Heart of England NHS Foundation Trust

Annual Report and Accounts

2009/10

NHS

HEART of ENGLAND
NHS Foundation Trust

Annual Report and Accounts

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

What's in this report? - Table of Contents

Directors' Report

How have we done during the past year -

- Exceeded our finance surplus by £5m
- £25m investment in an eight ward block at Good Hope is well on course for completion by December 2010 with patient occupation in January 2011.
- A new state of the art CT Scanner for Birmingham Heartlands Hospital
- Opening the new Medical Innovation, Development and Research Unit and Diabetes Centre

- Failed to meet our A&E target for the year
- Monitor issued a red rating for governance on the basis that we were in breach of our Terms of Authorisation regarding A&E.
- Conditional registration from the Care Quality Commission with 3 conditions to be addressed
- Unsatisfactory performance in our patient care and staff survey

Overview

Our plan for the future by the Chief Executive

This will be the last time that I will be signing off an annual report on behalf of the Trust, as I leave at the end of July 2010. I have served almost 10 years as chief executive, and it has been a full 25 years since I first joined the Trust as a senior lecturer (consultant) in general surgery. So much has changed since then that cannot be captured in this report. The organisation I joined, East Birmingham Hospital, a medium sized district general hospital has grown to become one of the largest foundation trusts in the NHS with a growing presence in academia and services that extend to patients in the North of the City, and on into Stafford down to Solihull and into Warwickshire.

In all of those years, both as a clinician and as a manager, we have scarcely had a more difficult year than reported in these accounts. Nevertheless, the excellent staff of this Trust have overcome numerous difficulties and we are able to present at the end of the year, a financially sound position with achievement in the vast majority of our performance targets.

During the year we saw an unprecedented amount of additional activity, far in excess of that predicted by our local commissioners. Taken in conjunction with increasing numbers of elderly patients presenting to our A&E departments, it has not been possible to achieve the four hour accident and emergency target for the second consecutive year. In the light of the fact that we failed to deliver the winter target for three consecutive years, the Trust's regulator, Monitor, elected to find us in breach of our terms of authorisation. This is something we intend to reverse at the earliest opportunity. Importantly, external reviews carried out as a consequence of this did not show that patients were receiving substandard care, merely that the time some were taking to be found beds, exceeded the four hour target on too many occasions. In practice, we finished the year less than one per cent short of the target. Some data collection issues in cardiology and cancer were also advised to the Care Quality Commission (CQC), leading to our CQC rating falling. A failure of data collection is something very much to be avoided. However, it is important to note that these were data issues and no patient was failed to be seen in practice.

As ever, so many things are happening in an organisation of this size that are too numerous to mention and so many of them are contributing to improvements in patient care. I would particularly point out our investment in a state of the art CT scanner: the first of its kind in the region. The new research unit, MIDRU, will be an important contributor to the growth and development of best practice befitting an organisation with so many important patient services, including some services attracting patients from far and wide.

In order to ensure that in future years we succeed in delivering our targets and that we are an organisation in which our clinical staff truly lead, both at the patient level and also at the executive level, we have undergone a full and complete organisational restructure. This has involved creating five groups that break the organisation into smaller more manageable parts, each group being lead by a medical director. This greatly enhances the clinical contribution in decision making within the Trust and brings decisions much closer to the frontline. The effect of this will begin to be felt in the year that follows and thereafter.

It has been a great privilege to be involved with this Trust in many different roles over a quarter of a century. In particular, during the last several years it has been exciting to see the growth and development

of services as the amounts of resources available within the NHS have increased year on year. It seems fitting that the very last of the 'fever blocks' that were the hallmark of the original Hospital to which I was appointed, should be demolished during the final few weeks of my time here.

The past is the past and there is much to come in the future. I know my successor can look forward to the same support and encouragement from the staff that I have experienced over so many years. My thanks go out to each and every one of them.

Dr Mark Goldman
Chief Executive Officer
4 June 2010

Executive Team
Dr Mark Goldman - Chief Executive
Mrs Beccy Fenton - Deputy Chief Executive
Ms Pim Allen - Group Medical Director, Women and Children's Services
Mr Misra Budhoo - Group Medical Director, Planned Inpatient Care
Ms Mandy Coalter - Director of Human Resources and Organisational Development
Mr Ian Cunliffe - Medical Director
Ms Lisa Dunn - Director of Corporate Affairs
Mr Simon Hackwell - Commercial Director
Mr Andrew Laverick - Director of Information and Communications Technology
Ms Ellen Ryabov – Acting Chief Operating Officer (appointed 1 April 2009)
Mr John Sellars - Director of Asset Management
Dr Steve Smith - Group Medical Director, Emergency Services
Dr Roger Stedman - Group Medical Director, Ambulatory Care
Ms Mandie Sunderland – Chief Nurse
Mr Adrian Stokes - Director of Finance, Chief Finance Officer
Mr Mark Wake - Group Medical Director, Clinical Support
Dr Sarah Woolley - Director of Governance and Standards

Changes in Executive Committee Membership
Dr Hugh Rayner - Medical Director for Medicine (stood down 30.06.09)
Mr Alan Gurney - Operations Director for Surgery (stood down 30.06.09)
Mrs Kath Kelly - Operations Director for Medicine (stood down 30.06.09)

Overview of the year by the Chairman

The year has been one of progress and disappointment. On the progress side our finances are on a firm even keel, we have exceeded our targeted financial surplus of £5.8m, with a final result of an operational surplus of £10.1m.

The £25m investment in an eight ward block at Good Hope is well on course for completion, we purchased a new state of the art CT Scanner for Birmingham Heartlands Hospital, one of very few of its type in this country. We opened the new Medical Innovation, Development and Research Unit and Diabetes Centre. We met a substantial number of our targets despite the fact of a substantial increase in demand for our services.

On the disappointing side of the balance sheet, we just failed to meet our A&E target for the year but because we have failed to meet the target in the last two quarters this year and 2009 Monitor determined we were in breach of our Terms of Authorisation and gave us a red rating for governance. Plans have been put in place and substantial effort is being made to get us back to meeting the 4 hour target to enable us to request Monitor to review the red rating.

The Care Quality Commission has set up a regulatory system in which trusts need to self certify. There were 3 criteria where we felt we could not meet the Care Quality Commission's registration requirements and so we have a conditional registration but with action plans to deal with the 3 conditions placed on us.

The other areas of disappointment were the results of our patient care and staff survey. On both these measures we were in the bottom quartile as measured against the rest of England and Wales. Once again plans have been produced to show demonstrable improvement in performance and to move the Trust out of the bottom quartile within the year.

I was due to retire from the Trust at the end of the financial year but was asked by the Governors to stay on for another year to oversee the appointment of the new Chief Executive and replacement Chairman. I was very happy to do this and support the Trust in dealing with these two issues as well as managing the Board programme to deal with these areas of improvement.

I want to place on record my thanks to all members of staff for their hard work in a difficult year and for the support of my board colleagues in leading the Trust and thank the governors for the supportive way they hold the Board to account.

Clive Wilkinson
Chairman
4 June 2010

The Board

The Board of Directors is chaired by Mr Clive Wilkinson, who was appointed for a four year term commencing 1 April 2006 and whose term of office concluded on 31 March 2010. The Governors' Consultative Council re-appointed Mr Wilkinson as Chairman for a further twelve months until 31 March 2011 after an unsuccessful open recruitment process. The Council agreed to the extension of term, following guidance given by Monitor, in order to offer stability and continuity to the Board in the light of the resignation of the Trust's Chief Executive Officer, Dr Mark Goldman who will step down on 31 July 2010. 2011. The Trust's Appointments Committee will oversee the recruitment process for a new CEO during the spring of 2010. The Governor's Appointments Committee will oversee the recruitment process for a new Chair during the Autumn of 2010.

Other than the Chairman, there are seven Executive Directors and seven Non-Executive Directors. The Directors do not have material interests in organisations where those organisations or related parties are likely to do business, or are possibly seeking to do business, with Heart of England. Non-Executive Directors are appointed for four years and are terminable with one month's notice on either side. Anna East took over the role of Deputy Chairman with effect from 1 April 2008. Further details of the Directors, their remuneration and how they operate are disclosed in Remuneration Report on page 66.

HEFT Governance – an independent Board
– an informed Board
– a responsible Board

Board of Directors

Mr Clive Wilkinson – Chairman ¥ ‡ •

Dr Mark Goldman - Chief Executive (until 31/07/10)

Mr David Bucknall – Non-Executive Director ¥ † ‡ •

Ms Mandy Coalter - Director of Human Resources and Organisational Development

Mr Ian Cunliffe - Medical Director (until 30/09/10)

Mrs Anna East - Non-Executive Director ¥ † ‡ •

Mrs Beccy Fenton - Deputy Chief Executive ∞

Ms Najma Hafeez - Non-Executive Director ¥ † ‡ •

Professor Christopher Ham - Non-Executive Director ¥ † ‡ •

Mr Richard Harris - Non-Executive Director ¥ † ‡ •

Mr Paul Hensel - Non-Executive Director ¥ † ‡ •

Mr Richard Samuda - Non-Executive Director ¥ † ‡•

Mr Adrian Stokes - Director of Finance, Chief Finance Officer †

Ms Mandie Sunderland – Chief Nurse

Dr Sarah Woolley - Director of Governance and Standards

¥ Independent † Audit Committee ‡ Remuneration Committee

• Nominations Committee ∞ Non voting member of the Board

Board Members' profiles

Mr Clive Wilkinson, Chairman

Clive held the post of Chairman of Heartlands NHS Trust from December 2001 until the NHS Trust became a Foundation Trust in April 2005 and was appointed as the Chairman of the Foundation Trust for a further year. Clive then applied for the post of Chair of Heart of England NHS Foundation Trust through a process of open competition and was appointed for a 4 year term on 1st April 2006. Previously, Clive was Chairman of the NHS Executive West Midlands Region from 1997 to 2001, Chairman of Wolverhampton Healthcare NHS Trust from 1994 to 1997 and Chairman of Sandwell Health Authority from 1986 to 1994. He was also a member of the Audit Commission from 1986 to 1996 and a Non Executive Director of the Financial Services Authority from 2005 to 2007. Clive was a Birmingham City Councillor from 1970 to 1984. Clive is also Chairman of the Civic Housing Association, a Trustee of Bourneville Village Trust, Chair of Midlands Industrial Association and a former member of the Department of Health's Audit Committee. . Clive has also served terms as Deputy Chairman at the Redditch Development Corporation and also Non Executive Director of the Black Country Development Corporation and served 9 years representing Consumer interests with the Water Regulator OFWAT.

Dr Mark Goldman, Chief Executive

Mark has been Chief Executive since 2001. Mark qualified in medicine and became Senior Lecturer in Surgery at the University of Birmingham in 1985. His special interest is Vascular Surgery and he was an NHS consultant from 1985-2001. Mark became involved early in Clinical Management and was appointed Medical Director to the then Birmingham Heartlands Acute Trust in 1993. Mark was a member of the Modernisation Team which constructed the 10 year NHS plan. Mark has been involved in developing and leading clinical services as well as leading major organisational change as the hospital has achieved first Trust status then Foundation Trust status and along the way has acquired two other local Hospitals to become one of the largest and most successful NHS foundation trusts. From November 2005 until March 2007, Mark was also Chief Executive of Good Hope Hospital and succeeded in turning around a deficit of £6m to a surplus of £1.7m. In April 2007 the Trust completed the first ever acquisition by a Foundation Trust of a failing NHS Trust. Heart of England was named as Acute Healthcare Organisation of the year in 2006 by the Health Service Journal. It has also received international recognition and Beacon site status for its partnership work with local primary care trusts on community based chronic disease management. In April 2009, Mark was invited to be the NHS Leadership Council's lead on clinical issues and has been seconded to the Council for 1 day per week.

Mr David Bucknall, Non-Executive Director

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

Ms Mandy Coalter, Director of Human Resources and Organisational Development

Mandy is currently Director for Human Resources & Organisational Development having taken up post in July 2006. Prior to joining the Trust, Mandy worked in local government for 12 years. Mandy is a graduate in Law, a Fellow of the Chartered Institute of Personnel & Development and a practitioner in NLP. Mandy leads the HR team and oversees workforce planning, education, organisational development, employee relations, employee well being and HR services such as pay and recruitment. During her time at the Trust, Mandy and her team have been involved in supporting the acquisition of Good Hope hospital, a programme of staff engagement and leadership development. Most recently, her team have developed the HEFT Faculty of Education, a first in the NHS that has already delivered excellence in education and training. Mandy has also overseen improvements to basic HR management in the Trust including reducing vacancies and time taken to hire staff, absence management, appraisal roll out and mandatory training. The Trust has been recognized as a Top Employer.

Mr Ian Cunliffe, Medical Director

Ian is a Consultant Ophthalmologist who has worked for the Trust for 13 years. Ian trained in Sheffield, Cambridge, and New Zealand, where he completed a clinical fellowship. Ian's specialist area of interest within ophthalmology is Glaucoma. Ian has been Clinical Director for Ophthalmology for three years and worked with the Modernisation Agency on its pilot project for clinical governance. He has also spent six months as Associate Medical Director for surgery before taking the post of Medical Director for Surgery in April 2006. Following the restructure in 2009 Ian became the Trust's Medical Director, leading the 5 Group Medical Directors, he also still practices clinically as an ophthalmologist.

Mrs Anna East, Deputy Chairman

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

Mrs Beccy Fenton – Deputy Chief Executive and Director of Transformation (non-voting Board member)

Beccy is the Deputy Chief Executive and Director of Strategy and Transformation with responsibility for Corporate Strategy, Business Planning and the Transformation Programme at the Trust. The Transformation Programme is an organisation wide continuous improvement programme applying improvement methodologies such as LEAN, organisational development and systems thinking to improve patient quality, staff morale and productivity. Beccy is also CEO of HEFT Consulting and leads the strategic development and delivery of HEFT's NHS consulting business. She is also the Executive Lead for Good Hope Hospital where she acts on behalf of the CEO leading the local strategy, stakeholder and staff engagement and a programme of improvement. Prior to her current role, Beccy was Chief Finance Officer/Finance Director at the Trust for 5 years and also held the role of Managing Director at the Trust during the merger and integration with Good Hope. Beccy has over 13 years experience in the NHS as well as 4 years experience working for Coopers & Lybrand (now PriceWaterhouseCoopers). Her experience with Coopers & Lybrand allowed her to work with many private sector companies and she has been able to integrate much of this learning into the business processes at Heart of England. Beccy has an MA in Engineering Science from Oxford University, is a Chartered Accountant and is an NLP Practitioner, a qualified Executive Coach and an EFQM Assessor.

Ms Najma Hafeez, Non-Executive Director

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

Professor Chris Ham, Non-Executive Director

Chris Ham has been professor of health policy and management at the University of Birmingham, England, since 1992. From 2000 to 2004 he was seconded to the Department of Health where he was director of the strategy unit, working with Ministers on NHS reform. Chris is the author of 20 books and numerous articles about health policy and management. His work focuses on the use of research evidence to inform policy and management decisions in areas such as health care reform, chronic care, primary care, integrated care, performance improvement and leadership. Chris has advised the WHO and the World Bank and has served as a consultant to governments in a number of countries. He is a governor of The Health Foundation, and an honorary fellow of the Royal College of Physicians of London and of the Royal College of General Practitioners, a companion of the Institute of Healthcare Management, a senior associate of the Nuffield Trust, and a visiting professor at the University of Surrey. In 2004 he was awarded a CBE for his services to the National Health Service and in April 2010 he was appointed as the Chief Executive of the King's Fund Chris was appointed as a Non-Executive Director in October 2007.

Mr Richard Harris, Non-Executive Director

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

Mr Paul Hensel, Non-Executive Director

Paul is an IT professional with 35 years' experience in the development and provision of IT systems. His early career encompassed roles with Dunlop, GKN, Chubb and West Midlands Regional Health Authority. Paul, together with his brother, started his own business in 1980 to exploit the emerging power of small scale computers. This company eventually became a leading supplier of software to the worldwide mobile telecommunications industries, particularly in South Africa and Europe and was acquired by CMG/Logica in 2003. Paul was appointed as a Non-Executive Director to the Trust in August 2005. He was granted a further four year term of office by the Governors Consultant Council in May 2008 and is the Non-Executive lead for IT issues.

Mr Richard Samuda, Non-Executive Director

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

Mr Adrian Stokes, Director of Finance

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

Ms Mandie Sunderland, Chief Nurse

Mandie joined as Chief Nurse in December 2008 and this is her third Executive Director position, having held previous posts in acute trusts in the North West of England. Mandie's clinical speciality is intensive care nursing and she has worked in both clinical and practice development posts in London, Manchester and Lancashire. Her main interests now lie in quality and governance and she has worked for regulators and the Department of Health in reviewing standards of care across several hospital trusts both in England and Northern Ireland. In the late 1990's Mandie spent time working at the Department of Health as a member of the Chief Nursing Officer's team and was the national nursing lead for many governance initiatives such as the establishment of NICE, Essence of Care and National Service Frameworks. In 2003 she returned to the Department of Health on secondment to lead on the National Consultation on Choice.

Dr Sarah Woolley, Director of Governance and Standards

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

Performance & Key Performance Indicators

We have set out here the key areas of performances for the Trust in the last twelve months. These areas include both national and local targets.

In 2009/10 the Heart of England NHS Foundation Trust aimed to improve its performance against the key national targets monitored by the Care Quality Commission.

The Trust was disappointed in its Annual Healthcheck for 2008/09 (published in October 2009) when it achieved Fair for the Quality of Service element, we did however achieve Excellent for Use of Resources.

In 2009/10 the Trust met the following national targets:

- C Difficile ongoing year on year reduction
- MRSA
- Maximum wait of 2 weeks for cancer urgent referrals and breast symptomatic referrals
- Cancer 31 day wait from decision to the start of treatment for all modalities including anti cancer drugs and surgery
- Cancer 62 day from urgent referral to treatment for all cancers
- 18 week from point of referral to treatment (admitted and non-admitted patients)
- Cancelled operations target less than 0.8% of operations were cancelled on the day
- 2 week access to Rapid Access Chest Pain Clinics
- Access to Revascularisation Service
- Access to GUM services
- Breast feeding

The Trust underachieved against the following national targets

- Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge
- Delayed transfers care
- Smoking in pregnancy

And achieved the following local targets:

- Hospital Standardised Mortality Rates reduced from 95.2 in 2008/09 to 88 in January 2010 (latest data)
- Emergency readmission rates 9.9% in 2009/10

Quality Report

Quality as a Business Strategy - Patient Quality, People and Productivity

Over the last few years the Trust has steadily moved away from an agenda focused purely on year-on-year financial stability towards one entirely focused on quality and patient safety, all delivered within our financial capability. Over the past year the Board has reaffirmed the Trust's vision and strategy to deliver quality improvements through meeting our obligations to the local community. As a Board we are very conscious of the financial restraints that the NHS will face over the coming year, and the only way to deliver quality and patient safety is to continue to improve health and wellbeing in collaboration with other public and private sector organisations. We remain committed to understanding the views and experiences of our patients and their GPs thus allowing them to shape the services we provide.

We readily acknowledge that our ability to deliver the quality and safety agenda rests on the co-operation and commitment of our staff and I would like to say a huge "thank you" to all those who have worked with us thus far. Our aim is that patients and their families will have appreciated a compassionate, dignified and clinically excellent service and that inspires us to continue our work in this vital area."

Mark Goldman
Chief Executive Officer
4 June 2010

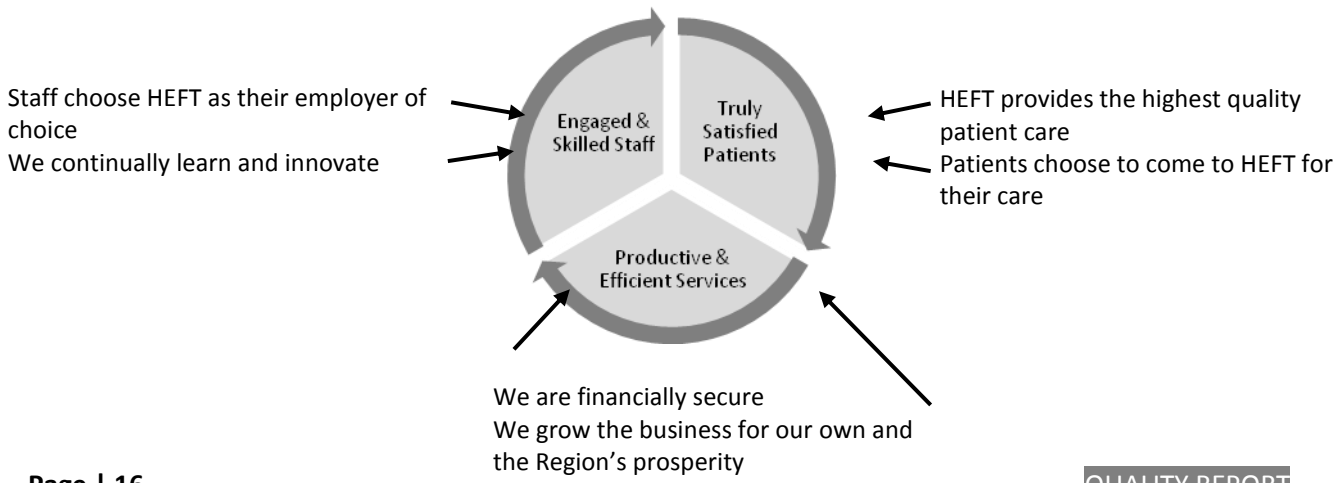
Our Quality Story So Far

Our Vision
"to be the most exciting and influential healthcare business worldwide"

Our Purpose
"to be a centre of excellence in the provision of healthcare, education and research"

Our Corporate Objectives

The Trust's original six Corporate Objectives have recently (December 2009) been consolidated into three new and simpler Corporate Objectives that focus on Quality. Together these three Corporate Objectives define our overall goal for Quality and act as our guiding "True North" in our quest for continuous improvement.



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

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

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

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

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

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

A number of board approved performance measures to monitor these have been in place for a number of years and include both national and local priorities. Our success in achieving these targets can be seen on page 15 of the Directors' Report.

The Trust has provided services in 69 specialties in 2009/10. This represents 99 % of our income from healthcare activity measured by income generated. The Board has reviewed the available data on the quality of care in the following areas over the year;

Review subject	**Specialities covered**
Re-admission rates	General Surgery, Gynaecology, Urology
Patient Satisfaction	Stroke and Maternity
Infection control	C-diff – Trust-wide and MRSA screening for emergency care
Nursing metrics	All inpatient areas

The Board is reviewing and considering the results of these reviews to develop a plan for improving the quality of the Trust's services.

Clinical Audits
During April 2009 – March 2010, 54 national clinical audits and 8 national confidential enquiries covered NHS services that the Trust provides. During that period the Trust participated in 87% of national clinical audits and 38% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. These are set out below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases as required by the terms of that audit or enquiry (where no entry is made, no requirements were specified.)

2009 BASH national audit group. Group audit on asymptomatic screening	100%
Audit of CD4 monitoring	100%
BCIS Angioplasty	100%
BHIVA National Clinical Audit of HIV and Hepatitis B/C co-infection	100%

BHIVA. HN1 and HIV Pts (Swine Flu)	100%
BTS National Asthma audit	100%
BTS National Asthma Audit	100%
cardiac rhythm management	100%
Carotid endarterectomy and audit of carotid intervention (HCC & Royal College)	Unknown
CEMACH: Perinatal mortality / CMACE	100%
College of Emergency Medicine: asthma	100%
College of Emergency Medicine: fractured neck of femur	100%
College of Emergency Medicine: pain in children	100%
Community acquired pneumonia	100%
Confidential Enquiry into maternal deaths and child health	100%
Confidential Enquiry into Stillbirths & Deaths in Infancy (CESDI)	100%
Cystic Fibrosis	100%
Cystic Fibrosis Annual Review (link with respiratory)	
DAHNO: head and neck cancer	100%
Delivery of single sex accommodation	Unknown
GRS audit	
Heart failure management	100%
ICNARC CMPD: Adult critical care units	100%
Inflammatory bowel Disease Audit	63%
LUCADA National Lung Cancer Audit	100%
Management of PID	Unknown
MINAP (inc ambulance care): AMI and other ACS	100%
National Comparative Audit of Blood Transfusion: changing topics Collection	Unknown
National COPD audit (NCROP)	100%
National Falls and Bone Health Audit (n=60)	
National Kidney Care Audit (2 days)	100%
National Mastectomy and Breast Reconstruction Audit	100%
National Oesophago-gastric Cancer Audit	100%
National Sentinel stroke Audit (n=40-60)	
National study of HIV in pregnancy and Childhood (NSHPC)	100%
National Thoracic returns	100%
NBOCAP: bowel cancer	100%
NCEPOD Elective & Emergency Surgery in the Elderly	
NCEPOD Parenteral Nutrition	
NCEPOD Peri-operative care	
NCEPOD Surgery in Children	
NCI / CISH	
NDA: National Diabetes audit	100%
NHFD: hip fracture	100%
NJR: hip and knee replacements	
NNAP: Neonatal care	100%
NorthStar Duchenne muscular dystrophy network and database	100%
Patient Satisfaction	Unknown
PROMS Hernia	59%
PROMS Hip Replacement	65%
PROMS Knee Replacement	77%
PROMS Varicose veins	20%

Pulmonary Hypertension Audit	
RCP Continence Care Audit	100%
Renal Registry: renal replacement therapy	100%
SMArtNet network and database	100%
Surgical site infection rates in elective bowel surgery	
SWORD (Surveillance of Work Related and Occupational Respiratory Disease)	100%
TARN: severe trauma	100%
UK Comparative Audit of Upper Gastrointestinal Bleeding and Use of Blood	100%
UKOSS (UK surveys of rare obstetric disorders)	100%
VSSGBI VSD	100%

The reports of 18 national clinical audits were reviewed by the provider in April 2009–March 2010 and the Trust intends to take the following actions to improve the quality of healthcare provided.

- Review of Service Standard Document to ensure compliance
- Develop a formal GI bleed rota
- Change the way communication with parents is recorded, a sheet was specially designed
- Address breast feeding issues in the NNU
- Respiratory Directorate to liaise with acute medicine to improve acute asthma management in AMU and subsequently in medical wards
- Establishment of acute asthma proforma in AMU
- Junior doctor induction and further nursing teaching (asthma nurses and respiratory team)
- Speak to staff to improve scanning of ambulance records
- Reinforce adherence to asthma treatment pathways
- Reinforce pain re-assessment and documentation with paediatric nurses
- Buy plastic PEGs for curtains
- Use patients own clothes
- Ensure everyone is aware of their responsibilities with regards to the Single Sex policy
- Ensure that Data completeness is in line with MINAP requirements
- Ensure that Data completeness is in line with BCIS requirements

The Trust undertakes a large amount of clinical audit activity each year which is reviewed and disseminated at local or group level as appropriate to enable learning and improvement. In 2009/10 the reports of 115 local clinical audits were reviewed by the provider in April 2009–Mar 2010. The Trust's Clinical Standards Committee monitors the overall audit activity across the Trust and drives improvement in the way that clinical audit is used. It report to Governance and Risk Committee which is a sub Committee of the Trust Board. It would not be appropriate or pragmatic for individual audits to be routinely reviewed by the Board however, where required, the issues addressed and raised by clinical audit will be escalated to Trust Board level

Research and innovation

The number of patients recruited in the previous year to clinical research (that is, research approved by a Research Ethics Committee) was 3397.

Use of the CQUIN framework

A proportion of our contracted income in 2009/10 was conditional upon achieving quality improvement and innovation goals agreed between us and our commissioners through the CQUIN payment framework. Further detail of the 2009/10 agreed goals and new goals agreed for 2010/11 is available on request from the Company Secretary at Heart of England NHS Foundation Trust, Heartlands Hospital, Bordesley Green East, Bordesley Green, Birmingham, B9 5SS.

Whilst we are still awaiting final confirmation on the payment of these amounts at present the total monetary amount of income reliant on the delivery of the CQUINs was 0 .5% of the outturn contract value, approx £2.3m

The Trust used the CQUINs to help define its clinical priorities in 2009/10. There were 6 CQUINs in place relating to

- Fetal Growth Restriction
- Stroke care
- Nursing Metrics
- Infection Control
- Patient feedback in strokes services and maternity care
- Readmission rates

Review of Services

During 2009/10 the Trust provided167 NHS services to other NHS bodies, which accounts for 1.3% of the total income of the Trust. We are in the process of reviewing the data available to us on the quality of care in many of these NHS services

Care Quality Commission

Legislation has brought in a new system that applies to all regulated health and adult social care services and registration is at the heart of that new system. From 1 April 2010, as a health provider who provides regulated activities we will be required by law to be registered with the Care Quality Commission (CQC). In order to register we have to show that we are meeting new essential standards of quality and safety across all of the regulated activities that we provide.

The new system aims to ensure that people can expect services to meet essential standards of quality and safety that respect their dignity and protect their rights. It is focused on outcomes, rather than systems and processes, and places the views and experience of people who use services at the centre.

The CQC Registration application confirmed identified that that the Trust declared fully compliant on 13 out of the 16 core quality and safety Regulations and in January 2010 we submitted our registration application to CQC and were registered with them on the 1st April 2010 with 3 conditions:

Condition 1

The registered provider is in breach of regulation 23 ('supporting workers') as follows: The trust has declared itself to be non-compliant with regulation 23 at the time of application. The action plan provided within the application confirmed that appraisals would be completed for all staff by September 2010. Information obtained during the site visit to all three main hospital sites identified that there was an inconsistent approach to identifying training needs relevant to job roles across the trust. Some staff members indicated that they had received no mandatory training in the past year and had not received any role specific training at all. Other areas of the trust staff indicated that they had received all mandatory training and were being supported through courses and having their educational needs met. The implementation of individual learning will ensure that staff are supported and competent to carry out their role and will identify training needs appropriate to their roles. In terms of appraisals we are aiming for 95% completion of appraisals by September 2010

Condition 2

The registered provider is in breach of regulation 22 (staffing) as follows: The trust declared non-compliant for regulation 22, but has provided an action plan that stated full compliance would be achieved by 31st March 2011. The action plan identified a full and complete nursing staff review with the introduction of an e-rostering system. The trust provided evidence of the current system for managing staff on a daily basis. Information obtained from staff members during a visit to the three main hospital sites identified that the current system being used by senior nurses resulted in clinical staff being moved from wards where

patients require long term personal and social care, which meant a regular reduction of clinical staff to meet these needs effectively. Bank nurses and nurses on overtime were regularly used to fill long term vacancies and there were no arrangements for maternity cover. It is important that the nursing staff levels are sufficient to ensure quality of service and minimise risk to those using the service.

Condition 3

The registered provider is in breach of regulation 11 (safeguarding service users from abuse) as follows: The trust declared non-compliant and provided an action plan that stated full compliance by 30th September 2010. Information obtained during the site visits to the three main hospital sites indicated that nursing and care staff working in the elderly care wards and medical admissions wards had inconsistent knowledge in recognising adult safeguarding and how to manage and raise concerns. Prioritising training for staff in areas of most risk will ensure that there is a raised awareness and that adult safeguarding concerns are identified earlier and managed effectively.

The CQC has not taken enforcement action against us since the start of the reporting year.

The Quality Report has been forwarded to the Trust's Local Involvement Networks (LINks), the Solihull Overview and Scrutiny Committee (OSC) and Birmingham OSC for review at their June meetings. The Birmingham OSC has since confirmed the Quality Report will now be shared with committee members for information only in July 2010. No formal feedback, issues or concerns with the Quality Report have been raised by either party since forwarding the documents for review

Overview of performance in 2009/10 against the key national priorities from the Department of Health's Operating Framework and against the Department of Health's National Core Standards.

