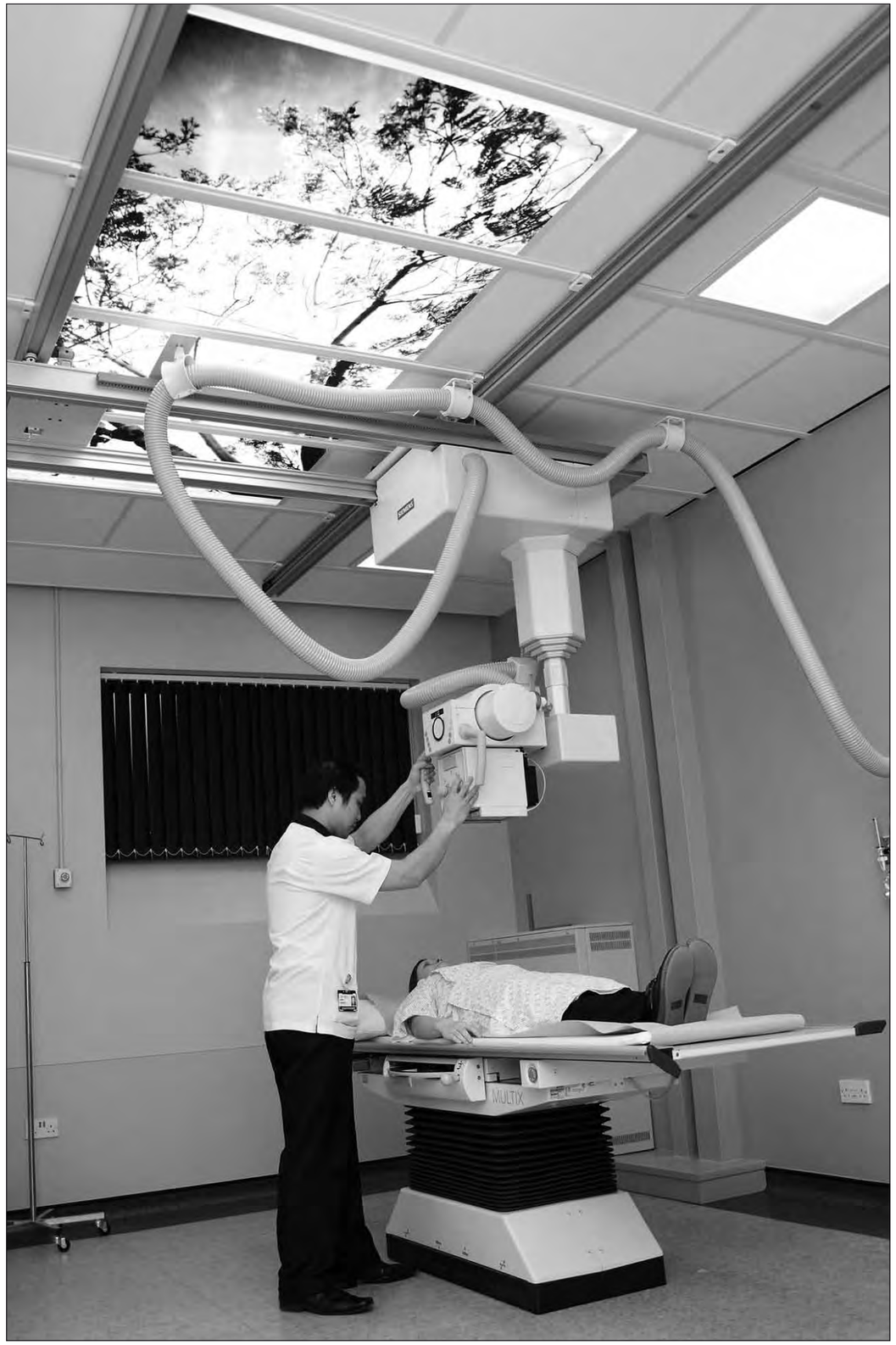
Improvements will be measured using performance indicators that relate to length of stay, delayed transfers of care and feedback from patient surveys on pharmacy delays and provision of information.

Priority 5: Patient feedback
As the Patient Experience Tracker (PET) is introduced across the Trust and we develop a user group or forum to represent each clinical discipline our understanding of patient experience will grow and we will have reliable qualitative user experience across the organisation on a regular basis. This will enable us to develop clear action plans to address any shortfalls that are identified. The key areas of focus for improvement will be information, staff attitude, and respect & dignity.

In determining these priorities, we have assessed our main quality improvement priorities and initiatives and, in consultation with our Governors' Consultative Council, identified each priority in terms of impact and feasibility.

Clive Wilkinson
Chairman
3 June 2009

Mark Goldman
Chief Executive Officer
3 June 2009



Membership Report

The Trust serves a population of over 1.3m and has more than 100,000 members from various constituencies.

The three main constituencies are:

1. Public Constituency: members who live in one of the Trust's ten governor zones . Residents of these zones become eligible for public membership when they are over the age of 16.
2. Staff Constituency: members of the Trust staff. All contracted staff are eligible to become members.
3. Patient Constituency: members who are patients of the Trust. Patients who live outside the ten governor zones are eligible for membership if they have had treatment in the previous three years.

A full listing of all the constituencies is available upon request from the Company Secretary. This listing also shows the minimum number of members, as well the number of governors required for each constituency.

Breakdown of total members

Public members: 84,230
Patient members: 6,262
Staff members: 9,602
Total membership: 100,094

Public Membership is broken down as follows:

Age (years)	Ethnicity		Gender	
0-16: 206	White:	57,673	Male:	48,016
17-21: 2,222	Mixed:	382	Female:	35,601
22+: 81,802	Asian/British Asian:	8,599	Not declared :	613
	Black/British Black:	2,130		
	Other:	358		
	Not declared:	15,088		

Staff Membership is broken down as follows:

Heartlands	Good Hope	Solihull
Clinical Staff: 3312	Clinical Staff: 1799	Clinical Staff: 833
Non-Clinical: 2111	Non Clinical: 1073	Non Clinical: 474

Patient Membership is broken down as follows:

Age (years)
0-16 : 11
17-21: 178
22+: 6,073

The membership strategy

The last 12 months saw a fall in membership numbers across all three constituencies, which, when analysed, was as a result of members either moving out of the catchment area or dying. As a result we initiated an opt-out recruitment drive in October 2008 enabling the Trust to achieve its target of 100,000 members.

The Trust offers three levels of membership:

Level 1	Members request a high level of engagement
Level 2	Members are provided with regular communications and invitations to some health seminars
Level 3	Members receive quarterly communications

This categorisation has enabled members to select the level of involvement they require to meet their individual and specific needs.

The Membership now stands at 100,094 members (including public, staff, and patient members) a 9.6 % increase in new public and patient members over the same period last year.

The Trust has updated the ACORN profiling and socio-economic grouping of its membership database to ensure the demographics remain representative of the local community. The Trust's membership is demographically representative in three of the five ACORN categories. There is a slight over representation of wealthy achievers due to the demographic make-up of the communities the Trust serves. There is an under representation in the urban prosperity category, due to this being a much younger group. Last year, urban prosperity made up 3.1% of our members, but following a targeted recruitment campaign 3.5% of new members were recruited from the urban prosperity category.

When looking at social grades there is some under representation in the C2 and E social grades. Again, with targeted recruitment this has been improved in social grade C2 this year. This confirms we are making progress in addressing these shortfalls. We are performing well regarding ethnic groups against the UK base and have one of the largest Asian populations. This is shown by ACORN Group 'Asian Communities' being the fourth largest group within our membership.

In the coming year there will be further analysis of the ACORN types, and plans will be put in place to address the membership demographic shortfalls. By understanding our catchment areas in more detail we will be able to use the ACORN profiling to effectively carry on the targeted recruitment campaigns.

We manage our own database which is linked to the Trust's patient system. This enables it to be automatically updated with any changes to members' details. Security processes are in place to ensure that there is no breach of patient confidentiality.

Membership growth and engagement is reported to the Governors' Consultative Council meeting which is also attended by Executive and Non-Executive Directors. A sub group of Governors is working with the Trust to continue to engage and develop the membership. This work includes further developing the Trust's website.

Recently we have successfully increased member representation of young people (aged 16-35) following a series of recruitment campaigns alongside the Trust's own schools programme which was established with the specific aim of enhancing the Trust's profile in the community. This joint approach has provided greater opportunities to engage with young people and encourage membership and higher levels of involvement. We also plan to introduce a young members club in 2009. This will be in collaboration with the children's wards on all Trust sites, PALS for children and a number of local schools within the catchment area. The approach will involve young members designing their own posters and membership material. Members (aged 11 – 17) will be empowered to plan their own activities with professional guidance from the young members steering group.

In 2009/10 the focus will be on even greater membership involvement assisted by the Trust's Governors and Level One members. This new focus will also include engaging with existing community groups and forums where strong relationships have been formed. Member volunteers sit on the Consultative Healthcare Council – the Trust's primary forum for engaging users. We are encouraging our member volunteers to widen their involvement in membership and Trust activities. This includes forming active e-members (reachable by e-mail) to help with patient surveys. It is planned that these members will also be invited to take part in recruitment campaigns and external membership events.

Patient members generally live outside the geographical catchment area and are either patients or patient carers. This constituency continues to grow as patient choice becomes more readily available.

The number of staff members remained constant this year and the goal for 2009/10 is to ensure they remain engaged and do not opt out. We will achieve this by continuing to encourage staff members to become champions along with the Governors, to recruit new members and to actively raise the profile of the Trust and its services.

Governors' Consultative Council

There are 44 Governors serving the Trust, who were appointed for a three year period and are eligible for re-election or reappointment for a further three years. The Governors are appointed as follows:

- 26 public Governors, by ballot of members.
- 5 staff Governors, by ballot of Trust staff.
- 11 stakeholder Governors, by appointment.
- 2 patient Governors, by ballot of members.

The Governors' Consultative Council is responsible for representing the interests of NHS foundation trust members and stakeholder organisations in the governance of the Trust and exercises certain statutory powers such as the appointment of Non-Executive directors and the external auditor. It meets at least four times each year and a record of Governors' attendance is maintained.

The Trust successfully held by-elections for the Governors' Consultative Council during 2008/9 for a number of constituencies where unplanned vacancies had occurred. Open days were held across all sites to engage with the local community and encourage members to stand for election and get actively involved. Community leaders and Trust Governors played an instrumental role in getting the message out to their constituents and were a key support in communicating with the hard to reach public members. The monthly health seminars continue to be a highly successful method of engaging with members to ensure they are kept informed of all Trust activities. Five new Governors were appointed and one vacancy for the constituency of Solihull North remains unfilled. A further by-election will be held to fill this vacancy during March 2010.

In addition, the Board can confirm that all elections to the Governors' Consultative Council were held in accordance with the election rules stated in the Constitution.

Election turnout 2008/09 for the Governors' Consultative Council

Date of election	Constituencies involved	Number of members in Constituency	Number of seats contested	Number of contestants	Election turnout %
1 Apr-09	Solihull North	5,859	1	1	Uncontested
1 Apr-09	Public: Birmingham Central	12,536	1	8	12.3%
1 Apr-09	Public: Birmingham at Large	4,166	1	3	13.6%
1 Apr-09	Patient	6,261	1	12	12.5%
1 Apr-09	Staff: Nursing, Midwifery & HCA	4,330	1	3	12.4%

The Governors' Consultative Council has recently reviewed its effectiveness and recommendations are now being followed through by the Chairman and Company Secretary.

The Governors are actively involved with the Healthcare Standards Annual Return. This year they assessed the Trust's processes on mandatory training and were fully assured on the evidence being submitted.

The Governors' Information Working Group established in 2008 is now looking at new ways to work with the community through attending local community meetings and hospital events.

The Governors' Consultative Council in place during the financial year is set out in the table overleaf and it met five times during the year. One of these meetings was a joint meeting with the Trust Board.

The local Health Overview and Scrutiny Committees (HOSC) have a statutory responsibility to Health to oversee, monitor and scrutinise the policies, services and activities relating to health, in accordance with the Health and Social Care Act 2001 and related regulations. Our Governors are exploring a developing relationship with the local HOSC to identify and encourage the development and implementation of policies and working practices, which improves people's health. As a foundation trust we have a statutory duty to consult with the HOSC on any major service changes or new developments planned and the HOSC has a responsibility to respond to each consultation. The relevant committees for each Governor constituency is shown in the table below along with the attendance record of the Governors in post during the year. The Constitution requires a report to the Governors in the event that any individual Governor does not attend two consecutive Governors' Consultative Council meetings without good reason.

Relevant Health Overview and Scrutiny Committee	Constituency	Name	Date of appointment	Date of end of first term	Date of maximum period of office	
Birmingham	Public: Birmingham At Large	Dr Jagjit Singh Taunque	1 April 2008	31 March 2011	31 March 2014	3/5
	Public: Birmingham At Large	Mr Michael Kelly	1 April 2009	31 March 2012	31 March 2015	Newly elected
	Public: Birmingham Central	Mrs Arshad Begum	1 April 2008	31 March 2011	31 March 2014	3/5
	Public: Birmingham Central	Mr Shahid Mir	1 April 2008	31 March 2011	31 March 2014	3/5
	Public: Birmingham Central	Mr Ian Pardoe	1 April 2008	31 March 2011	31 March 2014	1/5
	Public: Birmingham Central	Miss Famida Begum	1 April 2008	31 March 2011	31 March 2014	2/5
	Public: Birmingham Central	Ms Patricia Hathway	1 April 2009	31 March 2012	31 March 2015	Newly elected
	Public: Birmingham East	Mr David O'Leary	1 April 2005	31 March 2008	31 March 2011	5/5
	Public: Birmingham East	Mr Lee Smith	1 April 2008	31 March 2011	31 March 2014	5/5
	Public: Birmingham East	Mr John Jebbett	1 April 2005	31 March 2008	31 March 2011	5/5
	Public: Birmingham North	Mr John Simms	1 April 2008	31 March 2011	31 March 2014	2/5
	Public: Birmingham North	Ms Marion Thompson	1 August 2007	31 July 2010	31 July 2013	4/5
	Public: Birmingham North	Mr Thomas Webster	1 August 2007	31 July 2010	31 July 2013	4/5
	Public: Sutton Coldfield	Dr Mike Cooper	1 August 2007	31 July 2010	31 July 2013	4/5
	Public: Sutton Coldfield	Ms Carole Edwards	1 August 2007	31 July 2010	31 July 2013	3/5
	Public: Sutton Coldfield	Ms Bethan Ilett	1 August 2007	31 July 2010	31 July 2013	4/5
Solihull	Public: Solihull Central	Mrs Sheila Blomer	1 April 2005	31 March 2008	31 July 2011	4/4
	Public: Solihull Central	Mrs Frances Linn	1 April 2005	31 March 2008	31 July 2011	4/4
	Public: Solihull Central	Ms Elizabeth Steventon	1 April 2008	31 March 2011	31 July 2014	2/4
	Public: Solihull North	Mrs Valerie Egan	1 April 2005	31 March 2008	31 July 2011	3/5
	Public: Solihull North	Mr Aiden Cairns	1 April 2009	31 March 2012	31 July 2015	Newly elected
	Public: Solihull North	Vacancy				
	Public: Solihull South	Ms Bridget Sproston	1 April 2008	31 March 2011	31 March 2014	4/5
Staffordshire	Public: Tamworth	Ms Barbara Hayward	1 April 2007	31 July 2010	31 March 2013	1/5
	Public: Tamworth	Mr Richard Hughes	1 August 2007	31 July 2010	31 March 2013	3/5
	Public: Staffordshire South	Mr Victor Palmer	1 August 2007	31 July 2010	31 March 2013	4/5

