Annual Report and Accounts

2005-06

Heart of England NHS

NHS Foundation Trust

Contents

1.	Chairman's Statement	1
2.	Chief Executive's Statement	2
3.	Operating and Financial Review	3
4.	Going Concern	11
5.	Governors' Consultative Council	12
6.	Board of Directors' Report	13
7.	Membership Report	17
8.	Remuneration Report	20
9.	Statement of Accounting Officer's Responsibilities	23
10.	Statement on Internal Control	24
11.	Auditor's Opinion and Certificate	27
12.	Accounting Policies	30
13.	Income and Expenditure Account	35
14.	Balance Sheet	35
15.	Statement of Total Recognised Gains and Losses	36
16.	Cash Flow Statement	36
17.	Notes to the Accounts	37

1. Chairman's Statement

The first year as a Foundation Trust heralded the beginning of a new era for Heart of England NHS Foundation Trust and the population it serves. The Trust has experienced new levels of financial and operational freedom which have enabled better planning and development of services. Healthcare can now be specifically designed according to the current and future needs of the local community.

The 50,000 members, represented by a board of 33 Governors have already influenced the agenda. The Governors' Consultative Council has carried out the recruitment and appointment of three new non-executive directors.

Anna East and Paul Hensel bring a wide range of experience to the Trust in terms of legal expertise and IT knowledge respectively. The Governors also reappointed myself and another non-executive director, John Perry, for a further term. After a tendering and recruitment process, the Governors appointed PricewaterhouseCoopers as the Trust's external auditor. The Governors have also given interesting and useful feedback regarding the Trust's performance, nursing standards and infection control. Their views are of great value as they represent the local population and the wider public as a whole.

The staff continued to be the Trust's greatest asset and we are particularly proud of their efforts last year in improving efficiency and care standards. Staff embraced the challenge of adapting to ways of working that meet the needs of a new dynamic foundation trust, ensuring high standards of patient care remain a priority.

In November Heart of England embarked on a new challenge of helping another NHS trust. The work with Good Hope Hospital NHS Trust has allowed its Board to understand its historical difficulties and plan for the future. The strategy developed together involves Good Hope becoming part of a larger organisation. Within the next few months, it will be known whether this Trust will be that organisation. Just as partnerships with primary care are valuable, the opportunity should be taken to build a closer partnership with this neighbouring hospital for the benefit of the whole health economy.

Close clinical relationships with primary care through the Working Together for Health initiative continue. Last year almost 1,300 patients who would have come into hospital were treated in the Partners in Health Centre in the local community. Within the Centre, the Trust's consultants work alongside primary care practitioners to manage chronic disease through a multi disciplinary one-stop approach.

Last year was a tremendous year for the Trust and we look forward to the future with confidence. The Trust won a number of awards over the year, most notably the Highly Commended Trust in the Health Service Journal's 'Acute Trust of the Year' and the Nursing Times' 'Top 10 Places to Work'. I would like to express my gratitude to all those involved in our achievements, particularly the loyalty and efforts of our staff, who have helped ensure Heart of England is one of the best trusts in the country.

2. Chief Executive's Statement

This was the Trust's most successful year to date in terms of operational and financial performance. We met and, in many cases, exceeded the Government's targets for clinical standards and waiting times.

It has been a difficult time for the NHS as a whole, with the old horror stories about waiting times being replaced with a new kind of nightmare: financial deficit. While other local trusts seem to have difficulties, our position is entirely different. We are pleased to have ended the year with a surplus of over £5 million.

In our first year as a Foundation Trust we resolved to proceed cautiously. This approach has served us well. The Trust achieved excellent performance across all areas without incurring any financial problems. Great credit is due to all staff who have taken responsibility for managing the complex balance between maintaining the quality of service whilst also ensuring that we do not spend beyond our means. This is not easy, as the problems incurred by other organisations demonstrates.

Achieving financial balance is a challenge. As well as careful budgeting and management, it is essential to improve efficiency of staff and services. This ensures that we are paid for the services we provide and that any profits are channelled back into making further improvements. Since becoming a foundation trust, we have restructured the management team to reflect the changing needs of the organisation. This has included the appointment of a managing director to monitor and drive forward the overall performance of the business, as well as two operational directors to oversee the areas of medicine and surgery. This has led to a greater strategic direction, working alongside the existing model of clinical leadership.

These are some of the skills we have taken with us to Good Hope Hospital NHS Trust. There, I am currently Chief Executive as part of a management contract we have with their Board. I hope our relationship with Good Hope becomes a permanent one and that we can work together to provide equal access to good quality healthcare for people throughout Birmingham.

A great deal has been done to ensure that the coming year will be just as successful for Heart of England NHS Foundation Trust. We have agreed with the main primary care trusts how much work we will be doing. This has been translated into clear plans, within clinical standards and to workable budgets. By having sound financial planning, this Trust has avoided the pitfalls which have caught out so many other NHS organisations. We are free to concentrate our energies on a more important goal: to improve patient services.

By sheer hard work we have taken control of our destiny and protected our patients. At a time of uncertainty in the NHS, we can be confident. At a time of saving in the NHS, we can make planned investments. We remain poised to continue our development as one of the leading foundation trusts in the NHS.

3. Operating and Financial Review

Operational Reporting

Trust Background

Heart of England NHS Foundation Trust was formerly known as Birmingham Heartlands and Solihull NHS Trust (Teaching). It was founded in 1996 when Birmingham Heartlands Hospital and Solihull Hospital merged to form one Trust, operating across three sites at Heartlands Hospital, Solihull Hospital and Birmingham Chest Clinic in the city centre.

Since the merger, further developments have taken place across Heartlands and Solihull sites: opening new pathology laboratories; Elderly Care and Infections Diseases units; three new children's wards; new day surgery and women's units; new medical units, and West Midlands Adult Cystic Fibrosis unit.

On 1st April 2005, the Trust became a foundation trust and changed its name to Heart of England NHS Foundation Trust to reflect the additional opportunities that are available to the management as a foundation trust. The Trust was approved as a foundation trust following intensive scrutiny by Monitor, the Independent Regulator of NHS trusts, and by other professional organisations.

NHS foundation trusts are often referred to as 'foundation hospitals'. They are a new type of organisation, created under the Health and Social Care (Community Health and Standards) Act 2003. NHS foundation trusts remain part of the NHS but have been set free from central government control. They possess three key characteristics that distinguish them from NHS Trusts:

- Freedom to decide locally how to meet their obligations.
- Accountable to local people, who can become members and governors.
- Authorised and monitored by Monitor.

Trust Specialities

The hospitals within the Trust have national and regional clinical services on site as well as secondary care, emergency and elective practices. The Trust employs over 6,000 staff, has over 1,100 beds and serves a population of half a million. It cares for 84,000 inpatients, treats over 350,000 outpatients and approximately 140,000 accident and emergency attendees each year. This makes the Trust one of the largest in England.

The Trust has regional specialities in invasive cardiology; renal dialysis; neonatology; bone marrow transplants; HIV Aids; thoracic surgery; cystic fibrosis; oncology and neurology.

The accident and emergency department is not only one of the busiest in the country, but one of the most advanced of its kind in the UK. It even includes the region's only heli-pad equipped for night landings.

Management of the Trust

A review of the management structure of the Trust was conducted in April 2005 entitled 'Operational Management - the Next Evolution' which focussed on restructuring the clinical management teams and considered the interfaces with the non-clinical departments. In addition, the Trust has commissioned a review of its committee structure which is due to report in Summer 2006.

On becoming a foundation trust, the Trust also expanded the expertise base of its non-executive directors to bring in specialists with financial, legal and IT knowledge. This adds to the local expertise brought to the Board by the existing non-executives. A full listing of board members is shown in the Board Report on page 13.

Over the past 12 months, the Trust has also strengthened the operational team by creating new roles:

- The new Information Communications Technology Director gives more focus to technology within the Trust and its interface into wider NHS projects;
- The new Chief Finance Officer role allows more attention and focus on the more commercial aspects of being a foundation trust. Later in the year, this role was combined with the new Managing Director post, monitoring and driving forward the overall performance of the business;
- The Company Secretary role ensures the compliance codes and corporate governance codes issued by Monitor and the Healthcare Commission are being met.

In addition to regular Trust Board meetings, there are a number of sub-committees that meet regularly including Audit Committee, Donated Funds Committee and Operational Board. The Operational Board is in turn supported by sub-committees all of which meet monthly and produce reports, including Executive Directors' meetings; Human Resources; Finance; Site Strategy; Clinical Governance; Projects and Purchasing; Surgical Management; Medical Management and the Facilities Executive Board.

Trust Strategy

The vision of the Trust is to create a centre of excellence in the provision of healthcare and education.

Supporting this mission statement are six strategic objectives:

- To be financially secure;
- To be local provider of choice;
- To be local employer of choice;
- To provide highest quality care;
- To grow the business for our own and the City's prosperity; and
- To continually learn and innovate.

During the year, the Trust has developed an effective performance monitoring system based on the principles of the European Framework for Quality Management (EFQM) excellence tool. This has led to the Trust becoming more results focussed with an emphasis on continuous improvement.

Each of the six strategic objectives have been further spilt into performance measures. These performance measures have been developed into a Trust scorecard, or Key Performance Indicators (KPIs). Each indicator has an identified target, based on national and local targets and behind each result is an action plan. Every month, a full set of KPIs are presented to the Executive Directors who update their business planning models to reflect the action needed to achieve the targets. This is in-turn presented to the Trust Board to provide assurance that the Trust is achieving its strategic objectives.

As part of a longer term strategy, the Trust has developed a Transformation Map showing what general areas the Directors need to focus on to continue to deliver the Trust's mission.

Risk Management

The Trust reports on its risk register monthly to the Trust Board. The Directors have identified key risks to delivering this strategy, covering areas including infection control; operating under the Payment by Results and Choice frameworks; delivering an IT and new business strategy that is relevant to the Trust.

The Trust Board reviews the controls in place to mitigate these risks and monitors progress against agreed actions.

Patient Care

At the heart of the Trust's strategy is the belief that patients should be treated in the right place, by the right people at the right time. To support this, Dr Hugh Rayner, Medical Director for Medicine, reports:

"A very wide range of innovative services are now being delivered by collaboration between staff in the Trust and from Eastern Birmingham Primary Care Trust in the Partners in Health Centre, including patient education classes, group consultations, chronic disease management services and triage clinics. This will develop the Trust's role as the local provider of choice for specialist chronic disease management services."

Financial Re

Access

The accident and emergency four-hour wait target has been one of the most challenging to achieve, partially due to a growth in the number of patients attending the department. The final position for the Trust against this target was 98.1% of patients being treated within the four-hour wait target - see figure 1.

The Trust achieved all its inpatient and out-patient national targets, where no patients waits longer than:

- 13 weeks for an outpatient appointment
- Six months for inpatient care.

However, the Trust did not meet all of the very rigorous local targets. These local targets have been further reduced for 2006/07 as the Trust works towards continually improving and achieving the national target of 18 weeks from referral to treatment by December 2008.

The graphs in figures 2 and 3 demonstrate that there was no-one waiting above the national targets. The results highlighted in black show the locally agreed targets of 11 weeks for outpatient appointment and three months for inpatient treatment.

The Trust continued to maintain its 100% success rate throughout the year for:

- Patients being admitted for elective revascularisation within three months;
- Patients being seen in rapid access chest pain clinics within two weeks;
- Patients being readmitted within 28 days of a cancelled operation.