At the end of 2008/09 we had declared full compliance against these 44 standards. During the last year, however, further guidance was issued on safeguarding children which led us to declare non- compliance with this standard for the mid year declaration in 2009/10, resulting in the Trust declaring compliance with 43 of the 44 Healthcare Standards. Work has been undertaken to address this shortfall and at the end of 2009/10, we were fully compliant with the safeguarding standard as set out by the HCC.

The Trust has met all national targets with the exception of the 98% A&E access target these include:

- C Difficile ongoing year on year reduction
- MRSA
- Maximum wait of 2 weeks for cancer urgent referrals and breast symptomatic referrals
- Cancer 31 day wait from decision to the start of treatment all modalities including anti cancer drugs and surgery
- Cancer 62 day from urgent referral to treatment for all cancers
- 18 week from point of referral to treatment (admitted and non-admitted patients)
- Cancelled operations target less than 0.8% of operations were cancelled on the day

Unfortunately the Trust failed to deliver the following national targets

- Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge
- Delayed transfers care

Quality of data

In records submitted to the Secondary Uses System (SUS) for inclusion in Hospital Episode Statistics (HES), the percentage of records including the valid patient's NHS Number was as follows:

Patient Group	Valid NHS number %
In patient	98.19%
Out patient	99.09%
A&E	90.5%

Our HRG (Healthcare Resource Group) error rate for clinical coding (for diagnosis and treatment coding), as reported by the Audit Commission in the latest Payment by Results (PbR) clinical coding audit, is 19%. This is based on the audit of 300 finished consultant episodes of which 19% needed to be re-assigned to another HRG Code due to incorrect diagnosis or procedure codes.

These results should not be extrapolated further than the sample audited, the services reviewed within the sample were General Medicine, Obstetrics, Pain Management and Trauma Procedures

In records submitted to the Secondary Uses System (SUS) for inclusion in Hospital Episode Statistics (HES), the percentage of records including the valid patient's General Practitioner Registration Code was as follows:

Patient Group	Valid GP code %
In patient	100%
Out patient	99.8%
A&E	98.4%

Our score for Information Quality and Records Management assessed using the Information Governance Toolkit was 73%. (Data provided by IG Team), a slight improvement on last year's score. Trusts are rated red, amber or green denoting levels of concern. The Trust is compliant with the standards and has achieved a Green rating.

Progress on Quality Priorities set for 2009/10

The Board and Governors Consultative Council identified 5 key priority areas for improvement during 2009/10 in last year's Quality Report. This is what we achieved:

PRIORITY 1: TO FURTHER REDUCE OUR MRSA AND C.DIFFICILE RATES

Why we chose this priority

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

Our Aim/Goal: In 2009/10 we would continue to build on the work we had undertaken in the previous 12 months and would aim to have fewer cases of both MRSA and C.Difficile than we had in 2008/09. We would also work to deliver 100% compliance with the emergency and elective screening targets. We agreed further stretched targets with our commissioners which would be monitored through a health economy Quality Review Group.

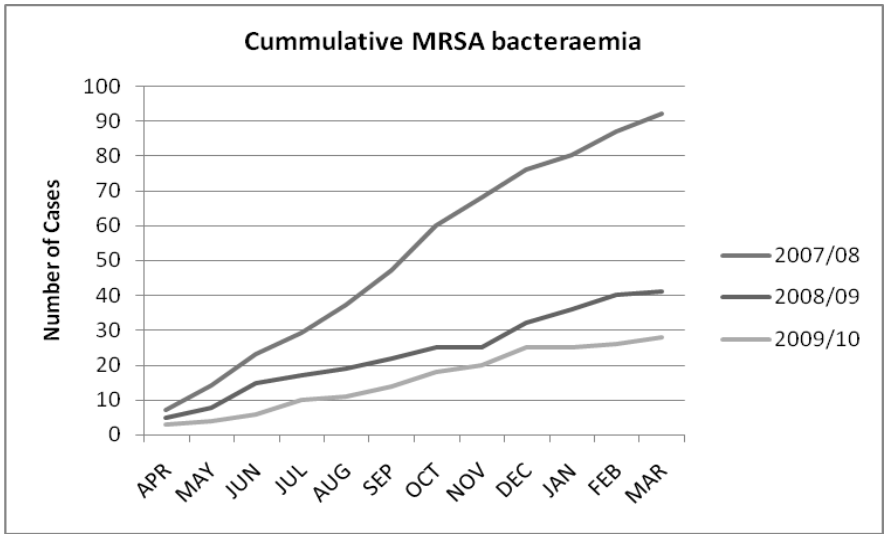
What we did

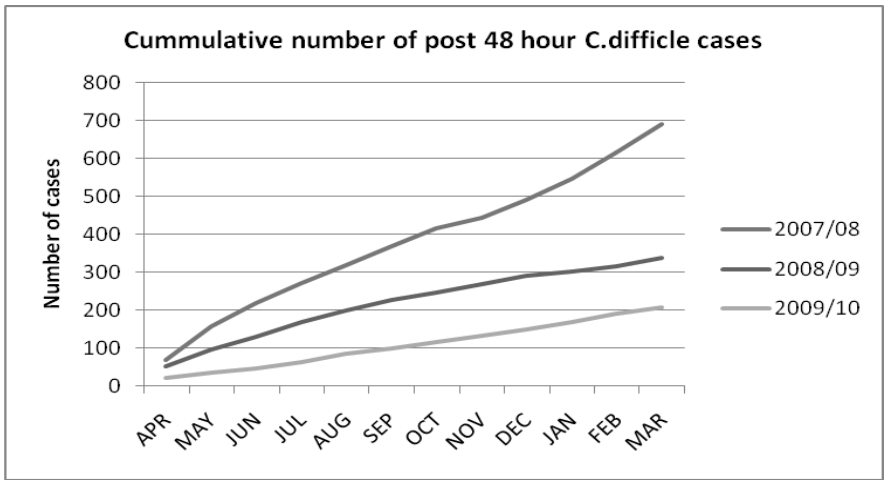
The infection prevention team have worked to improve the training of all trust staff over the year and to introduce the latest evidence based infection control practices. A detailed strategic approach to manage increased incidents of C.Difficile on wards was introduced during the year which resulted in a marked reduction in cross infection (the approach of the Trust was later recommended as best practice by the Department of Health in their C.Difficile guidance). The Trust met set targets and improved on their reduction of both MRSA and C.Difficile during 2009/10.

A detailed elective screening programme for MRSA was introduced and Targets against Department of Health standards were met. The Trust was unable to meet the stretch target of 100% MRSA screening compliance for emergency admissions set by the quality review group. Currently approximately between 70- 80% of cases are being screened. In collaboration with the Health economy infection control group, the IPCT were able to establish an IT system for automatic generation of letters to alert GPs and patients of positive MRSA results. This has been helpful as a number of very short stay patients have been discharged before their MRSA result.

Where we are now

This improvement is demonstrated in the graphs below:





Ongoing commitment

The Trust will continue its ongoing commitment to further reduction and zero tolerance to avoidable healthcare associated infection in 2010-11. Compliance for MRSA screening and further reduction of C.Difficile and post 48 hour MRSA against adjusted more stringent targets remain a Trust priority.

PRIORITY 2: TO INTRODUCE A NURSING QUALITY MEASUREMENT SYSTEM

Why we chose this priority

The pilot phase had already begun for the implementation of a Trust-wide system which would measure and monitor nursing care standards in 2009 and quality. This data would be cross checked against user views and outcome measures, to provide live performance information on nursing care across the Trust for senior nurses and the Trust Board. This work was already attracting interest both locally and nationally. The system would also link in with the Productive Ward programme and will be part of our aim of working towards 'Heart of England World Class Wards'. The key areas of focus for improvement would be cleanliness and dignity and privacy

What was the aim / objective?

To develop and implement a set of Nursing Metrics which include a patient feedback system and nursing care indicators which cover those areas which are our highest concerns in terms of risk. Those chosen provide a range of patient quality, safety and experience metrics which allow us to have robust monitoring of standards of care.

What we did

The nursing care metrics, initially developed in the North West of England were brought to HEFT by our Chief Nurse. These Metrics measure our standards of recordkeeping and the patient experience for the core activities that we undertake for our patients. A clinical "Back to the floor' approach from all matrons, corporate nurses, Head Nurses and the Deputy and Chief Nurse is used and real time data collection and reporting is available Trust wide following extensive collaboration with the IT Directorate. There has been a vigorous campaign to ensure that staff are prepared, with information giving sessions aimed at all groups of Nursing Staff. Concurrently, a non-clinical 'back to the floor' with commitment from non-clinical managers is being used to collect patient feedback from general ward areas; asking a minimum of 15 patients ten questions based on the Care Quality Commission's Inpatient Survey.

Where we are now

- Trust wide implementation in General Ward Areas since January 2010
- Neonatal, Paediatrics and Theatres care indicators implemented
- Maternity, Emergency Department, OPD, Endoscopy due to be fully implemented June 2010
- Real- time data feedback allows robust monitoring of standards of care
- Standards of care closely monitored and results reported to Quality and Standards Committee
- Problem areas identified and remedial action taken immediately to protect standards of care
- Patient Satisfaction - real-time feedback using a 'Back to the Floor' approach for non- clinical staff
- A dedicated section of the nursing intranet has useful information for all Trust staff.

This improvement is demonstrated as follows:

Trust Wide Overall Results	**Jan 2010**	**Feb 2010**	**Mar 2010**
Medication storage and custody	71%	85%	91%
Infection control & privacy & dignity	86%	88%	91%
Patient observations	75%	78%	84%
Pain management	75%	79%	81%
Tissue viability	69%	77%	80%
Nutritional assessment	60%	71%	71%
Falls assessment	67%	76%	81%
Continence assessment	34%	46%	54%
Total	71%	77%	81%

Ongoing commitment

- To continue with the monthly programme and to develop Care Indicators for further specialist areas such as A&E and ITU
- Problem areas to be easily identified and remedial action taken immediately to protect standards of fundamental care
- Areas with high standards of care and patient feedback can be celebrated and will become an integral part of staff appraisal
- Standards of care will become an integral part of staff appraisal
- Corporate themes from the Care Indicators data will be analysed and any necessary actions taken
- To share the system nationally and internationally

PRIORITY 3: TO IMPROVE STROKE MANAGEMENT CARE

Why we chose this priority

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

Our Aim/Goal: In line with NICE guidance issued in July 2008, the Trust will work towards improving stroke management care for all patients with a suspected stroke and patients with a high risk of TIA. Improvements will be measured using performance indicators that relate to thrombolysis within three hours and access times to CT scans. Alongside this we will undertake a bi-annual patient survey of patients treated at the Trust within stroke services to inform us of the identified service and quality improvements we can make.

What we did

- Closer working with the Emergency Department / Medical Assessment Unit and Radiology implementing tighter protocols to ensure CT requests are processed more efficiently
- Improved identification of Stroke patients by Stroke team (IT developments)
- Dedicated slots developed in Radiology – this ensures daily scanning is available
- % time patients spend on stroke units improved by dedicated bed management / designated beds / improved protection through bed protocols / improved identification of stroke patients in non stroke beds
- Closer working by the Stroke Thrombolysis Service with Emergency Department / Medical Assessment Unit with tighter / improved protocols and education programmes to ensure more calls received
- Education and collaboration by Stroke Thrombolysis Service with West Midland Ambulance Service (WMAS) to ensure more appropriate calls received
- Out of Hours service at Solihull Hospital allows for more access to the Stroke Thrombolysis Service. This ensures minimum service disruption in hours if site teams not available
- Stroke Sub-Directorate formed to drive / lead on changes with leads in medicine / nursing / AHP / management and links through people to ED / Radiology / WMAS etc.
- Cardiac & Stroke Network - development and production of service specifications linked to commissioning to aid processes. Also collaboration on stakeholder days and thrombolysis education programmes

Where we are now?

Definitive improvements in service provision and pathways are evident and work is continuing with internal and external teams to improve service and raise standards. Due to an extensive work programme a 'Senior Stroke review' takes place every 2 weeks to keep the work on track. Employment of Stroke Implementation officers and data clerks to assist in the process of change and ensure up to date data is available to show the progress and also identify performance issues.

The table below shows our performance against the CT waiting time targets set for us by the PCT as one of the Trust CQUINs for 2009/10

% of patients receiving a CT scan within 24 hours of a suspected stroke				
	Q1	Q2	Q3	Q4
Target	70%	70%	72%	75%
Performance	77.1%	72.3%	73.9%	81.2%

% of patients receiving a CT scan within 24 hours of a Transient Ischaemic Attack

	Q1	Q2	Q3	Q4
Target	45%	45%	47%	50%
Performance	72.9%	63.5%	72.2%	85.6%

At the end of 2009/10 72.75% of patients with a stroke spent 90% or more of their time in a specialized stroke unit.

CT scanning within 24hrs of presentation was 65% in April 09 and in Feb 10 had increased to 87%. The percentage of patients being treated on a Stroke Unit was 27% in April and in Feb 2010 had increased to 71%. The percentage of patients being thrombolysed was 3% during Feb-April 09 and in Dec 09 – Feb 10 this had increased to 7%. These figures are comparable to the best sites which will deliver 10% and these are generally academic centers.

Ongoing commitment

- To develop the Acute Stroke Units on all sites which will directly link to % of patients on stroke unit targets and by aiming to admit all stroke patients to these units will have a direct effect upon CT times
- To improve the resilience of the clinical service by developing medical and nursing teams so that 24/7 specialist advice available
- To continue to work with WMAS / ED / Cardiac and Stroke Network to ensure all patients suitable for thrombolysis have access to the treatment
- To continue with extensive audit and surveys and to action points that comes from these

PRIORITY 4: TO SPEED THE PROCESS OF HOSPITAL DISCHARGE

Why we chose this priority

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

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

What we did

There is a joint discharge team based on each hospital site providing a core service to each site. Each of the teams operates and links into one 'Central Point' that consists of senior operational staff that is further directed from a strategic level. Staff at every level is a mix of people internal and external to the Trust - representing all the major stakeholders (Acute, Mental Health Trusts, Local Authorities, voluntary organisations and PCTs).

Whilst the past year has been particularly challenging due to 'Winter Pressures' - that basically never ended from the previous year, the longest and coldest winter for over thirty years and the group restructure within the Trust the following areas of work have been developed:

SITREP - SitRep information used as a caseload for relevant managers to micro manage individual hard core cases and also help escalate those community shortfalls in services. Improvement measured by achieving end of year target for SitRep.

JOINT ACTION MEETINGS (JAM)- Continued with the weekly Joint Action Meetings (JAM) which have proved successful in discharging those patients truly stuck in hospital but also that forum creates the opportunity for collaborative working and networking.

LENGTH OF STAY >30 DAYS

Working groups set up across the Trust to focus on the various LOS. A firm and focus link has been achieved from publication of weekly SitRep on Mondays directly linked into JAMs on Tuesdays then directly linked into LOS on Thursdays. So far, LOS data for this target >30days at Heartlands is showing a reduction.

DELAY DISCHARGE ANCHORS

Based within each joint discharge team there is an anchor – the post has become instrumental in supporting delayed discharge out of hospital and also those discharges that begin to struggle. The posts also gather and share intelligence on individual discharges so the activity undertaken is on a massive scale and the information held is 100% accurate at any given time.

HOUSING DEPARTMENT - Birmingham

A new initiative and network "Central Point" has been finally established with the Birmingham Housing Department which provides accommodation for those needing community care services but with no accommodation or appropriate accommodation. This has recently extended to fast track housing repairs and adaptations thus avoiding the provision of new accommodation altogether. In recent months a total review of all posts and activities has been initiated to evaluate the value of the Central Point service. This is an important performance project and is on-going at the moment and the results of changes identified and implemented are yet to be determined. However, improvement is demonstrated by an almost zero housing delays on the SitRep for Birmingham residents in the last six months.

HOME FROM HOSPITAL – a registered charity establishing a scheme agreed and funded from ACUTE/BEN RIG. The resource has picked up all those patients struggling to discharge such as not meeting the need for social services assistance at home, or nursing, but were still considered by 'hands-on' nursing staff on the wards and social workers to be vulnerable frail older adults. A hugely successful scheme that in conjunction with an 'incidental' fund for emergency purchases such as electricity and food has helped to expedite discharges that has headed off hitting SitRep and LOS(if only for 2/3 days)

CAREHOME SELECTION – a private sector company which provides an ongoing programme that continues to support discharge to residential and nursing placement. The service continues to support reduced LOS.

MASTER LIST FOR DISCHARGE
This was a new initiative to produce a master list to discharge. Patients on the list are those most easily to be discharged with outside help once the list has gone to external commissioners and providers. Improvement is demonstrated by creating capacity during escalation when every bed back into the bed stock counts.

SENIOR MULTI-DISCIPLINARY TEAM WARD ROUNDS
This is an initiative in its second year of practice that again has proved successful in creating capacity during escalation when every bed back into the bed stock counts. MDT consists of team leads from joint Central Point supported by a Consultant.

COMMUNICATION
The Capacity Team notifies Central Point to escalate to partnership. Central Point triggers two actions one to communicate the position and two to physically mobilise social services to review all discharges with section 2 referral. Improvement is demonstrated by creating capacity during escalation when every bed back into the bed stock counts.

CHOICE POLICY AND PRACTICE
A national programme locally negotiated into local practice across the Trust with internal and external stakeholders to reduce DTOCs and speed discharge – a practice that continues to address and challenge expectations for both patients and staff. The policy is currently under review that involves patient information, letters issued and also trying to provide a universal definition for hospital staff what choice means in relation to discharge. The programme remains ongoing at the moment and involves participation from a patient group.

CHC COMMITTEE
Lead Community Discharge Nurses have gained membership on to this weekly board that is making decisions across Birmingham to smooth the access and transfer for patients into the service. This is new and the results as to how effective membership will be for the Trust's patients are yet to be known and evaluated.

BIRMINGHAM CITY WIDE DELAYED TRANSFERS OF CARE
The Trust has senior operational and strategic level staff on this board which provides a valuable forum to ascertain best practice specific to discharge and what working well at other Acute Hospitals across the city.

WHOLE SYSTEMS DISCHARGE GROUP
The Trust has senior operational and strategic level staff on this board which has created a new work stream to look at Care Homes contracted by Social Services. Work will involve the timings of patient returning to care home after an admission and also some of the reasons why care homes are sending to A&E in the first place. The aim is to help Social Services negotiate better contracts with Care Homes by taking into account issues faced by the acute sector when discharging. This is new and therefore the benefits of this have yet to be identified and evaluated.

COMMUNITY UNITS AT GOOD HOPE AND HEARTLANDS

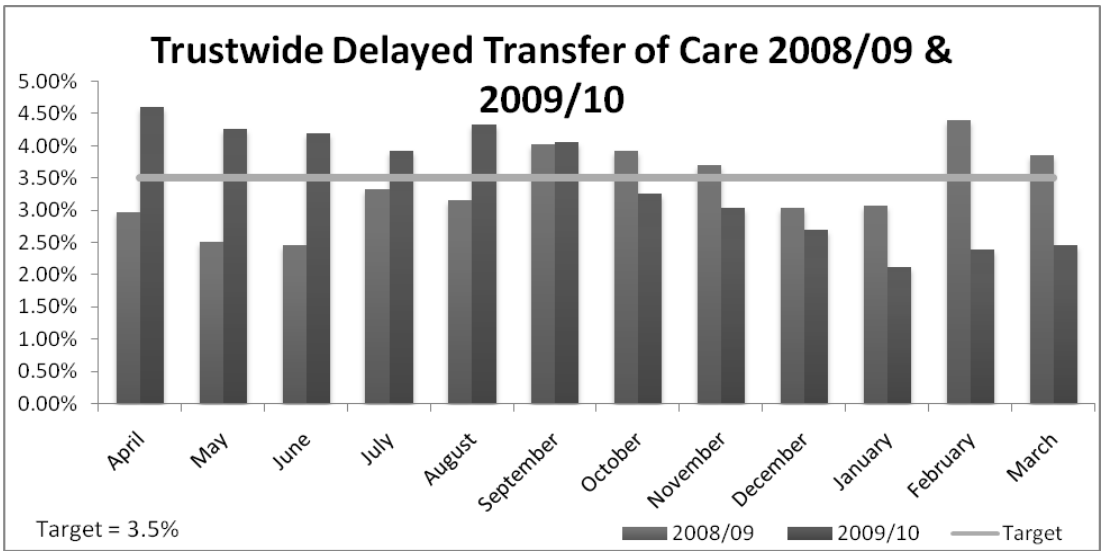
Working with BCC and BEN PCT through joint collaborative working and pooling of funds; 2 community units were established within the Trust to increase discharges to a community setting but allowing patients more time for ongoing non acute support and continual assessments'. This group of patients would stay in an acute bed a lot longer than they currently are and receive a better long term outcome when moving onto placement.

SUPPORT NURSES SOUTH STAFFS PCT

Working with South Staffs a review was carried out around discharge prevention, facilitated discharge and better support for patients from the Staffordshire area who are at Good Hope. Two nurses have recently been recruited with community service background who will assist in a speedier discharge process, no data is yet available to review the impact of this service.

<u>Where we are now</u>

This improvement is demonstrated in the graphs below:



<u>Ongoing commitment</u>

This work will continue to be a priority for the Trust.

PRIORITY 5: PATIENT FEEDBACK

Why we chose this priority

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

Our Aim/Goal: The key areas of focus for improvement would be information, staff attitude, and respect & dignity.

What we did

In 2009/10 the Trust selected and trained its own senior non-clinical managers to visit wards and ask a minimum of 15 patients 10 key questions each month about their stay and satisfaction with the care received whilst in hospital. This approach is currently being used on all base wards (with specialist wards / clinics due for inclusion Q2, 2010) and each manager is equipped with an electronic hand-held device that can be handed over to the patient at the bedside. Feedback from these surveys is transmitted 'real-time' to a central server and available instantly as a highly visual summary table. Trend analysis of patient experience results is used widely by nursing teams as part of their monthly review meetings which also includes the Trust's nursing metrics programme.

Patient/user feedback gained through the back-to-the-floor programme, weekly post-discharge patient surveys, the Trust's website, national websites, PALS (Patient Advice & Liaison Service), user groups and formal complaints is being included in a new style 'Ward-to-Board' bi-monthly report. The Trust's recently appointed Head of Patient Engagement has gained agreement from the independently managed 'Consultative Healthcare Council' (CHC - established to replace the Patient & Public Involvement Forums) to take a more active and central role in monitoring the results and trends in patient satisfaction at the Trust. From Q1 2010 the CHC will quality assure the new-style 'Ward-to-Board' bi-monthly report that summarises patient satisfaction results and have input into the actions. This will importantly provide independent reassurance to the Executive Directors and Trust Board that proposed actions are reasonable, being followed up and acted on appropriately.

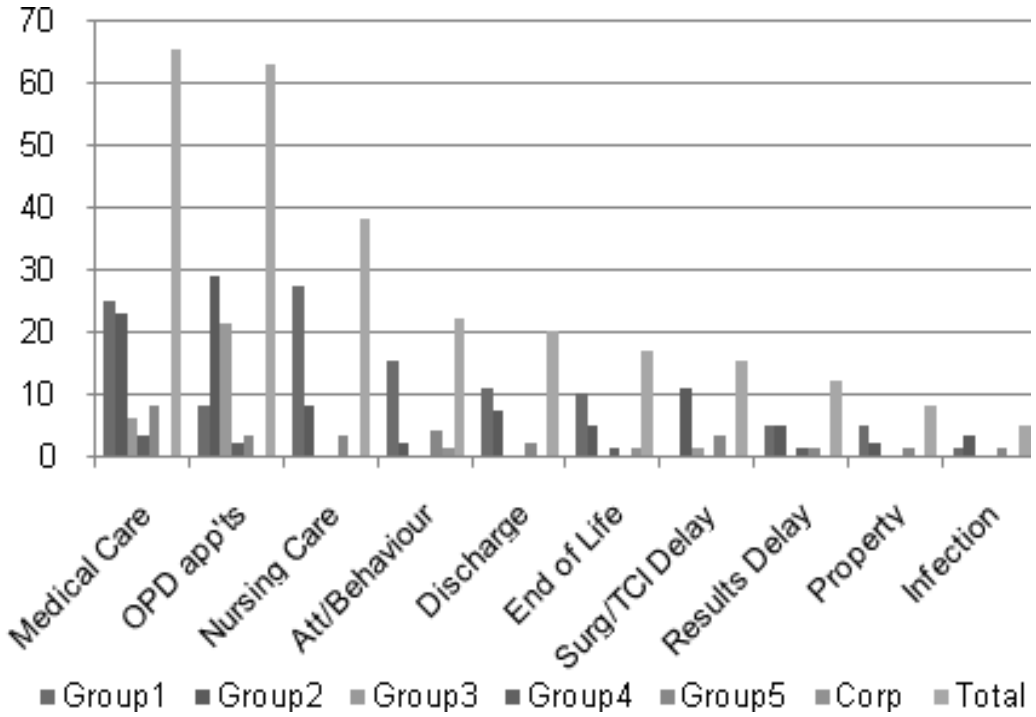
Concerns raised in the 2008/09 National Inpatient Survey around discharge, staff behaviours, availability of information and cancellation of procedures are being addressed through a targeted communications programme in conjunction with the operational teams. The 2009/10 National Outpatient Survey highlighted some concerns around the way important information is communicated to patients around possible side effects of medication and what would happen to patients during their appointments which are being addressed with the Outpatient team directly.

Where we are now - Back to the Floor – Bedside Survey results – Q4 2010

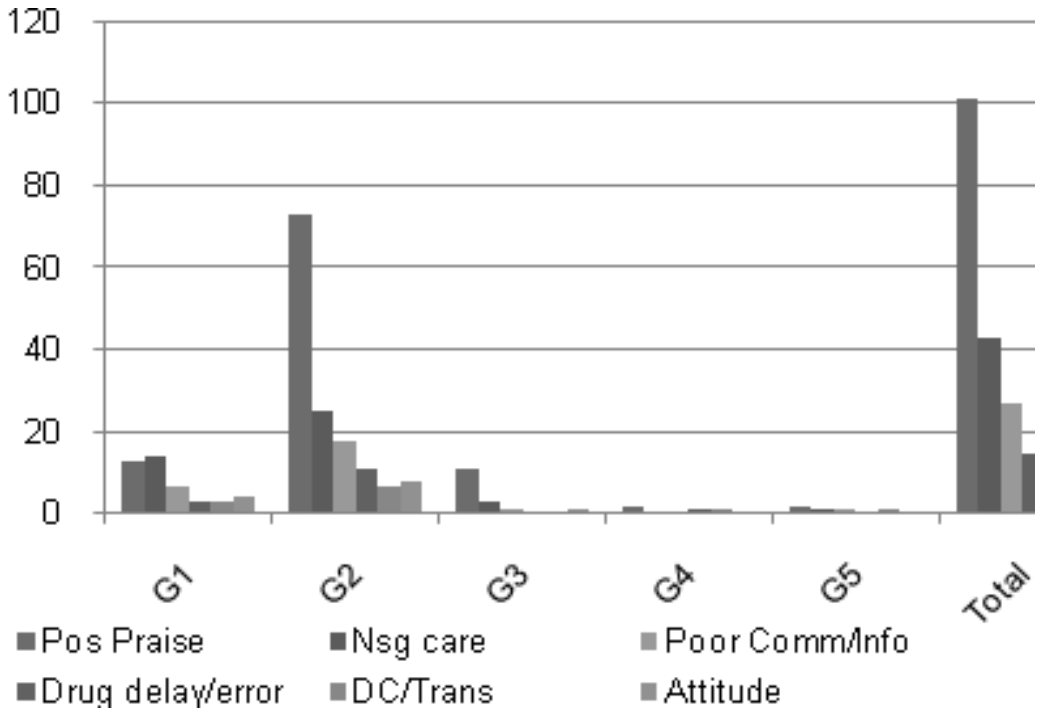
	Jan 2010	Feb 2010	Mar 2010	Q4 Average
Hand-washing	87% (Amber)	93% (Green)	95% (Green)	92% (Green)
Respect and Dignity	93% (Green)	91% (Green)	92% (Green)	92% (Green)
Help with Eating	85% (Amber)	82% (Amber)	79% (Red)	82% (Amber)
Pain Control	88% (Amber)	81% (Amber)	89% (Amber)	86% (Amber)
Discussed Discharge	47% (Red)	49% (Red)	57% (Red)	51% (Red)
Privacy	93% (Green)	98% (Green)	97% (Green)	96% (Green)
Cleanliness	93% (Green)	89% (Amber)	93% (Green)	92% (Green)
Info Meds	64% (Red)	84% (Amber)	79% (Red)	76% (Red)
Call Buzzer	77% (Red)	75% (Red)	83% (Amber)	78% (Red)

Single Sex	96% (Green)	93% (Green)	93% (Green)	94% (Green)
Total	82% (Amber)	84% (Amber)	86% (Amber)	84% (Amber)

PALS Feedback by Clinical Group Q4 2010



Free Text Comments Analysis – Weekly Survey Mail Out Q4 2010



Ongoing commitment

The Trust remains totally committed to collecting feedback, reporting trends and monitoring improvements based on patient's comments. A variety of methods are used to ensure the opportunity to leave feedback about services is open to all members of the community served by the Trust's three hospitals. A system is also in place and under constant review to monitor, follow-up and report progress made against the patient satisfaction agenda.

RELATIONSHIPS WITH EXTERNAL BODIES DURING 2009/10

We are required to report quarterly to Monitor against a number of key national targets and a quarterly compliance framework has been developed to support this. The table shows our performance for 2009/10 against our 2008/09 performance for these indicators.

Indicator	2008/09	2009/10	Threshold
Clostridium difficile year on year reduction	337	208	<337
MRSA – maintaining the annual number of MRSA bloodstream infections at less than half the 2003/04 level	41	28	<46
Maximum waiting time of 31 days for 2nd or subsequent treatment for all cancers - **Anti cancer drug treatments**	N/A	100%	98%
Maximum waiting time of 31 days for 2nd or subsequent treatment for all cancers - **Surgery**	N/A	98.94%	94.00%
Maximum 62 day wait for treatment from **urgent GP** referral to treatment : all cancers	N/A	87.43%	85.00%
Maximum 62 day wait for 1st treatment from **consultant screening** referral - all cancers	N/A	97.03%	90.00%
For admitted patients, maximum time of 18 weeks from point of referral to treatment	90.70%	93.10%	90.00%
For non-admitted patients, maximum time of 18 weeks from point of referral to treatment	96%	96.70%	95.00%
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	97.63%	97.17%	98.00%
Maximum waiting time of 31 days from diagnosis to 1st treatment for all cancers	99%	98.07%	96.00%
People suffering from heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack)	76.92%	N/A	N/A
Maximum waiting time of 2 weeks from urgent GP referral to date first seen for all urgent suspect cancer referrals	93.09%	93.59%	93.00%
Two week wait for symptomatic breast patients (cancer not initially suspected)	N/A	94.32%	93.00%
Screening all elective in-patients for MRSA	N/A	178.87%	100%
Each national core standard	44	44	44

We achieved the entire Monitor targets, with the exception of the A&E 4 hour target which we failed to achieve for 3 out of the 4 quarters for last year. As a result of this we have been working closely with

Monitor on the development of action plans to deliver the target in 2010/11. In February 2010, Monitor, placed us in significant breach of our Authorisation due to the repeated failure to deliver the 4 hour access target during the winter periods of 07/08, 08/09 and 09/10. This resulted in a red governance risk rating from Q3 2009/10 and we were required to provide additional monthly information to Monitor including: -

- a monthly forecast for reducing Length of Stay (LOS) and monthly performance against this;
- a forecast for A&E performance and actual performance by individual site;
- progress against programme plan actions; and
- submission to Monitor of 4 hour performance dashboard

Monitor's main concerns were about our capacity to drive through the trust-wide cultural and behavioural changes required to deliver the 4 hour access target. Every part of the organisation has become involved in the plans to ensure that we have the right patient, in the right bed first time. By the end of Q4 2009/2010 we achieved 97.18% for the four access target.

