Review and consolidated accounts of NHS foundation trusts 2004-05

Monitor
Independent Regulator
of NHS Foundation Trusts

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Front cover Laurence Skermer, Superintendent Radiographer at Heart of England NHS Foundation Trust

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We are required to prepare an overall summary of the accounts of NHS foundation trusts. To meet this requirement, we have produced a consolidation of NHS foundation trusts' audited accounts, alongside a review of their operation.

At the date of publication (November 2005) there are 32 NHS foundation trusts, as shown in the list and map on this page.

The consolidated accounts cover the financial year 1 April 2004 to 31 March 2005 and include only data for the period in which the organisations were NHS foundation trusts. It is therefore based on full-year data for the first 10 NHS foundation trusts and part-year data for 15.

NHS foundation trusts

Authorised 1 April 2004

1. Basildon and Thurrock University Hospitals
2. Bradford Teaching Hospitals
3. Countess of Chester Hospital
4. Doncaster and Bassetlaw Hospitals
5. Homerton University Hospital
6. Moorfields Eye Hospital
7. Peterborough and Stamford Hospitals
8. Royal Devon and Exeter
9. Stockport
10. The Royal Marsden

Authorised 1 July 2004

11. Cambridge University Hospitals
12. City Hospitals Sunderland
13. Derby Hospitals
14. Gloucestershire Hospitals
15. Guy's and St. Thomas'
16. Papworth Hospital
17. Queen Victoria Hospital
18. Sheffield Teaching Hospitals
19. University College London Hospitals
20. University Hospital Birmingham

Authorised 1 January 2005

21. Barnsley Hospital
22. Chesterfield Royal Hospital
23. Gateshead Health (authorised 5 January 2005)
24. Harrogate and District
25. South Tyneside

Authorised 1 April 2005

26. Frimley Park Hospital
27. Heart of England
28. Lancashire Teaching Hospitals
29. Liverpool Women's
30. The Royal National Hospital for Rheumatic Diseases
31. The Royal Bournemouth & Christchurch Hospitals

Authorised on 1 June 2005

32. Rotherham

NHS foundation trusts – key facts

The NHS foundation trusts:

- treat around seven million patients a year;
- employ 120,000 people; and
- have over 420,000 members.

The consolidated accounts of NHS foundation trusts for 2004-05 show:

- total income of £4.1 billion;
- surplus before dividends of £60.3 million; and
- deficit post dividends of £36.9 million.

NHS foundation trusts are using their new powers and freedoms:

- new independence and challenges for the Board of Directors (see page 10);
- targeting and engaging members (see page 18);
- borrowing to improve healthcare (see page 26); and
- innovation for patients (see page 30).

Foreword

This is Monitor's first annual report to Parliament on NHS foundation trusts.

There are now 32 NHS foundation trusts. By reducing the degree of central control over their operations and giving them a high degree of autonomy and responsibility, the Government's intention was that they should have the ability to adapt their services quickly to meet the changing requirements of patients. Is that being achieved in practice?

An NHS foundation trust will only succeed in that aim if it is financially stable and well-run. An organisation which is financially robust, with effective management, will be able to focus on its core purpose – the delivery of patient-focused care. A management team which is constantly remedying financial problems will only be able to look at the short term.

Monitor has therefore given particular focus to ensuring that NHS foundation trusts are financially stable and have effective management. These have been the key parameters against which we assess NHS trusts who are applying for NHS foundation trust status. They continue to be the core elements against which we monitor performance once an NHS foundation trust is authorised.

In NHS foundation trusts the board of directors is ultimately responsible for the organisation's performance. They must devise a strategy which ensures that they build a stable organisation delivering a high standard of care to patients within the contracts they negotiate with primary care trusts and other commissioners. The board must identify and mitigate the risks that this strategy brings. But they must do this within a new framework of governance, with members and governors having a key part to play in determining the strategy of the organisation.

Their financial freedoms bring opportunities, but also mean a much greater degree of expertise is required in managing the financial position, forecasting cash flows accurately and understanding the costs underlying activities. A new tariff-based payment system is being introduced, with inevitable uncertainties in the early years, which will encourage all NHS organisations to become more efficient. In addition, at present the NHS is enjoying rapid increases in investment each year, but this is not expected to continue beyond 2008, creating another pressure to improve efficiency and productivity.

As well as these new challenges, NHS foundation trusts must continue to deliver high standards of healthcare and meet national targets. They operate in a new relationship with the commissioners of healthcare, principally the primary care trusts, at a time when the policy framework is continuing to evolve. We have built into our monitoring regime specific steps to ensure that boards recognise the importance of maintaining the highest standards of healthcare quality.

In this report we have looked at how NHS foundation trusts are making progress in three key areas:

- strong corporate governance;
- financial viability and sustainability; and
- delivering improvements to patients.

As our report demonstrates, the pattern is one of strengthening finances, improving governance and increasing local engagement, which taken together has laid the foundations for improving services to patients. And, although the first NHS foundation trusts have existed for little more than a year, there is sound evidence already that they are using their operational and financial freedoms to improve their services.

Looking ahead, it will be important to ensure that the continuing reforms of the NHS enable further and faster progress to be made if patient choice is to have real meaning. It is particularly important to ensure that the changes currently underway enable strong and effective commissioning to emerge, so that decisions on the volume and type of services offered to patients are increasingly based on sound analyses of need, and clinical- and cost-effectiveness. The development of the tariff will also be crucial to the future success of NHS foundation trusts.

There is a challenge ahead for Monitor too. As the regulator we must ensure that the regulated environment provides the right incentives. That means taking a proportionate approach, monitoring to ensure that obligations are being met, providing guidance where that is helpful and only becoming directly involved where it is clearly required. We believe our assessment and compliance systems are efficient and effective, and command widespread support. However, many important elements of the regulatory framework remain to be devised, and a key task for Monitor in the year ahead is to complete the framework in consultation with a wide range of partners.

William Moyes
Executive Chairman

NHS foundation trusts – new freedoms for improved healthcare

What is an NHS foundation trust?

NHS foundation trusts are established in law as a new type of legal entity, a public benefit corporation. They remain part of the NHS but are not subject to direction by the Secretary of State or the performance management requirements of the Department of Health. They can borrow commercially, retain surpluses and invest to improve services for patients.

NHS foundation trusts have a new framework of accountability. They have members drawn from patients, the public and staff. They have an independent board of governors, the majority of whom are elected by patient and public members. The board of governors appoints the chairman and other non-executive directors and approves the appointment of the chief executive.

NHS foundation trusts are also accountable to their purchasers, principally through contracts with primary care trusts. And they are regulated by Monitor, the independent regulator of NHS foundation trusts. Within this framework, they set their own strategies and make their own decisions.

Each NHS foundation trust is accountable for its success or failure. So while they can retain surpluses, they can also become insolvent. NHS foundation trusts remain public institutions, committed to providing free care based on need and not ability to pay. An NHS foundation trust must operate within its Terms of Authorisation, which details the conditions under which it must operate. These include:

- protected core NHS services;
- a private patient cap to limit the proportion of total patient income from private patients;
- a borrowing limit which reflects the financial risks the NHS foundation trust faces;
- a list of assets such as buildings, land or equipment that are designated as 'protected' because they are needed to provide required NHS services; and
- a duty to co-operate with local partners in the NHS.

Applying to be an NHS foundation trust

An NHS trust wishing to be authorised as an NHS foundation trust must first apply to the Department of Health. Once the Secretary of State has given support, the NHS trust is able to apply to Monitor.

In deciding whether to authorise, Monitor considers whether the applicant will be:

- financially viable;
- well-managed; and
- legally constituted.

These are essential requirements for NHS foundation trusts to be able to operate with sufficient autonomy, to deliver national health priorities and to become increasingly responsive to local needs. Monitor conducts a rigorous, and well-respected, assessment process based on these essential requirements.

Regulation

After an NHS trust has been authorised as an NHS foundation trust, it is obliged to keep within its Terms of Authorisation. Monitor assesses whether it is doing this using the *Compliance Framework*. This was published in March 2005 and is available on the Monitor website at www.monitor-nhsft.gov.uk. The framework can be broken down into three main areas:

- annual assessment;
- in-year monitoring; and
- intervention, if required.

Annual assessment

NHS foundation trusts are required to submit an annual plan to Monitor which includes forward planning information for publication. Monitor assesses the risks identified in each NHS foundation trust's annual plan and assigns a risk rating in three areas – finance, governance and mandatory services. Monitor uses the risk ratings to guide the intensity of its monitoring and signal to the NHS foundation trust its degree of concern with the specific issues identified and evaluated in the annual assessment.