Not applicable	Patient	Ms Kath Bell	1 April 2009	31 March 2012	31 March 2015	Newly elected
	Patient	Ms Margaret Veitch	1 April 2009	31 March 2011	31 March 2014	5/5
	Staff: AHP, Technician or Clinical Support Worker	Ms Ann Brierley	1 April 2008	31 March 2011	31 March 2014	4/5
	Staff: Ancillary, Admin, Volunteer or Management	Mr Neil Harris	1 April 2008	31 March 2011	31 March 2014	4/5
	Staff: Medical & Dental	Mr Dev Sarmah	1 April 2008	31 March 2011	31 March 2014	2/5
	Staff: Nursing, Midwifery & Healthcare Assistant	Ms Veronica Morgan	1 April 2008	31 March 2011	31 March 2014	4/5
	Staff: Nursing, Midwifery & Healthcare Assistant	Ms Heidi Lane	1 April 2009	31 March 2012	31 March 2015	Newly elected
	Stakeholder: Birmingham Chamber of Commerce	Mr Aftab Chughtai	1 April 2008	31 March 2011	31 March 2011	5/5
	Stakeholder: Solihull Chamber of Commerce	Mr Roy Shields	1 April 2008	31 March 2011	31 March 2011	5/5
	Stakeholder: Birmingham City Council	Vacancy				
	Stakeholder: Birmingham Eastern & North PCT	Dr Qulsom Fazil	1 April 2005	31 March 2008	31 March 2011	3/5
	Stakeholder: Stepping Stones	Ms Jeanette Mulcare	1 April 2008	31 March 2011	2 October 2012	0/5
	Stakeholder: Solihull Metropolitan BC	Councillor Jim Ryan	15 May 2007	14 May 2010	14 May 2013	1/4
	Stakeholder: South Staffs PCT	Ms Yvonne Sawbridge	1 August 2007	31 July 2010	31 July 2013	3/5
	Stakeholder: Joint Lichfield & Tamworth Borough Council	Councillor Ian Lewin	1 September 2007	31 August 2010	31 August 2013	4/5
	Stakeholder: Birmingham City University	Professor Ian Blair	1 April 1998	31 March 2011	31 March 2014	4/5
	Stakeholder: University of Birmingham	Ms Helen Parker	1 April 2008	31 March 2011	31 March 2014	1/5
	Stakeholder: Solihull Care Trust	Dr Sunil Kotecha	1 September 2008	31 August 2011	31 March 2014	1/2

The Trust's Constitution describes the processes intended to ensure a successful and constructive relationship between the Governors' Consultative Council and the Board of Directors. It confirms the formal arrangements for communication within the Trust an approach to informal communications, and sets out the formal arrangements for resolving conflicts between the Governors' Consultative Council and the Board of Directors. The Constitution is available on the Trust's website and is available for inspection at the Trust's offices. In accordance with Clause B1.4 of the Monitor Code of Governance, the statement of rules and responsibilities of governors is set out at the front of the Governors' Handbook which was completed in 2009.

The Governors do not have material interests in organisations where those organisations or related parties are likely to do business, or are possibly seeking to do business, with Heart of England. You can access a register of Governors' interests or communicate with Governors or Directors by writing to:

Company Secretary
Devon House
Heart of England NHS Foundation Trust
Bordesley Green East
Birmingham, B9 5SS

Board of Directors

The Board of Directors is chaired by Mr Clive Wilkinson, who was appointed for a four year term commencing 1 April 2006. The Chief Executive is Dr Mark Goldman. There are eight Executive Directors and seven Non-Executive Directors. The Directors do not have material interests in organisations where those organisations or related parties are likely to do business, or are possibly seeking to do business, with Heart of England.

You can access a register of Directors' interests by writing to:
Company Secretary
Heart of England NHS Foundation Trust
Heartlands Hospital
Bordesley Green East
Bordesley Green
Birmingham
B9 5SS

Following consultation in February 2006, Monitor issued a final version of the NHS Foundation Trust Code of Governance in October 2006 for implementation. The Code applies with effect from 1 April 2006. The Code is issued as best practice advice and is not mandatory however the Code does imposes disclosure requirements on NHS foundation trusts.

The Board of Directors considers that throughout the year it was fully compliant with the principles of the NHS Foundation Trust Code of Governance. Any exceptions to the Code are set out fully in this Report with the respective paragraph of the Code's provisions. The Board has not appointed a senior independent director (Monitor Code Clause A3.3). Members and Governors have direct access to all members of the Board. In addition to direct access on request, all the members of the Board are invited to attend every Governor's Consultative Council meeting and participate fully in discussion with members of the Council. Members of the Board or Trust senior managers who might have issues, where contact through the normal channels with Chairman, Chief Executive or Finance Director is inappropriate, have right of direct access to the Chairman of the Audit Committee and the Deputy Chairman.

The Board has responsibility for the overall management and performance of the Trust and the approval of its long term objectives and strategy. Whilst the Board delegates the day-to-day management of the Trust to the Chief Executive, there is a formal schedule of matters reserved for the Board which was adopted by the Board on 29 August 2006. This schedule is available on the Trust's website and provides a framework for the Board to oversee the Trust's affairs.

The Board meets every month and, additionally, ad hoc as necessary. The Board of Directors are given accurate timely and clear information so that they can maintain full and effective control over strategic, financial, operational, compliance and governance issues. The Directors have a range of skills and experience and each brings independent judgement and considerable knowledge to the Board's discussions and determinations. This range of skills and experience ensures balance, completeness and appropriateness to the requirements of the Trust. The attendance of Directors at Board and Committee meetings is set out on page 30.

Trust Board committees include the Nominations Committee, Audit Committee, Governance and Risk Committee, Donated Funds Committee and Remuneration Committee. Their terms of reference are available on the Trust's website and for inspection at the Trust's offices.

Nominations Committee
Members: Clive Wilkinson (Chair)
Mark Goldman (CEO)
Anna East (NED)

The Nominations Committee of the Board undertakes to:

- Review the structure, size and composition of the Board and make recommendations with regard to any changes.
- Give full consideration to succession planning.
- Evaluate the balance of skills, knowledge and experience in relation to the appointment of both Executive and Non-Executive Directors.
- Identify and nominate suitable candidates to fill Executive Director vacancies.

In the case of Non-Executive Director vacancies including the chairman, the relevant information is passed to the Governors' Consultative Council Appointments Committee so that it can then incorporate the information into its deliberations. The Governors' Consultative Council Appointments Committee is then responsible for the identification and nomination of Non-Executive Directors, including the Chairman, and for making recommendations to the Governors' Consultative Council as to their terms and conditions of employment.

In the case of Executive Director vacancies, the Nominations Committee draws up the job description and person specification, undertakes the recruitment process and then makes a recommendation to the Appointments Committee of the Trust Board which may accept or reject the recommendation. It is for the Non-Executive Directors to appoint and remove the Chief Executive and such an appointment requires the approval of the Governors' Consultative Council.

Audit Committee
Members: Richard Samuda (Chair)
David Bucknall
Anna East
Najma Hafeez
Chris Ham
Richard Harris
Paul Hensel

The work of the Audit Committee is to:

- Review the establishment and maintenance of an effective overall system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives.
- Ensure that there is an effective internal audit function established by management that provides appropriate independent assurance to the Audit Committee, Governance and Risk Committee, Chief Executive and Board.
- Consider and make recommendations to Audit Appointments Committee of the Governors Consultative Council in relation to the appointment, re-appointment and removal of the Trust's External Auditor and to oversee the relationship with the External Auditor.
- Monitor the integrity of the financial statements of the Trust, reviewing significant financial reporting issues and judgements which they contain.
- Review significant annual returns to regulators and any financial information contained in certain other documents.

All non audit work by the External Auditors is proposed to the Audit Committee by the Finance Director. It is formally considered and, where appropriate, ratified by the Committee. The Trust places reliance on the External Auditors' own internal processes and procedures to ensure auditor objectivity and independence is safeguarded. As a matter of best practice, the External Auditors have held discussions with the Audit Committee on the subject of auditor independence and have confirmed their independence in writing.

In 2008/09 the Committee met seven times and discharged its responsibilities as set out in its terms of reference. It received comprehensive reports from the Director of Finance, the Director of Human Resources and Organisational Development, the Director of Governance and Standards, and the internal and external auditors. The Committee commissioned further reports in response to developing issues, requested clear objectives, timetables and achievement milestones against which performance could be measured.

Significant areas of review have been identified using a risk scoring assessment and a risk based approach has also been taken to prioritise work in collaboration with the Governance team and Trust Executive. The issues discussed by the Committee and the conclusions reached are reported to the next Trust Board meeting.

The Committee consists solely of independent Non-Executive Directors and at least one member has extensive relevant financial experience. All Committee members held office throughout the year and at the date of this report. Their attendance is shown in the table overleaf.

Remuneration Committee
A full report from this Committee is set out on page 35.

Directors' Attendance At Meetings:

	Trust Board		Audit Committee		Remuneration Committee	
Meetings per year	12		7		3	
Director	Attended	Relevant Number	Attended	Relevant Number	Attended	Relevant Number
Clive Wilkinson	12	12	N/A	0	3	3
Mark Goldman	9	12	N/A	0	N/A	0
Beccy Fenton	2	3	N/A	0	N/A	0
Sarah Woolley	11	12	N/A	0	N/A	0
Mandy Coalter	10	12	N/A	0	N/A	0
Hugh Rayner	9	12	N/A	0	N/A	0
Ian Cunliffe	10	12	N/A	0	N/A	0
Adrian Stokes	8	9	N/A	0	N/A	0
Mandie Sunderland	4	4	N/A	0	N/A	0
David Bucknall	8	12	4	7	2	3
Anna East	12	12	6	7	3	3
Najma Hafeez	10	12	2	7	1	3
Christopher Ham	9	12	5	7	1	3
Paul Hensel	9	12	7	7	2	3
Richard Harris	12	12	6	7	3	3
Richard Samuda	12	12	7	7	3	3

Performance of the Board and its Committees
As part of the Board's Effectiveness Programme, an independent consultant was appointed in 2008 to carry out a review of the Board's information provision, the workings of the sub-committees and the Board itself to give assurance as to the Board's effectiveness. The review combined a qualitative dialogue and a quantitative questionnaire to establish a comprehensive foundation from which to track board effectiveness. The findings of this review were considered by the Board at its away day in February 2009 and an action plan developed to continually improve the workings of the Board.

Board Members' profiles

Mr Clive Wilkinson, Chairman
Clive held the post of Chairman of Heartlands NHS Trust from December 2001 until the NHS Trust became a Foundation Trust in April 2005 and was appointed as the Chairman of the Foundation Trust for a further year. Clive then applied for the post of Chair of Heart of England NHS Foundation Trust through a process of open competition and was appointed for a 4 year term on 1st April 2006. Previously, Clive was Chairman of the NHS Executive West Midlands Region from 1997 to 2001, Chairman of Wolverhampton Healthcare NHS Trust from 1994 to 1997 and Chairman of Sandwell Health Authority from 1986 to 1994. He was also a member of the Audit Commission from 1986 to 1996 and a Non Executive Director of the Financial Services Authority from 2005 to 2007. Clive was a Birmingham City Councillor from 1970 to 1984. Clive is also Chairman of the Civic Housing Association, a Trustee of Bourneville Village Trust, Chair of Midlands Industrial Association and a former member of the Department of Health's Audit Committee.

Dr Mark Goldman, Chief Executive
Mark has been Chief Executive since 2001. Mark qualified in medicine and became Senior Lecturer in Surgery at the University of Birmingham in 1985. His special interest is Vascular Surgery and he was an NHS consultant from 1985-2001. Mark became involved early in Clinical Management and was appointed Medical Director to the then Birmingham Heartlands Acute Trust in 1993. Mark was a member of the Modernisation Team which constructed the 10 year NHS plan. Mark has been involved in developing and leading clinical services as well as leading major organisational change as the hospital

has achieved first Trust status then Foundation Trust status and along the way has acquired two other local Hospitals to become one of the largest and most successful NHS foundation trusts. From November 2005 until March 2007, Mark was also Chief Executive of Good Hope Hospital and succeeded in turning around a deficit of £6m to a surplus of £1.7m. In April 2007 the Trust completed the first ever acquisition by a Foundation Trust of a failing NHS Trust. Heart of England was named as Acute Healthcare Organisation of the year in 2006 by the Health Service Journal. It has also received international recognition and Beacon site status for its partnership work with local primary care trusts on community based chronic disease management. In April 2009, Mark was invited to be the NHS Leadership Council's lead on clinical issues and has been seconded to the Council for 1 day per week.

Mrs Beccy Fenton, Deputy Chief Executive (From 1 April 2007), Chief Finance, Officer and Managing Director
Beccy is the Deputy Chief Executive and Director of Transformation and has worked in the NHS for 12 years. Beccy is also Deputy Chief Executive and Director of Transformation with responsibility for transformation within the Trust – an organisation wide change programme applying LEAN methodologies, organisational development and systems thinking to the core business of the Trust to improve patient quality, staff morale and value for money. Beccy is also CEO of HEFT Consulting responsible for strategic development of the business, key client liaison officer and responsible for overall quality assurance. She is also the Trust lead for strategy, business planning and continuous improvement. Prior to her current role, Beccy was Chief Finance Officer and Managing Director. Beccy has over 12 years experience in the NHS as well as 4 years experience working as an accountant for Coopers & Lybrand (now PriceWaterhouseCoopers). Her experience with Coopers & Lybrand allowed her to work with many private sector companies and she has been able to integrate much of this learning into the business processes at Heart of England. Beccy has an MA from Oxford University, is a Chartered Accountant and is an NLP Practitioner and qualified Executive Coach.

Dr Hugh Rayner, Medical Director for Medicine
Hugh was appointed as a Consultant Nephrologist at the Trust in May 1993, having graduated from Cambridge University and the London Hospital Medical School. He trained in medicine and nephrology in Norwich, London, Nottingham, Leeds and Melbourne, Australia. He became Clinical Director for Acute Medicine at Heartlands Hospital in 1996 and then Trust Medical Director for Medicine in 2000. Hugh has taken a leading role in the 'Working Together for Health' initiative within East Birmingham and Solihull, having visited Kaiser Permanente in Northern California in 2003. He is also country investigator for the Dialysis Outcomes in Practice Pattern Study, a worldwide study of haemodialysis treatment for kidney failure.

Mr Ian Cunliffe, Medical Director for Surgery
Ian is a Consultant Ophthalmologist who has worked for the Trust for 13 years. Ian trained in Sheffield, Cambridge, and New Zealand, where he completed a clinical fellowship. Ian's specialist area of interest within ophthalmology is Glaucoma. Ian has been Clinical Director for Ophthalmology for three years and worked with the Modernisation Agency on its pilot project for clinical governance. He has also spent six months as Associate Medical Director for surgery before taking this post in April 2006. Ian's is responsible for the entire board of surgery and he also still practices clinically as an ophthalmologist.

Ms Mandie Sunderland, Chief Nurse
Mandie joined as Chief Nurse in December 2008 and this This is her third Executive Director position, having held previous posts in acute trusts in the North West of England.

Mandie's clinical speciality is intensive care nursing and she has worked in both clinical and practice development posts in London, Manchester and Lancashire. Her main interests now lie in quality and governance and she has worked for regulators and the Department of Health in reviewing standards of care across several hospital trusts both in England and Northern Ireland.

In the late 1990's Mandie spent time working at the Department of Health as a member of the Chief Nursing Officer's team and was the national nursing lead for many governance initiatives such as the establishment of NICE, Essence of Care and National Service Frameworks. In 2003 she returned to the Department of Health on secondment to lead on the National Consultation on Choice.