Looking ahead – our Quality Priorities for 2010/2011

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

The Board and Governors Consultative Council considered the quality priorities for 2010/11 and agreed to base them on the Commissioning for Quality and Innovation Framework agreed with the PCTs.

Key priority areas for improvement were identified as

1) Stroke Management – Improvement of stroke management care was a priority for 2009/10. A significant amount of work has been undertaken particularly working with other Departments more effectively and the development of the stroke thrombolysis services. However. It is felt that further work is required in order to place further resilience in the service. This will therefore remain a key priority – including the new CQUIN target of - Admission to a stroke unit within 4 hours of arrival at hospital.
2) Tissue Viability – there has been a significant amount of work undertaken to reduce the number of pressure ulcers in the Trust – with the development and implementation of the Tissue Viability Service. This target will enable further improvement in the prevention, assessment and management of pressure ulcers - which is a key quality indicator.
3) Patient Experience - The national CQUIN target will be looking for an improvement in the scores against the 5 key questions in the Inpatient survey. Patient experience is a key indicator for the Trust and with an increased focus on patient outcomes in the Care Quality Commission Regulations, it is important that managing patient experience remains a key priority for the Trust.
4) Venous Thromboembolism (VTE) – VTE is a significant patient safety issue, however outcome data is poor. Whilst work is underway to improve reliability of outcome data (there will be a national mandatory data requirement from June 2010), the process for measuring VTE risk assessments will set an effective foundation for appropriate prophylaxis. This gives the potential to save thousands of lives each year.

Operating and financial review

Patient care and stakeholder relations have already been covered in the Quality Report on page 16.

Our heritage

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

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

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

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

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

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

We offer national and regional clinical services, as well as secondary care, emergency and elective practice. As the second largest employer in Birmingham with 10,500 staff, the Hospitals play an important part in the local community.

The Trust has a reputation for pushing the boundaries, transforming the way care is delivered and shaping healthcare of the future.

Our principal activity

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

Our principal activity is managed by five groups. These are some of their highlights for the year under review:

GROUP 1 –EMERGENCY SERVICES – HIGHLIGHTS 2009-2010

- Successfully completed the Heartlands Emergency Department refurbishment at a cost of £1.4m. This investment has significantly improved the environment for patients and staff and enhances ability to improve patient experience, care and dignity with the addition of seven additional cubicles and 4 additional beds in CDU. The cubicles will support improved ambulance handover performance and performance against the 4 hour emergency access target. The additional beds when operational in CDU will help to reduce avoidable admissions.
- A planned capital redevelopment at Good Hope Hospital c£5m is in development; this will improve the environment, integrate clinical areas for major and minor cases and create a separate area for children.
- The Elderly Care Directorate in partnership with NHS BEN and Birmingham Social Services has successfully developed "Community Units" on both the Heartlands and Good Hope sites. Ward 29 and Ward 3 transferred to NHS BEN to provide a new model of care for people currently in an acute hospital whose therapy intervention is largely completed but would benefit from a period of additional assessment by the multidisciplinary team and consultation with the individual and their carer(s) to ascertain care needs thus allowing an informed decision to be made about how these needs will be met. These units allow patients a longer recovery period with the aim of maximising independence.
- In September 2009, the Stroke Team extended the thrombolysis service. Patients within the Trust's population now benefit from access to thrombolysis on a 24 hour basis and not just in "working hours". Patients receive their treatment and initial monitoring at Solihull Hospital and are then repatriated to their most local site.
- The Acute Medical Unit at Good Hope Hospital initially opened in February 2009 to receive all medical GP referrals. During 2009/10 this model has become embedded and aims to assess, treat and transfer or discharge within 5 hours.
- The therapy directorate have worked closely with Acute Medicine on both the Heartlands and Good Hope sites to develop a Rapid Emergency Assessment Community Team to ensure patients are returned to community settings as quickly as possible. The service has proved to be extremely effective at preventing patients being admitted to the hospital and development work is now underway to further extend the model.
- Introduced Nurse Metrics to measure performance and improvements in the quality and standards of nursing care on each ward. There has been some improvement in all areas and these will continue to be reviewed and reported to maintain continuous improvement in nursing standards and nursing care on all wards.
- In Cardiology there has been a 50% increase in angioplasty activity from 800 to 1200 per annum, 2008/09 - 2009/10.

GROUP 2 – PLANNED INPATIENT CARE – HIGHLIGHTS 2009-2010

- Commencement of co-located integrated knee service with BEN PCT.
- Appointment of key positions such as 5th Thoracic Consultant, 2 Orthopaedic Consultants, 2nd Plastic Reconstructive Surgeon, and fracture clinic manager.
- Introduction of Healthcare at Home project in T/O and Respiratory medicine.
- Admissions lounge at Solihull Hospital for orthopaedic patients.
- Aortic Screening Programme.
- Successful implementation of 'Winscribe' digital dictation.
- 6 quick win initiatives in Trauma and Orthopaedics (T/O) - on track to deliver all 6 initiatives.
- Successful increase in use of vascular lab and treatment centre for varicose vein surgery.
- Development of complex aneurysm service for the region.
- All access targets achieved (90% admitted achieved in all areas with the exception of T/O).

GROUP 3 – AMBULATORY CARE – HIGHLIGHTS 2009/10

- In January 2010 we implemented a Direct Booking Service allowing patients to choose the consultant and time of their appointment and book directly from their GP surgery or their own homes. In our first month 36% or 926 of our patients booked directly.
- Prior to our move to Lyndon Place in September 2009, less than 50% of patient calls to book their appointments were answered. In March 2010 91% of calls were answered.
- In April 2009, 5 specialties failed to achieve the 90% 18 week RTT target. By March 2010 all specialties with the exception of Trauma and Orthopaedics achieved this with patients waiting shorter times than ever before for their surgery. Ongoing work is required between the Trust and the PCT with regards to Dermatology and T&O to develop a capacity plan for the next 5-10 years which addresses the changes in demographics.
- 75% of complaints were responded to in 25 days YTD (81.3% in Q3).
- 84.4% of Basket 25 patients were treated as day cases (Trust target 80% and 84% at April 2009) Day case rate at BHH was lowest at 79% compared to 89% at Solihull and 83% at GHH.
- 570 patients were cancelled on their day of surgery or procedure this year and due to a particularly bad month in January we breached our 0.8% target. A concerted effort with a poster campaign in February saw the number of patients cancelled reduce resulting in a year end achievement of 0.71%.
- Business cases for new consultant posts were approved for Rheumatology, Dermatology, Weight Management, Ophthalmology and ENT in quarters 3 and 4.
- All of Group 3 specialties over performed against plan this year with most significant growth seen in Dermatology and Ophthalmology (day case) and across all specialties for OP with an additional 11,000 patients seen against plan. Many of these patients were seen in additional WLI clinics at a considerable cost to the Group (£1million).
- Trust wide OP DNA rates increased this year to 14.82% at their highest in January 2010 however changes implemented in Q4 have led to significant improvement with February DNAs the lowest since August 2009.
- 97.1% of patients were admitted on the day of their surgery this year compared to 90% in 2008/9 and 84.4% of B25 patients were treated as a DC , helping to reduce LOS for surgical patients.
- Theatre utilisation (session) rose to 96.4% (87.14% in 2008/9) and in-session rose to 87.1% (85.56% in 2008/09)

GROUP 4 – CLINICAL SUPPORT - HIGHLIGHTS 2009-2010

- The electronic referral system has now been rolled out Trust-wide. This is a major efficiency and safety improvement for requesting and reporting in radiography.
- The Aquilion 320 slice CT scanner has been installed at Heartlands. This is an outstanding improvement in CT scanning offering a very significant improvement in image quality and therefore more accurate diagnosis but by using far less radiation it is safer for our patients. It has also enabled trials of scanning patients with acute chest pain. The belief, and early indications are that this may provide earlier, more accurate and less invasive diagnosis of cardiac disease than existing methods.
- Appointment of key positions such as a clinical lead for Interventional Radiology (Dr Paul Crowe), Point-of- Care testing Co-ordinator (enabling safe governance of and further development of near-patient testing) and a Blood Transfusion Practitioner team to assist with clinical compliance.
- Opening of and continued service provision at Boots Community Centre in Solihull with the successful development of outreach pain clinics at Boots in Solihull.
- Selected to join the second wave Regional Pilot Sites for Cytology 14 day Turnaround times.
- Trust Board approval to commence with New Build – expansion of service on Heartlands site.
- In January the Infertility service at Good Hope had a full inspection by the Human Fertilisation and Embryology Authority. The feedback from the visit was very complementary with the service retaining a licence to undertake IUIs on site. The service was also recognised recently when it was awarded a prize in the internal trust awards under the chairman's partnership and multidisciplinary category.

- An accelerated roll-out of electronic prescribing across all sites, the outsourcing of all Outpatients dispensing at Heartlands to Boots and increased pharmacist input into specialist clinics in TB, Rheumatology, Diabetes and HIV.
- Relocation of the clinical trials service to MIDRU.
- Flu pandemic planning and readiness.
- Critical Care Outreach became a 24/7 service on all sites and delivered care to an increasing number of patients.
- Major environment improvement for the increased numbers accessing GUM services offering a dedicated facility for patients receiving immunoglobulin replacement therapy.

GROUP 5 – WOMEN AND CHILDREN'S SERVICES – HIGHLIGHTS 2009-10

In January 2010, the Trust announced that it would be putting in place temporary changes to the maternity services at Solihull Hospital. This decision had been taken on the advice of specialist clinical staff and several external groups who had encouraged the Trust to take early action to safeguard mothers and babies. Advice had suggested that the current maternity service at Solihull Hospital could continue as it was as it did not meet contemporary best practice standards particularly for resuscitation of newborns. Whilst it can seem unnecessary to make any changes when everything appears to be going well, it was right that we made changes now to ensure the service was as safe as possible to avoid any preventable risk to a mother or her baby in the future, despite the challenge that these changes presented to the Trust. These changes are temporary and will enable the PCTs to carry out a full consultation with the local population prior to any permanent changes being agreed. These changes included:

- Building works completed with the establishment of a Midwifery Led Unit and increased delivery rooms at Heartlands.
- Establishment of ambulatory gynaecology service at Heartlands
- Trust Board approval for additional staff within obstetrics and gynaecology
- Approval to increase capacity at Good Hope to accommodate increase in births
- Approval to establish a stand- alone Midwifery led Birthing Unit at Solihull

Other highlights included:

- Successful appointment to Professor of Obstetrics post – commenced in February 2010, with specialist interest in women with multiple miscarriages.
- Recruitment to the Head of Midwifery post – commences July 2010.
- Achievement of breast feeding performance target.

Other activities of the Trust include:

Business Development

The Trust continues to develop the Hollier Simulation Centre at Good Hope Hospital (www.hollier-simulation-centre.co.uk). In a simulation centre, clinical areas like wards and operating theatres are mocked up and clinical scenarios are run from a control room. Using animated dummies as patients, multi disciplinary teams are then trained to respond correctly to a variety of situations recreated in a realistic patient-free environment. The Hollier Centre is so called as it benefits from a generous legacy left to Good Hope Hospital from Mr and Mrs Hollier. The vision of the centre is to become the regional simulation training centre for all healthcare workers.

The Trust continues to look for new partners with whom it can work to improve its services to patients. We recently opened an outpatient and phlebotomy service in the Boots store in Solihull town centre. This is the first of its kind in the country and has attracted a great deal of positive patient feedback. Earlier in the year the Trust also decided to upgrade the retail facilities on the Solihull and Good Hope sites. WH Smith was appointed to provide improved facilities for patients, visitors and staff. As well as bringing in valuable additional income to the Trust the shops also offer longer opening hours and a wider product range.

The Commercial Director also plays a leading role in helping to shape the Trust's corporate strategy as the Trust prepares for a harsher economic climate. A key component of this will be working closely with colleagues in primary care to look at innovation around how services are delivered and moving care closer to home. In recognising the need for new thinking to address the different times ahead the Trust is about to launch its Innovation Strategy which is designed to engage front-line staff and patients in building understanding and solutions for some of the challenges the Trust faces.

HEFT Consulting

HEFT Consulting continues to operate successfully in the NHS marketplace and was established in order to meet several objectives;

- to provide first-rate consulting services,
- to develop HEFT staff through exposure to other NHS organisations, bringing both their own insights to other Trusts, and bringing back into HEFT the insights and learnings from those same organisations, and
- to generate funds for HEFT Academy, a virtual learning centre that explores issues pertinent to the NHS, and where appropriate takes them to market through HEFT Consulting.
- to establish a powerful staff retention tool, offering staff the opportunity to stretch themselves through external projects.

New projects include partnering with larger private-sector consultancies to offer a blended proposition, and developing medical consulting– both unique aspects of the business.

Feedback for the performance of HEFT Consulting has been very strong. The unique blend of using NHS staff, and being the sole in-house management consulting provider, has proved to be a compelling proposition for NHS organisations. Being 'up the learning curve' in terms of NHS issues is a key driver for this. This feedback validates the Trust's belief that there is a market gap for this type of business.

The assignment successes in 2008/09 created strong credentials in the marketplace for advisory work in the NHS. Current market demand is however weaker due to the extension of the Foundation Trust accreditation deadline beyond December 2010, and the tightening of resources in the NHS. The mix of opportunities has altered due to the prevailing economic climate; specifically, potential merger and acquisition activity being delayed until after the General Election in May 2010. Also, the overall appetite for Trusts to spend money on consulting has diminished due to the widely-publicised need for budgetary cuts across the NHS.

HEFT Consulting is focusing on the following three key objectives during 2010/2011:

- Win work
- Achieve margin
- Grow reputation

Research and Development

The Trust continues with its strategy to grow research. This year over 400 separate research projects were active within the Trust and we remain the largest recruiter for cancer trials in the West Midlands.

The year also saw the opening of MIDRU on the Heartlands site. This is a purpose built facility which brings together NHS, academia and industry to collaborate in research and innovation (www.midru.com). It is a fantastic building which is already helping to develop exciting multi-disciplinary research projects. MIDRU is also home to the Trust's new Heartlands BioMedical Research Centre for research into obesity, nutrition and lifestyle. This unit has attracted £1.3m in external funding to help bridge the gap from laboratory to the patient around the most effective clinical interventions in the management of obesity. Led by Professor Barnett and Dr Taheri the unit aims to become internationally recognised in this important area of research. Within the unit there are also four rooms for sleep research where patients can be monitored overnight for a variety of conditions.

MIDRU is making good progress in developing links with industry, one example being an externally funded service whose role is to support industry in evaluating new infection control technologies in healthcare.

The Trust continues to work closely with colleagues across Birmingham and the Comprehensive Local Research Network and has achieved higher levels of research funding this year which have been passed on directly to the staff involved in undertaking the projects.

A number of new clinical academic posts have been created this year as part of the Trust's continued investment in research. These include two joint appointments with the University of Warwick in Siobhan Quenby as Professor of Obstetrics and Babu Naidu as Associate Professor in Thoracic Surgery together with new posts at Aston University - Dr Sri Bellary, Senior lecturer in Metabolic Medicine and Dr Dev Banerjee Senior Research Fellow in Sleep Medicine.

Looking ahead the Trust will continue to work with its university partners in investing in research. In particular respiratory, cardiology and obstetrics are likely to grow significantly in the year ahead. These will complement the existing strengths the Trust has in research which include diabetes, anaesthetics, critical care and pain management, ophthalmology, vascular surgery and the prevention, detection and control of infection.

Corporate Affairs Directorate

Communications	457 positive pieces of media coverage valued at over £11m In excess of 158m opportunities to see for individuals Internal communication strategies delivered for • Staff survey 2009 and engagement • Swine flu pandemic • Corporate restructure • Solihull maternity reconfiguration
Membership	1.93% increase on public / patient membership Over 100,000 members in total Governor by-election delivered

Healthcare Information	64% increase in contacts at Heartlands HIC 28% increase in contacts at Heartlands Helpdesk 93% increase in contacts at Good Hope HIC
PPI	Back to the Floor programme delivered Concerns raised in National Inpatient Survey addressed
Volunteers	New volunteer induction processes implemented Over £500,000 in volunteer hours contributed to the Trust Supported flu pandemic training Supported uniform initiatives for both doctors & nurses
Events & Projects	Increased number of nominations to Staff Recognition Awards Commissioned to deliver bereavement conference Delivered Touch Rugby programme Commissioned to deliver National Early Pregnancy Unit conference
Multi –Media	Increased external income Increased external customer base
Graphics	New business software installed New processes implemented
Photography	Good Hope clinic photography now provided internally
GP Engagement	Conference on Bariatric Surgery attracting international speakers. Assisted commercial directorate with PCT negotiations for the clinic in Solihull Boots Set up Lean Academy training for SBPCT. Sexual health campaign. Set up Ante natal scanning in the community project (chair working party) Facilitated Solihull ENT care in the community project – new service went live on 26/04/10 Bowel cancer awareness Touch screen project for info screens in GP practices Worked with governance on improving reporting and actioning GP complaints I Care vortal service for GPs GP survey conducted in summer 09 GP training for Solihull GPs commenced autumn 09

Information Governance

Confidentiality - Serious Untoward Incidents

Department of Health guidance states that incidents relating to an actual or potential breach of confidentiality involving person identifiable data, including data loss should be considered serious untoward incident (SUI) and graded 0-5.

Level 0 incidents are not required to be reported. Level 1 and 2 incidents are reported as statistics and the following table details those incidents for 2009/10:

Summary of personal data related incidents

Nature of incident	Total
Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	
Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	
Insecure disposal of inadequately protected electronic equipment, devices or paper documents	3
Unauthorised disclosure	4
Other	8

No serious incidents were reported in relation to personal data. Several incidents were highlighted as potentially serious data loss incidents but upon investigation it transpired that the portable devices were encrypted in accordance with Trust policy and access was therefore of low risk.

Freedom of Information and Data Protection Requests

The Governance directorate processed 317 requests for information in 2009/10 of which 256 were Freedom of Information requests and 61 requests related to Data Protection. This represents an increase of 81 requests for information from 2008/09 when 188 Freedom of Information requests and 48 Data Protection requests were received.

Information Governance Toolkit

The Connecting for Health Information Governance Toolkit sets out standards for information governance systems and processes in NHS organisations. Following self assessment in 2009/10 the Trust maintained Green status. The Department of Health has stated that Trusts should be working towards achieving level 2 for all standards. Eight standards are currently below level 2 and action plans will be implemented by March 2011. Progress will be monitored by the Information Governance Committee.

Equality and Diversity Report

The Trust has a dedicated Diversity Manager to provide proactive advice and guidance to us on all equality matters including disability and progress. This is monitored through the Diversity Steering group, chaired by the Chief Nurse. The Group has an established set of Key Performance Indicators that it regularly reviews.

We have published our equality schemes which include our approach to disability and support for people with disabilities.

The Trust currently has an overall BME group representation of 24% which matches that of the combined populations in the areas surrounding each hospital. Monitoring of recruitment shows that there are some pockets where BME representation is low and there is also concern about low representation at senior levels. The priorities of the Equality in Employment Group outlined below relate to the particular areas which require action.

The Trust has an "equality in employment" group which looks specifically at workforce diversity issues. This reports annually to the Diversity Steering Group and Human Resources Committee. We monitor the workforce disability, gender and ethnicity profiles and publish the results. In addition, we develop an annual programme of work based on the issues raised through workforce monitoring, for example during 2009 we focused on improving data collection, particularly on disability. We seek feedback from disabled employees through our local staff survey and we have recently undertaken a data collection exercise to update information for staff monitoring purposes. The priorities for the group for the coming year include:

- Continuing focus on data collection
- Training and development for BME groups
- Proactive recruitment campaigns targeting specific areas
- Embedding diversity training across the Trust

The box below shows the breakdown of our workforce by age, ethnicity, gender and disability. All of our staff are automatically made members of the Trust unless they choose to opt out and since being authorised as a Foundation Trust we have not received any such requests.

	% Staff 2008/09	%	Staff 2009/10	%
Age				
0-16	0	0	4	0.04
17-21	155	1.66	235	2.48
22+	9198	98.34	9231	97.48
Ethnicity				
White	6146	64.90	6213	66.43
Mixed	71	0.75	80	0.86
Asian or Asian British	930	9.82	938	10.03
Black or Black British	576	6.08	588	6.29
Other	453	4.78	403	4.31
Not Given	1294	13.66	1131	12.09
Gender				
Male	1854	19.58	1861	19.90
Female	7616	80.42	7492	80.10
Recorded Disability	36	0.38	163	1.74%

We began our journey of undertaking local staff surveys in 2006. This was prior to the merger with Good Hope and was undertaken to get a view of where staff were at. We have continued to undertake local surveys each year since.

The local survey response rate has improved year on year. We began to measure engagement properly in 2007 and in 2008 brought in Ipsos MORI to support us with the process. In 2008 our engagement rate was 70%. All areas were asked to produce action plans to focus on areas where concerns existed and these were monitored through local group and directorate meetings. Significant communication took place around the results and all results were posted on the Trust's intranet site.

In 2009 we used the National Survey questionnaire, with added local questions, for our local survey. We saw a 42% response rate, a 10% increase from a local response rate perspective but a 4% decrease in the National Survey response rate. Our engagement rate has declined by 15%. The National and Local Survey outcomes and action plans are reported each year to the HR Committee and Trust Board.

Summary of Performance on National Survey 2008

Response rate 2009 42%

2009 TOP FOUR RANKING SCORES	SCORE TRUST/NATIONAL AVERAGE
Impact of health and well-being on ability to perform work or daily activities (low score better)	1.49 / 1.57
Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver	74% / 74%
Percentage of staff feeling valued by their work colleagues	77% / 77%
Percentage of staff experiencing physical violence from patients / relatives in last 12 months (low score better)	10% / 11%

BOTTOM FOUR RANKING SCORES	SCORE TRUST/NATIONAL AVERAGE
Percentage of staff having equality and diversity training in last 12 months	16% / 35%
Fairness and effectiveness of incident reporting procedures	3.30 / 3.42
Perceptions of effective action from employer towards violence and harassment	3.42 / 3.55
Staff intention to leave jobs (lower score better)	2.75 / 2.51

Response rate 2008 46%

2008 TOP FOUR RANKING SCORES	SCORE TRUST/NATIONAL AVERAGE
Percentage of staff agreeing that their role makes a difference to patients	93% / 89%
Percentage of staff receiving job-relevant training, learning or development in last 12 months	84% / 80%
Percentage of staff reporting errors, near misses or incidents witnessed in the last month	96% / 95%
Percentage of staff agreeing that they understand their role and where it fits in	47% / 45%

BOTTOM FOUR RANKING SCORES	SCORE TRUST/NATIONAL AVERAGE
Percentage of staff experiencing harassment, bullying or abuse from patients /relatives in last 12 months	31% / 22%
Percentage of staff experiencing physical violence from patients / relatives in last 12 months	17% / 12%
Percentage of staff working in a well structured team environment	29% / 37%
Percentage of staff having equality and diversity training in last 12 months	13% / 27%

Summary of Actions Taken In Response To 2008 Results

- Structured approach to improving staff understanding of Trust's policy and process around violence and bullying
- Collaborative working between HR and H&S team
- Re-launch of policy
- Communication campaign on harassment and violence
- Diversity training marketed more robustly

- Diversity training on the Equality in Employment Group action plan
- Local results and action plans link to National Survey results

The 2009 National Survey results have yet to be received, however, analysis of the raw data indicates an improvement in violence and bullying is likely to be seen.

The Trust has reviewed the local results for 2009 and has developed an action plan that addresses 4 ley areas:

- Leadership – including back to the floor, 360 feedback, coaching and development for top leaders
- Performance Management – specifically robust roll out of Appraisal for all staff
- Recognition and incentives – including an innovation scheme for staff called 'We think...'
- Values and engagement – including a review of induction and a scheme to follow up staff issues 'Answers on a Postcard'

WORKFORCE DEVELOPMENT

The Trust has launched its new workforce development strategy which sets out ambitious plans for education at HEFT that have been developed following extensive consultation with staff at all levels in the organisation.

This strategy will see education across the Trust brought together in a more coordinated way through the launch of the HEFT Faculty of Education. The Faculty will be innovative in that it will deliver a portfolio of service aligned and situated, accredited healthcare education, training and professional development programmes.

Benefits of the Faculty will include:

- Providing a clearly defined and accessible education service for the full range of staff
- Elimination of fragmentation, duplication and variability in learner experience
- Provision of a core in house education portfolio, and prospectus, explicitly linked to business needs, workforce plan and clinical vision
- Extensive programme of development for staff including pre-employment training, an extensive range of apprenticeships and a dedicated healthcare careers development unit.
- Wider access for staff to academically accredited courses, delivered in house and in a flexible way.
- Education linked to defined career frameworks, including opportunities for staff to develop clinical academic careers
- An increase in 'service situated' delivery of education that has high impact on quality and safety
- A Faculty Quality Unit that for the first time will measure return on investment of the Trusts education spend using key quality and safety outcome measures
- A range of contextualised programmes that are supported by a cadre of in house clinical academics and educators that will support knowledge transfer by working with learners in both classroom and service delivery environments
- Access to an extensive range of in house learning resources including state of the simulation

SICKNESS ABSENCE REPORT

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4
2008-09	4.28%	4.29%	4.74%	3.84%
2009-10	3.86%	4.60%	4.75%	4.34%

Sustainability Report

BACKGROUND

Sustainability is the process by which an organisation manages the social and environmental impact of its activities in a responsible manner. For the Trust this means contributing towards a healthy community, thriving local economy and clean environment. Good corporate citizenship and sustainability are one of the five priorities for the next ten years in Choosing Health: Making Healthy Choices Easier.

Strong environmental performance presents a compelling business case. Energy, waste and water reductions have the potential to deliver significant cost savings. In light of the recent UK recession and expected impact on NHS funding reinforces the case for strong environmental performance.

We have partnered with The Carbon Trust to develop an ambitious programme for energy reduction and carbon management with a target of a 25% reduction in emissions by 2013 (from a 2007/08 baseline) with potential financial savings to the Trust of around £5.56million. As a participating organisation in the forthcoming Carbon Reduction Commitment (CRC) Energy Efficiency Scheme we are already preparing for the potential financial impact of purchasing carbon credits in April 2011, at a cost of £12 per tonne, for emissions during the years 2010 and 2011.

INTRODUCTION

Through participation in the 5-year NHS Carbon Management Programme, we aim to:

- Reduce the environmental impact of our operations
- Reduce energy and water costs
- Increase awareness of the potential direct impact of climate change upon the Trust
- Contribute to our good corporate citizen agenda

We worked with the Carbon Trust throughout 2008/09 to:

- Establish Baseline Data and Agree Targets
- Develop an Effective Internal and External Communication Plan
- Establish Overall Governance Arrangements
- Work with Staff and Partners to Identify Opportunities
- Agree an Investment and Implementation Plan

Our target: "A 25% Reduction in CO_2e Emissions by 2013"

We have already implemented some significant energy-efficiency measures in past years but aim to build upon these to create even more energy-efficient estates, procurement, transport and waste management services to support our core business of healthcare provision.

Our low carbon vision: "Making Sustainability Mainstream"

We will continue to move towards more sustainable healthcare operations by:

- Creating a much more energy-efficient estate
- Increasing partnerships with local authorities and higher education
- Engaging with staff to capture their innovative intellectual capital
- Contributing to the Good Corporate Citizen agenda
- Taking practical actions to ensure we achieve our objectives

2007/08 was the 'baseline' year, against which we measure progress. In the baseline year, our carbon emissions were calculated to be:

Buildings	Trust buildings (204,974m^2) consumed 67 GJ/m^3 compared to a typical benchmark of 61 GJ/m^3 and a best practice of 55 GJ/m^3. CO_2 emissions due to buildings are 35,707 tC O_2.
Commuting	70% of 10,000 staff drove a car to work alone, 13% took the bus or train, 10% car shared, 7% walked or cycled. Total commuting emissions accounted for 5,789 tonnes CO2, equivalent to 0.58 tonnes per employee.
Transport	Fleet travel contributed 179 tonnes of CO_2. This has been calculated from fuel consumption, as mileage data is not currently recorded.
Waste	57% of trust waste by weight was sent to landfill, 37% was incinerated and 6% was recycled. Total CO_2 emissions associated were 3,085 tonnes.
Water	The trust consumed 321,507 m^3 water, equivalent to 130 tonnes CO_2

We have already invested in a number of high-value carbon-saving projects including:

- Combined Heat and Power (CHP) plant at Heartlands
- CHP plant at Solihull
- PC Inactivity shutdown
- Staff Awareness Campaign

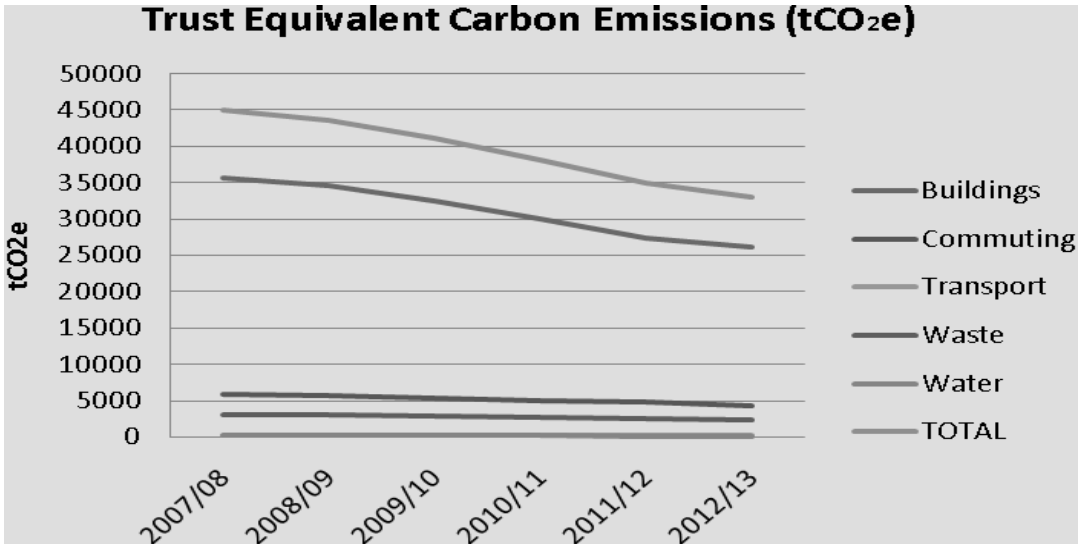
Over the lifetime of the plan, we aim to add other carbon-saving projects, including:

- CHP plant at Good Hope
- Voltage Optimisation
- Improved Metering

KEY AREAS OF FOCUS

- Procuring and installing energy-saving plant and equipment to create a much more energy-efficient estate
- Improving sub-metering across all sites to identify poor energy performance and develop remedial plans
- Engaging with patients, visitors, staff and the local community to improve energy, water and waste awareness, to avoid unecessary waste of finite resources
- Improved recycling to still further reduce the environmental impact of Trust operations
- Further developing Energy and Environmental Policies to help patients, visitors and staff to adopt more environmentally-friendly practices, both within Trust premises and in their homes, to magnify the environmental impact of our improvements to sustainability within the Trust

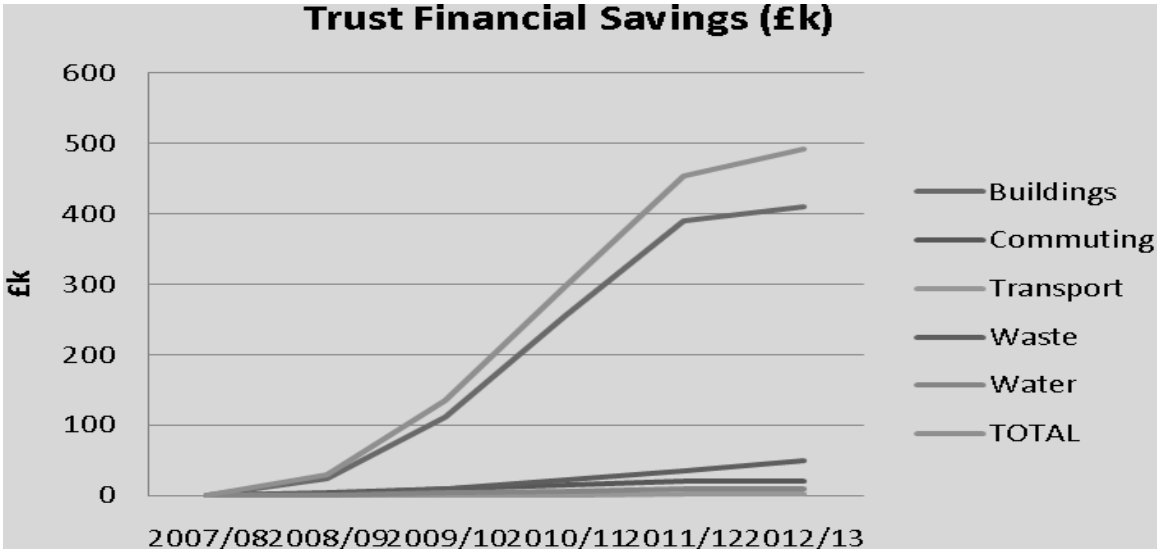
We regularly monitor progress against clear targets for achieving more environmentally sustainable operations. Our targets focus on both Carbon and Financial savings.