In-year monitoring

In-year monitoring is designed to monitor actual performance against the annual plan submitted at the time of the annual assessment. The frequency and depth of in-year monitoring is determined by the NHS foundation trust's risk ratings.

Intervention

It is, in the first instance, the responsibility of the boards of directors of NHS foundation trusts to remedy any potential compliance failures. Wherever it is appropriate, Monitor will work with an NHS foundation trust to provide support in resolving issues before considering formal exercise of statutory powers of intervention. This could involve regular reviews of progress in resolving the issue, or proposing the involvement of other parties, such as other NHS foundation trusts that have successfully dealt with such an issue, or an appropriate professional adviser. Where this developmental approach is not appropriate, for example for significant financial failures, or where a developmental approach is failing, Monitor will consider formally intervening. In determining whether or not to intervene, Monitor must make the judgement of whether an incidence of failure to comply with the Terms of Authorisation is or is not "significant" (under the terms of section 23 of the Health and Social Care (Community Health and Standards) Act 2003). Monitor will judge "significance" on a case-by-case basis, examining the circumstances to decide what action, if any, is appropriate. Monitor will aim to ensure that its responses are proportionate in all cases.

Monitor intervened at only one NHS foundation trust in 2004-05, Bradford Teaching Hospitals NHS Foundation Trust.

Freedoms

The freedoms NHS foundation trusts have create a significant opportunity to reshape and improve delivery of healthcare in England. They can invest in new patient care facilities, enter partnerships with primary care trusts to manage chronic disease better or develop long term care facilities. They can form partnerships with the private sector, alliances with other hospitals or specialise in selected services. They can also innovate and bring to England models of care that have worked in other countries. They can set local targets in consultation with their members.

In all of these areas, NHS foundation trusts are free to determine how they wish to improve patient services through innovation and investment.

Strong corporate governance

Key findings

- **NHS foundation trusts understand the importance of strong corporate governance; boards of directors are responding effectively to their new responsibilities.**
- **The role of non-executive directors is crucial; they must possess a range of experience and expertise. A strong component of financial expertise among non-executive directors is essential.**
- **Governors are beginning to make a significant contribution to effective corporate governance. It is essential that NHS foundation trusts develop and share best practice in this area.**
- **Monitor will continue to work with NHS foundation trusts to raise levels of corporate governance.**

The change from NHS trust to NHS foundation trust transforms the corporate governance of the organisation. There are new accountabilities to members and governors and different relationships with key stakeholders including the Department of Health, strategic health authorities and primary care trusts.

The most significant change is to the role of the board of directors. The NHS foundation trust is no longer directed by the Department of Health or performance managed by the strategic health authority and there is no longer a safety net if problems arise. The board of directors is responsible for the performance and success of the organisation. They must focus on leading it, setting strategy and assessing and managing risk.

NHS foundation trusts are complex organisations. In size, many of them are comparable to companies which are household names in the UK. The turnover of the Royal Devon and Exeter NHS Foundation Trust, for example, exceeds that of Manchester United plc. Managing NHS foundation trusts therefore requires the highest standards of corporate governance.

Strengthening the board of directors

An assessment of governance has therefore been an essential part of the process of applying for NHS foundation trust status.

Our analysis of the first group of applicants identified a number of concerns:

- the breadth and depth of experience of the non-executive directors was, in some applicant trusts, inappropriate given the organisation's size and complexity;
- specifically, there was often insufficient financial experience and knowledge to provide appropriate scrutiny of financial performance;
- non-executive directors often did not appear to be providing a strong challenge to the executive;
- the assessment of, and response to, the risks facing the organisation was not always of a high standard; and
- the system of financial controls within some applicant trusts needed improvement.

Only applicants who met the test of being effectively governed were authorised as NHS foundation trusts. In some cases the applicant proposed action plans to address specific weaknesses. It is recognised, for example, that it takes some time to build a group of non-executive directors with the right blend of experience. Where such plans were agreed at the time of authorisation, their progress towards implementation has been monitored.

University College London Hospitals NHS Foundation Trust – new independence and challenges for the Board of Directors

The ending of central Government control has brought invigorating freedom to the boards of NHS foundation trusts but profound new responsibilities too.

Finding a balance

The University College London Hospitals NHS Foundation Trust Board can decide locally what capital investment is needed and borrow without seeking external approval.

Says Non-Executive Director Philip Brading: "This means that we are on our own now. The Department of Health's safety net has been removed."

Chief Executive Robert Naylor believes that non-executive and executive directors need to develop their commercial skills and gain a much deeper understanding of the financial environment. Consideration is also being given to the creation of a role of a commercial director and to strengthening Board competencies in the areas of marketing, performance management, corporate governance and legal matters.

"We need to balance and synchronise the work of the execs and the non-execs...and the operation of the Board as a whole," Robert Naylor says, while cautioning against the idea that NHS foundation trusts will bring immediate root and branch changes. "Having been a three-star NHS trust for four years running, foundation status simply meant we could continue with our winning formula but more efficiently and effectively because we are now less tied up with bureaucratic controls."

Non-Executive Chairman Peter Dixon also believes the change is evolutionary rather than revolutionary. "We need to be better at all the things we should have been good at before," he says. "We can't rely on being bailed out if things go wrong."

But he adds: "I believe that the biggest change is in the Chairman's role which has become totally free-standing. There is no-one from outside to give instructions…or support."

On the front lines

The Board Chairman also chairs the new Members' Council, designed to broaden power and accountability within local communities. However, the first scheduled joint meeting of the Board and the Members' Council had to be postponed when armed police were called to search the building during the terrorist bomb scare which hit the capital on 21 July 2005, highlighting the NHS foundation trust's demanding position on the frontline of London's emergency services.

The new £422 million University College Hospital at the junction of Tottenham Court Road and Euston Road, is the biggest signed-off private finance initiative (PFI) in the country. It opened recently, on time and on budget. Its final stages of completion have been a major priority for the Board in the first year of NHS foundation trust status. But with a total of eight hospitals to run, providing specialist and general services for patients locally, regionally and nationally, many new demanding and complex issues lie ahead for the directors. "The Board now has to consider how we need to develop the shape of the executive structure to meet the different challenges of the next five years," says Robert Naylor.

The new £420 million University College Hospital, the biggest signed-off private finance initiative in the country

"We need to be better at all the things we should have been good at before. We can't rely on being bailed out if things go wrong."

Peter Dixon, Chairman, University College London Hospitals

Chairman of University College London Hospitals NHS Foundation Trust, Peter Dixon

Monitoring governance

The board of directors is the first line of regulation in Monitor's risk-based approach to regulating NHS foundation trusts. The assessment of risk for each NHS foundation trust signals the degree of concern with the issues identified and guides the intensity of in-year monitoring.

Monitor considers five elements when assessing the governance risk that an NHS foundation trust may face over the coming year:

- legality of constitution;
- growing a representative membership;
- appropriate board roles and structures;
- effective risk and performance management; and
- co-operation with NHS bodies and local authorities.

Governance is rated using a traffic-light system, where green indicates low risk and red indicates high risk.

- G NHS foundation trust's governance complies with Terms of Authorisation.
- A Concerns about one or more aspects of governance.
- R Concern that issue(s) significantly breach(es) Terms of Authorisation.

Under Monitor's *Compliance Framework*, the board of directors is responsible for ensuring that the organisation is compliant with its Terms of Authorisation. The board is asked to make a declaration to this effect, with regard to governance, as part of its annual plan submission. In analysing the annual plans, Monitor identified a number of issues, principally related to risk and performance management, including:

- several NHS foundation trusts have indicated that they are concerned with meeting some of the core national healthcare standards and targets such as cancer waiting times and MRSA. In only one case (Heart of England NHS Foundation Trust) did the Board make a declaration that not all targets were being met at the end of the year; one other (Stockport NHS Foundation Trust) self-certified that the plans in place may not ensure that the targets will be met in the year ahead. Both Heart of England and Stockport were rated amber for governance;
- where boards are going through substantial change, for example at Bradford Teaching Hospitals NHS Foundation Trust, they are rated as amber for governance;
- some NHS foundation trusts highlighted concerns relating to implementation of IT projects as being a key area of risk; in one case (Homerton University Hospital NHS Foundation Trust) delays to an electronic patient record system led to an amber rating; and
- some NHS foundation trusts have expressed concern regarding their management capacity and/or capabilities to deal with the significant challenges they face, due to the number of initiatives that the NHS foundation trust is intending to undertake, robust recovery plans that need to be defined and implemented, or mitigating the potential adverse impact of certain system reforms such as competition and patient choice.