Mr Adrian Stokes, Finance Director
Adrian has been Finance Director for the Trust since 2007 and formally came on to the Trust Board on 1st July 2008. Adrian graduated from Lancaster University in 1992 and worked his way through the NHS Finance Graduate Training Scheme. After this he held a variety of posts within Heart of England in addition to a period working for West Midland Strategic Health Authority as the financial and performance manager covering North and East Birmingham. During the acquisition of Good Hope Hospital Adrian also covered the post of Finance Director in Good Hope's final year and overseeing the financial turnaround of the organisation. Within the role of Finance Director, Adrian also takes the trust lead for Estates and Site Strategy.

Adrian also sits on the Working Together for Health Board and is a Board member of the Heartlands Education Centre Ltd.

Ms Mandy Coalter, Director of Human Resources and Organisational Development
Mandy is currently Director for Human Resources & Organisational Development having taken up post in July 2006. Mandy has successfully developed a 'One Trust' people strategy approach for the Trust's 10,000 workforce following the groundbreaking acquisition of Good Hope Hospital in 2007. This has involved embedding the trust values by developing the behaviours and skills of hundreds of leaders, staff engagement through a local staff survey and OD workshops, managing restructuring and securing staff efficiencies. Mandy has also made significant changes to the HR function, creating OD and Consultancy capacity, modernising employment policies and introducing a shared services approach to transactional services. This is now delivering performance improvements in key business areas for the Trust such as reduced sickness absence levels and faster time to hire. The Trust has been recognised as a Guardian 'Top Employer' and Health Care Top 100 Employer; HR has also won an HR Excellence Award 2008 and a Personnel Today Award 2008. Prior to joining the Trust , Mandy worked in local government for 12 years. Mandy is a graduate in Law, a Fellow of the Chartered Institute of Personnel & Development and a practitioner in NLP.

Sarah Woolley, Director of Governance and Standards
Sarah was appointed as Director of Governance and Standards in May 2007 and is responsible for leading the Trust's patient and organisational safety agendas. She has held a number of posts at Heart of England within safety, risk management and governance and has played a leading role in developing the Trust's approach to safety. Prior to this, Sarah trained as a clinical biochemist in the West Midlands, undertaking analytical and diagnostic services to support clinical care for patients. Before joining the NHS, Sarah worked as a research scientist at Manchester University, investigating the mechanism of Chronic Myeloid Leukaemia. Sarah graduated from Manchester University in 1992 and then went on to complete a doctorate in biochemistry at Birmingham University.

Anna East, Deputy Chairman
Anna was formerly Head of Group Legal and Company Secretary at Britannic Group plc and Halfords Group plc and has also practised as a solicitor at Eversheds. She is currently a Director of Dudley Building Society and Vice Chair of Dowell's Trust Housing Association. She chairs the Governance and Risk Committee and is a member of the Remuneration and Audit Committees. Anna was appointed as Non-Executive Director in July 2005 and as Deputy Chairman in April 2008.

Ms Najma Hafeez, Non-Executive Director
Najma is Managing Director of Russell Excel, a firm of international consultants specialising in management training, education, communication and leadership skills, human resources and change management. Ms Hafeez was the youngest and first Muslim woman elected to Birmingham City Council in 1983. During her years in office, she held several senior positions including Chair of Education, Chair of Social Services, Chair of Community Affairs and Chair of Euro-Cities Network. As an elected member and member of the executive team of Birmingham City Council, Najma was involved in the development of Birmingham City's regeneration programme, including the building of the International Convention Centre, Brindley Place, Millennium Point and other key projects, all of which have revitalised the city and its economic and commercial potential. Najma was appointed as a Non-Executive Director in April 2007.

Mr Paul Hensel, Non-Executive Director
Paul is an IT professional with 35 years' experience in the development and provision of IT systems. His early career encompassed roles with Dunlop, GKN, Chubb and West Midlands Regional Health Authority. Paul, together with his brother, started his own business in 1980 to exploit the emerging power of small scale computers. This company eventually became a leading supplier of software to the worldwide mobile telecommunications industries, particularly in South Africa and Europe and was acquired by CMG/Logica in 2003. Paul was appointed as a Non-Executive Director to the Heart of England NHS Foundation in August 2005 and is the Non-Executive lead for IT issues.

Mr Richard Samuda, Non-Executive Director
Richard has over 20 years' experience specialising in management consultancy as an advisory partner in KPMG. He is a Chartered Accountant with a wealth of business experience dealing with major private and public sector clients. He is also Chairman of Horton Estates, one of the largest private property companies outside London. Richard was appointed a Non-Executive Director in June 2006 and is currently the Chair of the Audit Committee.

Professor Chris Ham, Non-Executive Director
Chris Ham is Professor of Health policy and Management at the University of Birmingham. He has held posts at the universities of Leeds and Bristol and the King's Fund, and from 2000-2004 worked on secondment as Director of the Strategy Unit in the Department of Health. Chris is an expert on the financing and delivery of healthcare both in the UK and internationally and is the author or editor of 18 books and numerous papers and articles on health policy. He has advised the World Bank, the World Health Organisation, and the health departments of New Zealand and Sweden, and in the UK has served as a consultant to the Audit Commission, the British Medical Association, the NHS Confederation, and the House of Commons Health Committee. Chris is a Fellow of the Royal Society of Medicine, a founding Fellow of the Academy of Medical Sciences, and an Honorary Fellow of the Royal College of Physicians. He was awarded a CBE in 2004 for services to the NHS. Chris is a governor of The Health Foundation, a trustee of the Canadian Health Services Research Foundation, and a trustee of The New Health Network. He is also an Honorary Fellow of the Royal College of General Practitioners, a Senior Associate of the Nuffield Trust, and a visiting professor at the University of Surrey. He was appointed as a Non-Excecutive Director in October 2007.

Mr David Bucknall, Non-Executive Director
From the early 1960s, David led the transformation of Bucknall Austin from a small local Quantity Surveying Company into a successful plc, providing management services in the construction and property sector. He then retired on the sale to Citex in 1998 and took up a series of non-executive positions. He returned in 2003 to head up the purchase of the business from administration. He was part of the team leading the firm back into the marketplace – co-ordinating the merger with Rider Hunt and Levett and Bailey in 2007 to create the Rider Levett Bucknall Global Practice. As an indication of real commitment to regional regeneration in the mid-80s, Bucknall Austin purchased a derelict 20,000sq. ft. canal side factory on the West Side of Birmingham. This was converted into open plan workspace. The project won the RICS Regeneration Award and acted as a catalyst for the now burgeoning Convention Quarter. David has always encouraged innovation and best practice. He chairs the Birmingham Foundation – a leading People Regeneration Charity. He is also a member of the Birmingham Best Practice Club and a board member of both the West Midlands Centre for Constructing Excellence and the RICS Business Development Board. He was appointed as a Non-executive Director in January 2008.

Mr Richard Harris, Non-Executive Director
Richard was appointed as a Non-Executive Director on 1 May 2008. He is a Chartered Accountant and spent eight years as a partner with Price Waterhouse, followed by 11 years in senior finance roles, reporting to the main board finance directors with two FTSE100 companies. He brings to the Board a mixture of finance and business experience encompassing the management of large and complex projects, treasury management, taxation, investment appraisal, acquisitions and divestments, risk management, governance and accounting. He is a trustee of the Birmingham Community Foundation, a governor of the RSA Tipton Academy and a trustee of the pension fund of Action for Children.

Remuneration Report

Role of the Remuneration Committee
The Remuneration Committee is mandated to review the appraisal of the Executive Directors and decide their remuneration and allowances (and other terms and conditions of office) and to keep under review executive director development and succession planning. The Committee meets without the Chief Executive present to perform the same role in respect of that post. The Non-Executive Directors, sitting as the Remuneration Committee, also appoint or remove the Chief Executive and are joined by the Chief Executive to appoint or remove the executive directors. The Remuneration Committee reports to the Trust Board. The Committee met four times in the financial year on 11 June 2008, 5 August 2008, 4 November 2008 and 10 March 2009. Attendance figures can be seen in the attendance chart on page 30.

Composition of the Remuneration Committee
The membership of the Remuneration Committee is as follows:
Clive Wilkinson – Chairman
David Bucknall – Non-Executive Director
Anna East – Non-Executive Director
Najma Hafeez – Non-Executive Director
Chris Ham – Non-Executive Director
Richard Harris – Non-Executive Director
Paul Hensel – Non-Executive Director
Richard Samuda – Non-Executive Director

Remuneration Policy
The Remuneration Committee determines the remuneration policies and practices with the aim of attracting, motivating and retaining high calibre directors who will deliver success for the Trust and high levels of patient care and customer service. All appointments as Executive Directors are made as permanent appointments and will only be terminated on resignation of the employee or a fundamental breach of their employment contract.

As an exception to the Monitor Code of Governance Clause C.2.1, the Trust has not appointed Chief Executive and Executive Directors with fixed terms. Such "rolling fixed term" contracts are expensive to terminate and were abandoned by the NHS as a matter of policy some time ago. The insecurity of tenure, particularly in the case of the Chief Executive whose appointment is to be confirmed by the Governors' Consultative Council, will not support the recruitment and retention of candidates of the highest calibre required. Appraisal processes, employment policies and terms and conditions of appointment are in place to deal with the possibility of suboptimal performance and its consequences.

Executive Directors' Remuneration
Remuneration packages for Executive Directors who are members of the Board of Directors (also known as senior managers) consist of a salary and pension contributions. Salaries are reviewed annually with reference to the NHS Boardroom Pay Report published by Income Data Services (IDS). There are no performance related elements to remuneration.

The Remuneration Committee has access to the advice and views of Mark Goldman (Chief Executive), Mandy Coalter (Director of Human Resources and Organisational Development) and Claire Lea (Company Secretary). No director or employee is involved in the determination of, or votes on any matter relating to their own remuneration.

Performance is judged and reviewed as part of the annual appraisal and personal development review process in line with Trust policies. The appraisal of all Executive Directors is carried out by Mark Goldman and a report then made to the Remuneration Committee on their performance. Details of remuneration, including the salaries and pension entitlements of the Executive Directors, are published in the annual accounts on page 65-66.

The only non-cash element of the remuneration of Executive Directors is a pension related benefit accrued under the NHS Pensions Scheme. Contributions are made by both the employer and employee in accordance with the rules of the national scheme which applies to all NHS staff in the scheme.

All of the Executive Directors have a six month notice period for termination included in their contracts and there is no provision for compensation for early termination in their contracts. There were no amounts payable to third parties for the services of the executive directors and they received no benefits in kind (2007/08 nil).

The accounting policies for pensions and other retirement benefits are set out on page 56 of the accounts

Non-Executive Directors Remuneration and Appointment
Non-Executive Directors, including the Chairman, do not hold service contracts and are appointed for four years. Their appointment is terminable with one month's notice on either side. The Non-Executive Directors are appointed following interview by a sub-committee of the Governors' Consultative Council. Non-Executive Directors fees are determined by the Governors Consultative Council having received recommendations from the Governors' Remuneration Committee which is chaired by Professor Ian Blair. The Committee conducted an external review to market test the remuneration levels of the Chairman and other Non- Executive Directors in April 2009. The Committee also considers independent advice and guidance as issued from time to time by appropriate bodies such as the National Health Service Appointments Commission in relation to NHS trusts or the NHS Confederation (Foundation Trust Network) which provides benchmarked and externally validated guidance relevant to foundation trusts.

Name and title	First appointment date	Notice period	Unexpired term of contract as at 31 March 2009
Clive Wilkinson (Chairman)	1 December 2001	1 month	1 year
Richard Samuda (Non Executive Director)	14 June 2006	1 month	1 years, 3 months
Anna East (Deputy Chairman and Non Executive Director)	1 July 2005	1 month	3 months
Paul Hensel (Non Executive Director)	1 August 2005	1 month	4 months
Najma Hafeez (Non Executive Director)	1 April 2007	1 month	2 years
Chris Ham (Non Executive Director)	1 October 2007	1 month	2 years,5 months
David Bucknall (Non Executive Director)	8 January 2008	1 month	2 years, 9 months
Richard Harris (Non Executive Director)	1 May 2008	1 month	3 years, 1 months

The table above shows the Non-Executive Directors who have served the Trust during the year and the date of their first appointment. Details of their remuneration are published in the annual accounts on page 65-66. The Non-Executive Directors do not receive pensionable remuneration. There were no amounts payable to third parties for the services of the Non-Executive Directors and they received no benefits in kind (2007/08 nil).

Mark Goldman
Chief Executive
3 June 2009

Operational and Financial Review

Introduction
In 2008/09 the Trust continued to build on its successes of previous years.

Although we were disappointed that its rating in the Annual Healthcheck fell from Excellent for Quality of Services in 2006/07 to Good for 2007/08, the only indicator we failed to achieve was that relating to infection control, in particular MRSA. Actions have been taken in 2008/09 to successfully improve performance on infection control as can be seen in the Quality Report. The rating for Use of Resources remained as Excellent.

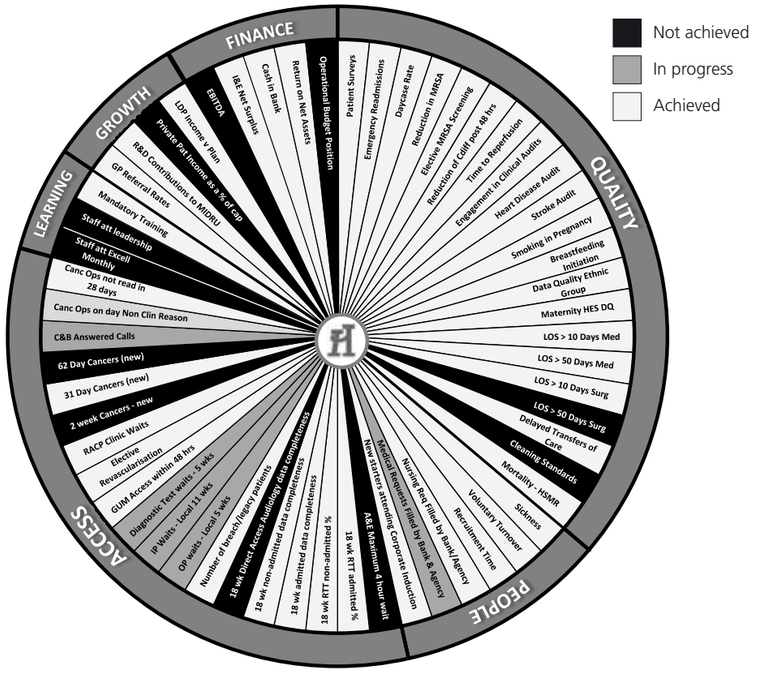
External scrutiny has never been greater in the NHS and the we are monitored by a number of external agencies including the Care Quality Commission, Monitor (the Independent Regulator of NHS Foundation Trusts) and the National Health Service Litigation Authority. This puts the onus on the Trust to have in place a number of performance management processes in place.

Performance is more than just monitoring against key national targets and standards and in addition to the key achievements set out in the Review of Business on page 8 we have also made significant progress across all clinical and non-clinical departments some of which are highlighted below:

- Reduced sickness rates
- Reduced mortality rates
- Guardian Top Employer status
- HSJ Top 100 Employer
- Two national HR awards
- Carbon footprint award

Vision
The Trust has focused its performance management framework to deliver its vision and key strategic objectives which are set out on page 12 of the Quality Report. Progress on each of these objectives is outlined on the following pages.

Trust Performance
In order to easily review progress against national, local and internally set targets, the performance team has developed a performance wheel which gives an at a glance view of compliance with these targets. This wheel is reviewed monthly at the Executive Directors meeting and Trust Board. The position as at 31 March 2009 is shown below.