Trust Equivalent Carbon Emissions

(tCO2e)

	2007/08 (Act)	2008/09 (Act)	2009/10 (Est)	2010/11 (Est)	2011/12 (Est)	2012/13 (Est)
Buildings	35,688	34,583	32,500	30,100	27,500	26,200
Commuting	5,791	5,612	5,300	5,000	4,800	4,300
Transport	180	174	170	155	145	130
Waste	3,097	3,002	2,900	2,630	2,450	2,275
Water	135	131	130	115	105	95
TOTAL	44,890	43,500	41,000	38,000	35,000	33,000



Trust Financial Savings (£k)						
	Actual 2007/08	Actual 2008/09	Estimated 2009/10	Estimated 2010/11	Estimated 2011/12	Estimated 2012/13
Buildings	0	24	111	254	390	410
Commuting	0	4	10	14	20	20
Transport	0	0	1	1	2	3
Waste	0	2	10	22	34	49
Water	0	0	4	6	9	10
TOTAL	0	30	136	298	454	492

Energy and Water usage is monitored, by site, on a monthly basis by the Facilities Committee. We plan to introduce additional sustainability performance indicators for wast and recycling before the end of 2009/10.

We recycle or recover some 40% of waste produced and currently recycle waste glass, fluorescent tubes, IT equipment, industrial batteries, plastics, cardboard and paper. A revised Waste Management Policy is in place and is available on the Trust intranet site.

We have also introduced a range of measures aimed at reducing private car usage for both business and commuting.

We have recently commissioned an external sustainability audit which will produce a prioritised action plan to ensure that we meet the targets we have set ourselves. It will also benchmark us against 'best in class', both within the NHS and the commercial world.

ENVIRONMENTAL INITIATIVES

We have already invested in a number of high-value carbon-saving projects and, during the lifetime of our carbon management plan, aim to add other carbon-saving projects, to ensure that we achieve the challenging targets we have set ourselves.

CHP plants are probably the most effective means of improving energy performance, since they re-use waste heat, achieving at least 80% efficiency, compared with typically less than 30% efficiency for electricity provided by the grid.

A second Combined Heat and Power (CHP) plant nears completion at Solihull Hospital, to complement the CHP at Heartlands which has been operational for two years. Plans for a third CHP at the Good Hope site have been brought forward to support the achievement of BREEAM 'Excellent' status for the new ward block currently under construction. BREEAM (BRE Environmental Assessment Method) is the leading and most widely used environmental assessment method for buildings. It sets the standard for best practice in sustainable design and has become the de facto measure used to describe a building's environmental performance.

At Heartlands, the deep cleaning of infected areas, by our Hotel Services Hygiene Technicians using peroxide vapour, continues to make a significant contribution to the reduction of infection rates. Due to the success of this programme, we have developed a plan to rollout a similar programme at Good Hope.

Our Site Strategy programme is progressing well. The MIDRU/Diabetes building has been completed and commissioned and staff have been able to transfer services to a new, much more energy-efficient building. This building is an exemplar environment in which to work and be treated. A&E and Maternity at Heartlands have benefitted from major refurbishments during the year. We anticipate much activity during the coming year, in defining and agreeing the briefs for further projects and building works.
We are committed to minimising the environmental impact of our activities and have introduced a range of specific measures and initiatives with the aims of:

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

To further reduce the environmental impact of its activities, we hope to recruit a Senior Environmental Manager to lead developments and manage environmental impact activities in an integrated way. The Carbon Trust has undertaken extensive energy surveys at all three hospital sites and we have implemented their recommendations to reduce energy consumption.

Finance Review

2009/10 was an incredibly challenging but ultimately successful financial year. Despite the uncertainty of the financial environment, the Trust continued to achieve financial targets, and has exceeded the plans submitted to monitor with an operating surplus of £10.1m. This operating surplus term in used in the context of the net surplus of the Trust before asset revaluation losses of £16.6m, because it is considered that these losses do not affect the day to day running of the Trust. The effect of these revaluation entries reduces the trust's overall performance to a net deficit in the year of £6.4m (as per SOCI).

The operating surplus of £10.1m can be reconciled to the statutory definition of operation surplus;

	£m	Reference
Statutory operating Surplus	2.3	SOCI
Less net finance costs included in Trust definition	-8.7	SOCI, includes interest receivable and interest payable on finance leases and PFI
Reported deficit for the year	-6.4	SOCI
Add back impairment costs	16.5	Note 3.1 operating expenses
Trust operating surplus definition	10.1	Chairman's statement

Maintaining this strong financial position of the Trust is imperative for continuing to improve the patient environment by ensuring longer term investment in the Trust's estates through the Cross Site Strategy programme.

<u>Income</u>
The Trust's total income has increased by almost 7% in year to £542m. This growth reflects continued high levels of activity and in particular the need to deliver the national 18 week referral to treatment waiting targets.

The level of private non-NHS fee paying income earned was £0.6million. This is 0.12% of total patient care income, which is well within the regulated upper limit of 0.20%. A revamped Private Patient Policy was issued in the early part of the year and has been applied since then to improve the recovery rate of private patient income.

<u>Expenditure</u>
In relation to expenditure, the Trust was exposed to a number of cost pressures in the year. This was recognised early in the year and the Finance Department led a programme of cost review for these areas with higher than expected costs. Each area was required to develop rectification plans to bring achieve

areas back into budgetary balance. Through effective programme management the majority of the affected departments were back on track by the second half of the year.

The Trust is continuously striving to improve the way resources are used through reviewing systems and processes, skill mix, procurement and capacity. The Trust's Financial Plan for 2009/10 included the delivery of cash-releasing efficiency savings of set percentages against budgets. Achievement of the targeted saving was monitored monthly and alternative plans devised where schemes were not successful. Savings were delivered by eliminating waste, through procurement negotiation and identification, staffing reviews, cross departmental process reviews and numerous smaller developments identified and delivered in individual wards or departments. The Trust is gearing itself up for continued requirements to improve efficiency and is developing a mindset of tight cost control and efficiency reviews to ensure it can react to future NHS and government announcements.

The Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector information guidance.

Capital Expenditure

Over the last year the Trust spent £23.4m improving the equipment, infrastructure, facilities and estates at the Trust. Of this, almost £10m was spent on delivering the first schemes of the Cross Site Strategy programme, including the completion of the MIDRU Diabetes Centre which opened September 2009, an extensive refurbishment of the Heartlands A&E department and the commencement of the construction of a new ward block on the Good Hope site. This ward block is planned to be operational in January 2011.The next group of large projects within the Cross Site Strategy programme are currently moving through the approval process and building work is expected to commence in the later part of 2010.

The Trust encourages its staff to utilise innovative technology where possible and almost £1m was spent in the year creating facilities for a CT scanner that was purchased in 2008/09 to enable the scanner to be used to its maximum capabilities and deliver an improved patient care.

Asset Valuations

Within the year, the Trust completed a revaluation of the Trust's land and Buildings to comply with the requirement for foundations trusts to have assets as at 31 March 2010 valued on a Modern Equivalent Asset (MEA) basis, i.e. the cost of replacing the service potential if the existing assets with a modern equivalent assets adjusted to take account of depreciation on the existing asset. As a consequence there is a total decrease in value of land and buildings of £72.3m, split between valuation decrease as at 1 April 2009, £33.6m and 31 March 2010, £38.7m. These decreases are in line with decreases seen elsewhere in the NHS and are partly due to macroeconomic factors. This decrease in value has resulted in a £16.6m charge to the Statement of Comprehensive Income (SOCI) in 2009/10. As this is a non-cash transaction it has no bearing on the Trust's financial viability, and Monitor excludes these items from consideration of the Trust's performance.

Treasury Management Activity

Cash balances as at 31 March 2010 were £90.7m and balances continued to be well managed throughout the year. The interest earned on these funds has reduced as a result of the lower base rates that have been in place for the whole of the financial year. In March 2010 a Treasury Management Committee was set up, chaired by a non-executive, to review the performance of the Trust's cash investments and determine other steps to be taken that will improve the interest earnt on surplus cash. The high cash balances held reflects the requirement to support future year's capital building projects whilst maintaining resilience as we move into a period of increased uncertainty.

During the year the Trust took part in the NHS wide transfer of bank accounts away from the PGO (Paymaster General Office) account to using more commercial banks. This transfer has been led by the Department of Health team. The Trust does not have a working capital facility.

Counter fraud

During the year the Trust has worked with the Counter fraud specialists to promote awareness of counter fraud and how to report it. A number of pro-active training sessions, policy reviews and other work has been completed. The Trust launched a revised Counter Fraud policy early in the 2010/11 year.

Future

As we look to the future there are a number of challenges facing the Trust. The Trust is preparing to cope with lower levels of funding whilst continuing to deliver improved quality, maintain or improve waiting times and deliver to contractual commitments and financial targets. This is particularly challenging in the light of national efficiency expectations and the local commissioning environment. Local commissioning bodies have declared intentions to reduce levels of demand coming through the Trust's hospitals. The challenge for the Trust is to determine these demand reductions and flex down resources across the Trust accordingly. The commissioning contract now has an increasing proportion of income based on the delivery against quality objectives and indicators. Contract performance will be closely monitored to ensure that any financial consequences of quality are noted early in the year and additional actions taken to reduce the risk of financial penalties.

Other disclosures - Risks and uncertainties

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

S16 Maternity Services - Current configuration of maternity services at Solihull Hospital is not sustainable beyond April 2010	20 - 5x4
S3 Patient Flow and Capacity - Failure to successfully address the operational arrangements for managing emergency patients that can result in delayed admissions and discharges	16 - 4x4
S13 Hospital at Night - Delays in the implementation of Hospital at Night, adopting a multidisciplinary team approach to managing the care of patients across 3 hospital sites over a 24 hour period, could create a risk for patient safety.	16 - 4x4
S5 Workforce Redesign - Failure to redesign clinical workforce to deliver safe quality clinical services	16 - 4x4
S11 Financial Strategy - Failure to fully consider efficiency and investment requirements, plan for the future external economic environment & the reduction in national budgetary allocations	16 - 4x4
S10 Current Clinical Service Business Development Strategy is unclear - HEFT does not adequately understand which specialties and services make a profit or loss to inform our strategy of which direction to grow the business	16 - 4x4
S8 Responsiveness of Services - Access &/ Waiting Times - Patient & Customer needs not met in accessing services	15 - 3x5
S12 Site Strategy - Failure to effectively implement the 10 year site strategy plan leading to financial insecurities & a hospital facility that does not meet the needs of the population	15 - 3x5
S15 Data Quality - The quality of the data reported to external stakeholders if not accurate has the potential to impact on financial & performance targets	15 - 3x5

Risks are reviewed regularly and actions are taken to mitigate and manage risks. The Risk Register for 2010/11 will be presented:

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

The Board conducts reviews of the Trust's system of internal controls. Full details of this is incorporated in the Chief Executive's Statement on Internal Control (SIC) starting on page 70.

Governance

Corporate Governance

Directors' Attendance At Meetings:

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

Performance of the Board and its Committees

As part of the Board's Effectiveness Programme in 2008/09 to assess the provision of Board information, the workings of the sub-committees and the Board itself an action plan was developed to continually improve the workings of the Board. The full development of this plan has been held over for the new Chairman to oversee.

During the year the Audit Committee carried out a self-assessment of its performance, the findings of which will be made available to the Board in May 2010.

An annual review of the Directors' material interests in organisations where those organisations or related parties are likely to do business, or are possibly seeking to do business, with the Trust is carried out and there are no material interests to declare. You can access a register of Directors' interests or communicate with the Directors by writing to:

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

Code of Governance Report

Monitor first issued the NHS Foundation Trust Code of Governance in 2006 and issued an updated code in 2010 which applies from 1 April 2010. The Code is issued as best practice advice and is not mandatory however the Code does impose disclosure requirements on NHS foundation trusts.

The Board of Directors considers that throughout the year it was fully compliant with the principles of the NHS Foundation Trust Code of Governance. Any exceptions to the Code are set out fully in this Report with the respective paragraph of the Code's provisions. In addition the Board has not appointed a senior independent director or a Lead Governor (Monitor Code Clause A3.3 and B1.3). Members and Governors have direct access to all members of the Board. In addition to direct access on request, all the members of the Board are required to attend every Governor's Consultative Council meeting and participate fully in discussion with members of the Council. Members of the Board or Trust senior managers who might have issues, where contact through the normal channels with Chairman, Chief Executive or Finance Director is inappropriate, have right of direct access to the Chairman of the Audit Committee and the Deputy Chairman. This requirement will, however, be reconsidered during 2010/11.

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

The Board meets every month and, additionally, ad hoc as necessary. The Board of Directors are given accurate timely and clear information so that they can maintain full and effective control over strategic, financial, operational, compliance and governance issues. The Directors have a range of skills and experience and each brings independent judgement and considerable knowledge to the Board's discussions and determinations. This range of skills and experience ensures balance, completeness and appropriateness to the requirements of the Trust. The attendance of Directors at Board and Committee meetings is set out on page 56.

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

Nominations Committee

The work of the Nominations Committee is to:

- Review the structure, size and composition of the board and make recommendations with regard to any changes
- Give full consideration to succession planning
- Evaluate the balance of skills, knowledge and experience in relation to the appointment of both executive and non-executive directors
- Identify and nominate suitable candidates to fill executive director vacancies

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

In the case of Executive Director vacancies, the Nominations Committee draws up the job description and person specification, and undertakes the recruitment process and then makes a recommendation to the Appointments Committee of the Trust Board which may accept or reject the recommendation. It is for the

Non-Executive Directors to appoint and remove the chief executive and such an appointment requires the approval of the Governors' Consultative Council.

Remuneration Committee

A full report from this committee is set out on 66. The full listing of members is set out on page 56 along with the member's attendance levels. The table of salary and pension entitlements of 'senior managers' is set out in the notes to the financial accounts on page 109-110.

Audit Committee

A full report from this committee is set out on 68. The full listing of members is set out on page 56 along with the member's attendance levels.

Governors' Consultative Council

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

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

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

The Trust successfully held by-elections for the Governors' Consultative Council during 2009/10 for a number of constituencies where unplanned vacancies had occurred. Open days were held across all sites to engage with the local community and encourage members to stand for election and get actively involved. Community leaders and Trust Governors played an instrumental role in getting the message out to their constituents and were a key support in communicating with the hard to reach public members. The monthly health seminars continue to be a highly successful method of engaging with members to ensure they are kept informed of all Trust activities. Four new Governors were appointed.

In addition, the Board can confirm that all elections to the Governors' Consultative Council were held in accordance with the election rules stated in the Constitution. The Trust held by-elections for the Governors Consultative Council during 2009/10 for a number of constituencies where unplanned vacancies had occurred. The election turnout is shown below. Open days were held across sites to engage with the local community and encourage members to stand for election. Governors played a key role in communicating with their constituents and the hard to reach public members. Monthly members' health seminars were also a successful platform to engage members and ensure they are kept informed of all Trust activities.

Constituency	**% Turnout**
Solihull North	11.01%
Birmingham North	11.27%
Birmingham Central	8.73%
Total	10.11%

The Governors' Consultative Council is continuing to work through the recommendations that resulted from the 2008/09 effectiveness review and a further review will be carried out during 2010/11.

The Governors have been actively involved with the Care Quality Commission registration process and with the Quality Report.

The Governors' Information Working Group continues to look at new ways to work with the community through attending local community meetings and hospital events.

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

The local Health Overview and Scrutiny Committees (HOSC) have a statutory responsibility to Health to oversee, monitor and scrutinise the policies, services and activities relating to health, in accordance with the Health and Social Care Act 2001 and related regulations. Our Governors continue to developing relationships with the local HOSC to identify and encourage the development and implementation of policies and working practices, which improves people's health. As a foundation trust we have a statutory

duty to consult with the HOSC on any major service changes or new developments planned and the HOSC has a responsibility to respond to each consultation.

The Constitution requires a report to the Governors in the event that any individual Governor does not attend two consecutive Governors' Consultative Council meetings without good reason. During the year two governors were removed from office for consistent failure to attend.

Name		Constituency Name	Elected/ appointed	Date of end of Term
David	O'Leary	Public: Birmingham East	Elected	31-Mar-11
John	Jebbett	Public: Birmingham East	Elected	31-Mar-11
Frances	Linn	Public: Solihull Central	Elected	31-Mar-11
Sheila	Blomer	Public: Solihull Central	Elected	31-Mar-11
Valerie	Egan	Public: Solihull North	Elected	31-Mar-11
Thomas	Webster	Public: Birmingham North	Elected	31-Jul-10
Victor	Palmer	Public: Staffordshire South	Elected	31-Jul-10
Bethan	Ilett	Public: Sutton Coldfield	Elected	31-Jul-10
Barbara	Hayward	Public: Tamworth	Elected	31-Jul-10
Richard	Hughes	Public: Tamworth	Elected	31-Jul-10
Carole	Edwards	Public: Sutton Coldfield	Elected	31-Jul-10
John	Simms	Public: Birmingham North	Elected	31-Jul-10
Margaret	Veitch	Patient	Elected	31-Mar-11
Jagjit Singh	Taunque	Public: Birmingham at large	Elected	31-Mar-11
Arshad	Begum	Public: Birmingham Central	Elected	31-Mar-11
Famida	Begum	Public: Birmingham Central	Elected	31-Mar-11
Shahid	Mir	Public: Birmingham Central	Elected	31-Mar-11
Lee	Smith	Public: Birmingham East	Elected	31-Mar-11
Liz	Steventon	Public: Solihull Central	Elected	31-Mar-11
Bridget	Sproston	Public: Solihull South	Elected	31-Mar-11
Ann	Brierley	Staff: AHP, Technician or Clinical Support Worker	Elected	31-Mar-11
Neil	Harris	Staff: Ancillary, Admin, Volunteer or Management	Elected	31-Mar-11
Dev	Sarmah	Staff: Medical & Dental	Elected	31-Mar-11
Veronica	Morgan	Staff: Nursing, Midwifery & Healthcare Assistant	Elected	31-Mar-11
Kath	Bell	Patient	Elected	31-Mar-12
Michael	Kelly	Public: Birmingham at large	Elected	31-Mar-12
Patricia	Hathway	Public: Birmingham Central	Elected	31-Mar-12
Aiden	Cairns	Public: Solihull North	Elected	31-Mar-12
Heidi	Lane	Staff: Nursing, Midwifery & Healthcare Assistant	Elected	31-Mar-12
Frances	Hamer	Public: Birmingham Central	Elected	31-Mar-11
Olivia	Craig	Public: Birmingham North	Elected	31-Jul-11
Stuart	Stanton	Public: Solihull North	Elected	31-Mar-11
Stuart	Clarkson	Stakeholder: Birmingham City Council	Appointed	31-Dec-13
Ian	Blair	Stakeholder: Birmingham City University	Appointed	31-Mar-11
Qulsom	Fazil	Stakeholder: Birmingham Eastern & North PCT	Appointed	31-Mar-11
Ian	Lewin	Stakeholder: Joint Lichfield & Tamworth Borough Council	Appointed	31-Aug-10
Sunil	Kotecha	Stakeholder: Solihull Care Trust	Appointed	31-Aug-11
Name		**Constituency Name**	**Elected/ appointed**	**Date of end of Term**

Roy	Shields	Stakeholder: Solihull Chamber of Commerce	Appointed	31-Mar-11
Glenis	Slater	Stakeholder: Solihull Metropolitan BC	Appointed	31-May-13
Yvonne	Sawbridge	Stakeholder: South Staffs PCT	Appointed	31-Jul-10
Tim	Freeman	Stakeholder: University of Birmingham	Appointed	31-Dec-13
Aftab	Chughtai	Stakeholder:Birmingham Chamber of Commerce	Appointed	31-Mar-11

There are currently two outstanding vacancies on the Council, namely a Stakeholder Governor for Stepping Stones and a Public Governor for Sutton Coldfield.

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

An annual review of the Governors' 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 is carried out and there are no material interests to declare. You can access a register of Governors' interests or communicate with Governors by writing to:

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

Membership Report

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

The three main constituencies are:

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

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

Breakdown of total members

Public members:	85,902
Patient members:	6,782
Staff members:	9,348
Total membership:	102, 032

Public Membership is broken down as follows:

Age (years)		Ethnicity		Gender	
0-16:	310	White:	58,198	Male:	36,242
17-21:	2,778	Mixed:	410	Female:	49,660
22+:	82,814	Asian/British Asian:	9,026		
		Black/British Black:	2,211		
		Other:	16,057		

Staff Membership is broken down as follows:

Heartlands		Good Hope		Solihull	
Clinical Staff:	3,360	Clinical Staff:	1,754	Clinical Staff:	791
Non-Clinical:	1,956	Non Clinical:	988	Non Clinical:	499

Patient Membership is broken down as follows:

Age (years)	
0-16:	11
17-21:	179
22+:	6,592

<u>Membership Strategy</u>
The last twelve months saw a fall in membership numbers across all three constituencies, which, when analysed, was as a result of members either moving out of the catchment area or dying. The Trust also undertook a data cleanse of its member's database in November 2009 to ensure the data was up to date and accurate. This also affected membership numbers along with the reducing staff numbers. As a result we initiated an opt-out recruitment drive in February 2010 enabling the Trust to maintain its target of 100,000 members.

The Trust offers three levels of membership:

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

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

The Membership now stands at 102,032 members (including public, staff, patient and volunteer members) which is an increase of 1.93% in new public and patient members over the same period last year. Our plan is to maintain the membership numbers at or just above 100,000 members.

The Trust has updated the ACORN profiling and socio-economic grouping of its membership database monitor to ensure the demographics remain representative of the local community. In terms of socio-economic grade, the Trust is representative in all grades except one. 9.3% of the region is classed as grade E; however they make up just 0.9% of the member profile. The most common ACORN groups amongst members are Secure Families, Struggling Families, Wealthy Executives and Asian Communities. This matches the Heart of England community.

The membership is largely representative of the community in terms of ACORN demographic groups, in a predominantly lower-affluent community. There is a large under-representation of socio-economic grade E amongst members, but this has been addressed somewhat in the past year by targeted recruitment which resulted in an 8% rise of members of this type.

There has also been targeted recruitment leading to a rise in proportions of Urban Prosperity and Hard Pressed groups – the typically younger, more urban communities, whom are generally under-represented in membership profiles. The most notable increase amongst new members is the rise in proportions of lower social grades, D and E. This confirms we are making progress in addressing any shortfalls. The Trust is performing well regarding ethnic groups against the UK base and has one of the largest Asian populations.

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

Analysis of the membership data is undertaken monthly and action taken in any area where change is needed. We manage our own database which is linked to the Trust's patient system. This enables it to be automatically updated with any changes to members' details. Security processes are in place to ensure that there is no breach of patient confidentiality. We are working with a partner to look at new ways of improving the database facilities and utilising the data more effectively in the forthcoming year.

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

Recently the Trust held a Health and Innovation event at Millennium Point in Birmingham. The membership office joined forces with local schools to host this unique event which was a joint collaboration involving schools both locally and within the Pan Birmingham area and the Trust membership. The aims of the event were to encourage young people to take an interest in the sciences and the health service. It was also a chance for Trust governors to meet and engage with the members and for local people to learn more about health topics. The event provided an opportunity to promote the good work the Trust is doing in the region. Member engagement played a key role. This joint approach has also provided greater opportunities to engage with young people and encourage membership and higher levels of involvement. This event was

so successful the membership office has been asked by exhibitors, schools, staff and members to repeat it again in 2010.

This year has seen an increase in younger members particularly in the age range 16-21. Increased member representation of young people was achieved following a series of targeted recruitment campaigns alongside the Trust's own schools programme which was established with the specific aim of enhancing the Trust's profile in the community. The programme is ongoing and several projects are already underway to involve and engage young people. The projects include a leadership programme run in collaboration with local schools. The Trust runs membership and schools engagement open weekends. This collaboration includes ongoing arts and reading projects which have been very successful with students whose work is displayed in cabinets at our hospital sites.

2009/2010 Youth Engagement Programme

- 6th Form research project on sleep in adolescence (5 year project)
- Support on the Society Health and Development Diploma
- Career Weekend
- Pathology Day
- Reading Project patients and parents
- Innovation and Health event
- Sutton Schools Outdoor Gallery
- Teachers Day
- Visits to schools/college to support and promote health
- IT Project developing links with young patients
- Leadership programme to link into young members club
- Work in partnership with school to recreate a business/marketing venture
- One day visits for health and social care students various schools

In 2010/11 the focus will be to have greater membership involvement assisted by the Trust's Governors and Level One members. This new focus will also include continuing to engage with existing community groups and forums where strong relationships have been formed. Member volunteers now sit on the Consultative Healthcare Council – the Trust's primary forum for engaging users and also Local Involvement Networks (LINks). We are continuing to encourage our member volunteers to widen their involvement in membership and Trust activities.

The forming of active e-members (reachable by e-mail) to help with membership and patient surveys has proved very successful and will continue to grow. These members are also invited to take part in recruitment campaigns and external membership events.

Our young people and schools projects will continue to play a key role in engagement with younger members. Some new projects for 2011 include a research project into healthy eating and the rise in diabetes in young people in particular in some ethnic communities. The Trust's new young people's interactive website will also be launched along with a monthly electronic newsletter produced by the young members' council. Additional items for the 2010/2011 Youth Programme include:

- Supporting schools science week/events
- Health promotion with colleges on various campuses
- Offer health information and support to 'isolated young people'
- Young editor scheme linking retirement club members with support from young writers

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

The number of staff members has reduced by 2.6% this year although the goal for 2010/11 is to ensure they remain engaged and do not opt out. We will achieve this by increasing staff/governor awareness sessions and by continuing to encourage staff members to become champions along with the Governors, to recruit new members and to actively raise the profile of the Trust and its services.

Attendance at Trust events, the youth engagement programme and members monthly health seminars will continue to play an important part in the membership engagement programme for 2010/2011. Engagement of existing and new members remains a priority. A new membership website has been developed and was launched in April 2010. This site will include more interactive facilities including voting and survey buttons to get instant feedback from our members and the public on the services the Trust provides. The website also has links to social networking sites and members can use the blog and leave their comments. Our aim is to encourage our members to become more e-active.

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

Remuneration Report

The Remuneration Committee is mandated to review the appraisal of the Executive Directors and decide their remuneration and allowances (and other terms and conditions of office) and to keep under review executive director development and succession planning. The Committee meets without the Chief Executive present to perform the same role in respect of that post. The Non-Executive Directors, sitting as the Remuneration Committee, also appoint or remove the Chief Executive and are joined by the Chief Executive to appoint or remove the executive directors. The Remuneration Committee reports to the Trust Board. The Committee met three times in the financial year under review. Attendance figures can be seen in the attendance chart on page 56.

Remuneration Policy

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

Executive Directors' Remuneration and Appointment

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

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

Performance is judged and reviewed as part of the annual appraisal and personal development review process in line with Trust policies. The appraisal of all Executive Directors is carried out by Mark Goldman and a report then made to the Remuneration Committee on their performance. Details of remuneration, including the salaries and pension entitlements of the Executive Directors, are published in the annual accounts on pages 109-110.

All of the Executive Directors have a six month notice period for termination included in their contracts and there is no provision for compensation for early termination in their contracts. There were no amounts payable to third parties for the services of the executive directors and they received no benefits in kind (2008/09 nil). The only non-cash element of the remuneration of Executive Directors is a pension related benefit accrued under the NHS Pensions Scheme. Contributions are made by both the employer and employee in accordance with the rules of the national scheme which applies to all NHS staff in the scheme.

The Trust's Appointments Committee has overseen the appointment of Ellen Ryabov during the year and will oversee the recruitment process for a new CEO during the spring of 2010.

Non-Executive Directors Remuneration and Appointment

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

Appointments Commission in relation to NHS trusts or the NHS Confederation (Foundation Trust Network) which provides benchmarked and externally validated guidance relevant to foundation trusts.

Terms of office

Name and Title	First Appointment date	Notice period	Unexpired term of contract as at 31 March 2010
Clive Wilkinson (Chairman)	01 December 2001	1 month	1 year
Richard Samuda (Non Executive Director)	14 June 2006	1 month	3 months
Anna East (Deputy Chairman and Non Executive Director)	01 July 2005	1 month	3 years, 9 months
Paul Hensel (Non Executive Director)	01 August 2005	1 month	3 years, 8 months
Najma Hafeez (Non Executive Director)	01 April 2007	1 month	1 year
Chris Ham (Non Executive Director)	01 October 2007	1 month	1 year,5 months
David Bucknall (Non Executive Director)	08 January 2008	1 month	1 year, 9 months
Richard Harris (Non Executive Director)	01 May 2008	1 month	2 year, 1 months

The table above shows the Non-Executive Directors who have served the Trust during the year and the date of their first appointment.

As an exception to the Monitor Code of Governance Clause C.2.2, the Governor's Council has appointed the Non-Executive Directors on a four term of office. During the year the Governor's Appointments Committee has recommended that further terms of office be offered to Anna East and Paul Hensel. This recommendation was approved by the Governor's Council. Whilst this leads to a total length of service of eight years, the decision was taken to maintain continuity and stability of the non-executive function within the Board. Appraisal processes, employment policies and terms and conditions of appointment are in place to deal with the possibility of suboptimal performance and its consequences.

In addition the Governors' Consultative Council re-appointed Mr Wilkinson as Chairman for a further twelve months until 31 March 2011 after an unsuccessful open recruitment process. The Council agreed to the extension of term, following guidance given by Monitor, in order to offer stability and continuity to the Board in the light of the resignation of the Trust's Chief Executive Officer, Dr Mark Goldman who will step down on 31 July 2010. The Governor's Appointments Committee will oversee the recruitment process for a new Chair during the Autumn of 2010.

Details of their remuneration are published in the annual accounts on pages 109-110. The Non- Executive Directors do not receive pensionable remuneration. There were no amounts payable to third parties for the services of the Non-Executive Directors and they received no benefits in kind (2008/09 nil).