In addition, the Trust has been equally as successful with 100% of patients being fully booked for outpatient referrals, day cases and inpatient elective procedures at the end of the year.

Figure 1 **A&E 4hr Performance**

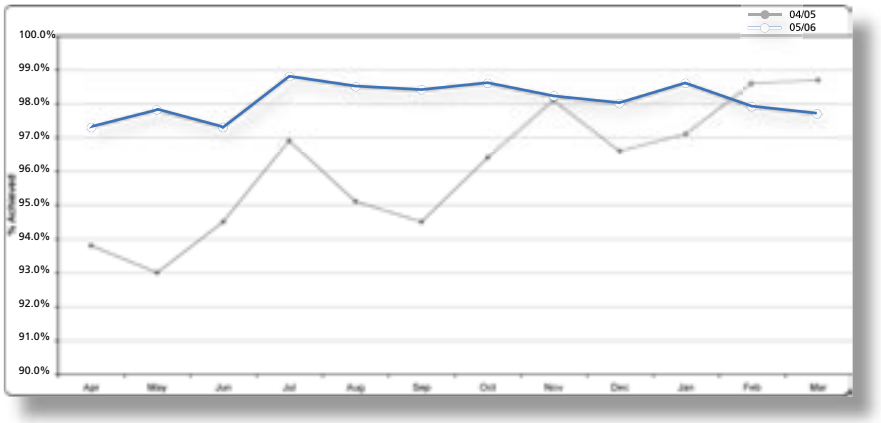


Figure 2 **Outpatient Waiting List at 31 March 2006**

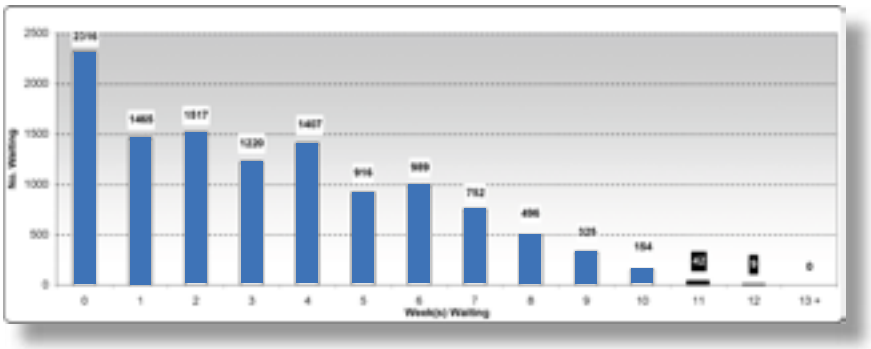
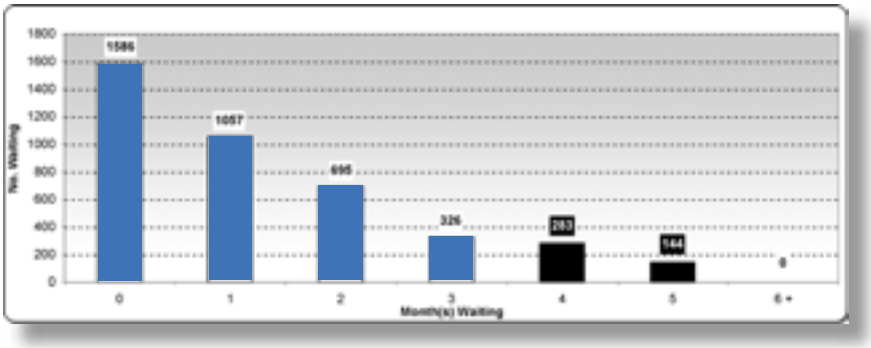


Figure 3 **Daycase and Elective Waiting List at 31 March 2006**



The national cancer targets of 100% of patients being seen within:

- Two weeks for urgent referral for suspected cancer;
- 31 days from diagnosis to treatment of cancer;
- 62 days from urgent referral to treatment;

were all achieved by the December 2005 deadline.

Patient Satisfaction

Dame Jill Ellison, Nursing Director, says:

> *"The provision of high standards of patient care is crucial to the long term success of the Trust. Customer care is now second only to infection control on the Trust's Strategic Risk Register. Many of the Trust's KPIs are aimed at providing high standards of patient care and have been produced directly in response to feedback from patients and carers. It is very encouraging, therefore, that in 2005/06, solid progress has been made against the majority of performance indicators."*

The Trust is committed to ensuring that patient satisfaction is improved and results were developed in four key areas to measure this:

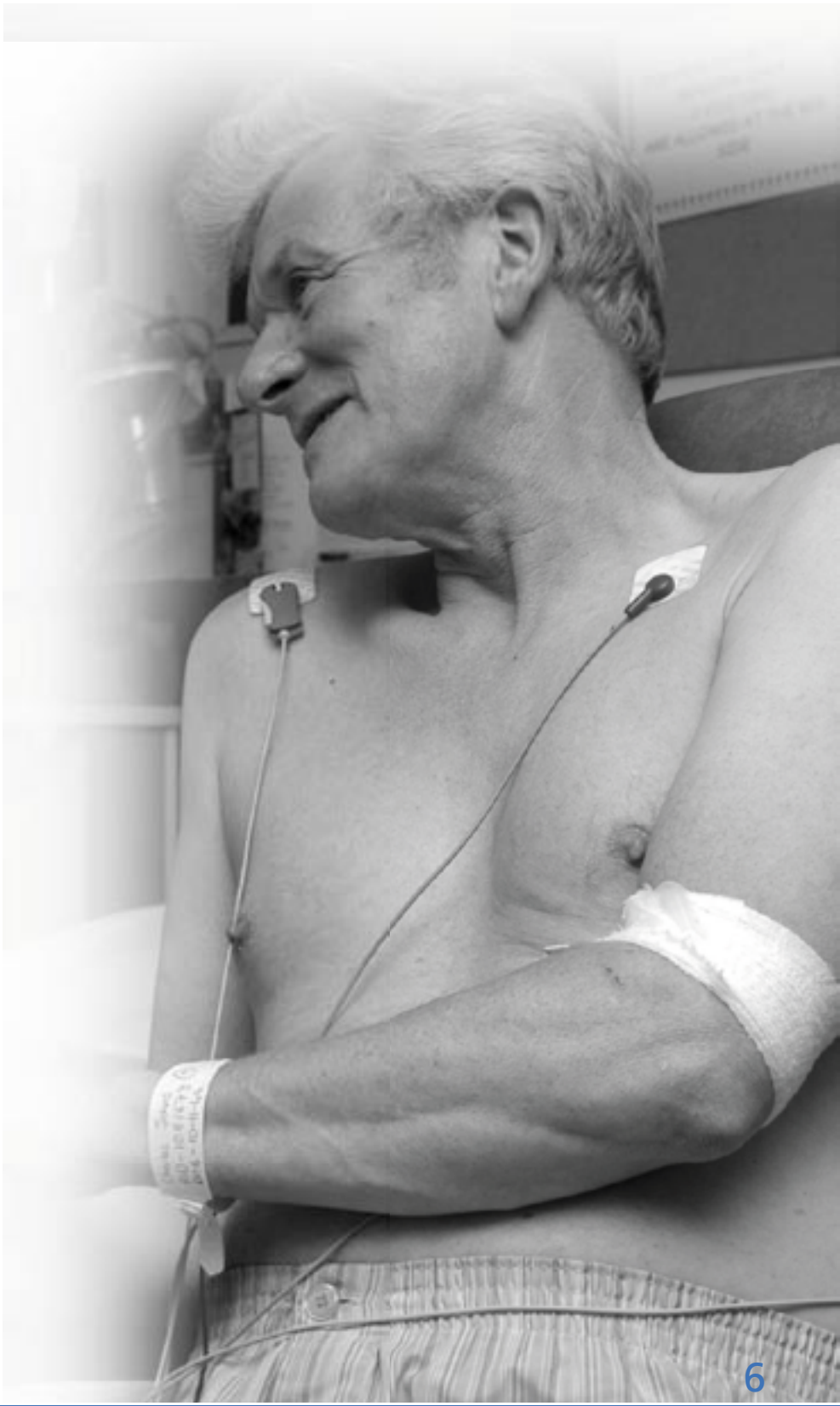
- Perception
- Environment
- Treatment outcomes
- Behaviour.

Hugh Rayner, Medical Director for Medicine, states:

> *"The importance of the quality of our patient care was recognised during the year by the writing of an In-patient Care Strategy, subtitled 'Putting Ourselves in the Patient's Position'. The strategy deals with all aspects of the quality of our service and includes a detailed implementation plan against clear targets. This is being managed by a dedicated Board, chaired by the Deputy Director of Nursing, Nicola Rabjohns."*

Patient Perception

The Trust has reviewed how patents perceive the care they receive using patient feedback in the form of complaints and claims.



Towards the end of the year there was a reduction in the number of complaints being responded to within 20 days. The Trust out-turned at 80.8% against a national target of 85%, this is a decrease against the 90.4% achieved for 2004/05.

The number of successful claims against the Trust has reduced from 2004/05 (table 1) and work is focussed on continuing this trend.

Table 1 - Successful claims

Type of claim	2004/05	2005/06
Clinical Claims	19	16
Non-Clinical Claims	17	7

Patient Environment

The Trust regularly reviews a number of aspects of the environment, including cleanliness, health and safety and other aspects of risk management.

Dr Rowland Hopkinson, Medical Director for Governance, states:

"In March, the Trust successfully renewed its Clinical Negligence Scheme for Trusts (CNST) Level 2 accreditation, a significant achievement given the increasingly stringent standards. This complements the achievement of the Maternity Services in obtaining CNST Level 3. The Trust is also using risk prioritisation to guide investment decisions with developed risk registers at all levels of the organisation."

In 2005/06, the Trust reduced the number of serious patient incidents from eight to five, there were no serious staff incidents and no Health and Safety Executive Enforcement Notices served on the Trust.

Whilst the Trust participated in the national patient surveys and a number of MORI polls were undertaken on specific issues, a plan to develop regular quarterly surveys to provide feedback from patients is being taken forward in 2006/07.

The MORI polls produced very positive results, with the national inpatient surveys identifying real improvements compared with the previous year in relation to patients' confidence in nursing staff, being treated with respect and dignity, and cleanliness. The vast majority of patients felt that the quality of care they received was good or excellent, only 2% thought it was poor.

Early in the year, the Trust received adverse publicity in relation to cleaning standards. A considerable amount of work was undertaken to address the issues raised and the feedback following this work was extremely positive.

A number of detailed measures were developed to monitor cleaning standards and these have been achieved.

Treatment Outcomes

The measures for treatment outcomes have been primarily based on current or previous national targets. Mortality rates following surgery have shown a continued downward trend on the last two years - table 2.

Table 2 - Mortality rates

Result	Target	March 04	March 05	March 06
Clinical Claims	≤ last years actual	7.04%	4.73%	16

For the first six months of the year, the Trust recorded a low level of MRSA. However the second half of the year saw an increase which resulted in a year end position of 77, a rise of 9 on 2004/05 out-turn. This was within the national target of 85 set for the Trust.

The Trust has significantly fewer cases of clostridium difficile, down 30% to 513 from 729 in 2004/05.