Developing the boards

Monitor has committed to work closely with NHS foundation trusts and the Foundation Trust Network, the representative body for NHS foundation trusts, to continue enhancing board skills. In February 2005 Monitor and the Foundation Trust Network carried out a comprehensive survey of board members. The objectives were to evaluate the strengths and weaknesses of governance with a view to identifying means of improvement.

The main areas for development which were identified were:

- greater challenge by non-executive directors of the NHS foundation trust's strategy and financial performance;
- implementation of clinical risk management strategy at all levels of the organisation;
- increased use of training programmes;
- more effective use of directors' skills; and
- proper evaluation of board performance.

Following the survey conferences were held for all boards to help them develop skills, particularly in developing organisation strategy.

Monitor is also developing *The NHS Foundation Trust Governance Code*. This aims to clarify the corporate governance framework for NHS foundation trusts and encourage the adoption of best practice.

Bradford Teaching Hospitals NHS Foundation Trust – Challenges for the Board

The deteriorating financial situation at Bradford Teaching Hospitals was highlighted by its first quarterly monitoring report submitted at the end of July 2004. Following discussions with its Board, Monitor determined that the NHS foundation trust was failing to comply with its duty under both its Terms of Authorisation and the Health and Social Care (Community Health and Standards) Act 2003 to exercise its functions effectively, efficiently and economically, and that the failure was significant.

Monitor intervened in October 2004 to appoint external advisers to review the financial position of Bradford Teaching Hospitals and make recommendations for remedial action. Both prior to that appointment and following the presentation of a report by the advisers, Monitor consulted extensively with the trust's Board and Senior Management Team and considered their responses. After lengthy reviews by its Board, Monitor determined that it still had serious concerns.

The NHS foundation trust's severe financial predicament, particularly its forecast liquidity position, gave rise to crucial questions of leadership. Monitor therefore intervened again in December 2004 to remove the Chairman and appoint a new Chairman on an interim basis.

The appointment of the interim Chairman strengthened the leadership of Bradford Teaching Hospitals. This change allowed the NHS foundation trust to take more effective action to address its financial position, improve relations with the local health community and properly adjust to the cultural and organisational challenges of being an NHS foundation trust.

These positive steps have been strengthened by the appointment of a new permanent Chairman, David Richardson, a new Chief Executive, Miles Scott, and Brian Millar as Chief Financial Officer. The trust's annual plan for 2005-06 projected a break even position, compared with a £7.9m deficit for 2004-05. Good progress is being demonstrated towards the achievement of this challenging target. Furthermore the new team has instigated a more fundamental review of its operations to underpin the financial strength of the trust for the longer term.

The experience of the intervention at Bradford has further underlined the importance of an NHS foundation trust's Board of Directors' understanding that it is fully accountable for the performance of the organisation.

The board of governors

NHS foundation trusts possess unique governance arrangements that are designed to align strategy with the needs of the local community. They recruit members drawn from patients, the public and staff. They have an independent board of governors; the majority are elected by members, with others appointed by organisations with an interest in the NHS foundation trust such as primary care trusts and the local authority. The board of governors appoints the chairman and other non-executive directors and approves the appointment of the chief executive.

The board of governors has a number of statutory responsibilities set out in legislation. It must:

- appoint, remove and decide the terms of office of the chairman and other non-executive directors, and approve the appointment of the chief executive;
- appoint and remove the auditor;
- review the annual accounts, auditor's report and annual report at a general meeting; and
- express a view on the board's forward plans.

The first challenge for boards of governors has often been to develop a common understanding of the issues which they face. NHS foundation trusts have spent much time on induction for new governors, helping them understand complex issues such as the NHS financial regime and clinical governance.

As they develop, governors will increasingly focus on how to ensure they add value to the organisation, ensuring that the views of members are properly represented. The board of directors of an NHS foundation trust needs to work closely with its governors so that they become central to the development of strategy.

Members

Membership of an NHS foundation trust is divided into three possible constituencies:

- the public constituency;
- the staff constituency; and
- an optional patient or carers constituency.

NHS foundation trusts have made a positive start to recruitment of members, particularly bearing in mind the short assessment timescale of the first twenty foundation trusts.

At 31 March 2005 the 32 NHS foundation trusts had membership of 422,000. As part of their annual plan submission to Monitor they are asked to forecast membership numbers for the following year. Collectively the NHS foundation trusts are forecasting an increase to 517,000.

The table opposite lists current membership figures, supplied as part of the membership reports included in the annual plans supplied to Monitor. These are broken down by membership constituency. The last column in the table gives projections resulting from the membership growth strategy of each foundation trust.

The Health and Social Care (Community Health and Standards) Act 2003 makes clear that NHS foundation trusts should take steps to ensure that membership is representative. While absolute numbers contribute to a broad representation, Monitor is primarily concerned that NHS foundation trusts take steps to ensure that the make-up is representative, taking into account factors such as age and ethnicity.

NHS foundation trusts have taken many different initiatives to attract new members. These include:

- establishing membership offices with a dedicated member of staff, helping to maintain an accurate and accessible register of community members;
- direct mailings to patients;
- using local media to reach all areas of constituencies;
- membership sections on the organisation's website;
- advertising membership in local GP surgeries;
- promoting new links and developing existing relationships with community forums, citizens' panels and other local groups;
- working with local organisations such as co-ops to share knowledge and expertise; and
- providing information to local businesses and schools with membership registration details.

After the initial recruitment of numbers, NHS foundation trusts have taken a more considered view on the whole about future membership. Rather than achieving substantial increases in membership numbers, the focus has been on continuing to develop more representative membership and engaging more effectively with existing members.

NHS foundation trusts have used various initiatives to engage members including:

- regular membership newsletters;
- members' annual meetings, including presentation of the annual report and accounts;
- surveys on local healthcare preferences to improve service delivery;
- lectures on local healthcare issues, for example, "What is the trust doing to combat MRSA?"; and
- member surgeries conducted by governors.

As with boards of governors, it has taken time for NHS foundation trusts to identify how to maximise the effectiveness of their members. Monitor has been content during its first year of operation to observe how NHS foundation trusts use their membership. It is encouraging to see that best practice is starting to emerge. Monitor anticipates giving closer scrutiny to issues around membership and governors in the coming twelve months. While the board of directors provides the first line of regulation for an NHS foundation trust, members and governors have a vital role to play in ensuring governance is robust and effective.

Membership figures at NHS foundation trusts

Authorised April 2004	Total	Public	Staff	Patient	Projected total membership at 31 March 2006
Basildon and Thurrock University Hospitals	**10,062**	6,139	3,923	N/A	**12,273**
Bradford Teaching Hospitals	**3,485**	1,591	1,635	259	**7,000**
Countess of Chester Hospital	**3,611**	3,169	442	N/A	**4,333**
Doncaster and Bassetlaw Hospitals	**7,378**	2,022	5,200	156	**7,596**
Homerton University Hospital	**4,544**	3,877	667	N/A	**5,064**
Moorfields Eye Hospital	**11,436**	9,084	1,000	1,352	**14,966**
Peterborough and Stamford Hospitals	**8,685**	5,036	3,649	N/A	**11,150**
Royal Devon & Exeter	**15,184**	9,462	5,722	N/A	**20,300**
Stockport	**11,535**	7,823	3,712	N/A	**17,505**
The Royal Marsden	**2,397**	712	674	1,011	**4,662**
Authorised July 2004					
Cambridge University Hospitals	**22,397**	8,147	7,351	6,899	**23,296**
City Hospitals Sunderland	**7,101**	1,605	4,496	1,000	**18,000**
Derby Hospitals	**9,647**	2,348	7,299	N/A	**17,350**
Gloucestershire Hospitals	**15,203**	13,458	874	871	**16,880**
Guy's and St. Thomas'	**13,490**	2,191	8,521	2,778	**14,690**
Papworth Hospital	**8,156**	7,570	586	N/A	**15,200**
Queen Victoria Hospital	**12,838**	11,902	936	N/A	**12,888**
Sheffield Teaching Hospitals	**6,505**	1,873	1,281	3,351	**22,480**
University College London Hospitals	**8,592**	287	6,865	1,440	**10,365**
University Hospital Birmingham	**96,406**	62,239	7,103	27,064	**96,406**
Authorised January 2005					
Barnsley Hospital	**12,508**	9,241	2,834	433	**12,955**
Chesterfield Royal Hospital	**9,799**	6,642	3,157	N/A	**11,700**
Gateshead Health	**9,121**	5,809	3,312	N/A	**12,330**
Harrogate and District	**10,559**	9,914	645	N/A	**13,800**
South Tyneside	**4,526**	2,244	2,282	N/A	**5,782**
Authorised April 2005					
Frimley Park Hospital	**5,841**	4,817	1,024	N/A	**7,300**
Heart of England	**48,141**	39,125	5,249	3,767	**53,795**
Lancashire Teaching Hospitals	**9,394**	1,822	5,578	1,994	**11,078**
Liverpool Women's	**10,074**	9,218	856	N/A	**10,674**
The Royal National Hospital for Rheumatic Diseases	**4,557**	721	422	3,414	**4,878**
The Royal Bournemouth and Christchurch Hospitals	**13,305**	12,330	975	N/A	**14,848**
Authorised June 2005					
Rotherham	**5,373**	4,404	969	N/A	**5,373***
Totals	**421,850**	**266,822**	**99,239**	**55,789**	**516,917**

*** Monitor forecast for total membership at 31 March 2006**

Heart of England NHS Foundation Trust – targeting and engaging members

An NHS foundation trust is required to recruit and maintain a representative membership from its local community who can then be productively engaged in the organisation's work.