The accounting policies for pensions and other retirement benefits are set out on page 94 of the accounts

Mark Goldman
Chief Executive
4 June 2010

Audit Committee Report

The work of the Audit Committee is to:

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

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

In 2009/10 the Committee met seven times and discharged its responsibilities as set out in its terms of reference. It received comprehensive reports from the Director of Finance, the Director of Human Resources and Organisational Development, the Director of Safety and Governance, and the internal and external auditors. The Committee commissioned further reports in response to developing issues, requested clear objectives, timetables and achievement milestones against which performance could be measured.

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

The three main strategic areas that audits have focused on in the 2009/10 year, on top of the regulatory requirements for financial systems audits, were HR (temporary and medical staffing, consultant job planning and capacity utilisation and workforce productivity), IT (project management, computer controls and disaster recovery) and data integrity (CQC registration process, cancer targets, locally managed records and information governance).

Reviewing the activities of the Counter fraud team ensured that the Fraud Compound Indicator score was maintained at a level 3, where 4 was the highest level. Level 3 was achieved in 2008/09, an improvement from level 2 in previous years and the Trust anticipates it will reach a level 3 in 2009/10.

The Committee consists solely of independent Non-Executive Directors and at least one member has extensive relevant financial experience. All Committee members held office throughout the year and at the date of this report. Their attendance is shown in the table on page 56.

Other disclosures -

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

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

Under the National Health Service Act 2006, Monitor has directed Heart of England NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Heart of England NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- Observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgments and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements
- Prepare the financial statements on a going concern basis

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

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

Mark Goldman
Chief Executive
4 June 2010

Other disclosures - Statement on Internal Control

1. Scope of responsibility

The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

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

2. The purpose of the system of internal control

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

- Identify and prioritise the risks to the achievement of the policies, aims and objectives of Heart of England NHS Foundation Trust.
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place at Heart of England NHS Foundation Trust for the year ended 31 March 2010 and up to the date of approval of the annual report and accounts.

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

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

3. Capacity to handle risk

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

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

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

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

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

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

4. The risk and control framework

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

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

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

The purpose of the Trust's Whistle blowing policy and procedure is to outline ways in which all Trust employees can express concerns about malpractice/wrongdoing and to encourage employees to raise these at an early stage and in an appropriate way in line with the Public Interest Disclosure Act 1998. Staff have a right, and a duty, to raise with their employer any matters of concern they may have about health service issues associated with the organisation and delivery of care. The policy is designed therefore to provide a clear commitment to staff that concerns will be taken seriously, and to encourage staff to communicate their concerns through the appropriate channels. The 'Whistle Blowing' Policy and Procedure is primarily for concerns where, due to malpractice, fraud, abuse or other inappropriate acts/omissions, the interest of others or the organisation itself is at risk.

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

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

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

- Board of Governors
- Patient and Public Involvement Forums
- Overview and Scrutiny Committees

- Patient/ Customer Surveys
- Patient Focus Groups
- Foundation Trust Membership
- Meetings with Commissioners

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

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

There were no Serious Untoward Incidents involving personal data as reported to the Information Commissioners office in 2008/9.

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

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

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects. This ensures that the Trust's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Before the introduction of the CQC we were required each year to make a declaration against 44 national core standards for the Health Care Commission (HCC). At the end of 2008/09 we declared full compliance against these 44 standards. During the last year, however, further guidance was issued on safeguarding children which led us to declare non- compliance with this standard for the midyear declaration - in December 2009. Work has been undertaken to address this shortfall and at the end of 2009/10, we were fully compliant with the safeguarding standard as set out by the HCC.

In January 2010 we submitted our registration application to CQC and were registered with them on the 1st April with 3 conditions relating to breaches of regulation 23 ('supporting workers'), regulation 22 (staffing) and regulation 11 (safeguarding service users from abuse). Full action plans have been developed to address these conditions and have been submitted to CQC.

We achieved the entire Monitor targets, with the exception of the A&E 4 hour target which we failed to achieve for 3 out of the 4 quarters for last year. As a result of this we have been working closely with Monitor on the development of action plans to deliver the target in 2010/11.

In February 2010 Monitor put the Trust in significant breach of the Terms of Authorisation due to the repeated failure to deliver the four hour access target during the winter periods of 2007/08, 2008/09 and 2009/10. Monitor's concerns led to the Trust being paced in breach of the following three Terms of Authorisation.

- Condition 2 – General duty to exercise its functions effectively, efficiently and economically

- Condition 5 – Governance duty to ensure the existence of appropriate arrangements to provide representative and comprehensive governance to maintain the organisational capacity necessary to deliver the agreed patient care and education and training services
- Condition 6 – Trust's duty to monitor performance and provide the quality of healthcare required under the relevant legislation, in this instance the A&E 4 hour wait target

As a result the Trust has a red governance risk rating from quarter three in 2009/10.

The Trust has reviewed its general duty to exercise its functions effectively, efficiently and economically and has concluded that with the exception of not hitting the A&E target, it is comfortable that this condition is not being breached for the following reasons;

- The Trust has generated a surplus of £10.1m in year and has consistently been delivering a monthly surplus in most months of the year
- The Trust reviews financial performance in detail every month and where costs are above the expected level a detailed investigation is carried out and rectifying actions taken. The Trust has successfully taken action in the year to reduced temporary pay costs
- The Trust has a financial risk rating of 4 which is regarded as a good financial basis, so does not indicate a Trust that is not utilising its resources effectively, efficiently and economically
- The Trust has had a healthy cash balance that has been well managed throughout the year
- The Trust has a rigorous CIP programme which has driven the delivery of £12.9m CIP in the year, the highest value the Trust has ever delivered in one year which demonstrates the Trust's commitment to efficient use of resources. Going in to 2010/11 the Trust has equally ambitious plans for an even greater level of CIP delivery
- The Trust has a benefits realisation review process where all significant revenue and capital investments are reviewed against the benefits they were due to be generating and where performance is below agreed levels the investment may be withdrawn
- The Trust has reference costs below 100 (2008/09 94), which indicates that it is using its resources more effectively, efficiently and economically than the average Trust
- Internal audit reviews have not identified any areas where use of resources is substantially inefficient or ineffective
- Throughout the year the Trust has met the vast majority of the national core targets and the specific Monitor targets
- The Trust has invested £23.4m of capital investment in the 2009/10 year and has a detailed review process to ensure the highest priorities are funded. There has been specific investment in A&E including a modular block at Good Hope, a refurbishment in the Heartlands site, a new ward block at Good Hope and an A&E redesign at Good Hope in the future

The Trust has reviewed its governance duties and has concluded that it is abiding to the terms of authorisation with the exception of the A&E target. As described in section 4 of this Statement on Internal Control, there is a robust risk and control framework in place to identify and act upon risks to the Trust.

The causes of missing the A&E target are many and complicated and the actions to resolve the issue are taking some time to have effect because in many cases they involve a number of parties, and sometimes groups external to the Trust. There is monthly reporting of performance metrics to the Executive Directors meeting and regular updates provided to the Trust Board. Where an issue emerges an action plan is devised to allocate a responsible lead who will follow through until the issue has been addressed. Because of the breach of healthcare standards, we are required to provide additional monthly information to Monitor including: -

- a monthly forecast for reducing Length of Stay (LOS) and monthly performance against this
- a forecast for A&E performance and actual performance by individual site
- progress against programme plan actions and

- submission to Monitor of 4 hour performance dashboard.

Since being placed in breach we have developed a detailed plan to improve our performance against this target. This plan has been reviewed separately by ECIST (Emergency Care Intensive Support Team) and Professor George Alberti who have endorsed our approach and have also communicated their approval to Monitor.

5. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. 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 organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by

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

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

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

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

6. Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

A year ago, at the start of the Quality Report process, the Trust Board and its governors agreed the five priorities which would be measured throughout the year. This selection process enables there to be a balance between targets important to all of the Trust's stakeholders including those of specific interest to regulators, e.g. infection control, and the less tangible factors of patient opinions. The Quality Report presented on pages 16 to 36 highlights where improvements have been made, but also lists the next steps to be taken in the ongoing commitment sections where we have either not achieved to the level we desired, where it is identified that there is still improvement to be made or where the journey to improvement identified that this was a valued added process that should be continued.

Three of the priorities included in the Quality Report (infection control, hospital discharge and stroke treatment) are targets set an measured by regulatory bodies, including CQC, Monitor and national standards and the PCTs via CQUINs so are reported to the Executive Directors meetings and Trust Board monthly and are part of the validation process to the regulators they are reported to. The nursing quality

priority has only been reported over the last three months, because it has taken several months to devise, implement and roll out a reporting process across all of the relevant areas. Each of the priorities has an executive director lead that is responsible for the delivery and reporting of that measure.

The Executive Directors were provided with a half year review of the Quality Report and the full year report has been compiled by the relevant Executive Director leads. The key aspects of the year end Quality Report have been presented to the board and the governors and they are in agreement with their contents. During the implementation process a number of actions have been identified to improve the processes for future years, including more regular updates being provided to the Board, ownership of the overall report and additional support for the quality of the processes behind the data provisions. Internal audit commenced reviews of the quality accounts processes and of the data quality around reporting of national targets. These reports will be completed in the early part of the 2010/11 year and their findings will produce action plans and give the Board more information about the assurance levels of quality reporting.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, Audit Committee, and Governance and Risk Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

With the exception of the internal control issues that I have outlined in this statement, my review confirms that Heart of England NHS Foundation Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.

Mark Goldman
Chief Executive
4 June 2010

Report on Monitor's Risk Ratings

In line with Monitor's Compliance Framework, in May of every year, the Trust Board makes an Annual Plan submission to Monitor that details the financials for that year by quarter and also makes statements about the expected level of governance and mandatory services for that year. Monitor then assesses the Trust's expected performance levels and issues a financial risk rating, a governance risk rating and a mandatory services risk rating. At the end of each quarter the Trust makes a submission to Monitor detailing the financial performance and governance levels at the Trust and again Monitor assesses these returns and issues a financial, mandatory services and governance risk rating.

Explanation of risk ratings

The financial risk rating is a weighted average of the following 4 factors;

- Achievement of plan – measures how well the Trust is meeting its forecast surplus at EBITDA level
- Underlying performance – measures the EBITDA (%) level of the Trust
- Financial efficiency – measures the return on assets and the I&E surplus margin (%)
- Liquidity – measures the number of days operating costs available to the Trust.

The highest score available is 5 and the lowest score is 1. More details on the basis of these calculations and the thresholds can be found in Monitor's Compliance Framework 2009/10, available on the Monitor website. The mandatory services risk rating is scored red, amber or green, and measures the level of risk of the Trust not providing the services it has agreed with its commissioning bodies. The governance risk ratings available are red, amber, and green. There are a number of factors that are used to determine the rating, including the legality of the constitution, having a representative membership, having appropriate board structures, having effective risk and performance management, co-operating with other NHS bodies and local authorities and meeting set standards on key clinical areas and achievement of national core standards. Again the detailed explanations for these calculations can be found in the Compliance Framework document.

Trust performance

The table below details the financial, governance and mandatory services risk rating for each quarter of the past 2 years and the expected year end position in the Annual Plan.

	Annual Plan 2009/10	Quarter 1 2009/10	Quarter 2 2009/10	Quarter 3 2009/10	Quarter 4 2009/10
Financial risk rating	3	3	3	4	4
Governance risk rating	Green	Green	Green	Red	Red
Mandatory services	Green	Green	Green	Green	Green

	Annual Plan 2008/09	Quarter 1 2008/09	Quarter 2 2008/09	Quarter3 2008/09	Quarter4 2008/09
Financial risk rating	5	5	5	5	4
Governance risk rating	Green	Amber	Green	Green	Green
Mandatory services	Green	Green	Green	Green	Green

Financial risk rating

When the Annual Plan was set in May 2009 it was expected that the Trust would be green for governance and mandatory services and that a level 3 financial risk rating would be achieved.

The planned surplus for the 2009/10 year of £5.8m was agreed by the Trust Board at a time when the Trust faced the financial challenge of continuing to deliver high activity levels but at a reduced cost. As described in the financial review section, the actions taken within the year have meant the Trust has exceeded the expected surplus level, giving a £10.1m surplus before impairment. This higher than planned EBITDA and

the improvement in return on assets as a result of the revaluation of the Trust's estate have resulted in a financial risk rating of 4.

In previous years the Trust had consistently achieved a financial risk rating of rating of 5. This declined in quarter 4 of 2008/09 because the Trust made the decision to remove its working capital facility due to the large levels of cash the Trust held , which reduced the liquidity score, and a decrease in the EBITDA percentage. Nonetheless, the £19.8m surplus in the 2008/09 year returned a financial risk rating of 4.

Governance risk rating

The Trust has always aimed to achieve a green governance risk rating every quarter and consistently meets the majority of the targets set out

In quarter 3 of 2009/10 the Trust did not meet the A&E 4 hour wait target, as and outlined in previous sections of this Annual Report, Monitor applied its overrule and placed the Trust is breach of its terms of authorisation, which means an automatic governance rating of red. The Trust will remain red rated until Monitor is confident that the issue has been addressed.

In quarter 1 of 2008/09, a amber rating was awarded because the Trust had not met the target on MRSA reductions. When this rating was given the Trust were already tackling the issue and were at the end of a six month programme of improvement that meant the MRSA has been met every quarter since this June 2008.

Other disclosures - Going Concern

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

Other disclosures - Directors' Responsibilities for preparing the financial statements

The following statements, which should be read in conjunction with the Statement of Auditor's Responsibilities included in the Independent Auditor's Reports, are made to distinguish the respective responsibilities of the Directors and the Auditors in relation to the financial statements for 2009/10.

The Directors are responsible for preparing the Annual Report and Accounts 2009/10. The Directors are required by the Trust's terms of authorisation to prepare financial statements for each financial year, giving a true and fair view of the state of affairs of the Trust at the end of the financial year, and of the surplus or deficit for the financial year. Our financial statements must be prepared in accordance with International Financial Reporting Standards, the NHS Foundation Trust Annual Reporting Manual 2009/10 and the Companies Acts 1985 and 2006.

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

The Directors have responsibility for ensuring the maintenance of proper accounting records that disclose, with reasonable accuracy at any time, the financial position of the Trust and to enable them to ensure that the financial statements and the Directors' Remuneration Report comply with the NHS Foundation Trust Annual Reporting Manual 2009/10 and the Companies Acts 1985 and 2006. They are also responsible for safeguarding the assets of the Trust and for taking reasonable steps to prevent and detect fraud and other irregularities.

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

Other disclosures - Directors' Responsibility Statement

We confirm to the best of our knowledge that:

- The financial statements, prepared in accordance with International Financial Reporting Standards (IFRS), give a true and fair view of the assets, liabilities, financial position and surplus of the Trust.
- The Business review, which is incorporated into the Directors' report, includes the information required by the NHS Foundation Trust Annual Reporting Manual 2009/10, namely a fair review of the development and performance of the business and the position of the Trust, together with a description of the principal risks and uncertainties they face.

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

By order of the Board

Clive Wilkinson
Chairman
4 June 2010

Mark Goldman
Chief Executive Officer
4 June 2010

Other disclosures - Directors' Responsibility Statement in respect of the Quality Report
The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the Quality Report presents a balanced picture of the foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at http://www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at http://www.monitor-nhsft.gov.uk/annualreportingmanual)

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Clive Wilkinson
Chairman
4 June 2010

Mark Goldman
Chief Executive Officer
4 June 2010

Financial Statements and other information

Independent Auditors' Report to the Board of Governors of Heart of England NHS Foundation Trust

We have audited the financial statements of Heart of England NHS Foundation Trust for the year ended 31 March 2010 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity and the related notes. The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").
Respective responsibilities of directors and auditors

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

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

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

Opinion on financial statements
In our opinion the financial statements:

- give a true and fair view, in accordance with the NHS Foundation Trust Annual Reporting Manual, of the state of the NHS Foundation Trust's affairs as at 31 March 2010 and of its income and expenditure and cash flows for the year then ended; and
- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual.

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

- the part of the Directors' Remuneration Report to be audited (set out in notes 3.3 and 3.4 to the annual accounts) has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual; and
- the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception
We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if, in our opinion:

- adequate accounting records have not been kept, or returns adequate for our audit have not been received from locations not visited by us; or
- the financial statements are not in agreement with the accounting records and returns; or
- we have not received all the information and explanations we require for our audit; or

- the Statement on Internal Control does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual or is misleading or inconsistent with information of which we are aware from our audit; or
- we have not been able to satisfy ourselves that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

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

4 June 2010

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

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

FOREWORD TO THE ACCOUNTS

HEART OF ENGLAND NHS FOUNDATION TRUST

These Accounts for the year ending 31 March 2010 have been prepared by the Heart of England NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

Mark Goldman
Chief Executive
Date: 4 June 2010

PRIMARY STATEMENTS

Statement of Comprehensive Income

	Note	2009/10 £000	2008/09 £000
Operating Income	2	**541,938**	507,436
Operating Expenses	3	**(539,626)**	(479,942)
OPERATING SURPLUS / (DEFICIT)		**2,312**	**27,494**
FINANCE COSTS			
Finance income	6	**1,739**	4,915
Finance expense - financial liabilities	7.1	**(353)**	(328)
Finance expense - unwinding of discount on provisions		**(4)**	(4)
PDC Dividends payable		**(10,138)**	(10,884)
NET FINANCE COSTS		**(8,756)**	**(6,301)**
SURPLUS/(DEFICIT) FOR THE YEAR		**(6,444)**	**21,193**
Other comprehensive income			
Revaluation gains/(losses) and impairment losses on property, plant and equipment	9.6	**(22,163)**	(12,720)
Increase in the donated asset reserve due to receipt of donated assets		**169**	95
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets		**(715)**	(548)
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		**(29,153)**	**8,020**

PRIMARY STATEMENTS

Statement of Financial Position as at :-

	Note	31 Mar 2010 £000	31 Mar 2009 £000	1 Apr 2008 £000
Non-current assets				
Intangible assets	8	**2,575**	1,955	2,758
Property, plant and equipment	9	**293,220**	329,556	328,473
Trade and other receivables	12	**1,551**	1,604	1,396
Other financial assets	28	**0**	0	0
Total non-current assets		**297,346**	**333,115**	**332,627**
Current assets				
Inventories	11	**7,029**	6,147	4,750
Trade and other receivables	12	**30,462**	21,252	20,120
Other financial assets	28	**0**	55,000	30,359
Cash and cash equivalents	21	**90,715**	22,449	30,017
Total current assets		**128,206**	**104,848**	**85,246**
Current liabilities				
Trade and other payables	13	**(54,555)**	(40,890)	(38,434)
Borrowings	15	**(480)**	(481)	(480)
Other financial liabilities	29	**0**	0	0
Provisions	19	**(3,370)**	(2,634)	(3,401)
Tax payable	13	**(7,125)**	(10,372)	(124)
Other liabilities	14	**(8,652)**	(3,543)	(5,307)
Total current liabilities		**(74,182)**	(57,920)	(47,746)
Total assets less current liabilities		**351,370**	**380,043**	**370,127**
Non-current liabilities				
Trade and other payables	13	**0**	0	0
Borrowings	15	**(5,521)**	(5,802)	(6,053)
Other financial liabilities	29	**0**	0	0
Provisions	19	**(3,222)**	(2,461)	(1,734)
Other liabilities	14	**0**	0	0
Total non-current liabilities		**(8,743)**	**(8,263)**	**(7,787)**
Total assets employed		**342,627**	**371,780**	**362,340**
Financed By (taxpapers' equity)				
Public Dividend Capital		**211,114**	211,114	209,694
Revaluation reserve	20	**84,198**	108,809	132,478
Donated Asset Reserve		**3,202**	4,039	3,668
Other reserves		**(169)**	(169)	(169)
Income and expenditure reserve		**44,282**	47,987	16,669
Total taxpayers' equity		**342,627**	**371,780**	**362,340**

Mark Goldman, Chief Executive
Date: 4 June 2010

PRIMARY STATEMENTS

Statement of Changes In Taxpayers' Equity

	Note	Total	Public Dividend Capital	Revaluation Reserve	Donated Assets Reserve	Other Reserves	Income and Expenditure Reserve
		£000	£000	£000	£000	£000	£000
2009/10							
Taxpayers' Equity at 1 April 2009		**371,780**	**211,114**	**108,809**	**4,039**	**(169)**	**47,987**
Surplus/(deficit) for the year		**(6,444)**		0	0	0	(6,444)
Revaluation gains/(losses) and impairment losses property, plant and equipment	9.5	**(22,163)**		(21,872)	(291)	0	0
Increase in the donated asset reserve due to receipt of donated assets		**169**		0	169	0	0
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets		**(715)**		0	(715)	0	0
Additions/(reduction) in Other reserves		**0**		0	0	0	0
Other recognised gains and losses		**0**		0	0	0	0
Transfers to the income and expenditure account in respect of assets disposed of		**0**		0	0		0
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve		**0**		(2,739)	0		2,739
Public Dividend Capital received		**0**	0				
Public Dividend Capital repaid		**0**	0				
Public Dividend Capital repayable (creditor)		**0**	0				
Other transfers between reserves		**0**	0	0	0	0	0
Movements on other reserves		**0**	0	0	0	0	0
Taxpayers' Equity at 31 March 2010		**342,627**	**211,114**	**84,198**	**3,202**	**(169)**	**44,282**

PRIMARY STATEMENTS

Statement of Changes In Taxpayers' Equity

	Note	Total	Public Dividend Capital	Revaluation Reserve	Donated Assets Reserve	Other Reserves	Income and Expenditure Reserve
		£000	£000	£000	£000	£000	£000
Prior Year 2008/09							
Taxpayers' Equity at 1 April 2008		**362,340**	**209,694**	**132,478**	**3,668**	**(169)**	**16,669**
Surplus/(deficit) for the year		**21,193**		0	0	0	21,193
Revaluation gains/(losses) and impairment losses property, plant and equipment		**(12,720)**		(12,699)	(21)	0	0
Increase in the donated asset reserve due to receipt of donated assets		**95**		0	95	0	0
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets		**(548)**		0	(548)	0	0
Additions/(reduction) in Other reserves		**0**		0	0	0	0
Other recognised gains and losses		**0**		0	0	0	0
Transfers to the income and expenditure account in respect of assets disposed of		**0**		0	0		0
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve		**0**		0	0		0
Public Dividend Capital received		**1,420**	1,420				
Public Dividend Capital repaid		**0**	0				
Public Dividend Capital repayable (creditor)		**0**	0				
Other transfers between reserves (1)		**0**	0	(10,970)	845	0	10,125
Movements on other reserves		**0**	0	0	0	0	0
Taxpayers' Equity at 31 March 2009		**371,780**	**211,114**	**108,809**	**4,039**	**(169)**	**47,987**

(1) In the year ended 31 March 2009 the Trust performed a reconciliation of the revaluation reserve and the donated asset reserve by asset partly to ensure consistency of accounting treatment between Good Hope assets and other Trust assets. This resulted in a transfer between reserves.

PRIMARY STATEMENTS

Statement Of Cash Flows

	2009/10 £000	2008/09 £000
Cash flows from operating activities		
Operating surplus/(deficit)	**2,312**	**27,494**
Depreciation and amortisation	**20,593**	16,721
Impairments	**16,550**	651
Reversals of impairments	**0**	0
Transfer from the donated asset reserve	**(715)**	(548)
Amortisation of government grants	**0**	0
Amortisation of PFI credit	**0**	0
(Increase)/Decrease in Trade and Other Receivables	**(9,868)**	300
(Increase)/Decrease in Other Assets	**0**	0
(Increase)/Decrease in Inventories	**(882)**	(1,397)
Increase/(Decrease) in Trade and Other Payables	**8,744**	11,302
Increase/(Decrease) in Other Liabilities	**6,008**	0
Increase/(Decrease) in Provisions	**1,497**	(40)
Tax (paid)/received	**0**	0
Other movements in operating cashflows	**0**	51
Net cash generated from/(used in) operating activities	**44,239**	**54,534**
Cash flows from investing activities		
Interest received	**3,607**	3,276
Purchase of financial assets	**(105,000)**	(155,000)
Sales of financial assets	**160,000**	130,359
Purchase of intangible assets	**(270)**	(19)
Purchase of Property, Plant and Equipment	**(22,545)**	(31,032)
Sales of Property, Plant and Equipment	**0**	11
Net cash generated from/(used in) investing activities	**35,792**	**(52,405)**
Cash flows from financing activities		
Public dividend capital received	**0**	1,420
Public dividend capital repaid	**0**	0
Loans received	**0**	0
Loans repaid	**0**	0
Capital element of finance lease rental payments	**(84)**	0
Capital element of Private Finance Initiative Obligations	**(194)**	0
Interest paid	**0**	0
Interest element of finance lease	**(172)**	(178)
Interest element of Private Finance Initiative obligations	**(181)**	(150)
PDC Dividend paid	**(11,296)**	(10,884)
Cash flows from/(used in) other financing activities	**162**	95
Net cash generated from/(used in) financing activities	**(11,765)**	**(9,697)**
Increase/(decrease) in cash and cash equivalents	**68,266**	**(7,568)**
Cash and Cash equivalents at 1 April	**22,449**	**30,017**
Cash and Cash equivalents at 31 March	**90,715**	**22,449**

NOTES TO THE ACCOUNTS

1 ACCOUNTING POLICIES

1.1 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 Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2009/10 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) 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.

1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

The Trust makes an accrual in the statement of financial position at the year end to account for the value of partially completed patient spells. The year on year movement in the value of this accrual is recorded within income from activities.
Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.3 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.4 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights where expenditure of at least £5,000 is incurred. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised.
Expenditure on development is capitalised only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
• the Trust intends to complete the asset and sell or use it;

• the Trust has the ability to sell or use the asset;

• how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;

• adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
• the Trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. Subsequently intangible assets are measured at fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. The amortisation periods for intangible assets are, in general, 5-10 years for software licences.

1.5 **Property, Plant and Equipment**

Recognition

Property, Plant and Equipment is capitalised where:
• it is held for use in delivering services or for administrative purposes;
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
• it is expected to be used for more than one financial year; and
• the cost of the item can be measured reliably. The cost must be where;
  • individually items have a cost of at least £5,000; or
  • collectively they 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.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

Valuation

All property and plant assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

For freehold and leasehold properties fair value is based is based on periodic, but at least quinquennial, rolling valuations performed by external independent valuers less subsequent depreciation and impairment losses. The valuations are performed with sufficient regularity to ensure that the carrying value does not differ significantly from fair value at the balance sheet date.

Equipment is stated at historical cost less subsequent depreciation.

Revaluation and impairment

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

On an annual basis the Trust will transfer an amount from the revaluation reserve to the I&E reserve to account for the amortisation of the revaluation reserve over the life of the asset that have a revaluation reserve attributed to them.

Depreciation

Items of Property, Plant and Equipment are depreciated on a straight line basis over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated. Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Depreciation is applied in the quarter after the asset is brought into use.

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. Assets held under finance leases are depreciated over their estimated useful lives or, where shorter, the lease term.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as advised by the District Valuer. Leaseholds are depreciated over the primary lease term.

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

NOTES TO THE ACCOUNTS

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	5-8 years
furniture & fittings	5 years
dwellings	up to 50 years per District Valuers valuation
other buildings	up to 50 years per District Valuers valuation

De-recognition of Property, Plant & Equipment

Assets planned to be scrapped or demolished are held as operational assets with revised lives to reflect the period over which the assets economic life has been shortened. Once the asset has been disposed of it ceases to be recognised and is removed from the Trusts Fixed Asset Register.

Assets planned for sale on disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- there is documented management intent and approval in line with standing SFI's to sell the asset;
- an active programme has begun to find a buyer and complete the sale;
- the asset is being actively marketed at a reasonable price;
- the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
- it is highly unlikely that the plan to sell the asset will be cancelled or materially changed so as to delay or impair the process such that the sale will take longer than 12 months or cease completely.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Donated assets

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the income and expenditure account. Similarly, any impairment on donated assets charged to the income and expenditure account is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value of the donated asset is transferred from the donated asset reserve to the Income and Expenditure Reserve.

NOTES TO THE ACCOUNTS

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's Financial Reporting Manual, are accounted for as 'on-Statement of Financial Position' by the Trust. The underlying assets are recognised as Property, Plant and Equipment at their fair value which is periodically assessed by the district valuer. An equivalent financial liability is recognised in accordance with IAS 17. The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The finance cost is calculated using the effective interest rate for the scheme. The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

PFI transactions which do not meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's Financial Reporting Manual, 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.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;

b) Payment for the PFI asset, including finance costs; and

c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

Lifecycle replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

Assets contributed by the Trust to the operator for use in the scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

1.6 **Government grants**

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

1.7 **Inventories**

Inventories are valued at the lower of cost and net realisable value, on a first in first out basis.

1.8 **Research and Development**

Expenditure on research is not capitalised is charged as an expense through the SOCI. Expenditure on development is capitalised only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
• the Trust intends to complete the asset and sell or use it;
• the Trust has the ability to sell or use the asset;
• how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
• the Trust can measure reliably the expenses attributable to the asset during development.

1.9 **Cash and Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that are short-term and are readily convertible to known amounts of cash with insignificant risk of change in value.

1.10 **Provisions**

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 19.

Non-clinical risk pooling

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

1.11 **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 24 where an inflow of economic benefits is probable. Contingent liabilities are not recognised, but are disclosed in note 24, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

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

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

1.12 **Expenditure on Employee Benefits**

Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

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 Secretary of State, in England and Wales. It is not possible for the Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

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

1.13 **Critical accounting judgements and key sources of estimation uncertainty**

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.14 **Critical judgements in applying accounting policies**

The Trust is required under IAS1, Presentation of Financial Statements to disclose the critical judgements, apart from those involving estimations (see note 1.15) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements. The following areas are where the application of the Trust's accounting polices involved judgements;

(a) The assumption within the Research and Development business unit is that it breaks even in any financial year. The head of the business unit regularly reviews the income and costs and flexes resource and obtains sources of income depending on the activity of the department.

(b) The Trust's policy on stock valuation is based on a first in first out basis. Some of the stock is valued manually and in some cases it has been necessary to value this stock on an average cost basis of stock purchased during the year. This has no material impact on the year end stock valuation.

(c) The Trust's commissioned a valuation of its land, buildings and dwellings at 1 April 2009 and 31 March 2010. These valuations have followed the following principles:
(i) Fair value of operational assets is determined as market value with the explicit assumption that property is sold as part of the continuing enterprise in occupation. The approach is reflected primarily on the basis of depreciated replacement cost (DRC) for specialised operational property and existing use valuation for non-specialised operational property. DRC valuations were prepared using the Modern Equivalent Asset method of valuation in accordance with the requirements of the Department of Health and of the Royal Institute of Chartered Surveyors Valuation Information Paper 10, (ii)For assets with finance lease contracts,

- the land element is separated from the valuations as under IAS 17 it should be treated as an operating lease
- the assets are measured as the value of the underlying asset rather than the value of the lease, and
- the fair value of the asset will be the market value of the building subject to the assumption of the continuance of the existing use.

(iii)For each specialised operational property the actual building size and site size and site locations would be the basis of valuation.

This third point was set out as an assumption at the beginning of the valuation process to be consistent with the current Cross Site Strategy Programme. This current site developments are to have developments on the existing sites that are in keeping with the image of each site. Therefore the valuation has been performed to reflect these plans. If the valuation had been performed on a different basis, such as building taller buildings, having smaller sites or amalgamating activities into one large site the valuation may have resulted in significantly different results.

1.15 **Key sources of estimation uncertainty**

The Trust are required under IAS1, Presentation of Financial Statements, to disclose key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year. The Trust has reviewed the areas where there are sources of estimation uncertainty, including provision balances, PFI transactions, NHS injury scheme income and balances, income and debtor balances relating to contracted NHS income, debtor balances and asset valuations.

In order to arrive at an MEA valuation as at 1 April 2008 the Trust has applied an Indice to estimate the proportion of the value at 1 April 2009 that was attributable to market condition changes. This estimation was based upon the indice movement for the twelve month period and therefore is relfected in the estimated apportionment of the 1 April 2009 valuation. This does not effect the accuracy of the valuation at the SOFP date.