Behaviour

Dame Jill Ellison, Nursing Director, states:

> *"The Trust receives approximately one nursing complaint for every 825 episodes of care. A common thread in complaints relates to communications and in order to tackle this head on, there have been a number of new initiatives including the introduction of the new Redcoat role at ward level. Although it is too early to measure the impact, initial feedback is suggesting that these posts are proving popular with patients, visitors and staff."*

Stakeholder Relations

External Reputation

Lisa Dunn, Director of Corporate Affairs, states:

> *"The reputation of the Trust is crucial in determining its future in the era of Patient Choice. Key channels for promoting services and securing referrals were identified, with the main targets being the media, GPs and members of the Trust."*

MORI poll results for Birmingham and the Black Country suggested that 76% of patients will ask their GP which hospital to choose for their treatment. Therefore, two of the indicators tackled the issue of GP complaints and GP new referrals.

Referrals increased, and GP complaints dropped from 22 per month in April 2005 to just five a month in March 2006.

Despite some high profile negative media publicity the Trust has successfully increased its positive media coverage by over 50% on 2004/05 (table 3). Where there was an opportunity, the media team tried to include a Trust statement in negative stories, to give a more balanced view. Over 82% of all the media coverage the Trust received was positive or balanced in nature.

Table 3 - Positive media coverage

	2004/05	2005/06
Positive items of media coverage	243	372

Membership

With almost 50,000 members, the aim was to build a good reputation with members through regular communication. Although membership increased, the ambitious target set for 2005/06 was not met, as the level of attrition was greater than expected. However, the increases were in the Group 1 and 2 members, which are the groups that want a greater level of involvement.

Staff

Two things have dominated the Human Resources agenda this year:

- Agenda for Change – the new pay structure for the NHS. The Trust achieved all the targets set nationally and was consistently one of the best performing Trusts in the region against the targets.
- Improving Working Lives – during 2005/06, the Trust achieved practice plus status. The presentation of this award followed a week-long external review and demonstrates that the Trust is committed to the principles of:

- Flexible working and retirement
- Training and development
- Healthy working
- Equality and diversity
- Staff involvement
- Childcare and carers

Whilst there is still some outstanding work to be finalised for Agenda for Change, both of these initiatives go some way to ensuring that staff satisfaction is improved.

Other measures such as vacancy rates have not been easy to measure and work has been ongoing to ensure that this data will be provided for next year. Sickness has increased to 5.31% for March 2006 compared to 4.71% for the same time last year. The Trust will shortly begin a pilot study using a Sickness Call Centre – with the aim to facilitate a reduction in sickness rates.

The annual staff satisfaction survey for 2005 showed an improvement on the previous year, the Trust's score being higher than the average for acute trusts.

Anne Gynane, Acting HR Director, states:

> *"Staff satisfaction levels have improved this year, with the Trust scoring in the top 20% of Trusts in a number of areas of the annual Staff Opinion Survey conducted by the Healthcare Commission. This has impacted on staff turnover which continues to fall and is nearly 2% less than 2004/05."*

A Staff Charter has been developed detailing staff's rights and responsibilities and has been widely circulated to all staff.

Training

The Trust's aim is to ensure that all staff have state of the art training and equipment to carry out their job competently. As part of the Agenda for Change process, all posts in the Trust need to have a Knowledge and Skills Framework developed. The Trust successfully achieved the target of all posts having a KSF outline by the end of March 2006.

The Trust is keen to innovate and develop new ways of working. Dr Hugh Rayner, Medical Director for Medicine, explains:

> *"The Working Together for Health (WTfH) Programme has progressed well during 2005/06. The WTfH Service Strategy was developed by the Medical Directors of the Trust, Eastern Birmingham and Solihull PCTs following their attendance at the Permanente Medical Group's New Chiefs' Orientation Programme in California in October 2005. It was disseminated to a large number of staff from the three organisations at a week-long workshop held in Torbay in January 2006. Its content was subsequently reiterated in the Government White Paper 'Our Health, Our Care, Our Say.'"*

Innovative developments in care require the need for new skills and competencies; this will be taken forward through a new Organisational Development programme. Dr Rowland Hopkinson, Medical Director for Governance, commented:

> *"After a comprehensive tendering exercise, the Trust is in the process of commissioning an Organisational Development programme to target the changing demands of the service upon employees."*

Communication

All members of staff at the Trust are regularly updated on events and developments at the Trust using a variety of means including:

- Monthly e-mail bulletin from the Chief Executive;
- Monthly staff magazine 'Heart and Soul' where contributions are made by a variety of staff groups;
- Trust wide Intranet;
- Monthly Core Brief.

Finance

2005/06 Performance

Beccy Fenton, Chief Financial Officer, and Adrian Stokes, Finance Director, are pleased to report that:

> *"2005/06 has been one of the most successful years for the organisation financially. The Trust has exceeded all of its*

financial targets set out at the start of the year in Monitor's approved Annual Plan. We have achieved the lowest financial risk rating possible for a foundation trust in its first year. As well as achieving this excellent financial position, the Trust has been able to invest over £2.5 million recurrently in real quality improvements, which will benefit patients.

"Whilst the rest of the NHS faces significant financial difficulties, this Trust has had a prudent year, getting back into recurrent financial balance and putting ourselves in a strong position going into 2006/07 and beyond. This success is down to the strong financial management shown right across the organisation and the commitment from Clinical Boards, the Facilities Board and the Corporate departments to achieve financial balance."

The Trust has had a positive first year as a foundation trust, exceeding the planned net surplus target by £1.9m delivering a surplus of £5.4m. This is due to huge efforts across the organisation to deliver activity above the planned levels whilst still constraining costs within budgeted levels and excellent relationship building and negotiation with local PCTs and other commissioning agents.

The financial risk rating reported at March was at a level 4.

Activity has increased since last year and exceeded plan across all income classes. The improvement on the planned surplus is as a result of increases in income without large increases in cost. Income increased by £0.7m due to recognising income due on partially completed 'spells', recognising £0.7m of cumulative research profit, and by £6m from over-performing contracts. Costs were lower than planned because prudent contingency reserves, included at the beginning of the year, were not spent. This was partly offset by increased costs of delivering activity and £2.8m of accelerated depreciation.

As well as patient care income, there are a number of additional sundry income streams, including commercial research (£2.9m), catering income (£1.4m) and services provided for corporate services such as building maintenance, IT and Occupational Health Services.

Private patient income at £0.4m is in line with Plan and remains below the capped rate (see note 3 to the Accounts).

The cash flow over the year has been carefully managed, ensuring PCTs pay on time and older debts are chased routinely. There was a bad debt write-off in the third quarter of the year to clear off some older outstanding debt where there was minimal chance of the debt being recovered. This has assisted a review of the debtors' ledger. A bad debt provision has been created throughout the year to provide against other specific bad debts that may arise in the future. Where there has been a cash surplus, it has been placed on deposit with the National Loans Account to earn higher rate of interest. During the year, a Treasury Management Policy has been approved by the Trust Board. This policy was implemented on 1st April 2006 and allows deposits to be placed with commercial banks, in line with the guidelines on best practice issued by Monitor.

The Trust has not required the use of the overdraft facility at any point in the year and does not anticipate using it in the next financial year. There has been no borrowing by the Trust in 2005/06.

A capital plan of £7.9m was approved by the Trust early in summer 2005, based on a scoring matrix and the priorities of the Trust. This has been regularly reviewed and, although some of the plan was not delivered by the end of March 2006, this work is scheduled to be completed by the summer of 2007.

The capital plan included routine replacement and upgrades as well as some more strategic schemes to allow the Trust to grow and develop in line with its objectives. This capital plan was split between refurbishment and upgrade work of £4.5m and strategic developments of £3.4m.

The Trust is developing a five year Capital Plan outlining the developments expected over the next five years. This includes site developments, particularly on the Solihull Hospital site and other more strategic developments that will enhance the services and reputation of the Trust. The Trust is considering borrowing from external financing facilities against some of the larger and more commercial schemes.

Financial Risks

The key financial risks facing the Trust in 2005/06 were Agenda for Change costs, delivering planned activity levels and receiving payment for over-performance from PCTs. These risks have been closely managed by Finance Committee throughout the year to ensure that mitigating action to remove the risks was taken.

There have been no significant post balance sheet events that affect the Trust.

Charitable Funds

The Trust also runs a Charitable Trust, through a separate Charitable Funds Committee, which reports to the main Trust Board. Donations made by individuals and organisations to the Trust's Charitable Fund have a profound effect on care and treatment provided to the patients within the Trust. A separate Trustees' Report and set of Accounts are prepared each year. For a copy of this, or information on fundraising, please contact the Communications Department on 0121 424 3337 or e-mail communications@heartofengland.nhs.uk.

Improving Value for Money

The Trust measures its activity performance by month. The majority of the targets were achieved throughout the year and by month 12 the Local Delivery Plan (LDP) targets had been achieved across all categories. The Trust has also set itself targets for productivity measures including reducing inpatient length of stay for medical and surgical patients, outpatient 'did not attend' rates and increasing theatre cases per list.

Nationally, there has been a focus on the amount of money spent on agency nursing and medical staff. The Trust has reduced the expenditure on agency staff in 2005/06 compared to 2004/05.

Investment in new ventures

A new strategic objective has arisen from the Service Development Strategy produced for the Foundation Trust application. As a foundation trust, the Trust's income from non-LDP contracts is allowed to increase.

In 2005/06 there has been a small increase in the Trust's amount of private patient and research and development incomes. As a result of the loss of an external contract our catering income decreased.

Chief Finance Officer, Beccy Fenton, states:

"In our first year as a foundation trust we have begun to look at ways of generating income streams from non-traditional NHS markets. The Trust has generated over 50 ideas and a new committee, the Commercial Development Committee, established in April 2006, will start to prioritise these ideas and turn them into full business cases for consideration by the Trust Board.

"A Trust Commercial Strategy is currently being drafted which will set out the targets process for growing new income streams. Current areas of development include a Medipark on Belchers Lane, expansion of external catering contracts and development of private patient income. The performance for 2005/06 creates a sound basis for development of our Commercial Strategy."

4. Going Concern

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

5. Governors' Consultative Council

There are 33 Governors serving the Trust who have been appointed for a three year period and are eligible for re-election or reappointment for a further three years. There were no elections during 2005/06. The Governors were initially elected as follows:

17 - public governors, by ballot of members.
5 - staff governors, by ballot of Trust staff.
9 - stakeholders governors, by appointment.
2 - patient governors, by ballot of members.

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 NHS Foundation Trust.