Reaching all minority groups

These are early days for Heart of England NHS Foundation Trust in Birmingham but in the first few months of its new status, some 50,000 members have been recruited and Chairman Clive Wilkinson is determined that minority groups will be fully represented.

The city of Birmingham has a very culturally diverse population. In the vicinity of Heartlands Hospital, for example, 75 per cent of the population is from an ethnic minority background, largely Asian.

Members have been recruited from three groups: patients; staff; and public, across Birmingham and Solihull. They have been assessed to determine whether they wish to have intensive or modest involvement, or simply to receive a number of updates each year.

There has been a good response from the Asian community but work continues to map the ethnicity, age range and sex in each constituency to determine any areas of under representation. Such groups will then be targeted for membership.

"We will be making specific attempts to reach all minority groups on health and cultural issues," says Clive Wilkinson. "We intend to be very sophisticated in how we go about that. It is crucial that we feed in their concerns and priorities so that they can be reflected in the business plan.

"The membership is an invaluable resource that we have never had before. If we get things right, we

"Some members are already assisting us with the development of our services and this will grow as we all understand the benefits of working together."

Clive Wilkinson, Chairman, Heart of England NHS Foundation Trust.

Chairman of Heart of England NHS Foundation Trust, Clive Wilkinson, with Sharon Kaur, Health Information Officer

have 50,000 immediate friends of the hospital, although we are aiming for 75,000, who can influence the public more broadly by telling them what they feel about our work.

"Some members are already assisting us with the development of our services and this will grow as we all understand the benefits of working together."

Making a difference

One of those is patient member Marguerite Standing who was already chair of the hospital's disability advisory group. Marguerite is a wheelchair user who contracted polio as a child and felt her 68 years' experience of using hospitals made her well qualified to become an NHS foundation trust member.

"Over that time, I have seen a great culture change within the NHS, particularly in attitudes towards patients. But there is more which can be improved. My standards are high and I feel I have an obligation to play my part in helping to achieve them," she says.

The members elect more than 50 per cent of the foundation trust's governors. Five of the governors represent staff and one of those is Andrew Clements, Chief Corporate Accountant, who speaks on behalf of administration, management and ancillary employees as well as volunteers.

"I wanted to make a difference," he says.

"We already had a good committee structure asking staff for their views but things can always be improved. I see myself as another check when strategy is being set, ensuring that staff interests are properly represented.

"If staff are happy, they will all pull in the same direction. That can only be good for the patients and the broader community as a whole."

Staff governor Andrew Clements who is Chief Corporate Accountant at Heart of England NHS Foundation Trust

Financial viability and sustainability

Key findings

- **NHS foundation trusts faced a challenging year with the adjustment to a new regulatory regime and the implementation of new initiatives such as Payment by Results and Agenda for Change.**
- **NHS foundation trusts incurred an aggregate deficit of £36.9m in 2004-05; this is a very small percentage of income at 0.9%.**
- **The disciplines of NHS foundation trust status are pushing organisations towards higher standards of financial management.**

The financial freedoms which NHS foundation trusts enjoy demand a higher standard of financial management. They can generate surpluses; they can also run up deficits. What they can no longer do is rely on the rest of the health system to help them to an artificial end of year position of financial balance.

Assessment of financial positions

Financial stability is a key test within our assessment of applicants for NHS foundation trust status. An applicant trust is required to submit detailed financial projections and the board is asked to sign a statement confirming that it has sufficient working capital for the first twelve months. The trust's financial information is subjected to a detailed examination by Monitor.

With many applicants it was clear that the assessment process placed them under a greater degree of financial scrutiny than they had encountered before. Our analysis identified a number of issues which were common to many trusts:

- financial projections which were subject to frequent change during the assessment process;
- plans for cost improvement which were aspirational and lacked detail; and
- brokerage and other one-off items disguising true financial performance.

In some cases the assessment concluded that the applicant could not meet the test of financial viability and sustainability. However where applicants were able to meet this test, Monitor was confident that they could move into the demanding environment of being an NHS foundation trust.

Financial performance review

During 2004-05, 25 NHS foundation trusts were authorised. Their total consolidated income for the period from authorisation to 31 March 2005 was £4.1 billion. This is equivalent to an annual turnover of some £5.2 billion based on the NHS foundation trusts' annual plan submissions for 2005-06 and represents approximately 16% of the English acute sector.

Before dividend payments the 25 NHS foundation trusts made a surplus for the period of £60.3 million. However after £97.2 million of public dividend capital (PDC) payments to the Department of Health, this was reduced to a retained deficit of £36.9 million. In the context of the total income of the NHS foundation trusts, the overall deficit was very small, at 0.9% of total income.

Of the consolidated net deficit some £29 million, approaching 80%, is accounted for by four NHS foundation trusts that have encountered financial problems in their first accounting period. Three of these NHS foundation trusts were:

- Bradford Teaching Hospitals NHS Foundation Trust with a £7.9 million deficit;
- Peterborough and Stamford Hospitals NHS Foundation Trust with a £7.7 million deficit; and
- Royal Devon and Exeter NHS Foundation Trust with a £7.3 million deficit.

The fact that a number of NHS foundation trusts have incurred deficits in their first

year is a powerful reminder of the need for strong and effective financial management. Deficits in any one year are not necessarily a problem, provided that the organisation maps out and then follows a route to financial recovery. These NHS foundation trusts, where deficits relate to operating performance, have either compiled, or are compiling, plans with the assistance of external advisers identifying a path to successful recovery.

The fourth NHS foundation trust was University College London Hospitals NHS Foundation Trust with a deficit of £5.9 million. This was substantially accounted for by a £3.6 million impairment (devaluation) in the value of their land and buildings following an assessment by the District Valuer. They also experienced unanticipated cost pressures.

Income and expenditure surplus/deficit by NHS foundation trust from authorisation to 31 March 2005

Authorised April 2004

	I&E* surplus (actual 2004-05 post dividend) £m	I&E margin (actual)
Moorfields Eye Hospital	1.7	2.4%
The Royal Marsden	0.8	0.6%
Stockport	0.7	0.4%
Doncaster and Bassetlaw Hospitals	0.2	0.1%
Homerton University Hospital	0	0%
Countess of Chester Hospital	-0.3	-0.2%
Basildon and Thurrock University Hospitals	-0.6	-0.3%
Royal Devon & Exeter	-7.3	-3.3%
Peterborough and Stamford Hospitals	-7.7	-5.4%
Bradford Teaching Hospitals	-7.9	-5.5%

Authorised July 2004

	I&E surplus (actual 2004-05 post dividend) £m	I&E margin (actual)
Queen Victoria Hospital	0.3	0.9%
Sheffield Teaching Hospitals	0.1	0%
University Hospital Birmingham	0	0%
Papworth Hospital	-0.1	-0.1%
Guy's and St. Thomas'	-0.6	-0.2%
Derby Hospitals	-0.7	-0.4%
City Hospitals Sunderland	-2.8	-1.2%
Cambridge University Hospitals	-3.0	-1.7%
Gloucestershire Hospitals	-3.8	-1.7%
University College London Hospitals	-5.9	-1.8%

Authorised January 2005

	I&E surplus (actual 2004-05 post dividend) £m	I&E margin (actual)
South Tyneside	0	0.2%
Gateshead Health	0	0.1%
Chesterfield Royal Hospital	0	0%
Barnsley Hospital	0	0%
Harrogate and District	0	0%

* Income and expenditure

A challenging year for NHS foundation trusts

NHS foundation trusts have faced a challenging year with the adjustment to a new regulatory regime and the implementation of various Government initiatives including Agenda for Change, the new consultants' contract, and Payment by Results. Despite these challenges, the majority of NHS foundation trusts have managed their finances well.