During the year we have made progress on some key national priorities. Our success in reducing MRSA and C.Diff and the Hospital Standardised Mortality Rate is outlined on page 15 of the Quality Report. Other key national priorities include:

Key National Priorities – Waiting times
The focus in 2008/09 has been to deliver the 18 week referral to treatment times for both admitted and non-admitted patients. This has been one of the most demanding targets placed on organisations by the Department Health and a considerable amount of effort has gone into achieving these targets.

Key National Priorities – Cancer targets
The national cancer indicators changed from January 2009 and no national targets have been set for these as yet. However, up until December 2008 the Trust was achieving all of the national cancer waiting time targets:

- 99.94% of patients seen in outpatients within five weeks of a GP referral.
- 99.41% of patients receive inpatient treatment within 11 weeks from the decision to admit.

Key National Priorities – Accident and Emergency Target
The Trust marginally failed to achieve the A&E four hour maximum wait target of 98% achieving a year-end position of 97.63%. A remedial action plan is in place to ensure that this target is met in 2009 /10 and has been discussed with Monitor.

Key National Priorities – Core Standards
Every year the Trust is required to make a declaration against 43 national core standards. At the end of 2007/08 the Trust declared compliance against 42 of these with one area of non-compliance relating to mandatory training.

During the last year, work has been undertaken to address the shortfalls and at the end of 2008/09 the Trust is fully compliant with all the national core standards.

Other waiting time targets that the Trust has continued to maintain and achieve are highlighted below:

- Access to Rapid Access Chest Pain clinics within two weeks – 100%.
- Elective revascularisation admitted with 13 weeks – 100%.
- Patients offered an appointment to be seen in a Genito-Urinary Medicine Clinic within 48 hours -100%.
- All patients having their operation cancelled on the day are readmitted within 28 days – 100%.

Delivering Our Objectives – Delighted Patients

Relevant Strategic Objectives:
We Provide the Highest Quality Patient Care.
We are the Local Provider of Choice.

Significant progress has been made in the related areas of Nursing, the Clinical Business Units, Safety, Infection Control, the Environment and Patient Satisfaction. Whilst our progress in Infection Control and Patient Safety has been set out in the Quality Report on page 15 here is an outline of the progress made in the other related areas.

Nursing
- Electronic Nurse Handover system.
- AHP consultant roles.
- Bereavement Care.
- Tissue Viability.
- Equality and Diversity.

Mandie Sunderland, Chief Nurse reports that:

"A Corporate Nursing team has been established to improve standards of nursing and midwifery care across our four sites. This builds on the existing strategy which was launched during 2008. Following my appointment as Chief Nurse in December 2008 I have ensured that the team has formulated a vision for Nursing and Midwifery and is raising its profile within the Trust and beyond.

"The Electronic Patient Handover programme has been progressed across all three hospitals; a corporate nurse is leading the project and working with IT and nurses across the Trust to ensure that essential patient information is available electronically. A Professional Governance Nursing Forum has been established

which has rationalised, standardised and centralised the process for developing and maintaining nursing policies, guidelines and documentation.

"The Allied Health Professions (AHP) Advisory team has worked across a diverse range of projects which include supporting Therapies to identify and transfer to a single Trust-wide IT system for patient information and future electronic patient records; development of new consultant roles and professional education and training.

"Bereavement care staff provide a centralised service for the 4,500 deaths in the Trust each year. Improvements to the service include condolence cards, bereavement support volunteers to provide an 'at and after' service and the creation of two information DVDs on Coroner's Inquest. Regular training and education for staff in line with the Department of Health advice 'When a Patient Dies' is currently being provided and two national bereavement conferences have been held by HEFT. A bereavement questionnaire also allows relative's experiences of end of life care in the Trust to be captured. The Head of Bereavement Services is also leading two national Department of Health pilots focusing on bereavement care.

"The Tissue Viability Team has been in post since December 2007 and the number of patients developing pressure ulcers across the Trust has reduced by 50%. This has been achieved by the team providing advice and support to staff to ensure high standards of care are implemented; standardising and improving tissue viability documentation; formally educating over 700 members of staff in the prevention of pressure ulcers and improving the specification and accessibility to preventative equipment.

"There have been significant improvements in the area of Equality and Diversity. Achievements in 2008/09 have included compliance to NHS directives & legislation, the formation of a Diversity Staff Network and a Diversity Champions Network. A successful Festival of Cultures was held across the Trust and a new stained glass window for the multi faith chapel has been commissioned and installed. Training on equality impact assessment and human rights continues and a DVD has also been produced to educate staff. The interpreting staff won the Diversity Award in the Staff Recognition Awards."

Clinical Business Unit Achievements
The Operational Medicine and Surgery Business Units have undertaken a considerable amount of work to improve the quality of and access to the services they provide. These are summarised in the two tables below

Emergency Department	Significant additional staffing at Good Hope. Opening of Clinical Decisions Unit at Good Hope. Dedicated paediatric area at Heartlands.
Acute Medicine; BHH	Expansion of AMU assessment area. Opening AMU2 (Ward 9) to provide acute short stay admission beds.
Acute Medicine, Unit Good Hope	Redesign of the medical emergency pathway – introduction of a 20 trolley acute medical assessment unit, a 26 bedded acute medical short stay unit and a new modular ward.
Diabetes	Weight Management Service growth, both in the HEFT hospitals, and further afield via SLAs with non-host PCTs.
Dermatology	Establishment of permanent consultant medical staff on GHH site from April 2009. Much closer partnerships with BEN and Solihull Care PCTs, resulting in a community pilot from Oct 2008, and a further community service planned.
Neurology	Permanent consultant-led services on Good Hope site, in addition to those provided via University Hospital Birmingham (UHB) service level agreement.



Rheumatology	Commencement of outpatient clinics at the Good Hope Site.
Laboratory Medicine	Integration of the Trust Microbiology Services under the management of the Health Protection Agency incorporating a new robust service level agreement with agreed key performance indicators. Development of community based Phlebotomy and specialised Phlebotomy services for Paediatrics and HIV..
Elderly Medicine	Expansion of Elderly Care Assessment Unit (ECAU) at Heartlands and the opening of ECAU at Good Hope. Introduction of stroke thrombolysis service at Good Hope (via LEAN process) and patients successfully treated (patient treated was on GMTV).
Cardiology	Successful installation of new bi-plane catheter lab at Heartlands. Primary PCI service available for all of our catchment population.
Respiratory Medicine	Development of NIV service at Good Hope – all three sites now provide a service for non-invasive ventilation for respiratory patients.
Pharmacy	Accelerated roll out of Electronic Prescribing, due to complete in July 2009; Opening of Boots Pharmacy at Heartlands to provide a responsive, fast, high quality service to our outpatients.
Renal	Reduced dialysis catheter usage and associated MRSA infection rates.
Infectious Diseases	Commencement of dual-extensions to Hawthorn House to provide the increasing numbers of GUM patients with great access and a dedicated facility for patients receiving immunoglobulin replacement therapy.
Clinical Haematology/ Oncology	Full integration of oncology and haematology day units into one merged unit on the Sheldon Unit, Good Hope. Appointment of Marie Curie Consultant in Palliative Care funded by Marie Curie, BEN PCT and Solihull Care Trust, plus an appointment of a GP specialist working in specialist palliative care funded by Cancer Network.

Surgery Business Unit Details of Achievements

Access	18 weeks referral to treatment overdelivered Diagnostic waits – 2-3 weeks Cancer waits delivered Best ever day case rates
Safety and quality	CNST Level 3 in Obstetrics & Gynaecology. Significant reduction in hospital acquired infections (MRSA & C.Difficile). Significant reduction in pressure sores via Tissue Viability Team.
Expansion and developments	15% growth in Ear, Nose and Throat with repatriation of work from UHB Expansion of Bariatric Services with new consultant appointment Development of Laser Prostatectomy as Day Case at Solihull and Good Hope Leucentis Service funded and developed on three sites in Ophthalmology
Transformation and lean	Standardised cataract pathway across three sites Move of venous foam sclerotherapy and radio ablation to treatment room Establishment of neck of femur pathway Pilot amputation pathway developed – leading to a reduction in length of stay



Safety
Sarah Woolley, Director of Governance and Standards reports that:

"The common feature of our efforts to increase safety and governance over the last 12 months has been closer working with the clinical and corporate directorates. This has hugely increased the effectiveness of governance and safety in the operational areas and enabled us to jointly tackle some of the issues which we seem to have been grappling with for a number of years."

Whilst much of our progress in patient safety has been set out in the Quality Report on page 12 other key successes as a Trust have been:

- Surgery and Medicine Quality and Safety Committees: Led by the clinical and management teams and closely supported by the Governance Directorate, these Committees have really allowed the business units to understand and 'own' their safety and governance agendas. The success of these Committees has been demonstrated by more active identification and management of key risks and incidents experienced by the units, and more recently, by Business Unit reports to Governance and Risk Committee.

- Health and Safety and Security: This year the focus has been on developing and supporting a framework for ward and directorate based health and safety and security management. Rolling programmes of health and safety inspections and security/ violence assessments have been established and a policy and process to manage the risks associated with lone workers introduced. To support staff to undertake their health and safety duties and responsibilities a substantial training programme has been developed, facilitated by the Health and Safety team. The Trust has also become a registered centre to deliver the IOSH Managing Safely Course.

- Situation, Background, Assessment and Recommendations (SBAR): The need to improve and standardise communication was identified from analysis of recent serious untoward incidents and complaints. In April 2008 the SBAR communication tool was agreed as the preferred format for communication. It was then launched and widely disseminated throughout the Trust to all staff. A wide variety of strategies were used to elicit maximum exposure to all relevant professional groups. SBAR training is now established into a number of education programmes.

- Modified Early Warning System (MEWS): National Guidelines relating to the recognition and response to acutely unwell patients were issued in 2007. These national guidelines, along with local findings from serious untoward incidents (SUI's), complaints and initial findings from Global Trigger Tool reviews, have led to a number of improvements relating to MEWS being introduced across the Trust. These have included a more user friendly MEWS observation chart; development of a MEWS Policy and graded escalation pathway; Nursing Key Improvement Measures to measure compliance with the policy. This has also been supported by significant investment to provide 24 / 7 critical care outreach provision across the Trust.

- Joint working with Communications: One of the key tools of safety is effective communication of safety issues, practices and lessons learnt. This year has seen the appointment of a Communications Officer to work jointly between with the Governance and Standards team and Communications team.

The Environment
The environment in which we work is fundamental to the effective delivery of care. John Sellars, Director of Asset Management, reports on an extremely busy year throughout the various Asset Management teams.

- The Hotel Services team has developed and trained a group of Hygiene Technicians dedicated solely to the deep cleaning of infected areas including the use of peroxide gas. This team has contributed to the excellent results achieved on controlling our infection rates throughout the year.

- The Trust recently won a prestigious award for the combined heat and power plant recently opened on the Heartlands site. The award was for the generation of green electricity and the subsequent large reduction in the Trust's carbon footprint. This has been very much a win-win for the Trust in that it helps towards compliance with our requirement to reduce our carbon footprint while also provided cheaper ongoing energy to the Trust.

- The Site Strategy programme is progressing well with the first tranche of projects being approved by the Board in January 2009. Tranche 1 projects include the provision of a new 4-ward block and two new theatres at Good Hope, a new or refurbished Outpatients Department at Heartlands and the refurbishment of the existing A&E area at Good Hope. There will be much activity during the coming year in defining and agreeing the briefs for these projects and some building works will be undertaken on the Good Hope site during 2009/10.

- Meanwhile work has progressed well on the new MIDRU/ Diabetes building which complies with all modern standards and will be an exemplar building in which to work and be treated when it opens later in 2009.

We are committed to minimising the environmental impact of our activities and have introduced a range of specific measures and initiatives with the aims of:

- Minimising the use of energy and water
- Encouraging the use of more sustainable modes of travel and transport
- Reducing waste and increasing recycling

To further reduce the environmental impact of its activities, we are recruiting a Senior Environmental Manager to lead developments and manage environmental impact activities in an integrated way. The Carbon Trust has undertaken extensive energy surveys at all three hospital sites and we have implemented their recommendations to reduce energy consumption. We participated in the 2008/09 NHS Carbon Management Programme and have produced a detailed Carbon Management Plan. We have also introduced a range of measures aimed at reducing private car usage for both business and commuting. We recycle or recover some 56% of waste produced and currently recycle waste glass, fluorescent tubes, IT equipment, industrial batteries, plastics, cardboard and paper. A revised Waste Management Policy is in place and is available on the Trust intranet site.

Delivering Our Objectives – Happy and Motivated Staff

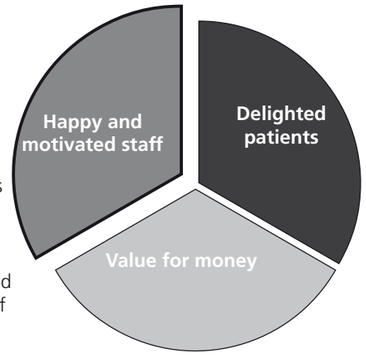
Relevant Strategic Objectives:
We are the Recognised Employer of Choice
We continually learn and innovate

Whilst much of our progress in Human Resources has been set out in the Quality Report on page 12 other key successes as a Trust have been:

Human Resources
The Trust has retained Guardian Top Employer status for 2009 and was also listed as a Health Service Journal Top 100 Employer. The HR team won two national awards for their work supporting the merger with Good Hope which was fantastic recognition for their efforts.

Nearly 500 Trust leaders have been developed through the Trust Leadership Academy and a new appraisal system for leaders is embedded and ready to roll out to the whole workforce during 2009.

Information Communication and Technology
Andy Laverick, Director of Information, Communication and Technology, reports on a number of key projects and developments delivered by the directorate including:



- PACS implemented into Heartlands and Solihull sites and the Good Hope PACS updated to deliver a Trust wide solution.
- The implementation of a web based form to support the introduction of electronic requesting for Radiology examinations.
- Trust-wide implementation of WiFi network to support use of mobile technologies in both clinical and non clinical areas.
- This year saw the re-engineering of the 'handover application' and its implementation into Good Hope. The application supports multi-disciplinary teams involved in the patients care and provides a central hub of communication, now accessible across all sites.
- Following consultation with clinicians, work to progress 'Organiser', which provides a clinical view of personalised and real time data, for example, scheduled outpatient appointments and current inpatients.
- The installation of Documentum, a secure document repository, has been delivered. This platform will be used to store both corporate and clinical documentation.
- ETTOs (Electronic To Take Out)
- A summary of patients medication prescribed for discharge. This application has now been implemented at Good Hope.
- A number of directorates are now benefiting from the introduction of clinical databases developed using the Dendrite application. This includes Oncology and Thoracic Surgery.
- In addition to the above, we have continued to make investment into the IT infrastructure. There are now computers on wheels (COWs) and tablet PCs in wards across the Trust.

Delivering Our Objectives – Value For Money

Relevant Strategic Objectives:
We grow the business for own and the region's prosperity
We are financially secure

Significant progress has been made in the related areas of Marketing and Finance as set out below.

Marketing
A significant new business opportunity is underway to develop and market a unique marketing services function to UK-based medical and surgical equipment supply companies and the wider NHS. Combining leading design, print, photography, website and multimedia services with access to our wide range of expertise and facilities. Profits generated will then be reinvested in order to develop new services for patients and users of the NHS.

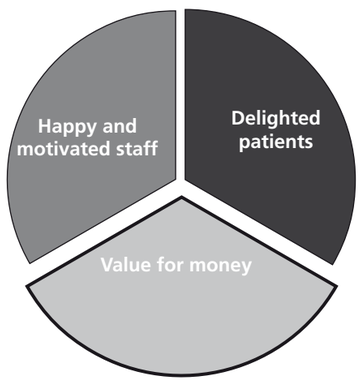
The Marketing team is committed to developing an insights function to help inform and drive the organisation moving forward. This includes delivering market intelligence, patient satisfaction and, in the new 'competitive' NHS environment, detailed competitor analysis to drive informed decisions within the Trust to the benefit of patients and the local community.