You can access a register of governors' interests by writing to:

Company Secretary
Heart of England NHS Foundation Trust
Heartlands Hospital
Bordesley Green East
Bordesley Green
Birmingham
B9 5SS

The Governors' Consultative Council includes:

Title	Forename	Surname	Constituency
Mr	Roy	Gillard	Public: Birmingham at large
Mrs	Julie	Keogh	Public: Birmingham at large
Dr	Syed Raza	Hussain	Public: Birmingham Central
Mr	John	Jebbett	Public: Birmingham Central
Mr	David	O'Leary	Public: Birmingham Central
Mrs	Pam	Sumner	Public: Birmingham Central
Mrs	Irene	Wright MBE	Public: Birmingham Central
Mr	David	Proctor	Public: Birmingham East (resigned 31/5/06)
Mrs	Olympia	Cargill	Public: Birmingham East
Mr	Mohammed	Zubair Khan	Public: Birmingham East
Mr	John R	Foster	Public: Solihull Central
Mrs	Frances	Linn	Public: Solihull Central
Mr	Peter	Grace	Public: Solihull Central
Mrs	Valerie	Egan	Public: Solihull North
Mrs	Janice Ann	Walford	Public: Solihull North
Mr	Tony	Whittle	Public: Solihull North
Mrs	Sheila	Blomer	Public: Solihull South
Mr	Alec	Weight	Patient
Mrs	Jean	Weight	Patient
Mr	Martin	Collard	Staff: AHP, Technician or Clinical Support Worker
Mr	Andrew	Clements	Staff: Ancillary, Admin, Volunteer or Management
Dr	Paul M	Dodson	Staff: Medical & Dental
Mrs	Maureen	Garland	Staff: Nursing, Midwifery & Healthcare Assistant
Mrs	Catherine	Wilson	Staff: Nursing, Midwifery & Healthcare Assistant
Mr	Aftab	Chughtai	Stakeholder
Councillor	Alderman Don	Lewis	Stakeholder
Professor	Christopher	Ham	Stakeholder
Professor	Stewart	Buchanan	Stakeholder
Mr	Roy	Shields	Stakeholder
Dr	Qulsom	Fazil	Stakeholder
Mrs	Jan	Prior	Stakeholder
Councillor	Bob	Sleigh	Stakeholder
Mr	Lee	Richards	Stakeholder

6. Board of Directors' Report

The Board of Directors is chaired by Mr Clive Wilkinson, who has been appointed by the Governors for a further four year period commencing 1 April 2006.

The Chief Executive Officer (CEO) is Dr Mark Goldman. Other than the Chairman and CEO, there are seven non-executive directors and six executive directors. Mr Mark Gannon resigned from the Medical Director for Surgery post on 31 March 2006. This post and two non-executive director posts are currently vacant. A new Director of Human Resources has been recruited and is to commence working at the Trust in July 2006. This post has previously been held by Anne Gynane, as Acting Director of Human Resources.

Non-executive directors are appointed for two or four years, dependent upon terms of appointment, and are terminable with one month's notice on either side.

The non-executive directors are:

Name
Mr Clive Wilkinson
Cllr Sue Anderson (resigned 31 March 2006)
Ms Anna East
Mrs Denise Friend (resigned 8 May 2006)
Mr Paul Hensel
Professor John Perry
Mr Bernard Spittle
Mr Alaba Okuyiga

The directors hold no material interests in organisations which may conflict with their responsibilities. Dr Mark Goldman is also Chief Executive of Good Hope Hospital NHS Trust.

You can access a register of director's interests by writing to:

Company Secretary
Heart of England NHS Foundation Trust
Heartlands Hospital
Bordesley Green East
Bordesley Green
Birmingham
B9 5SS

The executive directors on the Trust Board are:

Name	Title
Dr Mark Goldman	Chief Executive
Dame Jill Ellison	Nursing Director
Ms Anne Gynane	Human Resources Director (Acting)
Mrs Beccy Fenton	Chief Finance Officer and Managing Director
Mr Mark Gannon	Medical Director for Surgery (resigned 31/3/06)
Dr Rowland Hopkinson	Medical Director for Governance
Dr Hugh Rayner	Medical Director for Medicine

Mr Clive Wilkinson
Chairman

Clive Wilkinson has held this post since February 2001 when he was appointed by the Strategic Health Authority. Mr Wilkinson's term ended on 31 March 2006. After applying for the position of Chairman again, Mr Wilkinson was selected through a process of open competition to continue as Chairman for a four-year period commencing 1 April 2006. Previously, he 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. Mr Wilkinson was a Birmingham City Councillor from 1970 to 1984. Mr Wilkinson is also Chairman of the Civic Housing Association, a Trustee of Bournville Village Trust and non-executive director of the Financial Services Authority. He is also a member of the Department of Health Audit Committee. Mr Wilkinson is married with two grown-up daughters, four grandsons and lives in Selly Oak, Birmingham.

Mark Goldman
Chief Executive

Mark Goldman was appointed Chief Executive of the Trust in April 2001. Prior to this, he was a consultant vascular surgeon and Medical Director for Surgery at the Trust. He had previously worked as a senior lecturer at the University of Birmingham and honorary consultant surgeon at East Birmingham Hospital.

As Chief Executive, Dr Goldman led the Trust to three star status by meeting all national targets and then to Foundation Status in April 2005.

Dr Goldman was also involved in the original writing of the NHS Modernisation Plan and has subsequently served on the Modernisation Board.

Dame Jill Ellison
Nursing Director

Dame Jill Ellison OBE, has been Nursing Director at Heart of England NHS Foundation Trust since 1985. She trained as a nurse at the Middlesex Hospital in London and later worked in Israel as a kibbutz nurse and then at the Hadassah Hospital in Jerusalem in the Intensive Care Unit. After another period of nursing in London at the Charing Cross Hospital, Dame Ellison moved to Birmingham and undertook her health visitor training. Following this she worked as a health visitor and later as a nurse manager in West Bromwich.

Dame Ellison then moved to health authority level, becoming the senior nurse with responsibility for information, personnel and research. In 1990, she moved to East Birmingham Hospital taking a lead in resource management. Shortly after she became the Nursing Director and General Manager for Women's and Children's Services. Dame Ellison was lead nurse for the Birmingham and Black Country Strategic Health Authority on a part-time secondment basis until November 2003.

Ms Anne Gynane
Human Resources Director (Acting)

Anne Gynane has been acting HR Director at Heart of England NHS Foundation Trust since January 2005 and Deputy HR Director since July 2003. She has over ten years experience as a HR practitioner in the public sector, including health, local government and policing. She has experience of managing TUPE transfers including staff and trade union consultation. Together with a medical director she oversaw the implementation of the consultants' contract in 2004, and as Acting Director has ensured that all national HR targets and programmes have been delivered on time. Ms Gynane is a fellow of the Chartered Institute of Personnel and Development.

Mrs Beccy Fenton
Managing Director and Chief Finance Officer

Beccy Fenton has worked in the NHS for ten years and has also held the posts of Finance Director, Deputy Finance Director and Service Development Director at Heart of England NHS Foundation Trust. As Finance Director, she restructured the finance team, introduced new financial reporting systems, revised the Trust Board and directorate financial reporting and redesigned the Trust's business planning and performance management process. She has always had a close working relationship with the clinical teams to ensure delivery of significant year on year cost and efficiency savings, and delivering recurrent financial position in 2004/05 which enabled the Trust to be successful in its application for Foundation Status on 1 April

2005. Mrs Fenton gained a Masters Degree in Engineering Sciences from Oxford University in 1992. She then joined Coopers and Lybrand where she qualified as a Chartered Accountant with a first time pass before moving to the NHS.

Mr Mark Gannon
Medical Director

Mark Gannon graduated in Birmingham in 1979 and trained in General Surgery and Vascular Surgery throughout the West Midlands, as well as in Washington DC and Baltimore. He was appointed in 1990 and became Clinical Director for General Surgery and Urology in 1993; Medical Staff Committee Chairman in 1999 and Medical Director for Surgery in 2001.

Mr Gannon has led the improvement in access and efficiency in the surgical directorates, and modernised their services. He continues to teach and examine for the Royal College of Surgeons of England.

Dr Rowland Hopkinson
Medical Director

Rowland Hopkinson was appointed to consultant at East Birmingham Hospital, in 1978. As a medical director, Dr Hopkinson is currently the clinical governance lead and Caldicott Guardian for the Trust. Clinical interests as a consultant include sedation, cross-infection and haemodynamic management in, and design of, intensive care units.

Dr Hopkinson has considerable teaching and training expertise including training Scheme for Senior Registrars 1992-95 and President of the Midland Society of Anaesthetics 1997 – 1999. He lectures extensively on intensive care and anaesthetic topics as well as risk management, clinical governance and management issues. He is a founder member of the Association of Trust Medical Directors (ATMD) and Chairman of ATMD from 1997-99. He is also Board member of the British Association of Medical Managers and a representative of the Region's Medical Directors on the Chief Medical Officer's Medical Director panel.

Dr Hugh Rayner
Medical Director

Hugh Rayner 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, Melbourne Australia and Leeds. He became Clinical Director for Acute Medicine at Heartlands Hospital in 1996 and then Medical Director for Medicine in 2000.

Dr Rayner has taken a leading role in the development of the Working Together for Health initiative within Eastern 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 Bernard Spittle
Non-Executive Director and Vice Chairman

Bernard Spittle was born in Birmingham and has worked and lived in Birmingham and Solihull. He has been a Non-Executive Director since December 1998 and is the Vice Chairman of the Trust. He is also Director of Heartlands Education Centre Limited. Mr Spittle is an ex Chief Officer of Birmingham City Council, responsible for a wide profile of functions including sports and recreation, youth service, community service, libraries, museum and art gallery, parks and playing fields and adult education. He is a member of the Safer Major Sports Grounds Committee, has also been a member of the National Lottery Awards Panel for Sport, Trustee of the Football Trust and is currently Director of the English Institute of Sport, Sheffield.

Mrs Anna East
Non-Executive Director

Anna East was first appointed on 1 July 2005. Mrs East is a solicitor specialising in corporate governance, commercial and corporate legal issues and risk management. She was formerly Head of Legal and Group Company Secretary at Britannic Group plc and has also practised at Evershed's Solicitors in Birmingham. She chairs the Governance Committee and is a member of the Remuneration and Audit Committees. Mrs East is also a governor of Newman College of Higher Education and Vice Chairman of Dowells Trust Housing Association.

Ms Denise Friend
Non-Executive Director

Denise Friend was first appointed on 1 June 2005. Mrs Friend is the head of the corporate finance department in the leading regional firm of chartered accountants and business advisors, Friend LLP. Mrs Friend has over 25 years of corporate

finance experience. She has advised companies, institutions and management teams from the UK and USA on numerous transactions in a variety of sectors. Mrs Friend is also a director of the British American Business Council in the Midlands.

Mr Paul Hensel
Non-Executive Director

Paul Hensel was first appointed on 1 August 2005. Mr Hensel is an IT professional with 35 years experience in the development and provisioning of IT systems. His early career encompassed roles with Dunlop, GKN, Chubb and West Midlands Regional Health Authority.

Mr Hensel, 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.

Mr Hensel was appointed as a Non-Executive Director to Heart of England NHS Foundation Trust Board in August 2005 and is the Non-Executive lead for IT issues. He currently Chairs the IM&T Committee for the Trust.

Mr Hensel is also the Non-Executive Chairman for a small software company which is involved in innovative software development for the deployment of mobile systems.

Professor John Perry
Non-Executive Director

John Perry is a qualified Civil Engineer who has focussed his professional career on construction project management. After eight years in industry he began an academic career, firstly at UMIST and then at the University of Birmingham, where he was Head of the School of Civil Engineering for twelve years. He has provided consultancy and training for numerous clients in the UK and around the world and has served on several committees for the Institution of Civil Engineers. He has Chaired the Projects and Purchasing Committee and the Human Resources Committee. Mr Perry has been a governor at Bromsgrove School for a number of years.

Mr Alaba Okuyiga
Non-Executive Director

Alaba Okuyiga is a management consultant. He has worked in the areas of equality and diversity, change management, international management in developing countries and multicultural mental health training.