Within the calcuated figure of depreciation disclosed in the SOCI is an element of accelerated depreciation. This figure is based upon the Trust's judgement as to how the life and current use of buildings will change in direct relation to the site rationalisation plan and the Site Strategy that have been approved by the Trust's Board. The accelerated depreciation judgement reflects the Trust's view on the future use of these buildings as at 31 March 2010 and therefore could be different to actual future events.

With the exception of the two points above, the Trust has not made any further estimations or judgements that could have a significant risk of materially adjusting the carrying values of any other assets or liabilities within the next financial year.

1.16 **Value Added Tax**

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

1.17 **Foreign exchange**

The functional and presentational currencies of the Trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

1.18 **Third party assets**

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts (Note 21.2) in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.19 **Leases**

Finance 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 Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability. The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received (e.g. reduced rentals or rent free periods) are added to the actual lease rentals invoiced and charged to operating expenses over the life of the lease to give a similar rental charge per year across each year of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

1.20 **Public dividend capital**

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32. A charge, reflecting the forecast cost of capital utilised by the NHS foundation Trust, is paid over as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the actual average relevant net assets of the NHS Foundation Trust as recorded in the unaudited year end accounts. The calcualted dividend is not revised if any adjustments to net relevant assets are identified during the final audit process. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and cash held with the Government Banking Services (which includes cash held with the Office of the Paymaster General). Average relevant net assets are calculated as a simple means of opening and closing relevant net assets.

1.21 **Other reserves**

Other reserves are created to account for any differences between the value of fixed assets taken over by the Foundation Trust at inception and the corresponding figure in the opening capital debt.

1.22 Losses and Special Payments

Losses and special payments are incurred when there is an excess to pay on claims made through the MHS Litigation Authority for non-clinical claims or where the amount is below the excess so is paid directly to the individual or organisation. This would be the case for small monetary value items such as spectacles, cash and clothing.

Losses and special payment re reported on an accruals basis, but excludes provisions for future losses.

1.23 Corporation Tax

NHS Foundation Trusts are potentially liable to corporation tax in certain circumstances. A review of other operating income is performed annually to assess any potential liability in conjunction with guidance on the HMR&C website. As a result of this review it is concluded that the Trust did not have a corporation tax liability in 2008/09 or 2009/10.

1.24 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made. Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below. All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

Financial assets are categorised as 'Fair Value through Income and Expenditure', Loans and receivables. Financial liabilities are classified as 'Fair value through Income and Expenditure' or as 'Other Financial liabilities'.

Financial assets and financial liabilities at 'Fair Value through Income and Expenditure'

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities. These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments with are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS debtors, accrued income and 'other debtors'. Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset. Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the balance sheet date, which are classified as long-term liabilities. Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

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

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for the amounts payable more than 12 months after the balance sheet date, which are classified as long-term liabilities. Impairment of financial assets

At the balance sheet date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cashflows of the asset. For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

1.25 **NHS Charitable Funds**

The Trust is the Corporate Trustee for Heart of England NHS Foundation Trust General Purposes Charitable Fund (Charity Number 1052330). IAS 27 (Consolidated and Seperate Financial Statements) indicates that the Charity represents a subsidiary of the Trust. However, because HM Treasury has granted a dispensation to the application of IAS 27 in relation to the consolidation of NHS Charitable Funds for 2009/10 and 2010/11, consolidated accounts have not been prepared.

NOTES TO THE ACCOUNTS

1.26 **Accounting standards that have been issued but have not yet been adopted**

The following standards, interpretations and amendments has been issued by the International Accounting Standards Board (IASB) and adopted by the European Union but have note been adopted in the NHS in 2009/10. None of these standards are expected to have a material impact upon the Trust financial statements.

IFRS Detail	IASB Issued	EU adopted	IFRS Effective date	NHS implementation year
IAS 27 (Revised) Consolidated and separate financial statements.	Jan-08	12 Jun 2009	Annual periods on or after 1 July 2009	2010/11
Amendment to IAS 32 Financial instruments: Presentation on classification or rights issues	Oct-09	24 Dec 2009	Annual periods on or after 1 February 2010	2010/11
Amendment to IAS 39 – Eligible hedged items	Jul-08	16 Sep 2009	Annual periods beginning on or after 1 July 2009	2010/11
IFRS 1 (revised) First time adoption of IFRS	Nov-08	16 Nov 2009	Annual periods beginning on or after 1 July 2009	Not applying as IFRS already implemented
IFRS 2 Share-based payment – Group cash-settled share-based payment transactions	Jul-09	23 Mar 2010	Annual periods beginning on or after 1 January 2010	2010/11
IFRS 3 (Revised) Business combinations	Jan-08	12 Jun 2009	Business combinations occurring in Annual periods beginning on or after 1 July 2009.	2010/11
IFRIC 17 Distributions of Non-cash Assets to Owners	Nov-08	25 Nov 2009	Annual periods beginning on or after 1 July 2009	2010/11
IFRIC 18, Transfer of assets from customers	Jan-09	27 Nov 2009	Annual periods on or after 1 July 2009 although EU endorsed for annual periods on or after 31 October 2009	2010/11
Annual Improvements 2009	Apr-09	23 Mar 2010	Individual amendments apply for annual periods beginning either on or after 1 July 2009 or 1 January 2010.Note: HM Treasury has early adopted the amendment to IFRS 8 in relation to the disclosure of total assets by segment.	2010/11

NOTES TO THE ACCOUNTS

The following standards, interpretations and amendments has been issued by the International Accounting Standards Board (IASB) and have been recommended by the advisory subcomittees of the EU but have not yet been adopted by the European Union. None of these standards are expected to have a material impact upon the Trust financial statements.

Standard	Change
IFRIC 19	Extinguishing financial liabilities with equity instruments
Amendment to IFRIC 14	Prepayments of a minimum funding requirement
Amendments to IFRS 1	Additional disclosures
Amendments to IFRS 1	Exemption to not include new fair value heirarchy
Amendments to IAS 24	Related party disclosures

The IASB has issued IFRS 9, Financial Instruments, applicable for the 2013/14 year but has not yet been considered by the EU or its advisory bodies.

1.27 **Accounting standards issued that have been adopted early**

The amendment to IFRS 8 Operating segments that was included in the April 2009 Improvements to IFRS has been adopted early. As a result, total assets are not reported by operating segment.

NOTES TO THE ACCOUNTS

Note 2.1 Operating Segments

Trustwide summary of segments

	2009/10			2008/09		
	Operational Healthcare	Research and Development	Total Segments	Operational Healthcare	Research and Development	Total Segments
	£000	£000	£000	£000	£000	£000
Income	523,190	3,154	526,344	490,340	2,361	492,701
Costs	(449,963)	(3,154)	(453,117)	(399,607)	(2,361)	(401,968)
Net surplus/(deficit)	73,227	0	73,227	90,733	0	90,733

All activities are based in the UK.

Operational Healthcare refers to the core activities of the Trust that fall under the remit of the Chief Operating Officer (COO). This activity is primarily the provision of NHS healthcare, either to patients and charged to the Primary Care Trusts (PCTs) via the local delivery plan (LDP), or where healthcare related services are provided to other Trusts, Foundations Trusts, Strategic Health Authorities (SHAs) and PCTs and charged at service level agreement (SLA) prices.

The Operational Healthcare segment comprises the five clinical Operations Groups (Emergency Services, Planned Inpatient Care, Ambulatory Care, Clinical Support, and Women's and Children's Services). These Operations Groups have been agregated into a single operating segment because they have similar economic characteristics, the nature if the services they offer are the same (free NHS care), they have similar customers (the general public from the surrounding geographical areas) and have the same regulators (Monitor, Care Quality Commission and the Department of Health. The overlapping activities and interrlation between the Groups also suggests that aggreggation is applicable. The Group Operations Directors report to the COO, and it is the COO that ultimately makes decisions alongside the Finance Director about the allocations of budgets, capital funding and other financial decsions. The income the Trust earns for the operaitonal healthcare activity is not allocated out to the operational groups on a monthly basis.

The costs associated with the activities of the Operational Groups are the costs of providing these healthcare services, including running the wards, theatres and clinics where these services are provided and mostly comprise staffing costs, drugs and medical consumables and supplies. In addition, the capital costs of the Trust are included in this segment as the majority of the value of the estate and equipment relates to the assets required to provide healthcare services.

The PCTs account for more than 95% of the income of Operational Healthcare and the majority of the income is from the West Midlands.

The Research and Development segment refers to the activities of the Trust that focus specifically on pioneering developments and researching innovations and advancements in healthcare provision. The R&D directorate is funded by grants and income from commercial bodies, such as pharmaceutical companies, research organisations, medical charities and the Department of Health. The activities it conducts include medical trials, data analysis and writing medical journals and papers. The costs of the segment are mostly staffing costs and medical supplies costs and are distinctly identifiable from other Trust costs. Indirect overheads of Trust corporate departments are not included within these numbers.

NOTES TO THE ACCOUNTS

Because the Trust's assets are only reported at a consolidated level to Finance Committee and Trust Board it is not possible to separate them by segment.

Reconciliation between segments and Trustwide results

Income	**2009/10 £000**	**2008/09 £000**
Segmental income	526,344	492,701
Corporate and facilities income	15,594	14,735
Trustwide income	**541,938**	**507,436**

Surplus	**2009/10 £000**	**2008/09 £000**
Segmental surplus	73,227	90,733
Corporate and facilities deficits	(63,121)	(68,889)
Impairments	(16,550)	(651)
Trustwide surplus / (deficit)	**(6,444)**	**21,193**

The corporate and facilities departments are those that provide support services the the Operational Healthcare segment.

The facilities departments include catering (provisions to patients, staff and visitors), car parking (patients, staff and visitors), portering, cleaning services, post, and estates management. The corporate departments include the Board of Directors, Corporate Nursing, Finance, Human Resources and Organisational Development, Information Communications and Technology (ICT), Corporate Affairs, and Governance. The costs of the corporate departments are primarily staffing costs, insurance costs and legal and consultancy costs.

Although the corporate and facilities departments earn some income, this is ancillary to the main purpose of the department and is small relative to the size of the Trust, so is not deemed to be a segment of its own.

NOTES TO THE ACCOUNTS

Note 2.2 Operating Income

	2009/10 Total £000	2008/09 Total £000
Income from activities (See Note 2.2.1 below)	**483,974**	458,030
Other operating income (See Note 2.6)	**57,964**	49,406
TOTAL	**541,938**	**507,436**

Note 2.2.1 Income from activities

	2009/10 Total £000	2008/09 Total £000
NHS Foundation Trusts	**0**	0
NHS Trusts	**0**	60
Strategic Health Authorities	**0**	502
Primary Care Trusts	**479,613**	416,145
Local Authorities	**0**	675
Department of Health - grants	**0**	0
Department of Health - (MFF from DOH)	**0**	35,947
NHS Other	**1,203**	1,252
Non NHS: Private patients	**559**	570
Non-NHS: Overseas patients (non-reciprocal)	**97**	58
NHS injury scheme (was RTA)	**2,502**	2,821
TOTAL	**483,974**	**458,030**

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

The Department of Health income in 2008/09 was for market forces factor which was paid directly by PCTs in 2009/10, amounting to £18,893k. The uplift in 2009/10 was 5.7% (2008/09 12.8%).

Note 2.3 Mandatory and non-mandatory split of income from activities

Of the total income from activities, £480,816k (2008/09 £452,313k) is mandatory and £3,158k (2008/09 £5,717k) is non-mandatory income.

NOTES TO THE ACCOUNTS

Note 2.4 Private Patient Income

	2009/10 £000	2008/09 £000	Base Year £000
Private patient income	**559**	570	506
Total patient related income	**483,974**	458,030	257,459
Proportion (as percentage)	**0.12%**	**0.12%**	**0.20%**

The private patient cap has not been exceeded in 2009/10. The private patient cap percentage 0.20% was calculated in 2003/04 as the percentage of the Trusts patient related income generated by private patient income. Section 44 of the 2006 National Health Service Act requires that the proportion of private patient income to the total patient related income of the Foundation Trust should not exceed its proportion whilst the body was an NHS Trust in 2002 /03 or the base year.

New guidance on how private patient income should be operated by Foundation Trusts has been issued by Monitor. This comes into effect from 1 April 2010, and therefore does not impact on income received in 2009/10.

Note 2.5 Operating Lease Income

	2009/10 Total £000	2008/09 Total £000
Operating Lease Income		
Rents recognised as income in the period	**53**	55
Contingent rents recognised as income in the period	**0**	0
TOTAL	**53**	**55**
Future minimum lease payments due		
not later than one year;	**53**	53
later than one year and not later than five years;	**27**	80
later than five years.	**0**	0
TOTAL	**80**	**133**

The Trust leases the Clinical Waste Facility based at the Yardley Green Road site to Britcare. The lease is for a period of 10 years ending October 2011 and the contracted rental payment per annum is £40k and is subject to annual review.

NOTES TO THE ACCOUNTS

Note 2.6 Other Operating Income

	2009/10 Total £000	2008/09 Total £000
Research and development	**3,154**	2,361
Education and training	**20,349**	18,431
Transfer from donated asset reserve in respect of	**715**	548
Non-patient care services to other bodies	**21,087**	18,204
Car parking income	**3,816**	3,415
Staff recharges	**460**	1,091
Staff accomodation rentals	**158**	152
Clinical excellence awards	**1,316**	1,284
Catering income	**153**	248
Property rentals	**557**	779
Other	**6,199**	2,893
TOTAL	**57,964**	**49,406**

Car Parking includes £776k (2008/09 £617k) of income from charging staff who park on Trust Premises. Car parking income covers the cost of the car park and security staff, ground maintenance, services and utility and capital charges. The Trust does not make a surplus on this income.

Other income for 2009/10 of £6.2m (2008/09 £2.9m) includes £2m in respect of compensation received from a contractor on the Good Hope Hospital treatment centre, £1.8m in respect of charges levied on local authorities for delayed discharges from care and £1.1m in respect of income for the Trust's medical illustration department.

Property rentals of £557k (2008/09 £779k) comprises a number of agreements with third party organisations of both a formal and informal nature for the rental of Trust space. This is broken down as follows:

	£000
Sterilisation Services	80
Clinical waste services (Britcare see note 2.5)	53
Local Authority Social Service teams	57
PCT - community service wards	181
Other PCT use of space	139
Other commercial organisations	47
	557

NOTES TO THE ACCOUNTS

Note 3.1 Operating Expenses

	2009/10 Total £000	2008/09 Total £000
Employee Expenses (1)	**335,500**	319,702
Drug costs	**36,753**	31,906
Supplies and services - clinical (excluding drug costs)	**55,081**	48,475
Supplies and services - general	**15,888**	14,843
Establishment	**5,799**	6,053
Research and development (2)	**1,960**	1,192
Transport	**920**	985
Premises	**20,215**	20,270
Increase/(decrease) in bad debt provision	**4,465**	631
Other impairment of financial assets	**0**	0
Depreciation on property, plant and equipment	**19,915**	16,575
Amortisation on intangible assets	**679**	146
Impairments of property, plant and equipment (3)	**16,550**	651
Reversal of impairments of property, plant and equipment	**0**	0
Audit fees (4)		
audit services - statutory audit	**118**	136
audit services - regulatory reporting	**4**	0
Other auditors remuneration		
further assurance services	**0**	17
other services (4)	**39**	0
Clinical negligence	**8,897**	5,169
Loss on disposal of investments	**0**	0
Loss on disposal of intangible fixed assets	**0**	0
Loss on disposal of land and buildings	**0**	0
Loss on disposal of other property, plant and equipment	**0**	51
Legal fees	**1,388**	457
Consultancy costs	**5,646**	4,712
Training, courses and conferences	**1,499**	1,420
Patient travel	**2,392**	2,420
Car parking and Security	**817**	787
Redundancy	**274**	0
Early retirements	**519**	0
Hospitality	**190**	272
Publishing	**117**	71
Insurance	**766**	585
Other services	**1,972**	571
Losses, ex gratia and special payments	**48**	47
Other	**1,215**	1,798
TOTAL	**539,626**	**479,942**

(1) Employee Expenses is broken down as follows:

Executive Directors	**1,359**	1,418
Non Executive Directors	**166**	167
Staff	**333,975**	318,117
	335,500	**319,702**

(2) All of the research and development expenditure is current year expenditure.

(3) Relates to the revaluation of assets. Further details can be found in note 9.6.

(4) The audit fee of £122k (2008/09 136k) relates to statutory and regulatory audit external work. Other audit services of £39k (2008/09 £0k) were provided as part of a best practice procurement review. Further assurance services of £17k in 2008/09 was in respect of the IFRS opening balance conversion.

Note 3.2 Operating Lease Payments

	2009/10 Total £000	**2008/09 Total £000**
Minimum lease payments	**948**	1,000
Contingent rents	**0**	0
Less sublease payments received	**0**	0
TOTAL	**948**	**1,000**

	31 Mar 10 £000	**31 Mar 09 £000**
Future minimum lease payments due:		
not later than one year;	**853**	844
later than one year and not later than five years;	**1,676**	1,712
later than five years.	**805**	630
TOTAL	**3,334**	**3,186**

The Trust holds various non-cancellable operating lease agreements within a lease portfolio which covers assets including medical equipment, vehicles, photocopying equipment and several short term leasehold buildings.

There are currently 23 lease agreements in place for various items of medical equipment ranging from electric profiling beds to CT scanners. The length of these leases ranges between five to ten years. In addition, there are five operating contracts in place for the lease of buildings which includes three Renal dialysis units, an Outpatient clinic facility in Solihull Mell Square and a ward at Good Hope. These lease agreements range from five to twenty years in duration.

The Trust uses nine Lessors to provide various items of photocopying equipment. These leases are all five years in duration and the payments made during 2009/10 were £67k. (2008/09 £69k)

There are also several contracts in place for leased vehicles across all three hospital sites. These lease terms all terminate no later than 2011/12. The total lease payments made during 2009/10 were £33k (2008/09 £43k) with an additional £26k being due for the remaining life of the leases (2008/09 £51k).

The Trust has not paid for the outpatient clinic facility contingent rent during the 2009/10 financial year. Within the lease held with Boots UK Limited there is a requirement to achieve a contractual level of footfall within the facility and contingent rents for failing to achieve this are payable at £1 for every unit below the target. The maximum potential contingent rent exposure to the Trust is £61k.

The Trust utilises Leaseguard to support the renewal of the majority of the lease portfolio. The Trust does not have pre-determined purchase options written into the current lease agreements, but the right to purchase the leased assets is assessed at the decision point within each lease.

NOTES TO THE ACCOUNTS

Note 3.3 Salary And Pension Entitlements Of Senior Managers

A) Remuneration

Name and Title	2009-10			2008-09		
	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)	240-245	0	0	235-240	0	0
Mandy Coalter (HR Director)	150-155	0	0	145-150	0	0
Hugh Rayner (Medical Director Medicine up to 30 Jun 09)	20-25	5-10	0	115-120	50-55	0
Ian Cunliffe (Medical Director)	135-140	55-60	0	140-145	60-65	0
Sarah Woolley (Director of Safety and Governance)	140-145	0	0	135-140	0	0
Adrian Stokes (Director of Finance) (w.e.f. 1 Aug in 2008/09)	140-145	0	0	95-100	0	0
Mandie Sunderland (Chief Nurse) (w.e.f. 1 Dec in 2008/09)	130-135	0	0	40-45	0	0
Ellen Ryabov (Chief Operating Officer w.e.f. 01 Jul 09)	80-85	0	0	0	0	0
Beccy Fenton (Deputy Chief Executive and Director of Transformation)	205-210	0	0	175-180	0	0
Clive Wilkinson (Chairman)	50-55	0	0	45-50	0	0
Anna East (Non Executive Director)	15-20	0	0	15-20	0	0
Richard Samuda (Non Executive Director)	15-20	0	0	15-20	0	0
Richard Harris (Non Executive Director) (w.e.f. 1 May in 2008/09)	10-15	0	0	10-15	0	0
Paul Hensel (Non Executive Director)	10-15	0	0	10-15	0	0
Najma Hafeez (Non Executive Director)	10-15	0	0	10-15	0	0
Chris Ham (Non Executive Director)	10-15	0	0	10-15	0	0
David Bucknall (Non Executive Director)	10-15	0	0	15-20	0	0

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

Under IAS 24 (Related Party Disclosures) the Trust is required to disclose employment benefits of its key management personnel. In previous years the Trust has disclosed information about Trust Board members who have the right to a vote at Trust Board. The definition of key management personnel is somewhat broader and the Trust has examined the authority and responsibilities of several other members of staff employed by the Trust. The Trust has concluded that Beccy Fenton should also be disclosed as a member of the key management personnel cohort. Beccy Fenton is a member of Trust Board though she does not have a vote. However, her position as Deputy Chief Executive indicates that disclosure is required in respect of her employment benefits. As such Beccy Fenton is included within this note for current and prior year.

Under IAS 24 (Related Party Disclosures) there are additional disclosure requirements for all key management personnel. This additional disclosure is made in note 25.3.

Total Directors' Remuneration	**2009/10 Total £000**	**2008/09 Total £000**
Salary and Allowances	**1,611**	1,485
Compensation for loss of office	**0**	0
Value of non cash benefits	**0**	0
	1,611	**1,485**

NOTES TO THE ACCOUNTS

Note 3.3 Salary And Pension Entitlements Of Senior Managers (cont'd)

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 2010 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2010 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2010 £000	Cash Equivalent Transfer Value at 31 March 2009 £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension To nearest £100
Mark Goldman (Chief Executive)	2.5-5.0	7.5-10.0	105-110	320-325	2,657	2,439	110	0
Mandy Coalter (HR Director)	0.0-2.5	5.0-7.5	20-25	70-75	310	264	28	0
Ian Cunliffe (Medical Director)	0.0-2.5	0.0-2.5	50-55	150-155	908	838	34	0
Hugh Rayner (Medical Director Medicine up to 30.06.10)	0.0-2.5	2.5-5.0	45-50	135-140	1,011	825	29	0
Sarah Woolley (Director of Safety and Governance)	0.0-2.5	5.0-7.5	20-25	65-70	293	242	31	0
Adrian Stokes (Director of Finance)	0.0-2.5	5.0-7.5	20-25	65-70	318	266	32	0
Mandie Sunderland (Chief Nurse)	2.5-5.0	10.0-12.5	35-40	105-110	606	507	60	0
Beccy Fenton (Deputy Chief Executive and Director of Transformation)	0.0-2.5	5.0-7.5	20-25	65-70	310	264	28	0
Ellen Ryabov (Chief Operating Officer w.e.f. 01.07.10)	10.0-12.5	30.0-32.5	25-30	80-85	499	232	138	0

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

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

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

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

NOTES TO THE ACCOUNTS

Note 4.1 Employee Expenses

	2009/10 Total £000	2009/10 Permanent £000	2009/10 Other £000	2008/09 Total £000
Salaries and wages	**275,915**	275,915	0	256,098
Social security costs	**18,969**	18,969	0	19,324
Pension costs - employers contributions to NHS Pensions	**27,417**	27,417	0	28,078
Pension Cost - other contributions	**0**	0	0	0
Termination benefits	**0**	0	0	0
Agency/contract staff	**13,826**	0	13,826	16,035
TOTAL	**336,127**	**322,301**	**13,826**	**319,535**

Total employee expenses does not include non executive director costs but includes redundancy and early retirement costs as disclosed in note 3.1

Note 4.2 Average number of employees (whole time equivalent)

	2009/10 Number	2008/09 Number
Medical and dental	**913**	878
Ambulance staff	**0**	0
Administration and estates	**1,950**	1,919
Healthcare assistants and other support staff	**1,358**	1,308
Nursing, midwifery and health visiting staff	**2,794**	2,768
Nursing, midwifery and health visiting learners	**0**	0
Scientific, therapeutic and technical staff	**1,196**	1,187
Social care staff	**0**	0
Bank and agency staff	**219**	261
Other	**0**	0
TOTAL	**8,430**	**8,321**

Note 4.3 Employee benefits in kind

There were no employee benefits in kind in 2009/10 or 2008/09.

Note 4.4 Early retirements due to ill health

	2009/10	2008/09
No of early retirements on the grounds of ill-health	10	18
Value of early retirements on the grounds of ill-health (£000)	604	1,298

The cost of these ill health retirements will be borne by the NHS Business Services Authority (Pensions Division).

NOTES TO THE ACCOUNTS

Note 4.5 Staff sickness absence

	2009/10 Number	2008/09 Number
Days lost (long term)	68,609	58,206
Days lost (short term)	57,411	54,499
Total days lost	126,020	112,705
Total staff years	8,211	8,342
Average working days lost	15	14
Total staff employed in period (headcount)	9,348	9,603
Total staff employed in period with no absence (headcount)	2,997	3,188
Percentage staff with no sick leave	32.1%	33.2%

Note 4.6 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.pensions.nhsbsa.nhs.uk. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date.

The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the scheme actuary reported that employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008, the vast majority of employees paid contributions at the rate of 6% of pensionable pay. From 1 April 2008, employees contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

NOTES TO THE ACCOUNTS

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2008, is based on detailed membership data as at 31 March 2006 (the latest midpoint) updated to 31 March 2008 with summary global member and accounting data.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

The scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement, less pension already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die after retirement, is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the statement of comprehensive income at the time the Trust commits itself to the retirement, regardless of the method of payment.

The scheme provides the opportunity to members to increase their benefits through money purchase additional voluntary contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee/member can make contributions to enhance an employee's pension benefits. The benefits payable relate directly to the value of the investments made.

Note 5 Better Payment Practice Code

Better Payment Practice code-measure of compliance

	Number 2009/10	Value 2009/10	Number 2008/09	Value 2008/09
		£000		£000
Total bills paid in the year	**136,949**	154,964	158,611	159,153
Total bills paid within target	**126,537**	142,846	144,230	147,274
Percentage of bills paid within target	**92%**	92%	91%	93%

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.

NOTES TO THE ACCOUNTS

Note 6 Finance income

	2009/10 £000	2008/09 £000
Interest on loans and receivables	1,739	4,915
Interest on available for sale financial assets	0	0
Interest on held-to-maturity financial assets	0	0
TOTAL	**1,739**	**4,915**

The interest receivable arose from interest earned in the main current account and from surplus cash placed in commercial deposit accounts and in bank bonds.

Note 7.1 Finance costs	2009/10 £000	2008/09 £000
Finance leases	172	178
Finance Costs in PFI obligations:		
Main Finance Costs	181	150
Contingent Finance Costs	0	0
Other	0	0
TOTAL	**353**	**328**

The Trust holds three Finance lease contracts all of which relate to building assets and in duration range from 25 years to 99 years. The buildings held under finance lease are the Birmingham Chest Clinic, The Glaxo renal Unit and the Heartlands Education Centre Ltd. Within these agreements the Trust does not have a contingent rent liability and does not have any outstanding sublease payments to be received.

The finance lease contracts held by the Trust do not contain any potential for the Trust to be exposed to contingent rent liabilities. The Birmingham Chest Clinic lease does not contain an option to purchase the building due to the part occupancy nature of the tenancy. The Heartlands Education Centre reverts to Trust ownership at the end of the lease term.

The finance leases held by the Trust do not restrict the Trust in any way due to relatively small size and structure of the borrowing.

Note 7.2 Impairment of Property, Plant and Equipment Assets

	2009/10 £000	2008/09 £000
Loss or damage from normal operations	0	0
Loss as a result of catastrophe	0	0
Abandonment of assets in course of construction	0	0
Unforeseen obsolescence	0	0
Over specification of assets	0	0
Other	0	43,115
Changes in market price	39,036	18,584
TOTAL	**39,036**	**61,699**

These impairments are a result of valuations as at 1 April 2009 and 31 March 2010. Note 9.6 includes additional information.

NOTES TO THE ACCOUNTS

Note 8.1 Intangible assets 2009/10

	Total	Software licences (purchased)	Licences & trademarks (purchased)	Other (purchased)	Intangible Assets Under Construction
	£000	£000	£000	£000	£000
Gross cost at 1 April 2009	**5,051**	5,051	0	0	0
Impairments charged to revaluation reserve	**0**	0	0	0	0
Reclassifications	**1,029**	90	0	0	939
Revaluation surpluses	**0**	0	0	0	0
Additions - purchased	**263**	28	0	0	235
Additions - donated	**7**	7	0	0	0
Transfered to disposal group as asset held for sale	**0**	0	0	0	0
Disposals	**0**	0	0	0	0
Gross cost at 31 March 2010	**6,350**	5,176	0	0	1,174
Amortisation at 1 April 2009	**3,096**	3,096	0	0	0
Provided during the year	**679**	679	0	0	0
Impairments recognised in the income and expenditure account	**0**	0	0	0	0
Reversal of impairments recognised in the income and expenditure account	**0**	0	0	0	0
Reclassifications	**0**	0	0	0	0
Revaluation surpluses	**0**	0	0	0	0
Transferred to disposal group as asset held for sale	**0**	0	0	0	0
Disposals	**0**	0	0	0	0
Amortisation at 31 March 2010	**3,775**	3,775	0	0	0
Net book value					
NBV - Purchased at 1 April 2009	**1,939**	1,939	0	0	0
NBV - Donated at 1 April 2009	**16**	16	0	0	0
NBV total at 1 April 2009	**1,955**	1,955	0	0	0
Net book value					
NBV - Purchased at 31 March 2010	**2,556**	1,382	0	0	1,174
NBV - Donated at 31 March 2010	**19**	19	0	0	0
NBV total at 31 March 2010	**2,575**	1,401	0	0	1,174

The intangible asset base held by the Trust is currently valued using a depreciated cost model due to the individually low value of the assets and also due to the lack of evidence to suggest a fall in value. In accordance with paragraph 7.2.5 of the Foundation Trust Annual Reporting Manual (2009/10), an active market does not exist and, as the Trusts intangibles are not income generating the depreciated replacement cost model has been applied.

The Trust's intangible asset base has a finite life ranging from five to ten years and each asset is being amortised over this period. The Trust does not hold intangible assets funded by government grants and all are purchased rather than internally generated.