Finance
The 2008/09 Performance has been set out in the Business Review on page 8.

This year has been one of the most challenging this organisation has ever faced and for the first time since we became a Foundation Trust the planned surplus has not been achieved.

There are a number of factors contributing to this including:

- Investment in quality without financial reward.
- Achieving national targets.
- Recruitment to vacancies and ongoing use of temporary/agency staff.
- Additional activity not resulting in additional income.



Despite this, the Trust has a very strong balance sheet, holding £77.5m of cash at 31 March 2009, which is being used to fund the ten year site strategy programme.

Looking ahead to 2009/10 Operational Planning we recognise that there are difficult times ahead for this Trust and the Board is taking urgent action to ensure that costs are more tightly controlled and that the operational and management structure of the organisation is fit for purpose. The budget setting and CIP delivery programme are facing exceptional rigour and challenge and additional controls around expenditure, especially temporary staffing, have been strengthened.

As a response to the operational financial challenges that the Trust faces, a clinical and operational leadership corporate restructure was announced in late March 2009. We recognise that with a turnover in excess of £0.5bn across four sites, the current operational structure needs to be changed to reflect the size and complexity of the organisation. The restructure seeks to establish clear accountability from Board through to ward, to improve operational and financial performance, implement Trust strategy and support a process of

continuous improvement. The new structure will be led at Board level by a Chief Operating Officer working in conjunction with one Medical Director and Chief Nurse. It is proposed that the current two business units, Medicine and Surgery, will be replaced with five groups and dedicated site leads. A number of corporate business units will also be restructuring, partly to align their services to the operational set up, as well as a mechanism to continue to improve the efficiencies and reduce the costs of providing that service.

In addition, we have developed a financial plan for the next three years that anticipates a net surplus of £5.8m for 2009/10. This plan takes into account the commissioning intentions of local PCTs, the current cost base of the organisation and plans to reduce it, and macro-economic conditions such as interest rates which all affect the Trust's financial position. The Trust Board has accepted this plan and, whilst disappointed it does not match previous expectations, expects the the Trust Executive to deliver it.

The key risks to delivering this plan will be further changes in the economic environment, changes to public sector funding, changes to activity levels, efficiency non-delivery and pay control issues. These will be monitored and updated in the monthly Finance Committee meetings.

In 2009/10 the Trust will be accounting using International Financial Reporting Standards (IFRS) in line with Treasury and Monitor guidelines. During 2008/09 the IFRS conversion project re-stated the 31 March balances from UK GAAP to IFRS and identified two adjustments that would be required: a holiday pay accrual for annual leave entitled to but not taken by 31 March and creating fixed assets and loans to account for two small specific PFI schemes. The net impact on reserves of these two adjustments as at 31 March 2008 was £0.7m and as such, IFRS accounting will not have a material impact on the financial performance of the Trust.

It has been widely recognised that 2008/09 has been a turbulent year in the financial markets. We invest our cash surplus to immediate requirements in deposit accounts. Any deposits held for more than 3 months are subject to Finance Committee approval in advance and are placed with UK banks with credit ratings in line with the accounting policies. The longer term deals have proved to be fortuitous for us as higher rates were secured before the interest rates started to decrease. We do not hold any deposits with foreign banks.

A number of other developments within the Finance Directorate to support its vision to 'provide outstanding business support' have taken place throughout 2008/09 that will have a positive impact in the 2009/10 year.

- Service Line Reporting (SLR) and quarterly SLR reports are going to the Finance Committee. The next stage in the process is to roll out more detailed SLR reporting to the directorates and to ensure that the clinical and operational managers utilise the reports to drive to continuous improvement.

- The EP3 (Electronic Purchase Process Payment) project has been launched to deliver a fully automated, electronic and paperless purchase-to-pay process for the Trust. This will allow to electronically receive, or scan invoices into the Oracle system, thus delivering fully automated processing though to electronic payment. This will mean rapid invoice processing, which in turn means a timely payment and a paperless transaction flow. With processing being undertaken electronically, the scope for input error is minimal, meaning fewer exceptions.

- A new set of Finance Committee papers has been developed to provide greater clarity and transparency of the financial information.

- Good data quality is fundamental to support business making decisions and to ensure that the Trust receives all of its income. A Data Quality DVD and website has been developed to promote good data quality and a presentation to the Executive Directors Committee has resulted in data quality becoming one of the key priorities for the Trust in 2009/10.

The introduction of a talent management programme for school/college leavers to give them an insight in to the role of the finance function and to support succession planning has proved a great success. Over 100 applicants applied for six posts, one of whom has already been given a substantive role within Finance.

Statement of Accounting Officer

Statement of the Chief Executive's responsibilities as the Accounting Officer of Heart of England NHS Foundation Trust

The National Health Service Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the Accounting Officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the National Health Service Act 2006, Monitor has directed Heart of England 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 Heart of England 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 judgments 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.
- Prepare the financial statements on a going concern basis.

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

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

Mark Goldman
Chief Executive
3 June 2009

Statement of Internal Control

Scope of responsibility
As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- Identify and prioritise the risks to the achievement of the policies, aims and objectives of Heart of England NHS Foundation Trust.
- 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 at Heart of England NHS Foundation Trust for the year ended 31 March 2009 and upto 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's regulations are complied with.

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

Capacity to handle risk
Heart of England NHS Foundation Trust has a Trust Board approved Risk Management Strategy that provides explicit guidance for all staff concerning:

- Leadership and accountability.
- Roles and responsibilities for managing risks.
- Processes for risk management.
- Risk management education and training.

The Risk Management Strategy and Policy sets out the Trust's approach to risk by defining the structures for the management and ownership of risk at all levels of the organisation. It includes everyone's responsibilities for handling risk.

The Strategy and Policy clearly details that, as Accountable Officer, I have overall responsibility for the Trust's risk management programme and to ensure that it operates effectively. I have delegated operational responsibility for risk management to the Director of Governance and Standards. She is supported by the Executive Directors, who are accountable and responsible for overseeing risk management activities within their individual areas of responsibility.

The Governance and Standards Directorate has dedicated staff with specialist risk management expertise that work with the Trust's directorates and departments to implement risk management. They provide a range of training and ongoing support and advice through the governance team structure and working arrangements with directorates and departments.

Heart of England NHS Foundation Trust continues to ensure that staff can raise issues of concern, identify risks and report incidents. Review and assurance mechanisms are in place so that lessons can be learned. Sharing of good practice and learning from our mistakes are important processes for making improvements to patient and staff safety.

The risk and control framework
The Trust's Risk Management Strategy describes the risk management framework, which is based upon a 4-step cycle as follows: -

- Risk identification.
- Risk prioritisation.
- Risk control/treatment.
- Risk review.

The Trust's risk register process

represents the physical output from the risk management procedure outlined above. It forms the key tool for defining the Trust's appetite for risk and it is used to manage and escalate all risks (strategic, operational and financial).

The Trusts' Risk Management Strategy describes risk management as integral to the Trust's business planning processes and the Assurance Framework provides a method for monitoring that planned management action is mitigating risks to achieve the Trust's key objectives. The Assurance Framework maps the identified strategic risks to not achieving Trust objectives to controls and assurance mechanisms. It supports the annual Statement on Internal Control (SIC).

The Trust has had its Assurance Framework in place since March 2004 and it is revised on an annual basis. Throughout the year the Governance and Risk Committee reviews the Assurance Framework every quarter reporting by exception to the Trust Board.

The Risk Management Strategy considers how risk management should incorporate the consideration of stakeholders such as patients, partner organisations and other interests. This will include any risk assessments of integrated working arrangements. The Trust will ensure that all relevant stakeholders, including staff, are kept informed and, where appropriate, consulted on the management of risks faced by the organisation. The Trust engages its stakeholders through the following forums:

- Board of Governors
- Patient and Public Involvement Forums
- Overview and Scrutiny Committees
- Patient/ Customer Surveys
- Patient Focus Groups
- Foundation Trust Membership
- Meetings with Commissioners

The Trust Board is responsible for overseeing the delivery of the Risk Management Strategy and it is supported by the work of its sub-committees. The Board has delegated its risk management responsibilities to the Governance and Risk Committee, and gains independent assurance on the effectiveness of the operation of its risk management processes through the work of Internal Audit.

The Trust has arrangements in place for managing information governance through its Information Governance Committee. It is responsible for managing risk in relation to information governance and advising the Governance and Risk Committee where necessary. Following completion of an annual review of information flow mapping the Trust Board received assurance, in March 2009, that the Trust has no significant risks associated with the flow of person identifiable information.

In line with the Department of Health's guidance, the Trust has categorised one serious untoward incident concerning the loss of a set of medical notes in transit to another Trust as set out in the table below:

SUMMARY OF SERIOUS UNTOWARD INCIDENTS INVOLVING PERSONAL DATA AS REPORTED TO THE INFORMATION COMMISSIONER'S OFFICE IN 2007-08

Date of incident	Nature of incident	Nature of data involved	Number of people potentially affected	Notification steps
May 2008	Original medical notes belonging to the Trust were sent to another Trust in the external post without using the Recorded Delivery service.	Personal sensitive data	One	Affected patient notified by post PCT notified ICO notified
Further action on information risk	The Trust's Case Note Tracking Policy and Procedures will be reviewed to ensure that they are fit for purpose. Particular attention will be paid to the best interests of the patient and clinical opinion will be sought to ensure that the policy is appropriate from a patient safety perspective. All Clinical Directors and Directorate Managers should be contacted by the Trust's Caldicott Guardian to ensure that they understand their responsibilities and the responsibilities of their staff as described in the Trust's Case Note Tracking Policy and Procedures once review of the policy is complete.			

Review of economy, efficiency and effective use of resources
The Corporate Business Plan represents the principle mechanism, which the Board uses to review economy, efficiency and effective use of resources. This sets an annual delivery plan, which is aligned to the Trust's strategic objectives. As Accounting Officer I have overall accountability for delivery of this plan and am supported by the Executive Directors who have delegated accountability and responsibility for delivery of specific targets and performance objectives. These are formally reviewed and monitored on a monthly basis by the Trust Board and Executive Directors. Independent assurance on the use of resources is provided through the Trust's internal audit programme, Audit Committee and external agencies such as Monitor, External Audit and the Healthcare Commission.

The Trust has a policy framework in place to guide staff on the appropriate use of resources through its Standing Orders, Financial Instructions, Human Resources and Governance policies. This policy framework is operationalised through the Trust's budgetary and general management processes, business case processes for new developments and core financial processes such as purchasing.

Review of effectiveness
As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Audit Committee and the Governance and Risk Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

- Monitor Quarterly Reporting.
- Healthcare Commission Healthcare Standards and Annual Health Check.
- Health and Safety Executive.
- NHS Litigation Authority assessment of Risk Management Standards.
- Dr Foster information.
- The Patient Environment Action Team.
- External Audit.
- Peer Reviews.
- The Head of Internal Audit's Opinion.

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

Meeting the Healthcare Core standards self-assessment is part of the Trust's system of internal control. Heart of England NHS Foundation Trust has undertaken a full self-assessment of compliance against the Healthcare Standards to support its declaration.

- The Trust is compliant with 44 out of 44 core standards.

Significant Control Issues
I am assured that by applying these processes referred to above and in maintaining and reviewing the effectiveness of the system of internal control, significant control issues are identified, that have or could seriously impact upon the delivery of the Trust's principal objectives.

The Statement on Internal Control is a balanced reflection of the actual control position.

Mark Goldman
Chief Executive
3 June 2009

Independent Auditors' Report

Independent Auditors' Report to the Board of Governors of Heart of England NHS Foundation Trust
We have audited the financial statements of Heart of England NHS Foundation Trust for the year ended 31 March 2009 which 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. The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Financial Reporting Manual issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Respective responsibilities of directors and auditors
As explained more fully in the section "Directors' responsibilities for preparing the financial statements" within the Directors' Report, the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit the financial statements in accordance with relevant statute, the Audit Code for NHS Foundation Trusts issued by Monitor and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the Board of Governors of Heart of England NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Scope of the audit of the financial statements
An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the NHS Foundation Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the NHS Foundation Trust; and the overall presentation of the financial statements.

Opinion on financial statements
In our opinion the financial statements:

- give a true and fair view, in accordance with the NHS Foundation Trust Financial Reporting Manual, of the state of the NHS Foundation Trust's affairs as at 31 March 2009 and of its income and expenditure and cash flows for the year then ended 31 March 2009; and
- have been properly prepared in accordance with the NHS Foundation Trust Financial Reporting Manual.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Financial Reporting Manual;

and

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

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if, in our opinion:

- adequate accounting records have not been kept, or returns adequate for our audit have not been received from locations not visited by us; or
- the financial statements are not in agreement with the accounting records and returns; or
- we have not received all the information and explanations we require for our audit; or
- the Statement on Internal Control does not meet the disclosure requirements set out in the NHS Foundation Trust Financial Reporting Manual or is misleading or inconsistent with information of which we are aware from our audit; or
- we have not been able to satisfy ourselves that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

Mark Jones (Senior Statutory Auditor)
For and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
19 Cornwall Street
Birmingham
B3 2DT

4 June 2009

(a) The maintenance and integrity of the Heart of England NHS Foundation Trust website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

(b) Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

HEART OF ENGLAND NHS FOUNDATION TRUST
ANNUAL ACCOUNTS
YEAR TO 31 MARCH 2009

Foreword to the accounts

These accounts for the year ended 31 March 2009 have been prepared by Heart of England NHS Foundation Trust in accordance with paragraphs 25 and 25 of Schedule 7 to the 2006 Act.

Mark Goldman
Chief Executive
3 June

ACCOUNTING POLICIES

A Basis of Preparation of Accounts

Monitor has directed that the financial statements of NHS Foundation Trusts should meet the accounting requirements of the NHS Foundation Trust Financial Reporting Manual which should be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2008/09 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 the NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

B Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of tangible fixed assets at their value to the business by reference to their current costs. 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.

C Acquisitions and Discontinued Operations

Activities are considered to be 'acquired' only if they are acquired from outside the public sector. Activities are considered to be 'discontinued' where they meet all the following conditions:

a. the sale (this may be at nil consideration for activities transferred to another public sector body) or termination is completed either in the period or before the earlier of three months after the commencement of the subsequent period and the date on which the financial statements are approved;
b. the former activities have ceased entirely;
c. the sale or termination has a material effect on the nature and focus of the reporting NHS Foundation Trust's operations and represents a material reduction in its operating facilities resulting either from its withdrawal from a particular activity or from a material reduction in income in the NHS Foundation Trusts continuing operations; and
d. the assets, liabilities, results of operations and activities are clearly distinguishable, physically, operationally and for financial reporting purposes.

Operations not satisfying all these conditions are classified as continuing.

D Income Recognition

Income is accounted for applying the accruals convention. The main source of income for the Trust is under contracts from commissioners in respect of healthcare services. Income is recognised in the period in which services are provided. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

E Expenditure

Expenditure is accounted for by applying the accruals convention.

F Intangible Fixed Assets

Intangible assets are capitalised when they are capable of being used in a Trust's activities for more the one year; they can be valued; and they have a cost of at least £5,000.

Intangible fixed assets held for operational use are valued at historical cost and are depreciated over the estimated life of the asset on a straight line basis. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred. They are amortised over the shorter of the term of the licence or their useful economic lives.