Mr Okuyiga has worked extensively in the public and private sector and his clients have included PCTs, mental health, Borough Councils, the Police Service, the Crown Prosecution Service and the Prison Service.

Mr Okuyiga has taught undergraduate courses in older adult health care and related topics for Fircroft College and the University of Birmingham. He is also a Home Secretary's appointee West Midlands Police Authority Selection Panel.

7. Membership Report

The Trust has over 50,000 members, which are categorised into three main constituencies, namely:

1) a public constituency
2) a staff constituency
3) a patients constituency

Public Constituency

Members of the Trust who are members of the public constituency are individuals:

1) Who live in a specified area of the Trust **(as shown in table 1)**

2) Who:
- have each made an application for membership to the Trust; or
- are patients who having been invited by the Trust to become a member of the public constituency and have not informed the Trust that they do not wish to do so.

3) Who are not eligible to become a member of the staff constituency and are not members of any other constituency or otherwise disqualified for membership for;

(i) prejudice or impeding the ability of the Trust to fulfill its principal purpose or other of its purposes under its Constitution or otherwise to discharge its duties and functions; or

(ii) harming the Trust's work with other persons or bodies with whom it is engaged or may be engaged in the provision of goods and services; or

(iii) adversely affecting public confidence in the goods or services provided by the Trust; or

(iv) otherwise bringing the Trust into disrepute.

Table 1

1	2	3	4
Name of Constituency	Area/Qualification	Min. number of Members	Number of Council Members
Public Constituency	(a) Birmingham at large (excluding wards below)	100	2
	(b) Central Birmingham (Nechells, Washwood Heath, Sparkbrook, Fox Hollies Acocks Green)	100	5
	(c) Shirley/Elmdon (Shirley West, Shirley South, Shirley East, Olton, Lyndon, Elmdon, Solihull, Birchill)	100	3
	(d) East Birmingham (Yardley, Hodge Hill, Shard End, Sheldon)	100	3
	(e) North Solihull (Castle Bromwich, Smiths Wood, Kingshurst and Fordbridge, Chelmsley Wood)	100	3
	(f) South Solihull (Blythe, Dorridge and Hockley Heath, St Alphege, Knowle, Meriden)	100	1
			Total 17
Patient Constituency	Patients and Patient Carers as defined in the Constitution	50	2
Medical and Dental Practitioners Staff Class	As defined in paragraph 7.3.4 of the Constitution	50	1
Nurses and Midwives Staff Class	As defined in paragraph 7.3.5 of the Constitution	100	2
Other Health Professional Staff Class	As defined in paragraph 7.3.6 of the Constitution	100	1
Other Staff Class	As defined in paragraph 7.3.7 of the Constitution	100	1

Staff Constituency

Members of the Staff Constituency are individuals who:

a) are employed under a contract of employment with the Trust; or
b) are not employed under a contract of employment with the Trust but who exercise functions for the purposes of the Trust;
c) are contractors or the staff of contractors who work full time at the Trust providing services to the Trust;
d) provide Trust Volunteer Services; or
e) are based for at least 40 % of their working time in the Trust and staff employed by other key organisations but who are working in the Trust for the main purposes of research, training or education e.g. deanery employed by doctors in training;
f) are at least 16 years of age at the date of their application or invitation to become a member.

Patients' Constituency

Members of the Trust who are Members of the Patients' Constituency are individuals who:

a) are or have been patients
b) are not eligible to become a member of the staff constituency and who are not members of any other constituency and are not otherwise disqualified for membership;
c) have made an application for membership of the Trust or have been invited by the Trust to become members of the Patients' Constituency and have not informed the Trust that they do not wish to do so;
d) are at least 16 years of age at the dates of their application or invitation to become a member.

Breakdown of Members

Total Public Members: 37,312
Total Patient Members: 3,750
Total Staff Members: 6,800
Opt-out Initiative : 3,094
Governors: 25
Volunteers: 57
Total: 51,038
Birm Large: 3,523
Birm Cent: 12,976
Birm East: 5,821
Sol Cent: 7,973
Sol North: 3,814
Sol South: 3,291

The Membership Strategy

The membership strategy is based on three phases:

Phase 1

An initial requirement to recruit members prior to becoming an NHS foundation trust. This included creating and maintaining the database of members, communicating with prospective and existing members, and managing Board of Governors' elections - all with a low risk, cost efficient service. Recruitment was carried out through a variety of events in the community to ensure widespread engagement and a representative membership.

Phase 2

To encourage additional members, new approaches and incentive schemes are now being developed for members whilst ensuring the database is representative of the diverse population served.

Phase 3

Looking ahead, a sustainable ongoing programme will ensure the membership service to the Trust is delivered to the highest possible standard.

Currently, the Trust is in Phase 2 and focussing on new and innovative ways to incentivise members of the public to join the Trust. Steps are also being taken to ensure a representative membership of the Trust by attending local events and seminars, forging links with regional organisations and generally maximising awareness of the membership programme.

Membership incentives to be offered include discount schemes on local attractions and encouraging local suppliers that support the NHS's core values to advertise in the quarterly magazine, therefore helping to fund this process.

Recruitment

The Trust is currently increasing its public constituency membership by including an 'opt-out' information card with outpatient appointments. All new patients who receive cards during this period will automatically be made members of the Trust unless they inform the Trust they do not wish to be a member.

Current levels indicate the Trust will have 75,000 members by 1 October 2006. This will be carefully monitored to ensure fair representation across the constituencies. From October 2006, targeted marketing and communications will replace the 'opt-out' approach to ensure this fair representation is maintained.

8. Remuneration Report

Role of the Remuneration Committee

The Remuneration Committee is responsible for developing the Trust's policy on executive remuneration and for determining the remuneration of Executive Directors.

The Remuneration Committee reports to the Trust Board.

Composition of the Remuneration Committee

The membership of the Remuneration Committee is as follows;

Mr C Wilkinson – Chairman,
Mrs A East – Non-Executive Director,
Mr A Okuyiga – Non-Executive Director,
Professor J Perry – Non-Executive Director,
Mr B Spittle – Non-Executive Director,
Mr P Hensel - 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 to 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.

Executive Directors' Remuneration

Remuneration packages for executive directors 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 remunerations. Performance is judged and reviewed as part of the annual appraisal and personal development review process in line with Trust policies.

The table below shows the salaries and allowances that have been awarded to the Executive Directors who have served the Trust throughout the year.

Name and Title	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000
Mark Goldman (Chief Executive)	185-190	
Rebecca Fenton (Finance Director)	120-125	
Jill Ellison (Nursing Director)	90-95	
Anne Gynane (Acting Human Resources Director from January 2005)	75-80	
Rowland Hopkinson (Deputy Chief Executive and Medical Director)	40-45	165-170
Hugh Rayner (Medical Director)	40-45	135-140
Mark Gannon (Medical Director)	40-45	135-140

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. In the year to 31 March 2006 there have been no payments for compensation for loss of office, or any non-cash benefits in kind.

There were no amounts payable to third parties for the services of the Executive Directors.

Pension Benefits

The table below shows the real increase during the reporting year in the pension and related lump sum at age 60 for each of the Executive Directors.

Name and title	Real increase in pension at age 60 (bands of £2500) £000	Real increase in lump sum at age 60 (bands of £2500) £000	Total accrued pension at age 60 at 31 March 2006 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2006 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2006 £000	Cash Equivalent Transfer Value at 31 March 2005 £000	Real Increase in Cash Equivalent Transfer Value £000
Mark Goldman	12.5-15.0	42.5-45.0	70-75	215-220	1,249	957	187
Rebecca Fenton	0-2.5	5.0-7.5	10-15	35-40	130	102	18
Jill Ellison	0-2.5	5.0-7.5	30-35	100-105	530	484	23
Anne Gynane	0-2.5	2.5-5.0	0-5	10-15	39	21	12
Rowland Hopkinson	0-2.5	5.0-7.5	90-95	270-275	1,669	1,577	36
Hugh Rayner	2.5-5.0	10.0-12.5	45-50	135-140	705	613	54
Mark Gannon (a)	5.0-7.5	15.0-17.5	55-60	165-170	857	624	152

(a) Resigned on 31 March 2006

Non - Executive Directors Remuneration and Appointment

Non-executive directors are appointed for two or four years, dependent upon terms of appointment, and are terminable with one month's notice on either side. The Non-Executive Directors are appointed following interview by a committee of the Governors of the Trust.

Non-executive directors' fees are determined by the Governors' Consultative Council.

The table below shows the salaries and allowances that have been paid to the Non - Executive Directors who have served the Trust during the year and the date of their first appointment date. The Non - Executive Directors do not receive pensionable remuneration.

(a) There is no specific reference to notice period in the contract for this Non-Executive Director.

Amounts Payable to Third Parties

The only amounts payable to third parties for services by a senior manager were to Denise Friend where the fee for her service was to her company rather than her being on the payroll.

Dr Mark Goldman
Chief Executive

Date 14 June 2006

Name and Title	Salary (bands of £5000) £000	First Appointment date	Notice period	Unexpired term of contract
Clive Wilkinson (Chairman)	35-40	01 December 2001	1 month	4 years
Bernard Spittle (Deputy Chairman)	5-10	01 December 1998	(a)	8 months
Sue Anderson (Non-Executive Director)	5-10	20 March 2000	(a)	Resigned 31/3/06
Alaba Okuyiga (Non-Executive Director)	5-10	01 December 2003	(a)	1 year, 8 months
Professor John Perry (Non-Executive Director)	5-10	01 December 1997	I month	2 years
Anna East (Non-Executive Director)	5-10	01 July 2005	(a)	3 years months
Denise Friend (Non-Executive Director)	5-10	01 June 2005	(a)	Resigned 8/5/06
Paul Hensel (Non-Executive Director)	5-10	01 August 2005	(a)	3 years, 4 months

9. Statement of Accounting Officer's Responsibilities

The Health and Social Care (Community Health and Standards) Act 2003 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 Health and Social Care (Community Health and Standards) Act 2003, 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 judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

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

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

Signed 

Mark Goldman Chief Executive Date 14 June 2006

10. Statement on Internal Control

Scope of Responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Heart of England 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. In addition, I am accountable to the Board of Governors of Heart of England NHS Foundation Trust.

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, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Heart of England NHS Foundation Trust for the year ended 31 March (2006) and up to the date of approval of the Annual Report and Accounts.

Capacity to Handle Risk

The Trust has a defined Risk Management Strategy, Policy and Procedure and these provide explicit guidance for all staff about:

- leadership and accountability;
- roles and responsibilities;
- systems and processes for risk management within the Trust.

The Strategy and Policy clearly details that as the Accountable Officer, the CEO has overall responsibility for the Trust's risk management programme and ensuring that this operates effectively. I have delegated operational responsibility for risk management to the Medical Director for Governance and Director of Healthcare Governance. They are supported by each of my executive directors who are responsible for overseeing risk management activities within their individual areas of responsibility.

The Healthcare Governance Directorate has dedicated support personnel with specialist risk management expertise who work with all levels of Trust staff to implement risk management.

Risk Management training forms a key component of the Trust's induction process and the Healthcare Governance Directorate has a range of training programmes in place for all types of staff, at all levels across the organisation.

The Risk and Control Framework

The Trust's risk management procedure, including development of the risk register, is based upon the continuous utilisation of a 4 step cycle involving:

- risk identification;
- risk prioritisation;
- risk control/treatment;
- risk review.