NOTES TO THE ACCOUNTS

Note 8.2 Intangible assets 2008/09

	Total	Software licences (purchased)	Licences & trademarks (purchased)	Other (purchased)	Intangible Assets Under Construction
	£000	£000	£000	£000	£000
Gross cost at 1 April 2008	**3,945**	3,945	0	0	0
Impairments charged to revaluation reserve	**0**	0	0	0	0
Reclassifications	**1,087**	1,087	0	0	0
Revaluation surpluses	**0**	0	0	0	0
Additions - purchased	**19**	19	0	0	0
Additions - donated	**0**	0	0	0	0
Transferred to disposal group as asset held for sale	**0**	0	0	0	0
Disposals	**0**	0	0	0	0
Gross cost at 31 March 2009	**5,051**	5,051	0	**0**	**0**
Amortisation at 1 April 2008	**1,187**	1,187	0	0	0
Provided during the year	**146**	146	0	0	0
Impairments recognised in the income and expenditure account	**0**	0	0	0	0
Reversal of impairments recognised in the income and expenditure account	**0**	0	0	0	0
Reclassifications	**1,763**	1,763	0	0	0
Revaluation surpluses	**0**	0	0	0	0
Transferred to disposal group as asset held for sale	**0**	0	0	0	0
Disposals	**0**	0	0	0	0
Amortisation at 31 March 2009	**3,096**	3,096	0	**0**	**0**
Net book value					
NBV - Purchased at 1 April 2008	**2,738**	2,738	0	0	0
NBV - Donated at 1 April 2008	**20**	20	0	0	0
NBV total at 1 April 2008	**2,758**	2,758	0	**0**	**0**
Net book value					
NBV - Purchased at 31 March 2009	**1,939**	1,939	0	0	0
NBV - Donated at 31 March 2009	**16**	16	0	0	0
NBV total at 31 March 2009	**1,955**	1,955	0	0	0

NOTES TO THE ACCOUNTS

Note 9.1 Property, plant and equipment 2009/10

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2009	**416,181**	53,175	215,968	3,861	21,199	82,459	1,013	28,172	10,334
Additions - purchased	**23,159**	0	8,492	0	9,530	3,498	0	1,649	(10)
Additions - donated	**162**	0	0	0	0	153	0	0	9
Impairments charged to revaluation reserve	**(22,121)**	0	(21,938)	(183)	0	0	0	0	0
Reclassifications	**(1,029)**	0	15,209	0	(20,659)	1,805	0	2,579	37
Revaluation surpluses	**(27,455)**	0	(27,393)	(62)	0	0	0	0	0
Disposals	**(31,245)**	0	0	0	0	(28,471)	(320)	(2,426)	(28)
Cost or valuation at 31 March 2010	**357,652**	53,175	190,338	3,616	10,070	59,444	693	29,974	10,342
Accumulated depreciation at 1 April 2009	**86,625**		0	0		55,387	719	21,317	9,202
Provided during the year	**19,915**		10,738	125		6,265	63	2,580	144
Impairments recognised in operating expenses	**16,550**		16,546	4		0	0	0	0
Reversal of impairments	**0**		0	0		0	0	0	0
Reclassifications	**0**		0	0		0	0	0	0
Revaluation surpluses	**(27,413)**		(27,284)	(129)		0	0	0	0
Disposals	**(31,245)**		0	0		(28,471)	(320)	(2,426)	(28)
Accumulated depreciation at 31 March 2010	**64,432**	0	0	0	0	33,181	462	21,471	9,318
Net book value									
NBV - Owned at 1 April 2009	**316,723**	53,175	204,544	3,861	21,199	25,747	294	6,801	1,102
NBV - Finance lease at 1 April 2009	**8,810**	0	8,810	0	0	0	0	0	0
NBV - Donated at 1 April 2009	**4,023**	0	2,614	0	0	1,325	0	54	30
NBV total at 1 April 2009	**329,556**	53,175	215,968	3,861	21,199	27,072	294	6,855	1,132
Net book value									
NBV - Owned at 31 March 2010	**282,432**	53,175	180,510	3,616	10,070	25,351	231	8,490	989
NBV - Finance lease & PFI Assets at 31 March 2010	**7,605**	0	7,605	0	0	0	0	0	0
NBV - Donated at 31 March 2010	**3,183**	0	2,223	0	0	912	0	13	35
NBV total at 31 March 2010	**293,220**	53,175	190,338	3,616	10,070	26,263	231	8,503	1,024

Note 9.2 Analysis of property, plant and equipment 31 Mar 2010

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value									
NBV - Protected assets at 31 March 2010	**208,715**	53,175	155,481	59					
NBV - Unprotected assets at 31 March 2010	**84,505**	0	34,857	3,557	10,070	26,263	231	8,503	1,024
Total at 31 March 2010	**293,220**	53,175	190,338	3,616	10,070	26,263	231	8,503	1,024

The categorisation of assets as either protected or unprotected has been made in accordance with the guidance issued by MONITOR in the document "Protection of Assets – Guidance for NHSFT's"

Condition 9 of the Trust's Term of Authorisation defines a protected asset as "…protected if it is required for the purposes of providing either the mandatory goods or services or the mandatory education and training as defined in the Terms of Authorisation." Examples of protected assets for the Trust include Accident & Emergency departments, ward blocks and Theatres. Unprotected assets include and Devon House and other office areas.

NOTES TO THE ACCOUNTS

Note 9.3 Property, plant and equipment 2008/09

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2008	**411,568**	70,615	213,864	5,296	9,702	74,880	962	26,449	9,800
Additions - purchased	**30,320**	0	1,674	0	24,535	2,864	52	1,054	141
Additions - donated	**95**	0	0	0	0	90	0	0	5
Impairments charged to revaluation reserve	**(19,316)**	(17,440)	(1,876)	0	0	0	0	0	0
Reclassifications	**(1,087)**	0	6,676	(1,609)	(13,038)	5,822	(1)	675	388
Revaluation surpluses	**(4,196)**	0	(4,370)	174	0	0	0	0	0
Disposals	**(1,203)**	0	0	0	0	(1,197)	0	(6)	0
Cost or valuation at 31 March 2009	**416,181**	53,175	215,968	3,861	21,199	82,459	1,013	28,172	10,334
Accumulated depreciation at 1 April 2008	**83,095**		0	0		52,769	659	20,688	8,979
Provided during the year	**16,575**		9,944	197		3,753	60	2,398	223
Impairments recognised in operating expenses	**651**		347	304		0	0	0	0
Reversal of impairments	**0**		0	0		0	0	0	0
Reclassifications	**(1,763)**		0	0		0	0	(1,763)	0
Revaluation surpluses	**(10,792)**		(10,291)	(501)		0	0	0	0
Disposals	**(1,141)**		0	0		(1,135)	0	(6)	0
Accumulated depreciation at 31 March 2009	**86,625**	0	0	0	0	55,387	719	21,317	9,202
Net book value									
NBV - Owned at 1 April 2008	**316,015**	70,615	203,739	4,818	9,702	20,346	303	5,691	801
NBV - Finance Lease at 1 April 2008	**8,810**	0	8,810	0	0	0	0	0	0
NBV - Donated at 1 April 2008	**3,648**	0	1,315	478	0	1,765	0	70	20
NBV total at 1 April 2008	**328,473**	70,615	213,864	5,296	9,702	22,111	303	5,761	821
Net book value									
NBV - Purchased at 31 March 2009	**316,723**	53,175	204,544	3,861	21,199	25,747	294	6,801	1,102
NBV - Finance Lease & PFI Assets at 31 March 2009	**8,810**	0	8,810	0	0	0	0	0	0
NBV - Donated at 31 March 2009	**4,023**	0	2,614	0	0	1,325	0	54	30
NBV total at 31 March 2009	**329,556**	53,175	215,968	3,861	21,199	27,072	294	6,855	1,132

Note 9.4 Analysis of property, plant and equipment 31 Mar 2009

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value									
NBV - Protected assets at 31 March 2009	**230,374**	53,175	176,572	627					
NBV - Unprotected assets at 31 March 2009	**99,182**	0	39,396	3,234	21,199	27,072	294	6,855	1,132
Total at 31 March 2009	**329,556**	53,175	215,968	3,861	21,199	27,072	294	6,855	1,132

Note 9.5 Analysis of property, plant and equipment 01 Apr 2008

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value									
NBV - Protected assets at 01 April 2008	**242,371**	70,615	171,498	258					
NBV - Unprotected assets at 01 April 2008	**86,102**	0	42,366	5,038	9,702	22,111	303	5,761	821
Total at 01 April 2008	**328,473**	70,615	213,864	5,296	9,702	22,111	303	5,761	821

NOTES TO THE ACCOUNTS

Note 9.6 Property Plant and Equipment Revaluations in 2009/10

The District Valuation Service has carried out the current valuation as at 31st March 2010 of the Trust's Land, Buildings and in accordance with the terms of the Royal Institution of Chartered Surveyors' Valuation Standards, 6TH Edition, the requirements of HM Treasury and IAS 16 Property Plant and Equipment. Public sector bodies including the NHS are required to apply the Revaluation model set out in IAS 16 and value their capital assets to fair value.

Fair value is defined in IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction.

The assessment of fair value has been made on the assumption that the property is sold as part of the continuing enterprise in occupation (Existing Use Value).

Non-specialised operational assets

The basis used for the valuation of non-specialised operational Trust-occupied property for accounting purposes under IAS 16 is fair value, which is the market value, subject to the assumption that the property is sold as part of the continuing enterprise in occupation.

Specialised operational Property

Depreciated Replacement Cost (DRC) is the valuation approach adopted for reporting the value of specialised operational property for financial accounting purposes. The Royal Institute of Chartered Surveyors Standards at Appendix 4.1, restating International Valuation Application 1 (IVA 1) defines this as *"the current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all relevant forms of obsolescence and optimisation."*

Revaluation Losses 2009/10

Downwards movements to the Revaluation Reserve include the following assets whereby the impairment value was more than £1m (2009/10):

Building	Impairment £'000
Heartlands Accident & Emergency Department	1,758
Good Hope Richard Salt Unit	1,332
Heartlands Day Hospital	1,327
Good Hope Treatment Centre	1,237
Heartlands Outpatient Department	1,148

Revaluation Losses not covered by the Revaluation Reserve and so recognised in Operating Expenses include the following which are valued over £1m (2009/10):

Building	Impairment £'000
MIDRU / Diabetes Centre	6,304
Heartlands Theatres	1,378
Heartlands Cardiology / Thoracic	1,327

The impairments shown above have been recognised following the revaluation exercise conducted by the District Valuation Service. The impairments have arisen due to the fall in value of specialised property arising as a result of changes in market conditions and therefore do not relate to the movement in economic value or value in use of those assets. The reduction in value for the Trust overall is consistent with the movement in valuation indices for the region.

All of the assets with the exception of the R&D parts of the MIDRU / Diabetes Centre relate to the Trusts Operational Healthcare segment. Approximately 50% of the MIDRU / Diabetes Centre is used within the Research & Development operating segment.

The Trust has carried out two valuations in year:

(a) Valuation performed as at 1st April 2009 to value assets on an MEAV basis and

(b) Valuation performed as at 31st March 2010 to update the values for changes in the financial year.

NOTES TO THE ACCOUNTS

The previous revaluation at the Trust was carried out at 31st March 2008 using value in use as the approach for valuing specialised properly. Therefore, the difference in valuation between 31st March 2008 and 1st April 2009 was attributable to two factors:

(a) Change in valuation methodology
(b) Change in price/value of the assets

The part of the change that was due to change in valuation methodology has been accounted for as a prior period adjustment as at 1st April 2008, shown in the Statement of Changes in Taxpayers Equity and in the PPE statement.

The reduction in cost of £20,183k was charged to the revaluation reserve (£14,830k), the donated asset reserve £1,045k and the Income and Expenditure reserve (£6,398k).

Had this reduced cost value been changed as at 1st April 2008 it would have resulted in a lower depreciation charge by £2,262k. This is showing in the other transfers between reserves in the Statement of Changes in Taxpayers Equity.

The Income and Expenditure reserve amount reflects where assets valuation reduction was in excess of reserves held, so if the valuation was being processed in the 2007/08 year would have resulted in a charge to the Statement of Comprehensive Income.

The element of the valuation that related to the change in price between 31st March 2008 (£13,371k) and 1st April 2009 has been shown as a prior period adjustment in the 2008/09 year.

This is split between the reduction in revaluation reserve (£12,699k), donated assets reserve (£21k) and the Income and Expenditure reserve (£653k) in the Statement of Changes in Taxpayers Equity.

The revaluation that took place as at 31st March 2010 showed a reduction of (£38,713k) in value. Of this, £22,163k is shown in the other comprehensive income section and is split between charges to the revaluation reserve of £21,872k and of £291k to the donated assets reserve. The remaining charge of £16,698k has been charged to the Statement of Comprehensive Income. This is the net of impairments due to decreases (£39,036k as shown in note 7.2) and increases of £323k.

Note 9.7 Leased Assets to Other Organisations

The carrying amount of the assets leased to other organisations as at 31st March 2010 is £295k. (£361k 2008/09). The depreciation charged during 2009/10 was £6k. Upon revaluation as at 31st March 2010 the impairment loss recognised to revaluation reserve was £41k leaving a nil balance in the revaluation reserve for this asset.

Note 9.8 Donated Assets

Donated additions in year consist of the following:

DESCRIPTION	DESCRIPTION	COST £k
GHH Cardiac Care Unit	Ambulift Classic Mobile M	5.4
Paul Winter Charitable fund	Odfs111 Dropped Foot Stimulator Kit	7.1
Resuscitation Training	Resusci Anne Advanced Skill Trainer	8
Resuscitation Training	Resusci Anne Advanced Skill Trainer	7.6
Mat unit obstetric ultrasound	EBC-RS Probe	5.6
BHH Urology	Cuda 180w Xenon Lightsource	6.1
Ward 19 Heartlands	Labcold BS Blood Bank 68 Bag	5.8
Doris Burgess Fund	Eleganza Smart Bed	6
GHH Hollier Charity	Manniquin – Hollier Simulation Centre	40.7
Doris Burgess Fund	Standing Frame- Classic Electric	5.4
Renal Unit	ICE LabComm EDI Links	7.4
Doris Burgess Fund	Propaq LT 3 Lead Ecg Respiration Patient Monitor	37
Bacteriology-pathology	Fastprep-24 Instrument	6.1
Fibre Optic Course/ITU	LF-GP Intubating Fiberscope	12
Maternity Neonatal	Racking System	9
TOTAL DONATED ASSETS 09/10		**169.2**

NOTES TO THE ACCOUNTS

Note 10.1 Assets held under finance leases and PFI arrangements 2009/10

	Total Finance Lease and PFI Assets	Buildings excluding dwellings held under Finance Lease	PFI arrangements
	£000	£000	£000
Cost or valuation at 1 April 2009	**8,810**	**3,426**	**5,384**
Additions - purchased	**0**	0	0
Impairments charged to revaluation reserve	**(884)**	(119)	(765)
Revaluation surpluses	**(321)**	(321)	0
Disposals	**0**	0	0
Cost or valuation at 31 March 2010	**7,605**	**2,986**	**4,619**
Accumulated depreciation at 1 April 2009	**0**	**0**	**0**
Provided during the year	**232**	108	124
Impairments recognised in operating expenses	**0**	0	0
Reversal of impairments	**(11)**	(11)	0
Revaluation surpluses	**(221)**	(97)	(124)
Disposals	**0**	0	0
Accumulated depreciation at 31 March 2010	**0**	**0**	**0**
Net book value			
NBV - Purchased at 1 April 2009	**7,717**	2,333	5,384
NBV - Donated at 1 April 2009	**1,093**	1,093	0
NBV total at 1 April 2009	**8,810**	**3,426**	**5,384**
Net book value			
NBV - Purchased at 31 March 2010	**6,673**	2,054	4,619
NBV - Donated at 31 March 2010	**932**	932	0
NBV total at 31 March 2010	**7,605**	**2,986**	**4,619**

The Trust has two PFI Contracts:-

(1) BHE Heartlands Ltd is a contract to provide a new main entrance and retail facility at Heartlands Hospital. The net book value as at 31 March 2010 is £3,507k (31 March 2009 £3,930)

(2) Energy Combined Power ltd is a contract for the provision of energy management services at Heartlands Hospital. The net book value at 31 March 2010 is £898k (31 March 2009 £1,008k)

Note 18.3 provides more detail on these contracts

NOTES TO THE ACCOUNTS

Note 10.2 Assets held under finance leases and PFI arrangements 2008/9

	Total Finance Lease and PFI Assets	Buildings excluding dwellings held under Finance Lease	PFI arrangements
	£000	£000	£000
Cost or valuation at 1 April 2008	**8,810**	**3,426**	**5,384**
Additions - donated	**0**	0	0
Impairments charged to revaluation reserve	**0**	0	0
Revaluation surpluses	**0**	0	0
Disposals	**0**	0	0
Cost or valuation at 31 March 2009	**8,810**	**3,426**	**5,384**
Accumulated depreciation at 1 April 2008	**0**	**0**	**0**
Provided during the year	**226**	107	119
Impairments recognised in operating expenses	**0**	0	0
Reversal of impairments	**0**	0	0
Revaluation surpluses	**(226)**	(107)	(119)
Disposals	**0**	0	0
Accumulated depreciation at 31 March 2009	**0**	**0**	**0**
Net book value			
NBV - Purchased at 1 April 2008	**7,207**	1,823	5,384
NBV - Donated at 1 April 2008	**1,603**	1,603	0
NBV total at 1 April 2008	**8,810**	**3,426**	**5,384**
Net book value			
NBV - Purchased at 31 March 2009	**7,154**	1,770	5,384
NBV - Donated at 31 March 2009	**1,656**	1,656	0
NBV total at 31 March 2009	**8,810**	**3,426**	**5,384**

Note 11.1 Inventories

	31 Mar 2010	31 Mar 2009	1 Apr 2008
	£000	£000	£000
Materials	**7,029**	6,147	4,750
Work in progress	**0**	0	0
Finished goods	**0**	0	0
Inventories carried at fair value less costs to sell	**0**	0	0
TOTAL	**7,029**	**6,147**	**4,750**

NOTES TO THE ACCOUNTS

Note 12.1 Trade receivables and other receivables

	Total 31 March 2010 £000	Total 31 March 2009 £000	Total 1 April 2008 £000
Current			
NHS Receivables	**27,029**	14,215	15,932
Provision for impaired receivables	**(9,629)**	(5,827)	(7,248)
Prepayments	**3,734**	2,801	4,136
Accrued income	**1,785**	2,950	1,258
PDC receivable (1)	**1,158**	0	0
Other receivables (2)	**6,385**	7,113	6,042
TOTAL	**30,462**	**21,252**	**20,120**
Non-Current			
NHS Receivables	**0**	0	0
Provision for impaired receivables	**(880)**	(847)	(778)
Prepayments	**0**	0	0
Accrued income	**0**	0	0
Other receivables	**2,431**	2,451	2,174
TOTAL	**1,551**	**1,604**	**1,396**

(1) PDC Receivable has arisen because the value of PDC paid in the year was higher than the final calculated value. This is mainly due to the impact of the revaluation as at 31 March 2010, as this decrease in value was not known until after PDC was paid.

(2) Other receivables includes outstanding trade receivables of £5,356k (£3,996k, 2008/09).

Note 12.2 Provision for impairment of receivables

	2009/10 £000	2008/09 £000
At 1 April		
Increase in provision	**6,674**	8,026
Amounts utilised	**4,465**	631
Unused amounts reversed	**(630)**	(1,983)
At 31 March	**10,509**	**6,674**

Note 12.3 Analysis of impaired receivables

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Ageing of impaired receivables			
Up to three months			
In three to six months	**3,946**	3,119	3,100
Over six months	**1,362**	583	805
TOTAL	**5,201**	2,972	4,121
	10,509	**6,674**	**8,026**
Ageing of non-impaired receivables past their due date			
Up to three months			
In three to six months	**2,145**	3,661	1,742
Over six months	**1,688**	289	1,137
TOTAL	**5,920**	308	1,820
	9,753	**4,258**	**4,699**

NOTES TO THE ACCOUNTS

Note 13 Trade and other payables

	Total 31 March 2010 £000	Total 31 March 2009 £000	Total 1 April 2008 £000
Current			
NHS payables (1)	**10,300**	6,830	9,393
Trade payables - Capital	**5,741**	4,966	4,815
Other trade payables	**4,488**	1,504	783
Other payables	**1,087**	850	482
Accruals	**32,939**	26,740	22,961
Total Trade and other payables	**54,555**	**40,890**	**38,434**
Taxes payable	**7,125**	10,372	124
Total Tax payable	**7,125**	**10,372**	**124**
TOTAL	**61,680**	**51,262**	**38,558**

(1) NHS Payables includes £3,737k (£3,643k, 2008/09) relating to outstanding pension contributions.

There were no liabilities to buy out early retirements included above.

There are no non-current trade and other payables in 2009/10 (or in 2008/09 or 2007/08).

Note 14 Other liabilities

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Current			
Deferred Income	**8,652**	3,543	5,307
Deferred PFI credits	**0**	0	0
TOTAL	**8,652**	**3,543**	**5,307**

There are no non-current other liabilities in 2009/10 (or 2008/09, or 2007/08).

Note 15 Borrowings

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Current			
Bank overdrafts	**0**	0	0
Drawdown in committed facility	**0**	0	0
Loans from Foundation Trust Financing Facility	**0**	0	0
Other Loans	**0**	0	0
Obligations under finance leases	**256**	257	257
Obligations under Private Finance Initiative contracts	**224**	224	223
TOTAL	**480**	**481**	**480**
Non-current			
Bank overdrafts	**0**	0	0
Drawdown in committed facility	**0**	0	0
Loans from Foundation Trust Financing Facility	**0**	0	0
Other Loans	**0**	0	0
Obligations under finance leases	**2,159**	2,244	2,297
Obligations under Private Finance Initiative contracts	**3,362**	3,558	3,756
TOTAL	**5,521**	**5,802**	**6,053**

NOTES TO THE ACCOUNTS

Note 16 Prudential borrowing limit

	31 March 2010 £000	31 March 2009 £000
Total long term borrowing limit set by Monitor	**107,000**	102,100
Working capital facility agreed by Monitor	**30,000**	30,000
TOTAL	**137,000**	**132,100**
Long term borrowing at 1 April	**5,802**	6,053
Net actual borrowing/(repayment) in year - long term	**(251)**	(251)
Long term borrowing at 31 March	**5,551**	**5,802**
Working capital borrowing at 1 April	**0**	0
Net actual borrowing/(repayment) in year - working capital	**0**	0
Working capital borrowing at 31 March	**0**	**0**

The Trust is required to comply and remain within a prudential borrowing limit, as set out in Monitor's Prudential Borrowing Code. This limit is made up of two elements;

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

· The amount of working capital facility approved by Monitor.

Further information on the NHS foundation trusts Prudential Borrowing Code and Compliance Framework can be found on Monitor's website.

The Trust has a prudential borrowing limit of £107.0m in 2009/10 (£102.1m in 2008/09). The Trust borrowings of £6.0m are for the Trust's 2 PFI schemes and 3 finance leases only. The Trust has not raised any new borrowings in 2009/10.

Key ratios upon which the Prudential borrowing limit is based

Financial ratio	**Actual ratios 2009/10**	**Actual ratios 2008/09**
Minimum dividend cover	4	5
Minimum interest cover	116	152
Minimum debt service cover	65	79
Maximum debt service to revenue	0	0

Monitor has approved a working capital facility level of £30m (£30m in 2008/09). The Trust has not held a working capital facility agreed with a bank since Janaury 2009 because it holds sufficient surplus cash.

NOTES TO THE ACCOUNTS

Note 17 Finance lease obligations

	Minimum Lease Payments 31 March 2010 £000	Minimum Lease Payments 31 March 2009 £000	Minimum Lease Payments 01 April 2008 £000
Gross lease liabilities	**3,821**	**4,076**	**4,267**
of which liabilities are due			
not later than one year;	**257**	257	257
later than one year and not later than five years;	**1,028**	1,092	1,092
later than five years.	**2,536**	2,727	2,918
Finance charges allocated to future periods	**(1,405)**	(1,575)	(1,713)
Net lease liabilities	**2,416**	**2,501**	**2,554**
not later than one year;	**87**	84	53
later than one year and not later than five years;	**454**	419	260
later than five years.	**1,875**	1,998	1,532

	Present Value of Minimum Lease Payments 31 March 2010 £000	Present Value of Minimum Lease Payments 31 March 2009 £000	Present Value of Minimum Lease Payments 01 April 2008 £000
Gross lease liabilities	**2,375**	**2,486**	**2,585**
of which liabilities are due			
not later than one year;	**240**	240	240
later than one year and not later than five years;	**823**	827	827
later than five years.	**1,312**	1,419	1,518
Finance charges allocated to future periods	**(946)**	(1,035)	(1,106)
Net lease liabilities	**1,429**	**1,451**	**1,479**
not later than one year;	**88**	82	77
later than one year and not later than five years;	**387**	364	347
later than five years.	**954**	1,005	1,055

All of these finance lease obligations are for buildings.

Note 18.1 PFI obligations (on SoFP)

	31 Mar 2010 £000	31 Mar 2009 £000
Gross PFI liabilities	**5,436**	**5,822**
of which liabilities are due		
not later than one year;	**224**	224
later than one year and not later than five years;	**896**	896
later than five years.	**4,316**	4,702
Finance charges allocated to future periods	**(1,851)**	(2,039)
Net PFI liabilities	**3,585**	**3,783**
not later than one year;	**45**	36
later than one year and not later than five years;	**274**	237
later than five years.	**3,266**	3,510

NOTES TO THE ACCOUNTS

18.2 Obligations by Year

The Trust is committed to make the following payments for on-SoFP PFIs obligations during the next year in which the commitment expires:

	31 Mar 2010 Total £000	31 Mar 2010 PFI 1 £000	31 Mar 2010 PFI 2 £000	31 Mar 2009 Total £000
Within one year *	**0**	0	0	0
2nd to 5th years (inclusive) *	**0**	0	0	0
6th to 10th years (inclusive) *	**0**	0	0	0
11th to 15th years (inclusive) *	**690**	690	0	683
16th to 20th years (inclusive) *	**0**	0	0	0
21st to 25th years (inclusive) *	**35**	0	35	29
26th to 30th years (inclusive) *	**0**	0	0	0
31st to 35th years (inclusive) *	**0**	0	0	0
36th year and beyond **	**0**	0	0	0

18.3 PFI Contract Details

The Trust has entered into two PFI contracts:

PFI 1 - Main Entrance and Retail Facility at Heartlands Hospital

This is 25 year contract with BHE Heartlands Ltd which commenced in August 2005. This contract has been treated as being on-balance sheet by the Trust following a review of the contracts based on Treasury Taskforce Technical Note 1 "How to account for PFI transactions" which interprets IAS 16 "Property, Plant and Equipment" and IFRIC 12 "Service Concession Arrangements".

The contract states that the service provision must be made available for users of the Heartlands Hospital including patients, visitors and staff. The contract contains a range of measures upon which deficiency points are allocated if pre-agreed levels are not achieved. The deficiency points are valued and deducted retrspectively from the Trust unitary payment at the end of the following quarter. At the end of the contract, ownership of the Main Entrance structure transfers to the Trust, at this point the Trust is not liable to provide any compensation payment and the contract is deemed to have reached its natural termination. The Trust is entitled to terminate the contract voluntarily with 12 months written notice and there are specific circumstances such as hospital closure orsignificant reconfiguration.

PFI 2 - Provision of Energy Management Services at Heartlands Hospital

This is 15 year contract with EnerG Combined Power Ltd which commenced in August 2007. This contract has been treated as being on-balance sheet by the Trust following a review of the contracts based on Treasury Taskforce Technical Note 1 "How to account for PFI transactions" which interprets IAS 16 "Property, Plant and Equipment" and IFRIC 12 "Service Concession Arrangements".

The contract is for the provision of combined heat and power facilities at the Heartlands Hospital. If either party terminates the contract before the end of the agreement, there is provision for either party to be liable to pay compensation as detailed within the contract. The assets are transferred at the end of the agreement and become assets of the Trust. The service provision is implicitly for the patients, visitors and staff of Heartlands Hospital.

The annual unitary payments of £59k (PFI1) and £872k (PFI2) made by the operator are included in the SOCI on an accruals basis. There is a payment mechanism that allows for deductions to be made to the unitary payment where the quality standards set out in the contract are not met. The total charge made in 2008/09 was £897k (2007/08 £860k).

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

NOTES TO THE ACCOUNTS

Note 19 Provisions for liabilities and charges

	Current 31 March 2010 £000	Current 31 March 2009 £000	Current 1 April 2008 £000	Non-current 31 March 2010 £000	Non-current 31 March 2009 £000	Non-current 1 April 2008 £000
Pensions relating to former directors	0	0	0	0	0	0
Pensions relating to other staff	201	185	154	3,222	2,461	1,734
Other legal claims	344	237	235	0	0	0
Agenda for Change	549	506	857	0	0	0
Other	2,276	1,706	2,155	0	0	0
TOTAL	**3,370**	**2,634**	**3,401**	**3,222**	**2,461**	**1,734**

	Total £000	Pensions - other staff £000	Other legal claims £000	Agenda for Change £000	Other £000
At 1 April 2009	**5,095**	2,646	237	506	1,706
Prior period adjustments	**0**	0	0	0	0
At 1 April 2009, as restated	**5,095**	**2,646**	**237**	**506**	**1,706**
Change in the discount rate	**0**	0	0	0	0
Arising during the year	**2,553**	970	376	213	994
Utilised during the year	**(503)**	(197)	(178)	(9)	(119)
Reversed unused	**(557)**	0	(91)	(161)	(305)
Unwinding of discount	**4**	4	0	0	0
At 31 March 2010	**6,592**	**3,423**	**344**	**549**	**2,276**
Expected timing of cashflows:					
not later than one year;	**3,370**	201	344	549	2,276
later than one year and not later than five years;	**850**	850	0	0	0
later than five years.	**2,372**	2,372	0	0	0
TOTAL	**6,592**	**3,423**	**344**	**549**	**2,276**

The £3,423k pensions- other staff provision is made up of permanent injury and early retirement provisions. The calculations for these provisions are based on agreed annual payments, age, gender and estimated life expectancy. The final amount of payment that will be made is not known as this will depend on actual life expectancy which may differ from the estimated number of years. The estimated life expectancy is provided from Interim Life Tables provided by the Office for National Statistics and updated every 2 years. To the extent that some of these liabilities will not be settled for several years the provision is discounted using a nominal discount rate of 2.2% (2008/09 2.2%, 2007/08 2.2%).

The £341k of other legal claims relate to personal legal claims that have been lodged against the Trust with the NHS Litigation Authority (NHSLA) but not yet agreed. The exact timing or amount of any payment will only be known once the case is heard, although it is expected that all cases will be resolved within the 2010/11 year.

NOTES TO THE ACCOUNTS

The Agenda for Change accrual estimates the amount that will be paid over to several staff groups for unresolved applications of Agenda for Change. The calculations have been based on assumptions of headcount, number of cases put forward, average pay and increments for the relevant staff groups and the period time it will apply for. Only when the payroll team do the calculations by individual will the exact amounts be known. It is expected that these issues will have been resolved within the next 12 months.

The other provision includes £1,020k (2008/09 £720k, 2007/08 £470k) because of a dispute over the amount of rent payable to Birmingham City Council over the last 3 years for use of space for staff car parking on one of the Trust's sites. The Trust has provided for what it believe is a reasonable amount to pay for this rent, although how accurate this is will be determined at an arbitration panel, expected to be heard later in the year. There are also legal proceedings being taken against the Trust regarding Equal Pay and an individual dispute with an employee. In both these cases, the Trust has provided for legal costs incurred to date and an estimated pay out based on the current earnings of the individuals concerned. The intention is that this will be settled within 12 months.

Also in other provisions is a liability to HMRC (Revenue and Customs) of £137k (2008/09 and 2007/08 nil) as a result of a review of payments made to suppliers. HMRC have deemed that a number of the services the Trust is invoiced for should have been paid using the payroll system as the individuals are not according to its interpretation self employed and so there are underpaid tax liabilities. The Trust has estimated the provision value based on historic payments made to the suppliers concerned. When the HMRC finalise the conclusions of their investigations the Trust will have the final amount to be paid over. This is expected to be settled within 12 monrths.

No reimbursement is anticipated from any of these provisions, other than in some 'Other legal claims' when the Trust receives reimbursement for any sums paid out which exceed the Trust's excess level with the NHSLA.