G 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

- collectively have a cost of at least £5,000 and individually have a cost of more than £250, 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 equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

Valuation

Tangible fixed assets are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost (for leased assets, fair value) including any costs such as installation directly attributable to bringing them into working condition. The carrying values of tangible fixed assets are reviewed for impairment in periods if events or changes in circumstances indicate the

carrying value may not be recoverable. Costs arising from financing the construction of fixed assets are charged to the income and expenditure account in the year in which they relate.

All land and buildings are restated to current value using professional valuations in accordance with FRS15 every five years. A three yearly interim valuation is also carried out.

Professional valuations are carried out by the District Valuers of the Inland Revenue Government Department. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The latest interim valuation was carried out at 31 March 2008.

The valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value.

Additional alternative open market value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal.

Assets in the course of construction are valued at cost and were valued by professional valuers as part of the five year or three-yearly valuation or when they are brought into use.

The accounting treatment of revaluations requires the assets to be restated at their revalued amounts and any accumulated depreciation is eliminated. Where the value of the accumulated depreciation is greater than the difference in the net book value and the revalued amount, a negative cost revaluation is generated. This does not indicate an impairment.

Residual interests in off-balance sheet Private Finance Initiative (PFI) properties are included in tangible fixed assets as assets under construction and payments on account where the PFI contract specifies the amount, or nil value at which the assets will be transferred to the Trust at the end of the contract. The residual interest is built up, on an actuarial basis, during the life of the contract by capitalising part of the unitary charge so that at the end of the contract the balance sheet value of the residual value plus the specified amount equal the expected fair value of the residual asset at the end of the contract. The estimated fair value of the asset on reversion is determined by the District Valuer based on Department of Health guidance. The District Valuer should provide an estimate of the anticipated fair value of the assets on the same basis as the District Valuer values the NHS Trust's estate.

Operational equipment is valued at net current replacement cost. Equipment surplus to requirements is valued at net recoverable amount.

Depreciation, 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 estimated useful lives. No depreciation is provided on freehold land and assets surplus to requirements.

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

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as advised by the NHS Foundation Trust's professional valuers. Leaseholds are depreciated over the primary lease term.

Equipment is depreciated on current cost evenly over the estimated life of the asset.

In assessing estimated useful economic lives, consideration is given to any contractual arrangements and operational requirements relating to particular assets. Unless otherwise determined by operational requirements, the depreciation periods for the principal categories of tangible assets are, in general, as follows:

- plant & machinery	5-15 years
- transport equipment	7 years
- information technology	5 years
- furniture & fittings	5-10 years
- dwellings	up to 38 years per District Valuers valuation
- other buildings	up to 69 years per District Valuers valuation

Fixed asset impairment resulting from losses of economic benefits are charged to the income and expenditure account. All other impairments are taken to the revaluation reserve and reported in the statement of total recognised gains and losses to the extent that there is a balance on the revaluation reserve in respect of that asset.

H 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. Similarly, any impairment on donated assets charged to the Income and Expenditure Account is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value of the donated asset is transferred from the donated asset reserve to the Income and Expenditure Reserve.

I Government Grants

Government grants are grants from Government bodies other than income from primary care trusts or NHS trusts for the provision of services. Grants from the Department of Health, including those for achieving three star status, are accounted for as Government grants as are grants from the Big Lottery Fund. Where the Government grant is used to fund revenue expenditure it is taken to the Income and Expenditure account to match that expenditure. Where the grant is used to fund capital expenditure the grant is held as deferred income and released to the income and expenditure account over the life of the asset on a basis consistent with the depreciation of the asset.

J Private Finance Initiative (PFI) Transactions

The NHS follows HM Treasury's technical Note 1 (Revised) "How to Account for PFI Transactions" which provides definitive guidance for the application of application note F to FRS 5.

Where the balance of the risks and rewards of ownership of the PFI property are borne by the PFI operator, the PFI payments are recorded as an operating expense. Where the trust has contributed to land and buildings, a prepayment for their fair value is recognised and amortised over the life of the PFI contract by charge to the income and expenditure account. Where, at the end of the PFI contract, a property reverts to the trust, the difference between the expected fair value of the residual on reversion and any agreed payment on reversion is built up over the life of the contract by capitalising part of the unitary charge each year, as a tangible fixed asset.

Where the balance of risks and rewards of ownership of the PFI property are borne by the trust, it is recognised as a fixed asset along with the liability to pay for it which is accounted for as a finance lease. Contract payments are apportioned between an imputed finance lease charge and a service charge.

K Stocks and Work-In-Progress

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

L Research and Development

Expenditure on research is not capitalised. Expenditure on development is capitalised if it meets the following criteria:

- there is a clearly defined project;
- the related expenditure is separately identifiable;
- the outcome of the project has been assessed with reasonable certainty as to:
  - its technical feasibility and
  - its resulting in a product or service which will eventually be brought into use;
- adequate resources exist, or are reasonably expected to be available, to enable the project to be completed and to provide any consequential increases in working capital.

Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. Where possible the Trust discloses the total amount of research and development expenditure charged in the income and expenditure account separately.

Fixed assets acquired for use in research and development are amortised over the life of the associated project.

M Cash, & Bank, Overdrafts and Borrowing

Cash, bank and overdraft balances are recorded at the current values of those balances in the Trust's cashbook. These balances exclude monies held in the NHS Foundation Trust's bank account belonging to patients. 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 is recorded as, respectively, "finance income" and "finance costs" in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods they relate to.

The Trust is required to comply with the Prudential Borrowing Code set out by Monitor. The Trust is required to comply and remain within a prudential borrowing limit. This is made up of 2 elements:

- the maximum cumulative amount of long-term borrowing. This is set by reference to the five ratio tests set out in the code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit.
- the amount of working capital facility approved by Monitor.

Further information in the Prudential Borrowing Code and Compliance framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

N 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 material, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 2.2% in real terms.

Clinical Negligence Costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS 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 16.

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 as and when they become due.

O Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 22 where an inflow of economic benefit is probable. Contingent liabilities are provided for where a transfer of economic benefits is probable. Otherwise, they are not recognised, but are disclosed in note 22 unless the probability of a transfer 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 obligation cannot be measured with sufficient reliability.

P Pension Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. As a consequence it is not possible for the NHS Foundation Trust to identify its share of the underlying scheme assets and liabilities. Therefore the scheme is accounted for as a defined contribution scheme under FRS17.

The Scheme is subject to a full valuation by the Government Actuary every four years which is followed by a review of the employer contribution rates. The last valuation took place as at 31 March 2004 and covers the period 1 April 1999 to 31 March 2004. It was published in December 2007 and is available on the NHS Pensions Agency website at www.nhspa.gov.uk.

The notional deficit of the scheme was £3.3billion per the latest valuation and the conclusion of the valuation was that the scheme continues to operate on a sound financial basis. Employer contribution rates are reviewed every four years following the scheme valuation, on advice from the actuary. At the last valuation, it was recommended that employer contribution rates should continue at 14% of pensionable pay. From 1 April 2008, employees' contributions will be on a tiered scale from 5% to 8.5% of their pensionable pay.

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

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

Q 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.

R 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.

S 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. Details of third party assets are given in Note 28 to the accounts.

T Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as a tangible fixed asset and a debt is recorded to the lessor of the minimum lease payments discounted by the interest rate implicit in the lease. The interest element of the finance lease payment is charged to the Income and Expenditure Account over the period of the lease at a constant rate in relation to the balance outstanding. Other leases are regarded as operating leases and the rentals are charged to the Income and Expenditure Account on a straight-line basis over the term of the lease.

U Public Dividend Capital (PDC) and PDC Dividend

PDC is a type of public sector equity finance based on the excess of assets over liabilities i.e. the net assets of a public benefit corporation.

A charge, reflecting the forecast cost of capital utilised by the NHS 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 forecast average relevant net assets of the NHS Foundation 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.

V Other reserves

When Heart of England NHS Foundation Trust merged with Good Hope Hospital NHS Trust (GHH) on 8 April 2007, GHH has an other reserve in its balance sheet.

Other reserves are created to account for the following:

- any differences between the value of fixed assets taken over by the NHS Trust at inception and the corresponding figure in the opening capital debt;

- subsequent transfers of assets for nil consideration after the NHS Trust has been set up where, in error, those assets were not transferred at the NHS Trust inception.

W 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).

X Investments

Investments in subsidiary undertakings, associates and joint ventures are treated as fixed asset investments and valued at market value. Fixed asset investments are reviewed annually for impairments.

Deposits and other investments that are readily convertible into known amounts of cash at or close to their carrying amounts are treated as liquid resources in the cashflow statement. These assets, and other current assets, are valued at cost less any amounts written off to represent any impairments in value, and are reviewed annually for impairments.

Y Corporation Tax

HMRC have confirmed that corporation tax is not payable for foundation trusts in the 2008/09 year and as such no corporation tax liability or charge has been recognized.

Z Financial Instruments and Financial Liabilities

Financial assets and liabilities are recognised when the body becomes a party to the contract or, in the case of trade debtors/creditors, when the goods have been delivered. Financial assets should be derecognised when:

- the contractual rights to the cash flows of the financial asset have expired, or
- the financial asset has been transferred (eg sold) and the risks and rewards of ownership have transferred.

Financial liabilities should be derecognised when the liability has been discharged, that is, paid or expired.

Initially, all financial instruments must be measured at fair value. Fair value is a quoted market price, if available. If there is no market price, a valuation technique should be used, for example, the value of a recent similar transaction at arms' length or discounted cash flows (dcf) from the transaction. If dcf are used, the discount rate to use is the higher of the rate intrinsic to the financial instrument and the real discount rate set by Treasury (currently 2.2%). Exceptionally, if no reliable estimate of fair value can be made, cost can be used.

Financial assets are categorised as Loans and receivables, Assets at fair value through Income and Expenditure, Assets held to maturity or Available-for-sale financial assets.

Financial liabilities are classified as Liabilities at fair value through Income and Expenditure or as Other Financial liabilities.

Financial assets and financial liabilities at 'Fair Value through Income and Expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value , with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the income and expenditure account.

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise cash at bank and in hand, NHS debtors, accrued income and other debtors. The Trust's assets held to maturity include current asset investments.

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables and assets held to maturity is calculated using the effective interest method and credited to the income and expenditure account.

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-

term assets unless the Trust intends to dispose of them within 12 months of the balance sheet date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves. When items classified as 'available-for-sale' are sold or impaired, the accumulated fair value adjustments recognised in reserves are included in the income and expenditure account

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability

They are included in current liabilities except for the amounts payable more than 12 months after the balance sheet date, which are classified as long-term liablities

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to the income and expenditure account.

At the balance sheet date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cashflows of the asset.

INCOME AND EXPENDITURE ACCOUNT YEAR TO 31 MARCH 2009

	NOTE	2008/09 £000	2007/08 £000
Income from activities	2	458,030	425,815
Other operating income	4	48,958	45,545
Operating expenses	5-7	(481,018)	(443,041)
OPERATING SURPLUS		**25,970**	**28,319**
Profit (loss) on disposal of fixed assets	8	(51)	(77)
SURPLUS BEFORE INTEREST		**25,919**	**28,242**
Finance Income	9	4,915	5,660
Finance Costs - Interest Expense	9	(138)	(160)
Other finance costs		(4)	(4)
SURPLUS FOR THE FINANCIAL YEAR		**30,692**	**33,738**
Public Dividend Capital dividends payable		(10,884)	(11,339)
RETAINED SURPLUS FOR THE YEAR		**19,808**	**22,399**

All income and expenditure is derived from continuing operations.

BALANCE SHEET AS AT:

	NOTE	31 March 2009 £000	31 March 2008 £000
FIXED ASSETS			
Intangible assets	10	1,955	2,758
Tangible assets	11	355,921	343,532
		357,876	346,290
CURRENT ASSETS			
Stocks and work in progress	12	6,147	4,750
Debtors	13	22,856	21,516
Investments	14	55,000	30,359
Cash at bank and in hand	19.3	22,449	30,017
		106,452	86,642
CREDITORS: Amounts falling due within one year	15	(52,863)	(42,149)
NET CURRENT ASSETS (LIABILITIES)		53,589	44,493
TOTAL ASSETS LESS CURRENT LIABILITIES		**411,465**	**390,783**
CREDITORS: Amounts falling due after more than one year	15	(1,601)	(1,654)
PROVISIONS FOR LIABILITIES AND CHARGES	16	(5,095)	(5,135)
TOTAL ASSETS EMPLOYED		**404,769**	**383,994**
FINANCED BY:			
TAXPAYERS' EQUITY			
Public dividend capital	23	211,114	209,694
Revaluation reserve	17	133,430	146,163
Donated asset reserve	17	3,015	2,623
Other reserves	17	(169)	(169)
Income and expenditure reserve	17	57,379	25,683
TOTAL TAXPAYERS EQUITY		**404,769**	**383,994**

Mark Goldman
Chief Executive
3 June 2009

STATEMENT OF TOTAL RECOGNISED GAINS AND LOSSES YEAR TO 31 MARCH 2009

	2008/09 £000	2007/08 £000
Surplus / (deficit) for the financial year before dividend payments	30,692	33,738
Fixed asset impairment losses	0	(4,073)
Unrealised surplus/(deficit) on fixed asset revaluations/indexation	0	24,959
Increases in the donated asset reserve due to receipt of donated financed assets	95	158
Reductions in the donated asset reserve due to the depreciation, impairment and disposal of donated financed assets	(548)	(816)
Total recognised gains and losses for the financial year	**30,239**	**53,966**

CASH FLOW STATEMENT
YEAR TO 31 MARCH 2009

	NOTE	2008/09 £000	2007/08 £000
OPERATING ACTIVITIES			
Net cash inflow/(outflow) from operating activities	19.1	54,147	60,413
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:			
Interest received		3,276	5,433
Interest paid		0	0
Interest element of finance lease rental payments		(138)	(160)
Net cash inflow/(outflow) from returnst on investments and servicing of finance		**3,138**	**5,273**
CAPITAL EXPENDITURE			
Payments to acquire tangible fixed assets		(30,835)	(21,459)
Receipts from sale of tangible fixed assets		11	0
Payments to acquire intangible fixed assets		(19)	(58)
Net cash inflow/(outflow) from capital expenditure		**(30,843)**	**(21,517)**
DIVIDENDS PAID		(10,884)	(11,339)
Net cash inflow/(outflow) before management of liquid resources and financing		**15,558**	**32,830**
MANAGEMENT OF LIQUID RESOURCES			
Purchase of current asset investments		(155,000)	(596,359)
Sale of current asset investments		130,359	586,000
Net cash inflow/(outflow) from management of liquid resources		**(24,641)**	**(10,359)**
Net cash inflow/(outflow) before financing		**(9,083)**	**22,471**
FINANCING			
Public dividend capital received		1,420	5,500
Public dividend capital repaid		0	(5,513)
Other capital receipts		95	157
Net cash inflow/(outflow) from financing		**1,515**	**144**
Increase/(decrease) in cash		**(7,568)**	**22,615**

1. Segmental Analysis

The following information segments the results of the Trust by:

- Research activities
- Healthcare activities, being all the other activities of the Trust

	Healthcare 2008/09 £000	Healthcare 2007/08 £000	Research 2008/09 £000	Research 2007/08 £000	Total 2008/09 £000	Total 2007/08 £000
INCOME	504,627	468,876	2,361	2,484	506,988	471,360
SURPLUS/(DEFICIT)						
Segment surplus/(deficit)	25,919	28,242	0	0	25,919	28,242
SURPLUS/(DEFICIT) BEFORE INTEREST	**25,919**	**28,242**	**0**	**0**	**25,919**	**28,242**
TOTAL ASSETS EMPLOYED	**403,073**	**382,396**	**1,696**	**1,598**	**404,769**	**383,994**

2. Income from Activities

	2008/09 £000	2007/08 £000
Primary Care Trusts	416,145	385,578
NHS Trusts	60	501
Foundation Trusts	0	0
Strategic Health Authorities	502	410
Local Authorities	675	553
Department of Health	35,947	34,346
NHS Other	1,252	1,413
Non NHS:		
- Private Patients	570	563
- Overseas patients (non-reciprocal)	58	83
- NHS Injury Scheme (was Road Traffic Act (RTA))	2,821	2,368
TOTAL	**458,030**	**425,815**

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

2.1 Mandatory and non-mandatory split of income from activities

Of the total income from activities, £452,313k is mandatory and £5,717k is non-mandatory income.