The majority of NHS foundation trusts stood to gain from the early adoption of Payment by Results (PbR) as their reference costs were below the national average. Under the transitional arrangements, NHS foundation trusts were able to retain 25% of the PbR benefit in 2004-05. Assuming stability in the PbR tariff structure and the maintenance of good cost control by the NHS foundation trusts, the increasing benefit of PbR should improve the financial performance of the NHS foundation trust sector. 50% of the benefit will be realised in 2005-06 and the full benefit in 2007-08.

Despite the increase in income, some NHS foundation trusts were unable to contain the growth in their cost base to ensure a surplus for the period. The main drivers of deficits were:

In-year cost pressures were not fully anticipated

For some NHS foundation trusts costs grew above expectation largely due to under-estimation of costs relating to:

- the full impact of Agenda for Change, which was implemented from 1 October 2004. This caused pay costs to be significantly above plan; and
- resourcing requirements to meet the new NHS-wide targets and standards. In order to ensure 98% of patients attending an Accident & Emergency department are treated, admitted or discharged within four hours (a target required to be achieved by all of the NHS from 1 January 2005) some NHS foundation trusts had to open new wards or provided extra beds as Medical Assessment Units to meet the target. These unplanned actions served to increase the cost base of the NHS foundation trusts but were successful in their aim to meet the target. Recent data on A&E target performance shows that overall NHS foundation trusts performed well against this target and in aggregate outperformed the rest of the acute sector.

Change in accounting regime – compliance with Financial Reporting Standard 11: Impairments of Fixed Assets and Goodwill (FRS11)

Monitor's aim is to bring NHS foundation trusts in line with UK Generally Accepted Accounting Practice (UK GAAP). This results in greater transparency and comparability with the commercial sector in the UK. For this reason, a change was made to the accounting treatment for impairments during 2004-05. The change required NHS foundation trust to follow the accounting treatment for impairments in accordance with FRS11. The adoption of FRS11 caused £7.9 million of impairments to be charged to the income and expenditure accounts of the NHS foundation trusts. Prior to 2004-05 these impairments under the NHS accounting regime would have been either offset to the revaluation reserve or NHS trusts would have received offset funding and therefore they would not have impacted the income and expenditure position for the year.

No access to NHS financial brokerage

As NHS foundation trusts are financially independent bodies, they do not receive any financial support for either cash flow difficulties or deficits from other parts of the NHS ("brokerage"). The results shown in the consolidated accounts are free from the impact of unplanned financial brokerage.

Looking forward: 2005-06 annual plans

Each NHS foundation trust must submit an annual plan to Monitor which sets out its forecast financial performance.

Monitor assesses the annual plans against four criteria: achievement of plan for previous year; underlying performance; financial efficiency;

and liquidity. This is then used to determine the financial risk rating. The risk rating is forward-looking and is intended to reflect the likelihood of a financial breach of the Terms of Authorisation in the first year of the plan.

In aggregate the NHS foundation trusts are forecasting a surplus for 2005-06 prior to exceptional items. There are some uncertainties. Many NHS foundation trusts are relying on programmes to reduce costs and these need firm and effective management to deliver them successfully. There are also uncertainties around the forecast levels of activity which determine income, in particular whether commissioners can afford to pay for the forecast volumes of activity.

Key to ratings
Rating 5 Lowest risk – no regulatory concerns
Rating 4 No regulatory concerns
Rating 3 Regulatory concerns in one or more components. Significant breach of Terms of Authorisation is unlikely
Rating 2 Risk of significant breach in Terms of Authorisation in the medium term, e.g. 9 to 18 months, in the absence of remedial action
Rating 1 Highest risk – high probability of significant breach of Terms of Authorisation in the short-term, e.g. less than 9 months, unless remedial action is taken

Finance risk ratings for NHS foundation trusts (as at September 2005)

NHS foundation trust	Finance risk ratings
Barnsley Hospital	3
Basildon and Thurrock University Hospitals	3
Bradford Teaching Hospitals	2
Cambridge University Hospitals	3
Chesterfield Royal Hospital	4
City Hospitals Sunderland	3
Countess of Chester Hospital	3
Derby Hospitals	3
Doncaster and Bassetlaw Hospitals	4
Frimley Park Hospital	4
Gateshead Health	3
Gloucestershire Hospitals	3
Guy's and St. Thomas'	4
Harrogate and District	4
Heart of England	3
Homerton University Hospital	3
Lancashire Teaching Hospitals	2
Liverpool Women's	4
Moorfields Eye Hospital	4
Papworth Hospital	3
Peterborough and Stamford Hospitals	2
Queen Victoria Hospital	3
Rotherham *	n/a
Royal Devon and Exeter	2
Sheffield Teaching Hospitals	4
South Tyneside	4
Stockport	2
The Royal Bournemouth & Christchurch Hospitals	3
The Royal Marsden	4
The Royal National Hospital for Rheumatic Diseases	4
University College London Hospitals	3
University Hospital Birmingham	4

*** Authorised as an NHS foundation trust on 1 June 2005**

Delivering improved services to patients

Key findings

- **NHS foundation trusts are using their operating and financial freedoms to improve services for patients.**
- **The Foundation Trust Financing Facility approved loans of £69.5 million in 2004-05.**
- **Increased involvement of patients and public, bringing new thinking.**

The quality of services provided by NHS foundation trusts must achieve national standards and targets. This is one of the requirements written into their Terms of Authorisation. Like all other NHS bodies, NHS foundation trusts are subject to inspection by the Healthcare Commission which will assess their performance against national healthcare standards.

As NHS foundation trusts are set free from central Government control, with greater financial and operating freedoms and with enhanced local accountability, the expectation is that they will build on this and deliver improved services to patients. There is some evidence that these improvements are starting to occur.

Two ways in which NHS foundation trusts are delivering improvements to patients are by:

- using their financial freedoms; and
- engaging members in developing services.

Using financial freedoms to deliver improved services to patients

The Healthcare Commission's review of NHS foundation trusts (July 2005) stated that "NHS foundation trusts were finding that easier access to capital investment, combined with the ability to take quicker decisions on which services to develop, is allowing them to accelerate improvements for patients".

Borrowing

Each NHS foundation trust is able to borrow up to a limit set by Monitor. The basis for determining the borrowing limit is set out in the *Prudential Borrowing Code*, published by Monitor in March 2005 (available at www.monitor-nhsft.gov.uk). The limit consists of two components: a limit on long-term borrowing and on working capital facilities. The individual borrowing limits are calculated by reference to five ratio tests which take account of each NHS foundation trust's gearing (the ratio of debt to equity), its ability to service debt and its annual finance risk rating.

Details of the 2004-05 borrowing limits for each NHS foundation trust are given on the facing page. NHS foundation trusts wishing to use their borrowing powers have been able to use the Foundation Trust Financing Facility, which was established by the Department of Health.

During 2004-05 the facility approved loans of £69.5 million, with this figure increasing to over £100 million since the year end. The timing of the projects involved meant that only £6 million of borrowing had been drawn down by 31 March 2005. There has been an increased level of borrowing and approvals in the later part of the financial year, which indicates that the NHS foundation trusts are beginning to make use of their freedom to gain access more quickly to finance to improve and develop services.

Analysis of prudential borrowing limit	£ million
Long term borrowing limit set by Monitor for 2004-5	234.3
Working capital limits for 2004-5	156.5
Total prudential borrowing limit for 2004-5	**390.8**
Actual long term borrowing drawn down at 31 March 2005	6.0
Working capital facility drawn down at 31 March 2005	3.0

Significant loans to NHS foundation trusts			
NHS foundation trust	Amount of loan	Amount of loan drawn down in 2004-5	Use of loan
Moorfields Eye Hospital	£5.6 million	£5.6 million	Used in part to finance the £15.9 million capital programme at the trust.
Homerton University Hospital	£9.1 million	£0.4 million	To provide new facilities to mothers and babies in a Perinatal Centre.
Stockport	£21 million	Nil	To fund the development of a new Cardiology and Surgical Unit. This should be completed by the summer of 2006. Stockport first drew down on its loan in May 2005.