The Trust's risk register represents the physical output from the risk management process. This process is consistent with best international practice and is the principle mechanism that all staff, at all levels within the Trust, uses to manage risk.

The Trust considers risk management to be a continuous, dynamic process. It requires all directorates, departments and staff to adopt this type of approach and use it as the basis for the operational implementation of risk management at both a Trust-wide and local level. In addition to this, the Trust requires that all directorates and departments conduct a formal review of their risk management process and risk register status on a quarterly basis.

The Trust's risk register process forms the key tool that the organisation uses to define its appetite for risk. However, work is in progress to further define this now that we are a foundation trust.

The Trust Board is ultimately responsible for overseeing the delivery of the Risk Management Strategy. It is supported in this by the work of its sub committees. The Trust Board is independently assured on the effectiveness of the operation of its risk management processes through the work agreed by the Audit Committee.

The Trust has had its Assurance Framework in place since March 2004. The Assurance Framework enables the Trust Board to identify risks to achieving its key objectives, map the key controls in place to manage them and the assurance mechanisms in place to assess the effectiveness of these controls. The Trust Board has used its Assurance Framework to direct the activities of the Trust Audit Committee and the Internal Audit Department.

The Trust engages its stakeholders through the following forums:

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

Review of Economy, Efficiency and Effectiveness of the Use of Resources

The Corporate Business Plan represents the principle mechanism which the Board uses to review use of resources. This sets an annual delivery plan which is aligned to the Trust's strategic objectives. Overall accountability for delivery of this plan rests with the Chief Executive. He is supported in this role by the Executive Directors who have delegated responsibility for delivery of local targets and objectives. Delivery of objectives in the Corporate Business Plan is 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 department 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 results of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Operational Board including sub committees, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the Internal Audit work. Executive managers within the Trust who have responsibility for the development and maintenance of the system of internal control provide me with assurance through their line management and committee reporting responsibilities. The Assurance Framework and the Trust's risk management systems 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:

- Clinical Negligence Scheme for Trusts
- Healthcare Commission Healthcare Standards and Annual Health Check
- Monitor Quarterly Reporting
- Health and Safety Executive
- Risk Pooling Scheme for Trusts
- Improving Working Lives
- Dr Foster
- Patient Environment Action Team
- External Audit

No significant internal control issues have been identified for this financial year.

Signed 

Mark Goldman Chief Executive Date 14 June 2006

11. Independent Auditor's 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 2006 which comprise the Income and Expenditure Account, the Balance Sheet, the Statement of Total Recognised Gains and Losses, the Cashflow Statement and the related notes. These financial statements have been prepared in accordance with the accounting policies set out therein.

Respective Responsibilities of Directors and Auditors

The Foundation Trust is responsible for preparing the Annual Report and the financial statements in accordance with directions issued by the Independent Regulator of Foundation Trusts (Monitor). 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).

This report, including the opinion, is made solely to the Board of Governors of Heart of England NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 1 of the Health and Social Care (Community Health and Standards) Act 2003 (the Act) and for no other purpose. We do not, in giving this opinion, 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.

We report to you our opinion as to whether the financial statements give a true and fair view of the state of affairs of the NHS Foundation Trust and its income and expenditure for the year in accordance with the NHS Foundation Trust Financial Reporting Manual issued by Monitor.

We review whether the Accounting Officer's statement on internal control is misleading or inconsistent with other information we are aware of from our audit of the financial statements. We are not required to consider, nor have we considered, whether the directors' statement on internal control covers all risks and controls. We are also not required to form an opinion on the effectiveness of the NHS Foundation Trust's corporate governance procedures or its risk and control procedures.

We read other information contained in the Annual Report, and consider whether it is consistent with the audited financial statements. This other information comprises the Chairman's Statement, Chief Executive's Statement, Director's Report, Board of Governers Report, Operating and Financial Review, Membership Report and Remuneration report. We consider the implications for our report if we become aware of any apparent mis-statements or material inconsistencies with the financial statements. Our responsibilities do not extend to any other information.

Basis of Audit Opinion

We conducted our audit in accordance with section 28 and Schedule 5 of the Health and Social Care (Community Health and Standards) Act 2003 and Audit Code for NHS Foundation Trusts issued by Monitor, which requires compliance with relevant auditing standards issued by the Auditing Practices Board.

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

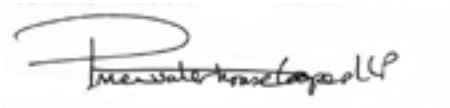
We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error. In forming our opinion we also evaluated the overall adequacy of the presentation of information in the financial statements.

Opinion

In our opinion the financial statements give a true and fair view of the state of affairs of Heart of England NHS Foundation Trust as at 31 March 2006 and of its income and expenditure for the year then ended and have been properly prepared in accordance with the NHS Foundation Trust Financial Reporting Manual issued by Monitor.

Certificate

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



Date:15 June 2006

PricewaterhouseCoopers LLP
Birmingham

Trust Annual Accounts

Heart of England NHS Foundation

1 April 2005 to 31 March 2006

Foreword to the Accounts

These accounts for the year ended 31 March have been prepared by the Heart of England NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 1 to the 2003 Act.

12 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 2005/06 NHS Foundation Trust Financial Reporting Manual issued by Monitor. The accounting policies contained in that manual follow UK generally accepted accounting practice for companies (UK GAAP) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to 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 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 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 contract 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. The NHS Foundation Trust changed the form of its contracts with NHS Commissioners to follow the Department of Health's Payment By Results methodology in 2005/06. To manage the financial impact of this transition, PbR clawback is being paid back to the Department of Health. The income recognised in the accounts is net of this clawback payment.
At 31 March 2006 an accrual has been made for partially completed spells, which has resulted in recognising £711k of accrued income relating to patients who have not been discharged from hospital at the end of 31 March 2006. This is as a result of NHS Foundation Trusts having to apply Application Note G of FRS 5, Reporting the Substance of Transactions. An opening balance adjustment has not been made for 1 April 2005 because the contracting nature under the previous regime was different and because reliable data to make this estimate is not available.

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 and 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

Digital hearing aids have previously been capitalised to comply with the NHS Capital Accounting Manual. However, as this expenditure is less than £5,000 and is capable of independent function, this is not compliant with FRS 15. Within the year, expenditure of £299,000 has been charged to the Income and Expenditure account. Hearing aids previously capitalised with a net book value of £273,000 have had accelerated depreciation applied and have been disposed of as fixed assets in 2005/06.

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.

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. In accordance with the requirements of the Department of Health, the last asset valuations were undertaken in 2004 as at the prospective valuation date of 1 April 2005 and the revaluation was accounted for on 31 March 2005. 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.

Residual interests in off-balance sheet Private Finance Initiative 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 58 years per District Valuers valuation

- **other buildings**
  up to 58 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 value of the sale proceeds 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 for the provision of services. Grants from the Department of Health, including those for achieving three star status, are accounted for as Government grants. Where the Government grant is used to fund revenue expenditure it 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.

This policy has been applied for the first time as at 1 April 2005 because it is a requirement for NHS Foundation Trusts to comply with SSAP 4, Accounting for Government Grants under UK GAAP. The opening balance reserve of £1,801,000 has been moved to be shown in the creditors balance. At 31 March 2006 the balance of £1,653,000 relating to government grants is held in the accruals and deferred income balance.

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 recognied 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 and Overdrafts

Cash, bank and overdraft balances are recorded at the current values of those balances in the NHS Foundation 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, "interest receivable" and "interest payable" in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods they relate to.

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 occurance 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 econmic benefits will arise or for which the amount of obligation cannot be measured with suffucient 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.

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 changed 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 29 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 trust.

Relevant net assets are calculated as the value of all assets less the vlaue of all liabilities, except for donated assets and cah held with the Office of the Paymster General. Average relevant net assets are claculated as a simple mean of opening and closing relevant net assets.

V 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).

W 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.

13. Income And Expenditure Account

For The Period From 1 April 2005 to 31 March 2006	NOTE	£000
Income from activities	2	247,414
Other operating income	4	33,635
Operating expenses	5-7	(269,008)
OPERATING SURPLUS		12,041
Profit (loss) on disposal of fixed assets	8	(75)
SURPLUS BEFORE INTEREST		11,966
Interest receivable	9	865
Interest payable	9	0
Other finance costs		(42)
SURPLUS FOR THE FINANCIAL YEAR		12,789
Public Dividend Capital dividends payable		(7,353)
RETAINED SURPLUS FOR THE YEAR		5,436

All income and expenditure is derived from continuing operations.

14. Balance Sheet

As at:	NOTE	31 March 2006 £000	1 April 2005 £000
FIXED ASSETS			
Intangible assets	10	886	980
Tangible assets	11	225,327	232,988
		226,213	233,968
CURRENT ASSETS			
Stocks and work in progress	12	4,158	4,343
Debtors	13	15,762	11,477
Investments	14	11,500	0
Cash at bank and in hand	19.3	284	13
		31,704	15,833
CREDITORS: Amounts falling due within one year	15	(22,368)	(19,595)
NET CURRENT ASSETS (LIABILITIES)		9,336	(3,762)
TOTAL ASSETS LESS CURRENT LIABILITIES		235,549	230,206
CREDITORS: Amounts falling due after more than one year	15	0	0
PROVISIONS FOR LIABILITIES AND CHARGES	16	(2,472)	(2,377)
TOTAL ASSETS EMPLOYED		233,077	227,829
FINANCED BY:			
TAXPAYERS' EQUITY			
Public dividend capital	23	128,845	128,845
Revaluation reserve	17	91,646	91,195
Donated asset reserve	17	6,366	7,005
Income and expenditure reserve	17	6,220	784
TOTAL TAXPAYERS EQUITY		233,077	227,829

Signed: .....(Chief Executive)

Date: 14 June 2006

15. Statement Of Total Recognised Gains And Losses

For Period From 1 April 2005 to 31 March 2006	£000
Surplus (deficit) for the financial year before dividend payments	12,789
Fixed asset impairment losses	0
Unrealised surplus/(deficit) on fixed asset revaluations/ indexation	510
Increases in the donated asset and government grant reserve due to receipt of donated and government grant financed assets	101
Reductions in the donated asset and government grant reserve due to the depreciation, impairment and disposal of donated and government grant financed assets	(741)
Total recognised gains and losses for the financial year	12,659

16. Cash Flow Statement

For Period From 1 April 2005 to 31 March 2006	NOTE	£000	£000
OPERATING ACTIVITIES Net cash inflow/(outflow) from operating activities	19.1		24,062
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE: Interest received		865	
Net cash inflow/(outflow) from returns on investments and servicing of finance			865
CAPITAL EXPENDITURE Payments to acquire tangible fixed assets Payments to acquire intangible fixed assets		(5,384) (79)	
Net cash inflow/(outflow) from capital expenditure			(5,463)
DIVIDENDS PAID			(7,353)
Net cash inflow/(outflow) before management of liquid resources and financing			12,111
MANAGEMENT OF LIQUID RESOURCES Purchase of current asset investments		(11,500)	
Net cash inflow/(outflow) from management of liquid resources			(11,500)
Net cash inflow/(outflow) before financing			611
FINANCING			
Other loans repaid Other capital receipts		(800) 460	
Net cash inflow/(outflow) from financing			(340)
Increase/(decrease) in cash			271

17. Notes to the Accounts

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 2005/06 £000	Research 2005/06 £000	Total 2005/06 £000
INCOME	278,172	2,877	281,049
SURPLUS/(DEFICIT)			
Segment surplus/(deficit)	11,097	869	11,966
Common costs	0	0	0
Surplus/(deficit) before interest	11,097	869	11,966
NET ASSETS:			
Segment net assets	231,541	1,536	233,077

2. Income from Activities

	£000
Primary Care Trusts	264,957
Department of Health	(19,301)
NHS Other	159
Non NHS:	
- Private Patients	360
- Overseas patients (non-reciprocal)	60
- Road Traffic Act	1,179
TOTAL	247,414

Road Traffic Act income is subject to a provision for doubtful debts of 8.7% to reflect expected rates of collection.