3. Private patient cap

The private patient cap has not been exceeded in 2008/09.

	2008/09	Base Year
Private patient income (£'000)	570	506
Total patient related income (£'000)	458,030	257,459
Proportion (%)	0.12%	0.20%

4. Other Operating Income

	2008/09 £000	2007/08 £000
Research and development	2,361	2,484
Education and training	18,431	17,704
Transfers from donated asset reserve	548	816
Non-patient care services to other bodies	18,204	15,233
Other income	9,414	9,308
TOTAL	**48,958**	**45,545**

Other income includes car parking income of £3.4m (2007/08 £3.0m), of which £0.6m is charges to staff who park on Trust premises. Car parking income covers the costs of car park and security staff, grounds maintenance and improvement, services and utility costs and capital charges, including depreciation. The Trust does not make a surplus on this income.

5. Operating Expenses

5.1 Operating expenses comprise:

	2008/09 £000	2007/08 £000
Directors' costs	1,585	1,498
Staff costs	317,891	292,503
Drug costs	31,906	27,712
Supplies and services - clinical	48,475	41,945
Supplies and services - general	14,843	13,660
Establishment	6,325	5,006
Research & Development	1,192	1,287
Transport	985	913
Premises	20,985	17,847
Bad debts	631	1,897
Depreciation and amortisation	18,786	18,132
Fixed asset impairments	0	401
Audit fees	136	166
Other auditor's remuneration	17	6
Clinical negligence	5,169	5,695
Other	12,092	14,373
TOTAL	**481,018**	**443,041**

The audit fee of £136k relates to statutory external audit work. Other auditor's remuneration of £17k is in relation to an IFRS (International Financial Reporting Standards) audit in preparation for the introduction of IFRS in 2009/10.

The research and development value includes £964k of staff costs. All of the research and development expenditure is current year expenditure.

5.2 Operating leases

5.2/1 Operating expenses include:

	2008/09 £000	2007/08 £000
Hire of plant and machinery	500	519
Other operating lease rentals	242	241
TOTAL	**742**	**760**

5.2/2 Annual commitments under non - cancellable operating leases are:

	Land and buildings		Other leases	
	2008/09 £000	2007/08 £000	2008/09 £000	2007/08 £000
Operating leases which expire:				
Within 1 year	18	0	145	18
Between 1 and 5 years	163	95	392	383
After 5 years	0	142	57	89
TOTAL	**181**	**237**	**594**	**490**

5.3 Salary and Pension entitlements of senior managers

A) Remuneration

Name and Title	2008-09			2007-08		
	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100
Mark Goldman (Chief Executive)	235-240	0	0	225-230	0	0
Beccy Fenton (Chief Finance Officer and Managing Director up to 31-7-08)	55-60	0	0	160-165	0	0
Fay Baillie (Acting Nursing Director up to 30-11-08)	65-70	0	0	80-85	0	0
Mandy Coalter (HR Director)	145-150	0	0	130-135	0	0
Hugh Rayner (Medical Director Medicine)	115-120	50-55	0	40-45	125-130	0
Ian Cunliffe (Medical Director Surgery)	140-145	60-65	0	35-40	110-115	0
Sarah Woolley (Director of Healthcare Governance)	135-140	0	0	130-135	0	0
Adrian Stokes (Director of Finance w.e.f. 1-8-08)	95-100	0	0	n/a	n/a	n/a
Mandie Sunderland (Director of Patient Care w.e.f. 1-12-08)	40-45	0	0	n/a	n/a	n/a
Clive Wilkinson (Chairman)	45-50	0	0	45-50	0	0
Anna East (Non Executive Director)	15-20	0	0	15-20	0	0
Richard Samuda (Non Executive Director)	15-20	0	0	15-20	0	0
Richard Harris (Non Executive Director w.e.f. 1-5-08)	10-15	0	0	n/a	n/a	n/a
Paul Hensel (Non Executive Director)	10-15	0	0	10-15	0	0
Najma Hafeez (Non Executive Director)	10-15	0	0	10-15	0	0
Chris Ham (Non Executive Director)	10-15	0	0	5-10	0	0
David Bucknall (Non Executive Director)	15-20	0	0	0-5	0	0

Other remuneration reflects salary paid to Medical Directors for their posts as Clinical Directors.

5.3 Salary and Pension entitlements of senior managers

B) Pension Benefits

Name and title	Real increase in pension at age 60	Real increase in lump sum at age 60	Total accrued pension at age 60 at 31 March 2009	Lump sum at age 60 related to accrued pension at 31 March 2009	Cash Equivalent Transfer Value at 31 March 2009	Cash Equivalent Transfer Value at 31 March 2008	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5,000) £000	(bands of £5000) £000	£000	£000	£000	To nearest £100
Mark Goldman (Chief Executive)	2.5 - 5	10 - 12.5	100-150	305-310	2,439	1,703	486	0
Beccy Fenton (Chief Finance Officer and Managing Director up to 31-7-08)	0 - 2.5	2.5 - 5	15-20	55-60	264	180	19	0
Fay Baillie (Acting Nursing Director up to 30-11-08)	0 - 2.5	0 - 2.5	25-30	85-90	566	426	61	0
Mandy Coalter (HR Director)	0 - 2.5	5 - 7.5	20-25	60-65	264	193	47	0
Ian Cunliffe (Medical Director Surgery)	5 - 7.5	15 - 17.5	45-50	145-150	838	580	171	0
Hugh Rayner (Medical Director Medicine)	2.5 - 5	7.5 - 10	35-40	115-120	825	579	162	0
Sarah Woolley (Director of Healthcare Governance)	0 - 2.5	5 - 7.5	15-20	55-60	242	173	45	0
Adrian Stokes (Director of Finance w.e.f. 1-8-08)	0 - 2.5	2.5 - 5	20-25	60-65	266	187	35	0
Mandie Sunderland (Director of Patient Care w.e.f. 1-12-08)	0 - 2.5	0 - 2.5	30-35	90-95	507	387	26	0

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

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

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

The significant difference in the real increase in CETVs between years is due to a change in the factors used to calculate CETVs, which came into force on 1 October 2008 as a result of the Occupational Pension Scheme (Transfer Value Amendment) regulations. These placed responsibility for the calculation method for CETVs (following actuarial advice) on Scheme Managers or Trustees. Further regulations from the Department for Work and Pensions to determine cash equivalent transfer values (CETV) from Public Sector Pension Schemes came into force on 13 October 2008.

6. Staff costs and numbers

6.1 Staff costs

	2008/09 £000	2007/08 £000
Salaries and wages	255,872	238,927
Social Security Costs	19,324	18,600
Employer contributions to NHS Pensions Agency	28,078	26,032
Bank, Agency and Contract staff	16,035	10,294
	319,309	**293,853**

6.2 Average number of persons employed

	2008/09 Number	2007/08 Number
Medical and dental staff	878	876
Administration and estates staff	1,919	1,814
Healthcare assistants and other support staff	1,308	1,288
Nursing, midwifery and health visiting staff	2,768	2,721
Scientific, therapeutic and technical staff	1,187	1,149
Bank, Agency and Contract staff	261	245
Total	**8,321**	**8,093**

6.3 Employee benefits

There were no employee benefits in 2008/09 or 2007/08.

6.4 Management costs

	2008/09 £000	2007/08 £000
Management costs	20,052	18,360
Income	506,988	471,360
Percentage (%)	3.96	3.90

Management costs are defined as those on the management costs website at www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSManagementCosts/fs/en..

6.5 Retirements due to ill-health

During 2008/09 there were 18 (2007/08, 9) early retirements from the trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £1,298k (2007/08, £522k). The cost of these ill-health retirements will be borne by the NHS Pensions Agency.

7. Better Payment Practice Code

7.1 Better Payment Practice Code - measure of compliance

	Number 2008/09	Value 2008/09 £000	Number 2007/08	Value 2007/08 £000
Total bills paid in the year	158,611	159,153	134,484	131,026
Total bills paid within target	144,230	147,274	122,710	118,521
Percentage of bills paid within target	91%	93%	91%	90%

The Better Payment Practice Code requires the Trust 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. Profit/(Loss) on Disposal of Fixed Assets

There was a loss on diposal of fixed assets of £51k in 2008/09 (2007/08 £77k), all of which was on non-protected assets.

9. Finance Income

	2008/09 £000	2007/08 £000
Interest on loans and receivables	4,915	5,660
Interest on available for sale financial assets	0	0
Interest on held-to-maturity financial assets	0	0
Total	**4,915**	**5,660**

The interest receivable arose from interest earned in the main current account and from surplus cash placed in commercial deposit accounts for periods not exceeding 12 months.

9.1 Finance Costs

	2008/09 £000	2007/08 £000
Finance leases	138	160
Other	0	0
Total	**138**	**160**

10. Intangible Fixed Assets

	Software Licences £000	Total £000
Gross cost at 1 April 2008	3,945	3,945
Reclassifications	1,087	1,087
Additions purchased	19	19
Additions donated	0	0
Gross cost at 31 March 2009	**5,051**	**5,051**
Amortisation at 1 April 2008	1,187	1,187
Provided during the year	146	146
Reclassifications	1,763	1,763
Amortisation at 31 March 2009	**3,096**	**3,096**
Net book value		
- Purchased at 1 April 2008	2,738	2,738
- Donated at 1 April 2008	20	20
- Total at 1 April 2008	**2,758**	**2,758**
- Purchased at 31 March 2009	1,939	1,939
- Donated at 31 March 2009	16	16
- Total at 31 March 2009	**1,955**	**1,955**

11. Tangible Fixed Assets

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

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and payments on account £000	Plant and Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2008	70,615	229,120	5,099	9,702	74,880	962	26,449	9,800	426,627
Additions purchased	0	1,674	0	24,535	2,864	52	1,055	141	30,321
Additions donated	0	0	0	0	90	0	0	5	95
Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	6,676	(1,609)	(13,038)	5,822	(1)	675	388	(1,087)
Other revaluations	0	0	0	0	0	0	0	0	0
Disposals	**0**	**0**	**0**	**0**	**(1,197)**	**0**	**(6)**	**0**	**(1,203)**
At 31 March 2009	**70,615**	**237,470**	**3,490**	**21,199**	**82,459**	**1,013**	**28,173**	**10,334**	**454,753**
Depreciation at 1 April 2008	0	0	0	0	52,769	659	20,688	8,979	83,095
Provided during the year	0	11,950	256	0	3,753	60	2,398	223	18,640
Impairments	0	0	0	0	0	0	0	0	0
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	(1,763)	0	(1,763)
Other revaluations	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(1,135)	0	(5)	0	(1,140)
Depreciation at 31 March 2009	**0**	**11,950**	**256**	**0**	**55,387**	**719**	**21,318**	**9,202**	**98,832**
Net book value									
- Purchased at 1 April 2008	70,615	228,016	4,621	9,702	20,346	303	5,691	801	340,095
- Donated at 1 April 2008	0	1,104	478	0	1,765	0	70	20	3,437
Total at 1 April 2008	**70,615**	**229,120**	**5,099**	**9,702**	**22,111**	**303**	**5,761**	**821**	**343,532**
- Purchased at 31 March 2009	70,615	223,929	3,234	21,199	25,747	294	6,801	1,102	352,921
- Donated at 31 March 2009	0	1,591	0	0	1,325	0	54	30	3,000
Total at 31 March 2009	**70,615**	**225,520**	**3,234**	**21,199**	**27,072**	**294**	**6,855**	**1,132**	**355,921**

An interim valuation was performed by the District Valuers at 31 March 2008. This used the depreciated replacement costs basis for its valuation rather than the Modern Equivalent Asset in Use basis recommended in the Royal Institute of Chartered Surveyors (RICS) Appraisal Valuation Manual that is referred to in accounting policy note. The Trust will be undertaking a full revaluation as at 31 March 2010 and this will be performed using the recommended basis under International Financial Reporting Standards (IFRS).

11.1 Tangible Fixed Assets (contd)

Of the totals at 31 March 2009, there were no land, buildings or dwellings valued at open market value.

The Trust holds one building extension under a finance lease. Its gross cost is £1,875k (2007/08 £1,875k). Depreciation charged in the year was £52k (2007/08 £52k). Its net book value at 31 March 2009 is £1,770k (2007/08 £1,823k).

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

	31 March 2009	31 March 2008
	£000	£000
Freehold	297,349	302,655
Long leasehold	2,020	2,179
Short leasehold	0	0
TOTAL	**299,369**	**304,834**
	£000	£000
Protected assets	232,190	239,556
Unprotected assets	67,179	65,278
TOTAL	**299,369**	**304,834**

12. Stocks and Work in Progress

	31 March 2009	31 March 2008
	£000	£000
Raw materials and consumables	6,147	4,750
Work-in-progress	0	0
Finished goods	0	0
TOTAL	**6,147**	**4,750**

13. Debtors

	31 March 2009	31 March 2008
	£000	£000
Amounts falling due within one year:		
NHS debtors	14,215	15,932
Provision for impaired debtors	(5,827)	(7,248)
Prepayments	2,801	4,136
Accrued income	2,950	1,258
Other debtors	7,113	6,042
Sub Total	**21,252**	**20,120**
Amounts falling due after more than one year:		
NHS debtors	0	0
Provision for impaired debtors	(847)	(778)
Other debtors	2,451	2,174
Sub Total	**1,604**	**1,396**
TOTAL	**22,856**	**21,516**

There were no prepaid pension contributions at 31 March 2009 (2007/08 £Nil).

14. Investments

	HBOS Fixed Deposit	RBS Treasury reserve	Alliance & Leicester Deposit	Total
	£000	£000	£000	£000
Cost at 1 April 2008	0	30,359	0	30,359
Additions	30,000	115,000	10,000	155,000
Disposals	0	(120,359)	(10,000)	(130,359)
Cost at 31 March 2009	**30,000**	**25,000**	**0**	**55,000**

15. Creditors

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

	31 March 2009	31 March 2008
	£000	£000
Amounts falling due within one year:		
NHS creditors	6,830	9,393
Capital Creditors	4,966	4,815
Tax and social security costs	10,372	124
Other creditors	2,354	482
Obligations under Finance Leases	191	191
Accruals	24,607	21,835
Deferred income	3,543	5,309
Sub Total	**52,863**	**42,149**
Amounts falling due after more than one year:		
NHS creditors	0	0
Obligations under Finance Leases	1,601	1,654
Other	0	0
Sub Total	**1,601**	**1,654**
TOTAL	**54,464**	**43,803**

15.2 Prudential borrowing limit

	31 March 2009	31 March 2008
	£000	£000
Total long term borrowing limit set by Monitor	102,100	97,800
Working capital facility agreed by Monitor	30,000	30,000
Total Prudential Borrowing Limit	**132,100**	**127,800**

There was no long term borrowing or working capital borrowing as at 31 March 2009 (2007/08 £Nil)

15.3 Finance Lease Obligations

	31 March 2009 £000	31 March 2008 £000
Finance Lease Obligations:		
- within one year	191	191
- between one and five years	764	764
- after five years	2,101	2,292
Subtotal	3,056	3,247
Finance charges allocated to future periods	(1,264)	(1,402)
Net obligation	**1,792**	**1,845**

15.4 Future Finance Lease obligations

	31 March 2009 £000	31 March 2008 £000
Minimum payments	191	191
Number of years commitment	16	17

16. Provisions for liabilities and charges

	Pensions £000	Legal claims £000	Agenda for change £000	Other £000	Total £000
At 1 April 2008	1,888	235	857	2,155	5,135
Arising during the year	1,034	248	322	520	2,124
Utilised during the year	(183)	(130)	(94)	(541)	(948)
Reversed unused	(97)	(116)	(579)	(428)	(1,220)
Unwinding of discount	4	0	0	0	4
At 31 March 2009	**2,646**	**237**	**506**	**1,706**	**5,095**
Expected timing of cashflows:					
Within one year	185	237	506	1,706	2,634
Between one and five years	729	0	0	0	729
After five years	1,732	0	0	0	1,732
	2,646	**237**	**506**	**1,706**	**5,095**

£40,180k (£34,308k, 2007/08) is included in the provisions of the NHS Litigation Authority at 31/3/2009 in respect of clinical negligence liabilities of the Trust.