Prudential borrowing limit 2004-05 by NHS foundation trust			
NHS foundation trust	Long-term borrowing £ millions	Working capital facility £ millions	Total prudential borrowing limit £ millions
University College London Hospitals	45.1	5.0	50.1
Cambridge University Hospitals	6.1	23.0	29.1
Stockport	25.0	2.0	27.0
Sheffield Teaching Hospitals	10.0	15.0	25.0
Gateshead Health	12.7	12.0	24.7
Royal Devon & Exeter	17.1	4.0	21.1
Guy's & St Thomas'	10.0	10.0	20.0
University Hospital Birmingham	11.0	8.0	19.0
Harrogate and District	9.0	7.5	16.5
The Royal Marsden	10.0	5.5	15.5
South Tyneside	8.5	7.0	15.5
Derby Hospitals	10.4	3.5	13.9
Homerton University Hospital	10.0	3.0	13.0
Chesterfield Royal Hospital	9.0	4.0	13.0
Moorfields Eye Hospital	5.6	6.0	11.6
Peterborough and Stamford Hospitals	3.5	8.0	11.5
Barnsley Hospital	7.1	4.0	11.1
Countess of Chester Hospital	5.8	5.0	10.8
City Hospitals Sunderland	5.0	5.0	10.0
Basildon and Thurrock University Hospitals	3.4	4.0	7.4
Doncaster and Bassetlaw Hospitals	4.0	3.0	7.0
Bradford Teaching Hospitals	3.3	3.0	6.3
Papworth Hospital	2.0	3.0	5.0
Queen Victoria Hospital	0.7	3.0	3.7
Gloucestershire Hospitals	0.0	3.0	3.0
Total	**234.3**	**156.5**	**390.8**

Homerton University Hospital NHS Foundation Trust – borrowing to improve healthcare

Using borrowing powers

Before achieving NHS foundation trust status, Homerton, a medium-sized hospital in Hackney, found it difficult to borrow money, severely curtailing its ability to invest quickly in meeting local needs.

Thinking more commercially

Funds came either in block allocations based on the size of its asset base or from discretionary strategic capital, usually allocated some years in advance. The block allocation for last year would have been between £3m and £4m, says Finance Director Caroline Clarke. But with an estate worth £100m, much more would have been required to develop it, let alone take care of repairs and maintenance.

Now, funding is either self-generated or comes through borrowing within Monitor's prudential borrowing limit.

Last year, Homerton borrowed £9.1m from the NHS Financing Facility to fund a planned Perinatal Centre, medical equipment and basic improvements to infrastructure. The result will be a state-of-the-art facility for mothers and babies, a leading edge IT system, a modern pathology block and a high level of automation allowing patients to be catered for more efficiently.

Homerton is also looking at other areas of possible development including how to make best use of its new freedom to trade through subsidiary organisations.

"We are now thinking more commercially," says Caroline Clarke. "Of course, our primary role is to serve patients rather than to make money, but we need to be financially viable and generate a surplus so that we can re-invest in new facilities for the future."

Moving more quickly

Chief Executive Nancy Hallett says NHS foundation trust status has given her a much greater sense of control over the capital situation and building plans. "If the clinical and business case has been made, and the funding secured, then you know you will be able to do it. In the past, it could take forever." She adds: "It has also driven our business competence. There is a big push to make the organisation more productive."

Caroline Clarke, Finance Director at Homerton University Hospitals NHS Foundation Trust

Nancy Hallett OBE, Chief Executive of Homerton University Hospitals NHS Foundation Trust

"If the clinical and business case has been made, and the funding secured, then you know you will be able to do it. In the past, it could take forever."

Nancy Hallett, Chief Executive

The Perinatal Centre will specialise in babies born prematurely or of low birth weight. Hackney historically has a high level of such infants although the reason for this remains the subject of research. The development, rationalising neonatal care currently provided, will also serve other hospitals in surrounding areas of London and has been envisioned for some time.

"The difference now we are an NHS foundation trust," says Senior Consultant Neonatal Paediatrician Professor Kate Costeloe, "is that we are moving forward much more quickly."

Currently, under emergency circumstances, mothers and premature babies sometimes have to travel huge distances to be looked after due to a lack of capacity. If the child requires intensive care, they can be separated for long periods many miles from each other.

"The community in Hackney may perhaps feel that the centre is not truly local because it also serves a wider area," says Professor Costeloe. "But with people from Hackney having such a particular need for this facility, they are actually advantaged because this is a vital service which is local to them. It's terrific that we can develop a tertiary service that will benefit families across East London but for which the greatest need is within our own local community."

Professor Kate Costeloe, Senior Consultant Neonatal Paediatrician at Homerton University Hospitals NHS Foundation Trust

Delivering improved services to patients (continued)

Borrowing (continued)

From 2005-06 the prudential borrowing limits (PBL) of the 25 NHS foundation trusts will be £1,259.8 million. In addition, the further seven NHS foundation trusts authorised in 2005-06 have PBL of £251.4 million. This brings the total PBL for all 32 NHS foundation trusts to £1,511.2 million. The borrowing limits for 2005-06 are based on the final *Prudential Borrowing Code*, published in March 2005. The limits set for 2004-05 were interim limits.

Working capital facilities
As at 31 March 2005, the NHS foundation trusts had working capital limits totalling £156.5m. The first group of NHS foundation trusts which were authorised in April 2004 secured their working capital facilities with the Department of Health. These facilities will need to be refinanced with commercial banks prior to 31 March 2006. All NHS foundation trusts authorised after 1 April 2004 have arranged working capital facilities with commercial banks to support their working capital requirements.

Private finance initiative schemes

NHS foundations trusts also use private finance initiative (PFI) schemes to finance major capital investment. Such schemes are usually accounted for "off balance sheet". The table below shows major PFI schemes which have reached financial close.

In addition, University Hospitals Birmingham NHS Foundation Trust is in the late stages of negotiating a major PFI scheme to build Birmingham's first new acute hospital for almost 70 years. The £521 million project will deliver a 21st century environment to support new models of care. The project is expected to complete in four years. Peterborough and Stamford Hospitals NHS Foundation Trust are leading on the "Greater Peterborough Health Investment Plan" to develop healthcare services within Peterborough. The aim is to have the £270 million project formally approved in January 2006.

NHS foundation trust	Private finance initiative scheme
University College London Hospitals	A £422 million scheme to develop a new 18 storey University College Hospital on Euston Road in London. This will consolidate four of the existing hospitals into one central London site. The new building will open in two phases – stage one in 2005 and stage two in 2008. A number of the existing trust properties will be sold and the funds received will be invested in the scheme.
Derby Hospitals	Derby is currently building a new £333 million hospital on the Derby City General Hospital site. The new hospital is due for completion in 2008 and will provide the very latest in modern healthcare.
Gloucestershire Hospitals	A £32 million scheme to develop accident and emergency, acute medical inpatients, outpatients and therapy services and a dedicated Children's Centre on the Gloucestershire Royal Infirmary site as part of the Gloucestershire Healthcare Partnership Scheme.
Cambridge University Hospitals	In October 2004 the Trust signed a PFI deal for the construction of an Elective Care, Diabetes and Genetics Centre. The facility will open in the autumn of 2007 providing 128 beds and six theatres for day procedures and short-stay surgery.
Sheffield Teaching Hospitals	A £30 million scheme reached financial close in December 2004. The scheme relates to the construction of a new medical ward block on the Great Northern Hospital site due for completion by September 2006.

Increasing patient and public involvement to develop services

The new governance arrangements for NHS foundation trusts give an opportunity for patient and public representatives to shape the organisation's services. The initial consultation carried out by NHS trusts on becoming an NHS foundation trust also provided the opportunity to engage with a wider range of organisations, community and representatives and other stakeholders than previously had been the case. Many NHS foundation trusts have, as a consequence, developed initiatives to improve services.

At a practical level a common initiative has been to improve travel arrangements to hospitals with:

- increased car parking – Basildon and Thurrock University Hospital NHS Foundation Trust opened a new car park on land leased by Thurrock and Basildon College, providing an additional 320 spaces. The arrangement was a direct result of the College Principal being an appointed governor on the Members' Council; and
- improved public transport access such as 'park and ride' services – Royal Devon and Exeter NHS Foundation Trust has this year expanded its 'park and ride' bus service with the operator bringing into service three buses with greater capacity and easier access for people with mobility problems.

Members have also been involved in helping NHS foundation trusts deal with infection control. At Chesterfield NHS Foundation Trust, members were invited to have their say on proposals to adopt controlled visiting hours and restrict the number of patients at a patient's bed. The proposals aimed to reduce the risk of infection, make cleaning easier throughout the day, give patients protected mealtimes and longer rest times. The response was high – 40% of members responded, with 98% in favour of the proposals.

In addition to these practical initiatives, NHS foundation trusts are involving their governors in developing future plans. For example, at Gateshead Health NHS Foundation Trust, governors are working with the Board of Directors to contribute to the development of the Top 10 priorities for their annual plan. Members are being asked for their views via a questionnaire and five working groups covering key topics, each with an executive and non-executive director, will take these views into account, ensuring that members have their say. All the work is being fed back through the Board of Governors and will be debated at members' constituency meetings in November.