Income from PCTs includes £711,000 of income accrued for partially completed spells to comply with Application Note G of FRS5 for spells that have started but not completed at 31 March 2006 at 2005/06 prices. This income will be recovered from the PCTs when the spell is completed using the 2006/07 Payment by Results prices.

As part of the transitional arrangements of the implementation of Payment by Results, the Trust paid £19,301,000 to the Department of Health as PbR clawback.

2.1 Mandatory and non-mandatory split of income from activities

Of the total income from activities, £246,249,000 is mandatory and £1,165,000 is non-mandatory income.

3. Private patient cap

The private patient cap has not been exceeded in 2005/06

	2005/06	Base year
Private patient income (£'000)	360	356
Total patient related income (£'000)	247,414	223,477
Proportion (%)	0.15%	0.16%

4. Other Operating Income

	2005/06 £000
Education, training and research	14,506
Transfers from donated asset reserve	741
Services to other bodies	10,098
Other income	8,290
TOTAL	33,635

5. Operating Expenses

5.1 Operating expenses comprise:

	2005/06 £000
Directors' costs	756
Staff costs	172,607
Drug costs	16,478
Supplies and services - clinical	26,101
Supplies and services - general	9,793
Establishment	3,125
Research & Development	2,008
Transport	477
Premises	10,139
Bad debts	3,593
Depreciation and amortisation	13,779
Audit fees	113
Clinical negligence	3,747
Other	6,292
TOTAL	269,008

Of the total audit fees, £75,000 relates to audit services statutory audit work, £5,000 for additional services provided by the auditors and £33,000 for audit related regulatory reporting.

The research and development value includes £1,032,000 of staff costs. All of the research and development expenditure is current year expenditure.

5.2 Operating leases

5.2/1 Operating expenses include:

	2005/06 £000
Hire of plant and machinery	0
Other operating lease rentals	272
TOTAL	272

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

	Land and buildings 2005/06 £000	Other leases 2005/06 £000
Operating leases which expire:		
Within 1 year	0	0
Between 1 and 5 years	0	70
After 5 years	0	148
TOTAL	0	218

5.3 Salary and Pension entitlements of senior managers

A) Remuneration

Name and Title	2005-06			2004-05		
	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)	185-190			155-160		
Beccy Fenton (Chief Finance Officer and Managing Director)	120-125			100-105		
Dame Jill Ellison (Nursing Director)	90-95			85-90		
Anne Gynane (Acting Human Resources Director from January 2005)	75-80			15-20		
Rowland Hopkinson (Deputy Chief Executive and Medical Director)	40-45	165-170		40-45	150-155	
Hugh Rayner (Medical Director)	40-45	135-140		40-45	120-125	
Mark Gannon (Medical Director)	40-45	135-140		40-45	130-135	
Clive Wilkinson (Chairman)	35-40			20-25		
Bernard Spittle (Vice Chairman)	5-10			5-10		
Sue Anderson (Non Executive Director left March 2006)	5-10			5-10		
Alaba Okuyiga (Non Executive Director)	5-10			5-10		
John Perry (Non Executive Director)	5-10			5-10		
Anna East (Non Executive Director)	5-10					
Denise Friend (Non Executive Director)	5-10					
Paul Hensel (Non Executive Director)	5-10					

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 "(bands of £2500) £000"	Real increase in lump sum at age 60 "(bands of £2500) £000"	Total accrued pension at age 60 at 31 March 2006 "(bands of £5,000) £000"	Lump sum at age 60 related to accrued pension at 31 March 2006 "(bands of £5000) £000"	Cash Equivalent Transfer Value at 31 March 2006 " £000"	Cash Equivalent Transfer Value at 31 March 2005 " £000"	Real Increase in Cash Equivalent Transfer Value " £000"	Employers Contribution to Stakeholder Pension To nearest £100
Mark Goldman (Chief Executive)	12.5-15.0	42.5-45.0	70-75	215-220	1,249	957	187	0
Beccy Fenton (Chief Finance Officer and Managing Director)	0-2.5	5.0-7.5	10-15	35-40	130	102	18	0
Dame Jill Ellison (Nursing Director)	0-2.5	5.0-7.5	30-35	100-105	530	484	23	0
Anne Gynane (Acting Human Resources Director)	0-2.5	2.5-5.0	0-5	10-15	39	21	12	0
Rowland Hopkinson (Deputy Chief Executive and Medical Director)	0-2.5	5.0-7.5	90-95	270-275	1,669	1,577	36	0
Hugh Rayner (Medical Director)	2.5-5.0	10.0-12.5	45-50	135-140	705	613	54	0
Mark Gannon (Medical Director)	5.0-7.5	15.0-17.5	55-60	165-170	857	624	152	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.

6. Staff costs and numbers

6.1 Staff costs

	Total	Permanently Employed	Other
	£000	£000	£000
Salaries and wages	147,779	139,251	8,528
Social Security Costs	11,340	11,340	0
Employer contributions to NHSPA	15,183	15,183	0
	174,302	165,774	8,528

6.2 Average number of persons employed

	Total	Permanently Employed	Other
	Number	Number	Number
Medical and dental	537	537	0
Administration and estates	1,182	1,182	0
Healthcare assistants and other support staff	638	638	0
Nursing, midwifery and health visiting staff	1,662	1,662	0
Scientific, therapeutic and technical staff	707	707	0
Bank and Agency staff	168	0	168
Other	118	118	0
Total	5,012	4,844	168

6.3 Employee benefits

There were no employee benefits.

6.4 Management costs

	2005/06 £000
Management costs	11,100
Income	281,049
Percentage (%)	3.95

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 2005/06 there were 5 early retirements from the trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £218,000. 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
Total bills paid in the year	98,911
Total bills paid within target	89,734
Percentage of bills paid within target	91%

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 £75,000 in 2005/06, all of which was on non-protected assets.

9. Interest Payable and Receivable

There was no interest payable in 2005/06.

The interest receivable arose from interest earned in the main current account or surplus placed on the National Loans Account for periods not exceeding three months.

10. Intangible Fixed Assets

	Software Licences	Total
	£000	£000
Gross cost at start of period for new FTs	1,204	1,204
Additions purchased	79	79
Gross cost at 31 March 2006	1,283	1,283
Amortisation at start of period for new FTs	224	224
Provided during the year	173	173
Amortisation at 31 March 2005	397	397
Net book value		
- Purchased at 1 April 2005	980	980
- Donated at 1 April 2005	0	0
- Total at 1 April 2005	980	980
- Purchased at 31 March 2006	886	886
- Donated at 31 March 2006	0	0
- Total at 31 March 2006	886	886

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 start of period for new FT's	51,330	154,858	2,333	2,254	50,753	971	17,235	6,282	286,016
Additions purchased	0	1,754	0	1,456	1,045	0	1,083	83	5,421
Additions donated	0	29	0	0	72	0	0	0	101
Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	1,845	0	(1,846)	560	(1)	(507)	(36)	15
Other in year revaluation	0	510	0	0	0	0	0	0	510
Disposals	0	0	0	0	(1,749)	(386)	0	0	(2,135)
At 31 March 2006	51,330	158,996	2,333	1,864	50,681	584	17,811	6,329	289,928
Depreciation at start of period for new FT's	0	43	0	0	33,864	838	14,001	4,281	53,027
Provided during the year	0	7,387	337	0	4,032	20	936	894	13,606
Impairments	0	0	0	0	0	0	0	0	0
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	697	0	0	(95)	1	(521)	(67)	15
Other in year revaluation	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(1,663)	(384)	0	0	(2,047)
Depreciation at 31 March 2006	0	8,127	337	0	36,138	475	14,416	5,108	64,601
Net book value									
- Purchased at 1 April 2005	51,330	149,896	2,333	2,254	14,815	133	3,234	1,988	225,983
- Donated at 1 April 2005	0	4,919	0	0	2,074	0	0	13	7,006
Total at 1 April 2005	51,330	154,815	2,333	2,254	16,889	133	3,234	2,001	232,989
- Purchased at 31 March 2006	51,330	146,053	1,996	1,864	12,546	109	3,395	1,210	218,503
- Donated at 31 March 2006	0	4,816	0	0	1,997	0	0	11	6,824
Total at 31 March 2006	51,330	150,869	1,996	1,864	14,543	109	3,395	1,221	225,327

In the year the asset lives have been reviewed and £3,155,000 has been charged as accelerated depreciation. The Trust will continue to review its asset lives and adjust where necessary on an ongoing basis.

In 2005/06 the Trust has performed a physical asset verification exercise which identified some disposals and assets that required accelerated depreciation. This exercise was still in progress at 31 March 2006 and any remaining adjustments identified before its completion will be noted in 2006/07.

Of the totals at 31 March 2006, £51,330,000 related to land valued at open market value and £146,733,000 related to buildings valued at open market value and £1,996,000 related to dwellings valued at open market value.

There are no fixed assets held under finance leases.

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

	£000
Freehold	202,349
Long leasehold	1,846
Short leasehold	0
TOTAL	204,195
	£000
Protected assets	103,230
Non-Protected assets	100,965
TOTAL	204,195

12. Stocks and Work in Progress

	31 March 2006 £000
Raw materials and consumables	4,158
Work-in-progress	0
Finished goods	0
TOTAL	4,158

13. Debtors

	31 March 2006 £000
Amounts falling due within one year:	
NHS debtors	11,372
Provision for irrecoverable debts	(4,951)
Other prepayments and accrued income	4,394
Other debtors	3,974
Sub Total	14,789
Amounts falling due after more than one year:	
Provision for irrecoverable debts	(192)
Other debtors	1,165
Sub Total	973
TOTAL	15,762

NHS Debtors include £0 prepaid pension contributions at 31 March 2006.

14. Investments

The investments held of £11,500,000 are deposits made on the National Loans Account to earn additional interest on short term cash surplus. These funds are held over a number of periods, none exceeding 3 months.

15. Creditors

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

	31 March 2006 £000
Amounts falling due within one year:	
NHS creditors	2,910
Non - NHS trade creditors - revenue - other	720
Non - NHS trade creditors - capital	1,550
Tax and social security costs	123
Other creditors	629
Accruals and deferred income	16,436
Sub Total	22,368
Amounts falling due after more than one year:	
NHS creditors	0
Sub Total	0
TOTAL	22,368

NHS creditors include;
- £0 for payments due in future years under arrangements to buy out the liability for 0 early retirements over 5 years; and
- £0 outstanding pensions contributions at 31 March 2006.

Accruals and deferred income includes £1,653,000 of government grants.

15.2 Finance Lease Commitments

The Trust does not have any commitments under finance leases.