£10,422k (£9,513k, 2007/08) is included in the provisions of the NHS Litigation Authority at 31/3/2009 in respect of the existing liabilities scheme of the Trust.

Other provisions includes £176k relating to a legal dispute with an external contractor relating to a Capital project, an equal pay provision of £540k and a provision of £720k relating to the payment of land rent.

17. Movements on Reserves

Movements on reserves in the year comprised the following:

	Revaluation Reserve £000	Donated Asset Reserve £000	Available for sale investments £000	Other reserves £000	Income and Expenditure Reserve £000	Total £000
At 1 April 2008 as previously stated	146,163	2,623	0	(169)	25,683	174,300
Opening Balance Adjustments	0	0	0	0	0	0
At 1 April 2008 as restated	146,163	2,623	0	(169)	25,683	174,300
Transfer from the income and expenditure account					19,808	19,808
Fixed asset impairments	0	0	0			0
Surplus/(deficit) on revaluations of fixed assets	0	0				0
Revaluations of available for sale investments			0			0
Receipt of donated assets		95				95
Transfers to the Income and Expenditure Account for depreciation, impairment, and disposal of donated assets		(548)				(548)
Transfer of realised profits/(losses) to the income and expenditure reserve	0	0			0	0
Other transfers between reserves*	(12,733)	845	0	0	11,888	0
At 31 March 2009	**133,430**	**3,015**	**0**	**(169)**	**57,379**	**193,655**

* The Trust has reviewed the revaluation reserve and donated assets balances and has made adjustments to correct some historical errors. These adjustments have no impact upon the Income and Expenditure statement for the year ended 31 March 2009.

There will be an annual transfer between the revalaution reserve and the I&E reserve to account for the amortisation of the revaluation reserve over the life of the assets that have a revaluation reserve attibuted to them. This transfer was £4,415k in 2008/09.

18. Movement in taxpayers' equity

	2008/09 £'000	2007/08 £'000
At 1 April 2008 as previously stated	383,994	340,017
Opening Balance Adjustments	0	0
At 1 April 2008 as restated	383,994	340,017
Surplus/ (deficit) for the financial year	30,692	33,738
Fixed Asset Impairments	0	0
Surplus/(deficit) on revaluations of fixed assets	0	20,886
Public Dividend capital dividends	(10,884)	(11,339)
New public dividend capital received	1,420	5,500
Public Dividend Capital repaid in year	0	(5,513)
Additions/ (reductions) in donated asset reserve	391	(663)
Additions/ (reductions) in other reserves	(844)	1,368
Taxpayers equity at 31 March 2009	**404,769**	**383,994**

19. Notes to the cash flow Statement

19. 1 Reconciliation of operating surplus to net cash flow from operating activities:

	2008/09 £000	2007/08 £000
Total operating surplus (deficit)	25,970	28,319
Depreciation and amortisation charge	18,786	18,132
Fixed asset impairments and reversals	0	401
Transfer from donated asset reserve	(548)	(816)
(Increase)/decrease in stocks	(1,397)	833
(Increase)/decrease in debtors	300	6,787
Increase/(decrease) in creditors	11,076	7,348
Increase/(decrease) in provisions	(40)	(591)
Net cash inflow from operating activities	**54,147**	**60,413**

19.2 Reconciliation of net cash flow to movement in net funds

	2008/09 £000	2007/08 £000
Increase/(decrease) in cash in the period	(7,568)	22,615
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	24,641	10,359
Change in net debt resulting from cashflows	17,073	32,974
Non - cash changes in debt	0	0
Net funds /(debt) at 1 April 2008	60,376	27,402
Net funds/(debt) at 31 March	**77,449**	**60,376**

19.3 Analysis of changes in net funds

	Cash £000	Investments £000
At 1 April 2008	30,017	30,359
Changes in year	(7,568)	24,641
At 31 March 2009	**22,449**	**55,000**

20. Capital Commitments

Commitments under capital expenditure contracts at the balance sheet date were £9,996k (£13,410k at 31 March 2008).

21. Post Balance Sheet Events

There are no significant post balance sheet events.

22. Contingencies

The NHS litigation authority has identified a contingent liability of £115k relating to non-clinical Liabilities to Third Parties (LTPS) claims.

The Trust made a commercial decision during the 2007 / 08 financial year to opt out of a contract. The Trust tested the open market and decided to procure its own solution. The Trust's view was that the open market solution is functionally stronger and will offer more flexibility in the future. Crucially, the Trust believes that the open market solution offers better value for money than the original option.

There is a possibility that the Trust may incur an abortive fee (a fine, in effect) in relation to opting out of the original option. This fine could amount to as much as £3.7m and if paid would have to be charged to the Income and Expenditure Account.

As at 31/3/09 it is not clear what contractual obligation the Trust has in relation to the possible abortive fee. The Trust is taking legal advice on the matter and will challenge the validity of any fee being imposed on it. The Trust recognises that there is a possible obligation as a result of the decision made in the past. Its existence will be confirmed by the occurrence of one or more uncertain events not wholly within the Trust's control and therefore should be disclosed as a contingent liability.

23. Movement in Public Dividend Capital

	2008/09 £000	2007/08 £000
Public Dividend Capital as at 1 April	209,694	209,707
New public dividend capital received	1,420	5,500
Public Dividend Capital repaid in year	0	(5,513)
Public Dividend Capital as at 31 March	**211,114**	**209,694**

24. Related Party Transactions

During the year none of the Board members, governors, key management or parties related to them have undertaken any material transactions with the Trust.

See Note 31 for an analysis of the relationship with Heartlands Education Centre Ltd.

The Trust has entered into a significant number of material transactions with the following organisations in 2008/09:

	Income >£5m £000	Expenditure >£5m £000	Debtor >£500k £000	Creditor >£500k £000
Birmingham & Solihull Mental Health NHS FT	0	0	897	0
Birmingham City Council	0	0	867	0
Birmingham East and North PCT	244,136	0	2,385	572
Heart of Birmingham PCT	20,537	0	0	0
HM Revenue & Customs	0	0	0	10,372
NHS Litigation Authority	0	5,493	0	0
NHS Pension Scheme	0	28,078	0	2,406
NHS Purchasing & Supply Agency	0	10,658	0	817
Sandwell & West Birmingham Hospitals NHS Trust	0	0	824	1,286
Solihull Care PCT	83,634	0	2,741	0
South Birmingham PCT	17,688	0	571	0
South Staffordshire PCT	34,351	0	749	0
University Hospital Birmingham NHS FT	0	0	1,327	645
Walsall Teaching PCT	5,701	0	0	0
Warwickshire PCT	7,539	0	0	0
West Midlands Strategic Health Authority	19,989	0	0	0
Total	**433,575**	**44,229**	**10,361**	**16,098**

25. Private Finance Transactions (PFI)

The Trust has entered into two PFI contracts PFI1 with BHE Heartlands Ltd and PFI2 with EnerG Combined Power Ltd. PFI1 (a 25 year contract) commenced in August 2005 to provide a new main entrance and retail facility at the Heartlands Hospital site. PFI2 (a 15 year contract) commenced in August 2007 for the provision of energy management services at Heartlands Hospital. These contracts are both treated as being off-balance sheet by the Trust following a review of the contracts based on Treasury Taskforce Technical Note 1 "How to account for PFI transactions" which interprets FRS 5 "Reporting the substance of transactions" issued by the Accounting Standards Board.

The annual unitary payments of £28k (PFI1) and £855k (PFI2) made by the operator are included in the income and expenditure account on an accruals basis. There is a payment mechanism that allows for deductions to be made to the unitary payment where the quality standards set out in the contract are not met. The total charge made in 2008/09 was £883k (2007/08 £860k).

The Trust signed a third PFI agreement on 22 December 2008 with EnerG Combined Power Ltd for the provision of energy services at Solihull Hospital. The scheme is scheduled to commence in April 2010 and unitary payments of £681k per year will be paid over the 15 year agreement.

26. Pooled Budgets

The Trust has no pooled budgets.

27. Financial Instruments

FRS 25, 26 and 29, Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities.

The NHS Foundation Trust is not exposed to significant financial risk factors arising from financial instruments. The continuing service provider relationship that the NHS Foundation Trust has with local Primary Care Trusts and the way those Primary Care Trusts are financed, means that the NHS Foundation Trust is not exposed to the degree of financial risk faced by business entities. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities.

Market Risk

Market risk is the possibility that financial loss might arise as a result of changes in such measures as interest rates and stock market movements. The NHS Foundation Trust's transactions are undertaken in sterling and so it is not exposed to foreign exchange risk. It holds no signifcant investments other than short-tem bank deposits. Other than cash balances, the NHS Foundation Trust's financial assets and liabilities carry nil or fixed rates of interest and the NHS Foundation Trust's income and operating cashflows are substantially independent of changes in market interest rates.

Credit Risk

Credit risk is the possibility that other parties might fail to pay amounts due to the NHS Foundation Trust. Credit risk arises from deposits with banks and financial institutions as well as credit exposures to the NHS Foundation Trust's commissioners and other debtors. Given the current economic climate surplus operating cash is only invested with banks and financial institutions that are rated independently with a minimum score of A1 (Standard and Poor's), P-1 (Moody's) or F1 (Fitch). The NHS Foundation Trust's net operating costs are incurred largely under annual service agreements with local primary care trusts, which are financed from resources voted annually by Parliament.

Liquidity risk

Liquidity risk is the possibility that the NHS Foundation trust might not have funds available to meet its commitments to make payments. Prudent liquidity risk management includes maintaining sufficient cash and the availability of funding from an adequate amount of committed credit facilities. NHS foundation trusts are required to comply with the Prudential Borrowing Code made by Monitor, the Independent Regulator of Foundation Trusts, and further details of the NHS Foundation Trust's compliance can be found at note 32 'Prudential Borrowing Code'. The

Note 27.1 Financial assets by category

	Total	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale
	£000	£000	£000	£000	£000
Assets as per balance sheet					
NHS Debtors	14,215	14,215	0	0	0
Provision for irrecoverable debts	(5,306)	(5,306)	0	0	0
Accrued income	2,950	2,950	0	0	0
Other debtors	4,692	4,692	0	0	0
Current asset investments	55,000	55,000	0	0	0
Cash at bank and in hand	22,449	22,449	0	0	0
Total at 31 March 2009	**94,000**	**94,000**	**0**	**0**	**0**
NHS Debtors	10,110	10,110	0	0	0
Provision for irrecoverable debts	0	0	0	0	0
Accrued income	1,258	1,258	0	0	0
Other debtors	6,013	6,013	0	0	0
Current asset investments	30,359	30,359	0	0	0
Cash at bank and in hand	30,017	30,017	0	0	0
Total at 31 March 2008	**77,757**	**77,757**	**0**	**0**	**0**

Note 27.2 Financial liabilities by category

	Total	Other financial liabilities	Liabilities at fair value through the I&E
	£000	£000	£000
Liabilities as per balance sheet			
NHS Creditors	(6,830)	(6,830)	0
Other creditors	(2,354)	(2,354)	0
Accruals	(24,607)	(24,607)	0
Capital Creditors	(4,966)	(4,966)	0
Finance lease obligations	(1,792)	(1,792)	0
Provisions under contract	(2,449)	(2,449)	0
Total at 31 March 2009	**(42,998)**	**(42,998)**	**0**
NHS Creditors	(9,393)	(9,393)	0
Other creditors	(5,297)	(5,297)	0
Accruals	(21,559)	(21,559)	0
Capital Creditors	0	0	0
Finance lease obligations	(1,845)	(1,845)	0
Provisions under contract	0	0	0
Total at 31 March 2008	**(38,094)**	**(38,094)**	**0**

Notes

In accordance with FRS 29, the fair value of short term financial assets and liabilities (held at amortised cost) are not considered significantly different to fair value.

Fair value is not considered significantly different to book value for the long term financial liabilities.

Foreign Currency Risk

The Trust has negligible foreign currency income or expenditure.

27.3 Fair Values

Set out below is a comparison, by category, of book values and fair values of the Trust's financial assets and liabilities as at 31 March 2009.

	Book Value	Fair Value	Basis of fair valuation
	£000	£000	
FINANCIAL ASSETS			
Debtors over 1 year:	0	0	
Other	55,000	55,000	
Total	**55,000**	**55,000**	
FINANCIAL LIABILITIES			
Creditors over 1 year - Finance lease obligations	1,601	1,601	Note a
Provisions under contract	2,449	2,449	Note b
Total	**4,050**	**4,050**	

Notes

a To obtain fair value, cash flows have been discounted at prevailing market interest rates for finance leases for a similar term.

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.

28. Third Party Assets

The Trust held £22k (£10k 2007/08) cash at bank and in hand at 31/03/09 which relates to monies held by the Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts.

29. Intra-Government and Other Balances

	Debtors: amounts falling due within one year	Debtors: amounts falling due after more than one year	Creditors: amounts falling due within one year	Creditors: amounts falling due after more than one year
	£000	£000	£000	£000
Balances with other Central Government Bodies	10,531	0	3,446	0
Balances with local authorities	901	0	12,800	0
Balances with NHS Trusts and Foundation Trusts	4,132	0	3,384	0
Balances with public corporations and trading funds	11	0	0	0
At 31 March 2009	**15,575**	**0**	**19,630**	**0**
Balances with other Central Government Bodies	13,011	0	6,473	0
Balances with local authorities	399	0	38	0
Balances with NHS Trusts and Foundation Trusts	2,918	0	2,915	0
Balances with public corporations and trading funds	3	0	5	0
At 31 March 2008	**16,331**	**0**	**9,431**	**0**

30. Losses and Special Payments

There were 200 cases of losses and special payments totalling £362k approved during 2008/2009 (307 in 2007/08). These are the cash payments made during the year and are not calculated on an accruals basis. In addition, bad or irrecoverable debts were written off totalling £65k (83 cases) in the year as a result of a cleanse of the debtors ledger (£62k and 233 cases in 2007/08).

There were no cases in the current or prior year where the net payment exceeded £100k.

31. Subsidiary relationships

In applying the principles of FRS 2 Heart of England Foundation Trust has a subsidiary relationship with Heartlands Education Centre Limited (HECL). The net assets of the Company are not deemed material to the group position, and therefore is not consolidated into group accounts and no group accounts are prepared. The following table sets out the net assets of the Company in relation to Heart of England Foundation Trust and the Company's net profit results.

	2008/09	2007/08
	£000	£000
HECL net assets	(142)	(144)
HEFT net assets	404,769	383,994
%	**-0.04%**	**-0.04%**
HECL net profit	3	16
HEFT net profit	19,808	22,399
%	**0.02%**	**0.07%**

Adrian Stokes (Finance Director for the Trust) also sits on the Board of Directors with HECL.