Cambridge University Hospitals NHS Foundation Trust – innovation for patients

Malcolm Stamp, Chief Executive of Cambridge University Hospitals NHS Foundation Trust sees that what patients want is changing: "Patients' expectations are growing. They want faster, more efficient care and they want to decide when and where they will be treated."

An ambitious programme

The freedoms now available to the NHS foundation trust have allowed it to embark on an ambitious programme of innovative services, initiatives and facilities to improve patient care.

A state-of-the-art neuroangiography suite has improved the accuracy of images used in the diagnosis and treatment of neurological conditions.

New genito-urinary medicine clinic facilities have meant achievement of modern standards of service delivery in line with the national sexual health strategy and a streamlined, multi-disciplinary renal, genetic and tubular disorders clinic has reduced waiting times, allowing patients to see all their specialists in one visit.

A plastic surgery breast re-construction nurse specialist has provided support and advice for patients on their journey though clinic visits, check ups and surgery.

Provision of a surgical practitioner in plastic and reconstructive surgery has freed up surgeons' time by assisting in theatre and performing a range of clinical and supportive duties as well as discussing procedures with patients in pre-assessment clinics, whilst the award-winning cardioversion clinic has speeded up the assessment and treatment of patients with irregular heart rhythms.

"Many of these things would have happened anyway, but they would have taken years to initiate rather than 12 months," says Malcolm Stamp.

New freedoms

An exciting project to reorganise emergency care is underway at the hospital, scheduled for completion early in 2006. A new Emergency Assessment Unit (EAU) is being built to provide a 'one front door' facility where patients will be assessed and treated quickly by the right staff.

Accident and Emergency Consultant Susan Robinson is looking forward to the changes the unit will bring: "A key difference is that there will be a complete re-structuring of processes involving all specialists in the hospital.

"Getting the right patients to the right wards, being looked after by the right specialists reduces mortality, morbidity and length of stay."

Malcolm Stamp, Chief Executive of Cambridge University Hospitals NHS Foundation Trust speaks with staff in the new neuroangiography suite

Accident and Emergency Consultant Susan Robinson

Stephen Graves is Director of Corporate Development at Cambridge University Hospitals NHS Foundation Trust. His job is to drive forward change, improving working practices to provide better services for patients, to encourage good ideas and to help implement them. He believes the EAU project will be operational years in advance of what would have happened without NHS foundation trust status and that it will bring the freedom to make decisions quickly.

"The connection between idea, concept and reality is now in a different ballpark," he says. "The added element of accountability to governors and the membership is pushing us quickly to the philosophy that patients are our customers, reminding us that we are here to provide services to the public."

Stephen Graves, Director of Corporate Development

"Many of these things would have happened anyway but they would have taken years to initiate, rather than 12 months."

Malcolm Stamp, Chief Executive, Cambridge University Hospitals NHS Foundation Trust

Analysis of consolidated accounts of NHS foundation trusts

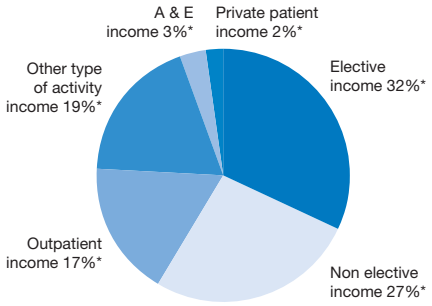
Income and expenditure analysis

Income and expenditure		
Total income	**Year ended 31 March 2005 (£ million)**	**% of income**
Income from activities	3,376.8	83%
Other operating income	715.1	17%
Total income	**4,091.9**	**100%**
Operating expenses	(4,038.3)	
Operating surplus	**53.6**	**1.3%**
Loss on disposal	(1.3)	
Interest and other finance charges	8.0	
Surplus for the year	**60.3**	**1.5%**
PDC dividends payable	(97.2)	
Retained deficit	**(36.9)**	**(0.9)%**

Income from activities

Income from treating elective inpatients and day-case patients accounted for 32% of NHS foundation trusts' income in 2004-05, with 27% relating to non-elective treatments being emergency admissions and 3% of activity relating to A&E attendances. Other activity income representing 19% of income relates to other patient related income which is not under tariff and includes such areas as community midwifery and critical care.

Consolidated income from activities



	£ million
Elective income	1,113.4
Non-elective income	924.5
Outpatient income	599.0
Other type of activity income	653.8
A & E income	112.9
Private patient income	73.3
Subtotal before net clawback	**3476.9**
Net clawback	(100.1)
Total	**3,376.8**

* Excluding Payment by Results transitional gain net of clawback

Private patient income

Private patient income totalled 2% of total patient related income for the year ended 31 March 2005. Each NHS foundation trust is required to limit the percentage of private patient income to the same level as it was when the organisation was an NHS trust in 2002-03. The Royal Marsden NHS Foundation Trust has the highest private patient cap at 30.7% whereas Stockport NHS Foundation Trust, Barnsley NHS Foundation Trust and South Tyneside NHS Foundation Trust have the lowest cap at 0.1%. None of the NHS foundation trusts breached their respective private patient caps in 2004-05.

Total private patient income for NHS foundation trusts

	Year ended 31 March 2005 (£ million)
Private patient income	73.3
Total patient related income	3,376.8
Proportion (as percentage)	2.2%

Private patient income for each NHS foundation trust

NHS foundation trust	Private patient cap %
The Royal Marsden	30.7
Moorfields Eye Hospital	14.1
Papworth Hospital	6.1
University College London Hospitals	5.9
Harrogate and District	3.1
Guy's and St Thomas'	2.9
Gloucestershire Hospitals	2.1
Cambridge University Hospitals	2.0
University Hospital Birmingham	1.3
Royal Devon and Exeter	1.2
Derby Hospitals	1.2
Bradford Teaching Hospitals	1.0
Sheffield Teaching Hospitals	0.9
Basildon and Thurrock University Hospitals	0.6
Countess of Chester Hospital	0.6
Peterborough and Stamford Hospitals	0.6
City Hospitals Sunderland	0.4
Gateshead Health	0.3
Doncaster and Bassetlaw Hospitals	0.2
Homerton University Hospital	0.2
Queen Victoria Hospital	0.2
Chesterfield Royal Hospital	0.2
Stockport	0.1
Barnsley Hospital	0.1
South Tyneside	0.1

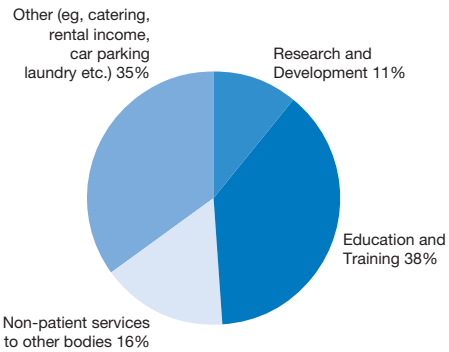
The private patient cap is calculated by dividing private patient income by total patient related income. Private patient income is defined as non-NHS private patient income. Patient related income includes the following:

- income received from primary care trusts and specialist commissioners for contracted patient care services;
- income received from other NHS trusts for contracted patient care services;
- income received from the Department of Health for patient care services;
- non-NHS private patient income;
- other income for patient care services (including income from Road Traffic Act, the Ministry of Defence, local authorities etc); and
- any amounts received from strategic health authorities for patient care services, including income for overseas patients treated under reciprocal agreements.

Other operating income

Other operating income totalled £715.1 million representing 17% of total income.

Other income analysis 2004-05



	£ million
Research and Development	76.3
Education and Training	279.6
Non-patient services to other bodies	111.9
Other	247.3
Total	**715.1**

Analysis of costs

Breakdown of costs at NHS foundation trusts	Year ended 31 March 2005 (£ million)	% of total
Staff costs	2,575.8	63.8%
Drugs and clinical supplies	698.5	17.3%
Other	764.0	18.9%
Total costs	4,038.3	100%

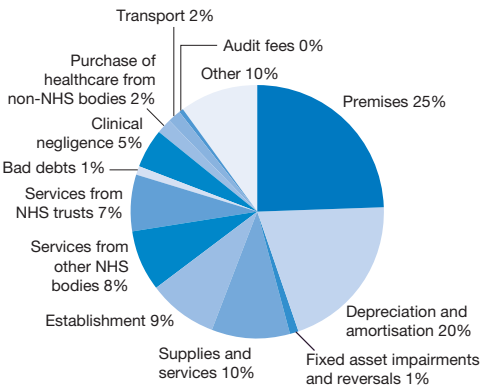
Staff costs

Staff costs are the single most significant cost to the NHS foundation trusts. In aggregate these were £2,575.8 million representing 63.8% of the total costs of the NHS foundation trusts in the year ended 31 March 2005. Underlying these costs, the average number of people working for all the NHS foundation trusts in the period was 98,772 including 10,790 doctors and dentists; 35,969 nurses; 12,457 healthcare assistants; and 14,529 scientific, therapeutic and technical staff.