16. Provisions for liabilities and charges

	Pensions relating to other staff £000	Legal claims £000	Other £000	Total £000
At start of period for new FTs	497	162	1,717	2,376
Change in the discount rate	31	0	0	31
Arising during the year	159	91	1,647	1,897
Utilised during the year	(53)	(70)	(837)	(960)
Reversed unused	0	(26)	(857)	(883)
Unwinding of discount	11	0	0	11
At 31 March 2006	645	157	1,670	2,472
Expected timing of cashflows:				
Within one year	45	80	1,670	1,795
Between one and five years	180	77	0	257
After five years	420	0	0	420
	645	157	1,670	2,472

£9,024,427 is included in the provisions of the NHS Litigation Authority at 31/3/2006 in respect of clinical negligence liabilities of the Trust.
£3,343,963 is included in the provisions of the NHS Litigation Authority at 31/3/2006 in respect of the existing liabilities scheme of the Trust.

Other provisions is for Agenda for Change liabilities that have not yet been paid.

17. Movements on Reserves

Movements on reserves in the year comprised the following:

	Revaluation Reserve £000	Donated Asset Reserve £000	Government Grant Reserve £000	Income and Expenditure Reserve £000	Total £000
At 31 March 2005 as previously stated	91,195	7,006	1,801	784	100,786
Opening Balance Adjustments	0	0	(1,801)	0	(1,801)
At start of period for new FTs	91,195	7,006	0	784	98,985
Transfer from the income and expenditure reserve	0	0	0	5,436	5,436
Surplus on other revaluations/indexation of fixed assets	510	0	0	0	510
Receipt of donated/government granted assets	0	101	0	0	101
Transfers to the Income and Expenditure Account for depreciation, impairment, and disposal of donated/government granted assets	(59)	(741)	0	0	(800)
At 31 March 2006	91,646	6,366	0	6,220	104,232

The government grant reserve at 1 April 2005 has been moved to deferred income to comply with SSAP4, Accounting for Government Grants, which is required as a NHS Foundation Trust. This is therefore included in the accruals and deferred income balance in note 15.1.

18. Movement in taxpayers equity

	£000
At 31 March 2005 as previously stated	229,631
Opening Balance Adjustments	(1,801)
At start of period for new FTs	227,830
Surplus/ (deficit) for the financial year	12,789
Public Dividend capital dividends	(7,353)
Additions/ (reductions) in donated asset reserve	(640)
Additions/ (reductions) in other reserves	451
Taxpayers equity at 31 March 2006	233,077

19. Notes to the cash flow Statement

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

	£000
Total operating surplus (deficit)	12,041
Depreciation and amortisation charge	13,779
Fixed asset impairments and reversals	0
Transfer from donated asset reserve	(741)
Transfer from the government grant reserve	0
(Increase)/decrease in stocks	185
(Increase)/decrease in debtors	(4,222)
Increase/(decrease) in creditors	2,925
Increase/(decrease) in provisions	95
Net cash inflow/(outflow) from operating activities before restructuring costs	24,062
Payments in respect of fundamental reorganisation/restructuring	0
Net cash inflow from operating activities	24,062

19.2 Reconciliation of net cash flow to movement in net debt

	£000
Increase/(decrease) in cash in the period	271
Cash at start of period for new FTs	13
Cash inflow from new debt	0
Cash outflow from debt repaid and finance lease capital payments	0
Cash (inflow)/outflow from (decrease)/increase in liquid resources	11,500
Change in net debt resulting from cashflows	11,784
Non - cash changes in debt	0
Net debt at 1 April 2005	0
Net debt at 31 March 2006	11,784

19.3 Analysis of changes in net debt

	Cash £000	Investments £000
At start of period as FT	13	0
Changes in year	271	11,500
At 31 March 2006	284	11,500

20. Capital Commitments

Commitments under capital expenditure contracts at the balance sheet date were £2,219,000

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 £84,850 relating to LTPS claims.

There are no other contingencies having a material effect on the accounts.

23. Movement in Public Dividend Capital

	£000
Public Dividend Capital as at 1 April 2005	128,845
New Public Dividend Capital received (including transfers from dissolved NHS Trusts)	0
Public Dividend Capital repaid in year	0
Public Dividend Capital as at 31 March 2006	128,845

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.

There are no other related party transactions in the year.

25. Private Finance Transactions

In August 2005 a PFI contract between the Trust and BHE (Heartlands) Ltd commenced in which BHE (Heartlands) Ltd provide a new main entrance and retail facility at the Heartlands Hospital Site. This 25 year contract is being treated as off balance sheet by the Trust, as approved by the Audit Commission following a review of the contract 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 unitary payment of £46,000 per annum charge made by the operator is 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 2005/06 was £28,531.

On expiry of the contract the property will revert to the ownership of the Trust for no payment.

26. Pooled Budgets

The Trust has no pooled budgets.

27. Financial Instruments

FRS 13, Derivatives and Other Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with local Primary Care Trusts and the way those Primary Care Trusts are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which FRS 13 mainly applies. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

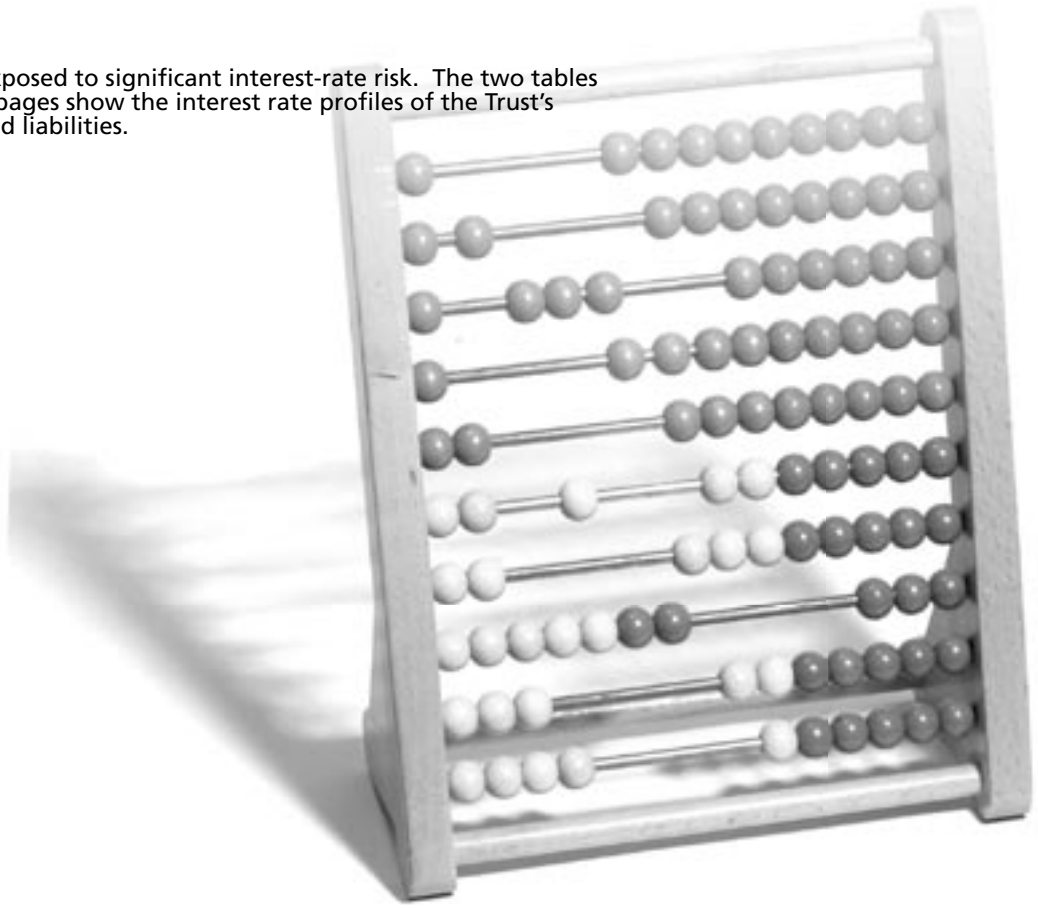
As allowed by FRS 13, debtors and creditors that are due to mature or become payable within 12 months from the balance sheet date have been omitted from all disclosures other than the currency profile. Provisions should be shown gross. Any amount expected in reimbursement against a provision (and included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

Liquidity risk

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

Interest-Rate Risk

The Trust is not exposed to significant interest-rate risk. The two tables on the following pages show the interest rate profiles of the Trust's financial assets and liabilities.



28.1 Financial Assets

					Fixed rate		Non-interest bearing
Currency	Total £000	Floating rate £000	Fixed rate £000	Non-interest bearing £000	Weighted average interest rate %	Weighted average period for which fixed Years	Weighted average term Years
At 31 March 2006							
Sterling	11,784	0	11,500	284	4%	0.2	0
Other	0	0	0	0	0%	0	0
Gross financial assets	11,784	0	11,500	284			

28.2 Financial Liabilities

					Fixed rate		Non-interest bearing
Currency	Total £000	Floating rate £000	Fixed rate £000	Non-interest bearing £000	Weighted average interest rate %	Weighted average period for which fixed Years	Weighted average term Years
At 31 March 2006							
Sterling	128,845	0	0	128,845	0%	0	0
Other	0	0	0	0	0%	0	0
Gross financial liabilities	128,845	0	0	128,845			

Foreign Currency Risk

The Trust has negligible foreign currency income or expenditure.

28.3 Fair Values

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

	Book Value £000	Fair Value £000	Basis of fair valuation
Financial assets			
Cash			
Debtors over 1 year:	284	284	
- Agreements with commissioners to cover creditors and provisions	0	0	Note a
Investments	11,500	11,500	
Total	11,784	11,784	
Financial liabilities			
Overdraft	0	0	
Creditors over 1 year:			
- Early retirements	0	0	Note b
- Finance leases	0	0	Note c
Provisions under contract	(2,472)	0	Note d
Loans	0	0	
Public dividend capital	128,845	128,845	Note e
Total	126,373	128,845	

Notes

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

b Fair value is not significantly different from book value since interest at 9% is paid on early retirement creditors.

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

d 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.

29. Third Party Assets

The Trust held £25,290 cash at bank and in hand at 31/03/06 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.

30. Intra-Government and Other Balances

	Debtors: amounts falling due within one year £000	Debtors: amounts falling due after more than one year £000	Creditors: amounts falling due within one year £000	Creditors: amounts falling due after more than one year £000
Balances with other Central Government Bodies	9,953	0	1,420	0
Balances with NHS Trusts and Foundation Trusts	1,336	0	1,453	0
Balances with bodies external to government	83	0	37	0
At 31 March 2006	11,372	0	2,910	0
Balances with other Central Government Bodies	4,078	0	1,455	0
Balances with NHS Trusts and Foundation Trusts	1,760	0	892	0
Balances with bodies external to government	4,648	990	15,447	0
At 31 March 2005	10,486	990	17,794	0

31. Losses and Special Payments

There were 43 cases of losses and special payments totalling £67,806 approved during 2005/2006. These are the cash payments made during the year and are not calculated on an accruals basis. In addition, 379 bad or irrecoverable debts were written off totalling £614,925 in the year as a result of a cleanse of the debtors ledger.

There were no cases in the current or prior year where the net payment exceeded £100,000.

32. Prudential Borrowing Code

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.

The Trust has a prudential borrowing limit set by Monitor of £63,350,000, including an £18,750,000 working capital facility. The Trust has not borrowed in 2005/06.