	Total	Pensions - other staff	Other legal claims	Agenda for Change	Other
	£000	£000	£000	£000	£000
At 1 April 2008	**5,135**	1,888	235	857	2,155
Prior period adjustments	**0**	0	0	0	0
At 1 April 2008, as restated	**5,135**	**1,888**	**235**	**857**	**2,155**
Change in the discount rate	**0**	0	0	0	0
Arising during the year	**2,124**	1,034	248	322	520
Utilised during the year	**(948)**	(183)	(130)	(94)	(541)
Reversed unused	**(1,220)**	(97)	(116)	(579)	(428)
Unwinding of discount	**4**	4	0	0	0
At 31 March 2009	**5,095**	**2,646**	**237**	**506**	**1,706**
Expected timing of cashflows:					
not later than one year;	**2,634**	185	237	506	1,706
later than one year and not later than five years;	**729**	729	0	0	0
later than five years.	**1,732**	1,732	0	0	0
TOTAL	**5,095**	**2,646**	**237**	**506**	**1,706**

NOTES TO THE ACCOUNTS

Note 20 Revaluation reserve

	Revaluation Reserve -property, plant and equipment
	£000
Revaluation reserve at 1 April 2009	**108,809**
Revaluation gains/(losses) and impairment losses property, plant and equipment	(21,872)
Transfers to the income and expenditure account in respect of assets disposed of	0
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	(2,739)
Other transfers between reserves	0
Movements on other reserves	0
Revaluation reserve at 31 March 2010	**84,198**
Revaluation reserve at 1 April 2008	**132,478**
Revaluation gains/(losses) and impairment losses property, plant and equipment	(12,699)
Transfers to the income and expenditure account in respect of assets disposed of	0
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	0
Other transfers between reserves	(10,970)
Movements on other reserves	0
Revaluation reserve at 31 March 2009	**108,809**

All revaluation reserve movements relate to property plant and equipment.

Note 21.1 Cash and cash equivalents

	31 March 2010	31 March 2009	31 March 2008
	£000	£000	£000
At 1 April	22,449	30,017	7,402
Net change in year	68,266	(7,568)	22,615
At 31 March	**90,715**	**22,449**	**30,017**
Broken down into:			
Cash at commercial banks and in hand	19	18,838	31,012
Cash with the Government Banking Service	90,696	3,611	(995)
Other current investments	0	0	0
Cash and cash equivalents as in SoFP	**90,715**	**22,449**	**30,017**
Bank overdraft	0	0	0
Cash and cash equivalents as in SoCF	**90,715**	**22,449**	**30,017**

During the year the Trust opened new bank accounts with Citibank and the Royal Bank of Scotland Group under the new Government Banking Service (GBS) initiative. The sum of Cash with the GBS above includes cash held in the Office of Paymaster General (OPG) bank account. This OPG bank account will be closed during 2010/11.

NOTES TO THE ACCOUNTS

Note 21.2 Third party assets held by the NHS Foundation Trust

The Trust held £16k (£22k 31 March 2009, £10k 1 April 2008)) cash at bank and in hand at 31/03/10 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.

Note 22.1 Contractual Capital Commitments

Commitments under contracts at the 'Statement of Financial Position' date were:

	£000
Property, Plant and Equipment	16,109
Intangible assets	0
Total as at 31 March 2010	**16,109**
Property, Plant and Equipment	9,996
Intangible assets	0
Total as at 31 March 2009	**9,996**
Property, Plant and Equipment	13,410
Intangible assets	0
Total as at 01 April 2008	**13,410**

The majority of these commitments at 31 March 2010 relate to site strategy developments of which ward block 1 is £14,822k.

Note 23 Events after the reporting period

There is a PFI schemes scheduled to commence during May 2010 relating to a contract with EnerG to provide energy services to the Trust via a Combined Heat and Power Unit at the Trusts Solihull Site. The Trust is committed to an annual unitary payment of £681k until 2025 at which point the contract terminates with no future obligation.

There were no other significant events after the end of the reporting period.

Note 24 Contingent (Liabilities) / Assets

	31 March 2010 £000	31 March 2009 £000	31 March 2008 £000
Gross value of contingent liabilities	(130)	(3,815)	(3,798)
Amounts recoverable against liabilities	0	0	0
Net value of contingent liabilities	**(130)**	**(3,815)**	**(3,798)**
Net value of contingent assets	0	0	0

The contingent liability in 2009/10 was identified by the NHS Litigation Authority.It relates to non-clinical Liabilities to Third Parties (LTPS) claims, which are public and employer liability legal claims.

These liabilities are expected to be settled within a year, and no reimbursement is expected.

NOTES TO THE ACCOUNTS

Note 25.1 Related Party Transactions

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

Note 31 gives an analysis of the relationship with Heartlands Education Centre Limited (HECL). Also, Adrian Stokes, Finance Director of the Trust is also a Director on the Board of HECL.

The Trust has entered into a significant number of material transactions with the following organisations for which there are no guarantees given or received:

	Income 31 March 2010 >£5m	Income 31 March 2009 >£5m	Expenditure 31 March 2010 >£5m	Expenditure 31 March 2009 >£5m
	£000	£000	£000	£000
Department of Health	6,972	0	0	0
Birmingham East and North PCT	270,663	244,136	0	0
Heart of Birmingham Teaching PCT	27,164	20,537	0	0
HM Revenue & Customs	0	0	20,651	0
NHS Litigation Authority	0	0	8,897	5,493
NHS Pension Scheme	0	0	29,910	28,078
NHS Purchasing & Supply Agency	0	0	13,135	10,658
Solihull Care PCT	96,783	83,634	0	0
South Birmingham PCT	21,984	17,688	0	0
South Staffordshire PCT	38,425	34,351	0	0
Walsall Teaching PCT	7,068	5,701	0	0
Warwickshire PCT	9,514	7,539	0	0
West Midlands Strategic Health Authority	21,083	19,989	0	0
Health Protection Agency	0	0	5,971	0
TOTAL	**499,656**	**433,575**	**78,564**	**44,229**

NOTES TO THE ACCOUNTS

Note 25.2 Related Party Balances

The Trust has entered into a significant number of material transactions with the following organisations for which there are no guarantees given or received:

	Receivables 31 March 2010 >£0.5m £000	Receivables 31 March 2009 >£0.5m £000	Receivables 31 March 2008 >£0.5m £000
Birmingham & Solihull Mental Health NHS FT	1,020	897	0
Birmingham City Council	2,167	867	0
Birmingham East and North PCT	9,013	2,385	4,443
Heart of Birmingham Teaching PCT	505	0	0
HM Revenue & Customs	1,069	0	0
NHS Litigation Authority	0	0	0
NHS Pension Scheme	0	0	0
National Heath Service Logistics Authority	0	0	0
Sandwell & West Birmingham Hospitals NHS Trust	1,066	824	532
Solihull Care PCT	4,182	2,741	2,140
South Birmingham PCT	550	571	0
South Staffordshire PCT	1,793	749	0
University Hospital Birmingham NHS FT	758	1,327	1,149
Walsall Teaching PCT	823	0	713
NHS Institute for Innovation and Improvement	0	0	0
Leicestershire County & Rutland PCT	705	0	0
West Midlands SHA	0	0	593
Worcestershire PCT	1,487	0	0
TOTAL	**25,138**	**10,361**	**9,570**

	Payables 31 March 2010 >£0.5m £000	Payables 31 March 2009 >£0.5m £000	Payables 31 March 2008 >£0.5m £000
Birmingham & Solihull Mental Health NHS FT	0	0	0
Birmingham City Council	0	0	0
Birmingham East and North PCT	0	572	2,518
Heart of Birmingham Teaching PCT	0	0	0
HM Revenue & Customs	7,131	10,372	0
NHS Litigation Authority	0	0	0
NHS Pension Scheme	3,788	2,406	0
National Heath Service Logistics Authority	803	817	0
Sandwell & West Birmingham Hospitals NHS Trust	1,408	1,286	1,005
Solihull Care PCT	0	0	0
South Birmingham PCT	0	0	0
South Staffordshire PCT	0	0	1,101
University Hospital Birmingham NHS FT	567	645	861
Walsall Teaching PCT	0	0	0
NHS Institute for Innovation and Improvement	500	0	0
Leicestershire County & Rutland PCT	0	0	0
Worcestershire PCT	0	0	0
TOTAL	**14,197**	**16,098**	**5,485**

NOTES TO THE ACCOUNTS

Note 25.3 Key Managment Personnel Compensation

Under IAS 24 there are additional disclosure requirements in respect key management personnel compensation. Note 3.3 discloses directors' remuneration as required under the Companies Act 2006. This note discloses compensation as defined under IAS 24:

Name and Title	2009-10						2008-09					
	Short term employee benefits £'000	Post employment benefits £'000	Other long term benefits £'000	Termination benefit £'000	Share based payment £'000	Total £'000	Short term employee benefits £'000	Post employment benefits £'000	Other long term benefits £'000	Termination benefit £'000	Share based payment £'000	Total £'000
Mark Goldman (Chief Executive)	272	110	0	0	0	**382**	267	486	0	0	0	**753**
Mandy Coalter (HR Director)	168	28	0	0	0	**196**	164	47	0	0	0	**211**
Hugh Rayner (Medical Director Medicine up to 30 Jun 09)	37	29	0	0	0	**66**	189	162	0	0	0	**351**
Ian Cunliffe (Medical Director)	218	34	0	0	0	**252**	226	171	0	0	0	**397**
Sarah Woolley (Director of Safety and Governance)	156	31	0	0	0	**187**	153	45	0	0	0	**198**
Adrian Stokes (Director of Finance) (w.e.f. 1 Aug in 2008/09)	161	32	0	0	0	**193**	165	35	0	0	0	**200**
Mandie Sunderland (Chief Nurse) (w.e.f. 1 Dec in 2008/09)	148	60	0	0	0	**208**	48	26	0	0	0	**74**
Ellen Ryabov (Chief Operating Officer w.e.f. 01 Jul 09)	122	138	0	0	0	**260**	0	0	0	0	0	**0**
Beccy Fenton (Deputy Chief Executive and Director of Transformation)	234	28	0	0	0	**262**	198	56	0	0	0	**254**
Clive Wilkinson (Chairman)	56	0	0	0	0	**56**	53	0	0	0	0	**53**
Anna East (Non Executive Director)	19	0	0	0	0	**19**	18	0	0	0	0	**18**
Richard Samuda (Non Executive Director)	19	0	0	0	0	**19**	18	0	0	0	0	**18**
Richard Harris (Non Executive Director) (w.e.f. 1 May in 2008/9)	15	0	0	0	0	**15**	14	0	0	0	0	**14**
Paul Hensel (Non Executive Director)	15	0	0	0	0	**15**	15	0	0	0	0	**15**
Najma Hafeez (Non Executive Director)	15	0	0	0	0	**15**	15	0	0	0	0	**15**
Chris Ham (Non Executive Director)	15	0	0	0	0	**15**	15	0	0	0	0	**15**
David Bucknall (Non Executive Director)	11	0	0	0	0	**11**	19	0	0	0	0	**19**
Total	1,681	490	0	0	0	**2,171**	1,577	1,028	0	0	0	**2,605**

For the purposes of this note 'short term employee benefits' includes the employer's contribution to National insurance

NOTES TO THE ACCOUNTS

Note 26.1 For PFI schemes deemed to be off-SoFP

As detailed in note 23, events after the reporting period, a contract for an Off SOFP PFI scheme is scheduled to commence in May 2010., This contract with EnerG is to provide energy services to the Trust via a Combined Heat and Power Unit at the Trust's Solihull Site. The Trust is committed to an annual unitary payment of £681k until 2025 at which point the contract terminates with no future obligation.

The Trust intends to account for as this scheme an off balance PFI contract using the NHS Finance, Performance and Operations Guidance on "Accounting for PFI under IFRS" and also has been classified as a non finance lease under IAS 17.

Note 27.1 Financial Risk Management

International Financial Reporting Standard IFRS7 (Financial Instruments:Disclosures) requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities.

The Trust is not exposed to significant financial risk factors arising from financial instruments. The continuing service provider relationship that the Trust has with local Primary Care Trusts and the way those Primary Care Trusts are financed, means that the Trust is not exposed to the degree of financial risk faced by business entities. In the current financial environment where affordability by PCT's has re-emerged as a theme, the Trust regularly reviews the level of actual and contracted activity with the PCT's to ensure that any income at risk is discussed and resolved at a high level at the earliest opportunity available. 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.

Market Risk

Market risk is the possibility that financial loss might arise as a result of changes in such measures as interest rates and stock market movements. The Trust's transactions are undertaken in sterling and so it is not exposed to foreign exchange risk and the Trust does not have any direct dealings with the stock market. Other than cash balances, the Trust's financial assets and liabilities carry nil or fixed rates of interest and the Trust's income and operating cashflows are substantially independent of changes in market interest rates. When the Trust is placing cash on deposit, it reviews future expected changes in interest rates, and this may determine the period over which the deposit is placed. In the current financial climate it is unusual for cash to be deposited for longer than a year.

Credit Risk

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

Liquidity risk

Liquidity risk is the possibility that the Trust might not have funds available to meet its commitments to make payments. Prudent liquidity risk management includes maintaining sufficient cash and the availability of funding from an adequate amount of committed credit facilities. NHS Foundation Trusts are required to comply with the Prudential Borrowing Code made by Monitor, the Independent Regulator of NHS Foundation Trusts, and further details of the Trust's compliance can be found at note 16 'Prudential Borrowing Code'. The Trust also seeks to minimise risk relating to prepayments made to suppliers, by keeping them to a minimum. Material prepayments are only made under contractual arrangements for periods not exceeding 12 months.

NOTES TO THE ACCOUNTS

Note 27.2 Financial assets by category

	Total	Loans and receivables	Assets at fair value through the I&E	Held to maturity
	£000	£000	£000	£000
Assets as per SoFP				
Trade and other receivables excluding non financial assets	**23,989**	23,989	0	0
Other Investments	**0**	0	0	0
Other Financial Assets	**0**	0	0	0
Cash and cash equivalents (at bank and in hand)	**90,715**	90,715	0	0
Total at 31 March 2010	**114,704**	**114,704**	**0**	**0**
Trade and other receivables excluding non financial assets	**16,551**	16,551	0	0
Other Investments	**0**	0	0	0
Other Financial Assets	**55,000**	55,000	0	0
Cash and cash equivalents (at bank and in hand)	**22,449**	22,449	0	0
Total at 31 March 2009	**94,000**	**94,000**	**0**	**0**
Trade and other receivables excluding non financial assets	**17,381**	17,381	0	0
Other Investments	**0**	0	0	0
Other Financial Assets	**30,359**	30,359	0	0
Cash and cash equivalents (at bank and in hand)	**30,017**	30,017	0	0
Total at 1 April 2008	**77,757**	**77,757**	**0**	**0**

The Financial Assets included above do not include Prepayments, PDC Receivable, amounts owing in respect of VAT from HMRC or amounts owing from the NHS Injury scheme. These are all included in Note 12.1 Trade receivables and other receivables.

Note 27.3 Financial liabilities by category

	Total	Other financial liabilities	Liabilities at fair value through the I&E
	£000	£000	£000
Liabilities as per SoFP			
Borrowings excluding Finance lease and PFI liabilities	**0**	0	0
Obligations under finance leases	**2,415**	2,415	0
Obligations under Private Finance Initiative contracts	**3,586**	3,586	0
Trade and other payables excluding non financial assets	**54,555**	54,555	0
Other financial liabilities	**0**	0	0
Provisions under contract	**3,169**	3,169	0
Liabilities in disposal groups excluding non-financial assets	**0**	0	0
Total at 31 March 2010	**63,725**	**63,725**	**0**
Borrowings excluding Finance lease and PFI liabilities	**0**	0	0
Obligations under finance leases	**1,792**	1,792	0
Obligations under Private Finance Initiative contracts	**3,782**	3,782	0
Trade and other payables excluding non financial assets	**40,890**	40,890	0
Other financial liabilities	**0**	0	0
Provisions under contract	**2,449**	2,449	0
Liabilities in disposal groups excluding non-financial assets	**0**	0	0
Total at 31 March 2009	**48,913**	**48,913**	**0**
Borrowings excluding Finance lease and PFI liabilities	**0**	0	0
Obligations under finance leases	**1,845**	1,845	0
Obligations under Private Finance Initiative contracts	**3,979**	3,979	0
Trade and other payables excluding non financial assets	**36,249**	36,249	0
Other financial liabilities	**0**	0	0
Provisions under contract	**0**	0	0
Liabilities in disposal groups excluding non-financial assets	**0**	0	0
Total at 1 April 2008	**42,073**	**42,073**	**0**

NOTES TO THE ACCOUNTS

Note 27.4 Fair values of financial assets

	Book value 31 March 2010 £000	Book value 31 March 2009 £000	Book value 31 March 2008 £000
Non current trade and other receivables excluding non financial assets (1)	1,551	1,604	1,396
Other Investments	0	0	0
Other	0	0	0
TOTAL	**1,551**	**1,604**	**1,396**

	Fair value 31 March 2010 £000	Fair value 31 March 2009 £000	Fair value 31 March 2008 £000
Non current trade and other receivables excluding non financial assets (1)	1,551	1,604	1,396
Other Investments	0	0	0
Other	0	0	0
TOTAL	**1,551**	**1,604**	**1,396**

(1) A breakdown of Non current trade and other receivables excluding non financial assets is given in Note 12.1 Trade receivables and other receivables.

Note 27.5 Fair values of financial liabilities

	Book value 31 March 2010 £000	Book value 31 March 2009 £000	Book value 31 March 2008 £000
Non current trade and other payables excluding non financial liabilities	0	0	0
Provisions under contract (1)	3,169	2,449	3,247
Loans	0	0	0
Other (2)	5,521	5,159	5,410
TOTAL	**8,690**	**7,608**	**8,657**

	Fair value 31 March 2010 £000	Fair value 31 March 2009 £000	Fair value 31 March 2008 £000
Non current trade and other payables excluding non financial liabilities	0	0	0
Provisions under contract (1)	3,169	2,449	3,247
Loans	0	0	0
Other (2)	5,521	5,802	6,053
TOTAL	**8,690**	**8,251**	**9,300**

(1) Provisions under contract include the Agenda for change provision, Other legal claims and Other provisions as shown on Note 19 Provisions for liabilities and charges.

(2) Other financial liabilities includes non current PFI and Finance lease obligations as shown on Note 15 Borrowings.

Note 27.6 Foreign Currency Risk

The Trust has no foreign currency income and negligible foreign currency expenditure.

NOTES TO THE ACCOUNTS

Note 28 Other Financial Assets

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Current			
Derivatives and Embedded Derivatives held at 'fair value through Income and Expenditure'	**0**	0	0
Held to maturity investments	**0**	0	0
Loan and receivables	**0**	55,000	30,359
TOTAL	**0**	55,000	30,359

Note 29 Other Financial Liabilities

There were no 'Other Financial Liabilities' during 2009/10 (or 2008/09 or 2007/08) such as derivatives and embbeded derrivatives held at fair value through income and expenditure.

Note 30 Losses and Special Payments

There were 166 cases of losses and special payments totalling £415k approved during 2009/10 (200 in 2008/09, costing £362k). Included in this, bad or irrecoverable debts were written off totalling £31k (65 cases) in the year as a result of a cleanse of the debtors ledger (£65k and 83 cases in 2008/09).

Legal claims totalling £178k (£130k, 2008/09) are included within these figures, but they are classified under 'Legal fees' rather than 'Losses, ex gratia and special payments' in Note 3.1 Operating Expenses.

In 2009/10 there were no individual cases where the net payment exceeded £100,000 (2008/09 zero).

These losses are reported on an accruals basis excluding provision for future losses.

Note 31 Subsidiary relationships

31.1 Heartlands Education Centre Limited (HECL)

In applying the principles of IAS 27 Consolidated and Separate Financial Statements the Trust has a subsidiary relationship with Heartlands Education Centre Limited (HECL). The net assets of HECL are not deemed material to the Trust's position, and therefore are not consolidated into group accounts and group accounts are not prepared. The following table sets out the net assets of the HECL in relation to the Trust's surplus and the HECL's net profit results.

	2009/10 £000	2008/09 £000
HECL net assets	(128)	(142)
HEFT net assets	342,627	371,780
%	**-0.04%**	**-0.04%**
HECL net profit	14	3
HEFT net profit	(29,153)	8,020
%	**-0.05%**	**0.04%**

The company was incorporated in the United Kingdom on 25 October 1994 as a company limited by guarantee and does not therefore have any share capital. As such the Trust does not hold a financial investment in HECL.

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

31.2 Charitable Funds

Charity), registered charity number 1052330.

In applying the principles of IAS 27 the charity would need to be consolidated. However the Annual Reporting Manual and the HM Treasure guidance has granted a dispensation for all NHS Foundation Trusts to not apply the IAS 27 until the 2011/12 financial year. Details of the charity can be obtained through the Trust's company secretary.

NOTES TO THE ACCOUNTS

Note 32 Transition to IFRS

32.1 UK GAAP to IFRS Reconciliation for Income and Expenditure Account 2008/09

INCOME AND EXPENDITURE ACCOUNT	UK GAAP 31/03/2009 £'000	UK GAAP Adjustment for revaluation (note 1)	UK GAAP Adjustment for other errors	IAS 1 Presentation of Financial Statements	IFRS adjustment for holiday pay accrual under IAS 19	IFRS adjustment for PFI schemes under IFRIC 12	Total	IFRS Restated 31/03/2009 £'000	STATEMENT OF COMPREHENSIVE INCOME
Income from Activities	458,030			49,406			49,406	507,436	Operating Income
Other Operating Income	48,958			(49,406)		448	(48,958)		
Operating Expenses	(481,018)	1,611		(51)	(226)	(258)	1,076	(479,942)	Operating Expenses
OPERATING SURPLUS / (DEFICIT)	**25,970**	**1,611**	**0**	**(51)**	**(226)**	**190**	**1,524**	**27,494**	**OPERATING SURPLUS / (DEFICIT)**
									FINANCE COSTS
				4,915			4,915	4,915	Finance income
				(328)			(328)	(328)	Finance expense - financial liabilities
				(4)			(4)	(4)	Finance expense - unwinding of discount on provisions
				(10,884)			(10,884)	(10,884)	PDC Dividends payable
Profit / (loss) on disposal of fixed assets	(51)			51			51		
SURPLUS / (DEFICIT) BEFORE INTEREST	**25,919**							**(6,301)**	**NET FINANCE COSTS**
Finance Income	4,915			(4,915)			(4,915)		
Finance costs - interest expense	(138)			328		(190)	138		
Other finance costs - unwinding of discount	(4)			4			4		
SURPLUS / (DEFICIT) AFTER TAXATION	**30,692**								
PDC dividends payable	(10,884)			10,884			10,884		
RETAINED SURPLUS FOR THE YEAR	**19,808**	**1,611**	**0**	**0**	**(226)**	**0**	**1,385**	**21,193**	**SURPLUS / (DEFECIT) FOR THE YEAR**
STATEMENT OF RECOGNISED GAINS AND LOSSES									**OTHER COMPREHENSIVE INCOME**
Surplus/(deficit) for the financial year before dividend payments	30,692								
Fixed asset impairment losses	0						0		
Unrealised surplus/(deficit) on fixed asset revaluations	0	(12,720)					(12,720)	(12,720)	
Increase in the donated asset reserve due to receipt of donated assets	95						0	95	Increase in the donated asset reserve due to receipt of donated assets
Reduction in the donated asset reserve due to depreciation, impairment, and/or disposal of donated assets	(548)						0	(548)	Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets
TOTAL RECOGNISED GAINS AND LOSSES IN THE FINANCIAL YEAR	**30,239**	**(12,720)**	**0**	**0**	**0**	**0**	**(12,720)**	**8,020**	**TOTAL COMPREHENSIVE INCOME AND EXPENSE FOR THE YEAR**

There was no change to the increase/(decrease) in Cash and Cash Equivalents figure in the 2008/09 'Statement of Cash Flows' reported under IFRS, compared to the equivalent figure reported in the 'Cash Flow Statement' under UK GAAP.

(1) The £1,611k operating expenses change relates to reduced depreciation (£2,262k) as a result of the a decrease in fixed asset values in the 1 April 2008 revaluation (MEA conversion date), off set by a £653k impairment charge due to the reduction in value of assets in the 2008/09 year. The £12,720k is the charge to revaluation reserve and donated asset reserve for decreases in value in the 2008/09 year. Note 9.6 provides more detail on these revaluations.

NOTES TO THE ACCOUNTS

32.2 UK GAAP to IFRS Reconciliation for Balance Sheet as at 31 March 2009

BALANCE SHEET	UK GAAP 31/03/2009 £'000	UK GAAP Adjustment for revaluation (note 1)	UK GAAP Adjustment for other errors (note 2)	IAS 1 Presentation of Financial Statements	IFRS adjustment for holiday pay accrual under IAS 19	IFRS adjustment for PFI schemes under IFRIC 12	Total	IFRS Restated 31/03/2009 £'000	STATEMENT OF FINANCIAL POSITION
FIXED ASSETS:									**NON-CURRENT ASSETS**
Intangible assets	1,955						0	1,955	Intangible assets
Tangible assets	355,921	(31,292)				4,927	(26,365)	329,556	Property, Plant and Equipment
				1,604			1,604	1,604	Trade and Other Receivables
TOTAL FIXED ASSETS	**357,876**	(31,292)	0	1,604	0	4,927	**(24,761)**	**333,115**	**TOTAL NON-CURRENT ASSETS**
CURRENT ASSETS:									**CURRENT ASSETS**
Stocks and work in progress	6,147						0	6,147	Inventories
Debtors	22,856			(1,604)			(1,604)	21,252	Trade and Other receivables
Investments	55,000						0	55,000	Other Financial Assets
Cash at bank and in hand	22,449						0	22,449	Cash and Cash Equivalents
TOTAL CURRENT ASSETS	**106,452**	0	0	(1,604)	0	0	**(1,604)**	**104,848**	**TOTAL CURRENT ASSETS**
CREDITORS:									**CURRENT LIABILITIES**
Creditors falling due within one year	(52,863)			14,106	(2,133)		11,973	(40,890)	Trade and Other Payables
			(66)	(191)		(224)	(481)	(481)	Borrowings
				(2,634)			(2,634)	(2,634)	Provisions
				(10,372)			(10,372)	(10,372)	Tax Payable
				(3,543)			(3,543)	(3,543)	Other Liabilities
NET CURRENT ASSETS/(LIABILITIES)	**53,589**	0	(66)	(2,634)	(2,133)	(224)	(5,057)	**(57,920)**	**TOTAL CURRENT LIABILITIES**
TOTAL ASSETS LESS CURRENT LIABILITIES	**411,465**								
CREDITORS:									**NON-CURRENT LIABILITIES**
Creditors falling due after more than one year	(1,601)					1,601	1,601	0	Trade and Other Payables
			(643)			(5,159)	(5,802)	(5,802)	Borrowings
Provisions for Liabilities and Charges	(5,095)			2,634			2,634	(2,461)	Provisions
								(8,263)	**TOTAL NON-CURRENT LIABILITIES**
TOTAL ASSETS EMPLOYED	**404,769**	(31,292)	(709)	0	(2,133)	1,145	(32,989)	**371,780**	**NET ASSETS**
FINANCED BY									**TAXPAYERS' EQUITY:**
Public dividend capital	211,114						0	211,114	Public Dividend Capital
Revaluation reserve	133,430	(25,766)				1,145	(24,621)	108,809	Revaluation reserve
Donated asset reserve	3,015	1,024					1,024	4,039	Donated asset reserve
Other reserves	(169)						0	(169)	Other reserves
Income and expenditure reserve	57,379	(6,550)	(709)		(2,133)		(9,392)	47,987	Income and expenditure reserve
TOTAL TAXPAYERS' EQUITY	**404,769**	(31,292)	(709)	0	(2,133)	1,145	(32,989)	**371,780**	**TOTAL TAXPAYERS' EQUITY**

(1) The decrease in tangible fixed assets is the combined impact of MEAV decrease as at 1 April 2008 (see below), the lower depreciation in 2008/09 (£2,262k) and a further market value decrease in 2008/09 of £13,371k. Note 9.6 provides more detail on the fixed asset revaluations.

(2) There were two properties (Glaxo Renal Unit and Birmingham Chest Clinic) that have been recorded as the Trust's fixed assets but the liability under the finance lease that they were acquired under has not previously been recorded. This was identified in the 2009/10 year, but the accounts have been restated to the 31 March 2009 for completeness.

NOTES TO THE ACCOUNTS

32.3 UK GAAP to IFRS Reconciliation for Balance Sheet as at 31 March 2008

BALANCE SHEET	UK GAAP 31/03/2008 £'000	UK GAAP Adjustment for revaluation (note 1)	UK GAAP Adjustment for other errors (note 2)	IAS 1 Presentation of Financial Statements	IFRS adjustment for holiday pay accrual under IAS 19	IFRS adjustment for PFI schemes under IFRIC 12	Total	IFRS Restated 01/04/2008 £'000	STATEMENT OF FINANCIAL POSITION
FIXED ASSETS:									**NON-CURRENT ASSETS**
Intangible assets	2,758						0	2,758	Intangible assets
Tangible assets	343,532	(20,183)				5,124	(15,059)	328,473	Property, Plant and Equipment
				1,396			1,396	1,396	Trade and Other Receivables
TOTAL FIXED ASSETS	**346,290**	(20,183)	0	1,396	0	5,124	(13,663)	**332,627**	**TOTAL NON-CURRENT ASSETS**
CURRENT ASSETS:									**CURRENT ASSETS**
Stocks and work in progress	4,750						0	4,750	Inventories
Debtors	21,516			(1,396)			(1,396)	20,120	Trade and Other receivables
Investments	30,359						0	30,359	Other Financial Assets
Cash at bank and in hand	30,017						0	30,017	Cash and Cash Equivalents
TOTAL CURRENT ASSETS	**86,642**	0	0	(1,396)	0	0	(1,396)	**85,246**	**TOTAL CURRENT ASSETS**
CREDITORS:									**CURRENT LIABILITIES**
Creditors falling due within one year	(42,149)			5,622	(1,907)		3,715	(38,434)	Trade and Other Payables
			(66)	(191)		(223)	(480)	(480)	Borrowings
				0			0	0	Other Financial Liabilities
				(3,401)			(3,401)	(3,401)	Provisions
				(124)			(124)	(124)	Tax Payable
				(5,307)			(5,307)	(5,307)	Other Liabilities
NET CURRENT ASSETS/(LIABILITIES)	**44,493**	0	(66)	(3,401)	(1,907)	(223)	(5,597)	**(47,746)**	**TOTAL CURRENT LIABILITIES**
TOTAL ASSETS LESS CURRENT LIABILITIES	**390,783**								
CREDITORS:									**NON-CURRENT LIABILITIES**
Creditors falling due after more than one year	(1,654)			5,410		(3,756)	1,654	0	Trade and Other Payables
			(643)	(5,410)			(6,053)	(6,053)	Borrowings
Provisions for Liabilities and Charges	(5,135)			3,401			3,401	(1,734)	Provisions
								(7,787)	**TOTAL NON-CURRENT LIABILITIES**
TOTAL ASSETS EMPLOYED	**383,994**	(20,183)	(709)	0	(1,907)	1,145	(21,654)	**362,340**	**NET ASSETS**
FINANCED BY									**TAXPAYERS' EQUITY:**
							0	0	
Public dividend capital	209,694						0	209,694	Public Dividend Capital
Revaluation reserve	146,163	(14,830)				1,145	(13,685)	132,478	Revaluation reserve
Donated asset reserve	2,623	1,045					1,045	3,668	Donated asset reserve
Other reserves	(169)						0	(169)	Other reserves
Income and expenditure reserve	25,683	(6,398)	(709)		(1,907)		(9,014)	16,669	Income and expenditure reserve
TOTAL TAXPAYERS' EQUITY	**383,994**	(20,183)	(709)	0	(1,907)	1,145	(21,654)	**362,340**	**TOTAL TAXPAYERS' EQUITY**

(1) The £20,183k decrease in tangible fixed assets is a result of a conversion of asset valuation to the Modern Equivalent Asset (MEA) valuation. This decrease was charged to revaluation reserve where a reserve existed with excess decreases over the value of that reserve being charged to the I&E reserve. In this valuation the donated assets increased in value and so the donated asset reserve increased. Note 9.6 provides more detail on the revaluations.

(2) There were two properties (Glaxo Renal Unit and Birmingham Chest Clinic) that have been recorded as the Trust's fixed assets but the liability under the finance lease that they were acquired under has not previously been recorded. This was identified in the 2009/10 year, but the accounts have been restated to the 1 April 2008 for completeness.