Drug and clinical supplies

Drug and clinical supplies purchased to support patient care totalled £698.5 million in the period representing 17.3% of total costs.

Analysis of other costs year ended 31 March 2005



	£ million
Premises	187.7
Depreciation and amortisation	154.8
Fixed asset impairments and reversals	7.9
Supplies and services – general	77.0
Establishment	67.4
Services from other NHS bodies	60.8
Services from NHS trusts	53.9
Bad debts	8.9
Clinical negligence	37.9
Purchase of healthcare from non-NHS bodies	15.0
Transport	14.1
Audit fees	2.4
Other	76.2
Total	**764.0**

Balance sheet analysis

At 31 March 2005 NHS foundation trusts had strong balance sheets including fixed assets of £4.4 billion and £117.2 million of cash. Total assets employed were £4.3 billion. All NHS foundation trusts had complied with their prudential borrowing limits (PBL) set by Monitor. As at 31 March 2005 actual borrowing was 4% of the limit set.

Summary balance sheet	Year ended 31 March 2005 (£ million)
Total fixed assets	4,361.4
Net current assets	46.8
Long term creditors	(95.9)
Total assets employed	**4,312.3**

Capital investment

NHS foundation trusts incurred capital expenditure on tangible fixed asset additions totalling £224.8 million during the year. £6 million of this expenditure was borrowed from the Foundation Trust Financing Facility, and a further £137.0 million was financed through the draw down of PDC. In addition NHS foundation trusts received £31.2 million of donated asset additions, bringing the total additions to £256.0 million. £114.0 million (45%) of the fixed asset additions occurred at five NHS foundation trusts.

NHS foundation trust	Capital expenditure
Cambridge University Hospitals	£19m was spent to support infrastructure improvements at the trust with the most significant project being expenditure on four new operating theatres.
Guy's and Thomas'	£29 million was spent on infrastructure improvement projects and completing the construction of the first new children's hospital in London in 100 years which opened in October 2005.
Royal Devon and Exeter	£18 million was invested in: the redevelopment of women's health services; a new MRI scanner; a walk-in centre for patients with minor ailments and the opening of a new education centre for trainee doctors.
Sheffield Teaching Hospitals	£25 million was spent to support initiatives on statutory compliance and infrastructure improvements, new and replacement medical equipment, waiting list and access improvements and new service developments (such as the Weston Park Hospital redevelopment, cardiology capacity expansion and modifications to urology).
University College London Hospitals	£23 million was spent on the redevelopment of the Royal London Homoeopathic Hospital, the VIE (Vacuum Insulated Evaporator) plant scheme and the Chenies Mews development as well as on medical equipment and other infrastructure developments.

Cash flow analysis

NHS foundation trusts increased their cash balances by £78.0 million in the year ended 31 March 2005. The improvement in the cash balance in the year resulted in interest receipts of £9.0 million.

Operating cash flow generated by the NHS foundation trusts in the year ended 31 March 2005 was £296.9 million which was primarily derived from operating surpluses of £53.6 million; the non-cash impact of depreciation of £154.8 million; and a net increase in working capital. The operating cash flow was primarily utilised to acquire £249.8 million of tangible fixed assets and to settle the dividend payments to the Department of Health. Other significant cash movements in the year related to funding for capital projects received in the form of public dividend capital of £137.5m and loans from the Foundation Trust Financing Facility totalling £6.0 million and other capital receipts of £36.5 million. These movements were the key drivers of the net increase in cash for the year.

Accounts
Foreword to the accounts

The Independent Regulator of NHS Foundation Trusts (Monitor) is responsible for authorising, monitoring and regulating NHS foundation trusts and was established under the Health and Social Care (Community Health and Standards) Act 2003 (the Act). Paragraph 25(6)(a) of Schedule 1 of the Act requires newly authorised NHS foundation trusts to prepare accounts for the period beginning with the date on which they are authorised and ending with the following 31 March and submit them to Monitor. These accounts must be audited by auditors appointed by each NHS foundation trust's board of governors.

Paragraph 11(3) of Schedule 2 of the Act requires Monitor to prepare a report which provides an overall summary of the accounts of NHS foundation trusts, lay this before Parliament and send a copy to the Secretary of State for Health. There is no specification as to the nature of this summary and no requirement for an audit of this summary. However, in order to ensure the transparency and accuracy of its report, Monitor has prepared a full consolidation of the accounts of NHS foundation trusts for its report and has requested the Comptroller and Auditor General to audit the consolidated accounts presented in this report.

The accounts presented in this report have been prepared from a consolidation of the audited accounts submitted by the 25 individual NHS foundation trusts who were authorised by Monitor during 2004-2005. The dates of authorisation of these 25 NHS foundation trusts and period of inclusion in the consolidated accounts presented in this report are as follows:

Authorised 1 April 2004 and consolidated for the year ended 31 March 2005

- Basildon and Thurrock University Hospitals NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Countess of Chester Hospital NHS Foundation Trust
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust
- Homerton University Hospital NHS Foundation Trust
- Moorfields Eye Hospital NHS Foundation Trust
- Peterborough and Stamford Hospitals NHS Foundation Trust
- Royal Devon & Exeter NHS Foundation Trust
- Stockport NHS Foundation Trust
- The Royal Marsden NHS Foundation Trust

Authorised 1 July 2004 and consolidated for the nine month period ended 31 March 2005

- Cambridge University Hospitals NHS Foundation Trust
- City Hospitals Sunderland NHS Foundation Trust
- Derby Hospitals NHS Foundation Trust
- Gloucestershire Hospitals NHS Foundation Trust
- Guy's and St. Thomas' NHS Foundation Trust
- Papworth Hospital NHS Foundation Trust
- Queen Victoria Hospital NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- University College London Hospitals NHS Foundation Trust
- University Hospital Birmingham NHS Foundation Trust

Authorised 1 Jan 2005 and consolidated for the three month period ended 31 March 2005

- Barnsley Hospital NHS Foundation Trust
- Chesterfield Royal Hospital NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- South Tyneside NHS Foundation Trust

Authorised 5 Jan 2005 and consolidated for the 85 day period ended 31 March 2005

- Gateshead Health NHS Foundation Trust

As NHS foundation trusts have only been established during 2004-2005, no prior period comparatives are included in the consolidated accounts. Individual NHS foundation trusts have included an opening balance sheet position in their accounts but this has not been replicated in the consolidation due to the different start dates for the NHS foundation trusts.

Consolidated results for the year ended 31 March 2005

In aggregate, NHS foundation trusts made a surplus before dividend payments for the period ended 31 March 2005 of £60.3 million.

As part of their financial duties NHS foundation trusts are required to pay a dividend to the Department of Health in respect of the public capital they utilise. After the payment of this dividend NHS foundation trusts made a deficit of £36.9 million for the year ended 31 March 2005.

Pages 4 to 31 set out a review of the NHS foundation trusts' development during the year.

Statement of responsibilities and accountability framework

Dr William Moyes is the Executive Chairman of Monitor. In this capacity under Paragraph 11(3) of Schedule 2 of the Act he is responsible for ensuring that Monitor prepares a report which provides an overall summary of the accounts of NHS foundation trusts to lay before Parliament. He is not the accounting officer for each individual NHS foundation trust; this is the role of each NHS foundation trust's chief executive.

Monitor is responsible for determining, with the approval of HM Treasury, the form of accounts that each NHS foundation trust must adopt. This is codified within the *Manual for Accounts*, which is based on the HM Treasury's *Resource Accounting Manual*. A list of divergences, which have been agreed with the Financial Reporting Advisory Board, can be found on Monitor's website. The manual specifically requires:

- the application of suitable accounting policies on a consistent basis;
- judgements and estimates to be made on a reasonable basis;
- a statement within the accounts as to whether applicable accounting standards have been followed, and to disclose and explain any material departures; and
- the preparation of the accounts on a going concern basis.

In discharging his responsibilities under Section 11(3) of Schedule 2 of the Act, Monitor has prepared a consolidated account on a basis consistent with the individual foundation trust accounts, and consolidated in accordance with UK Generally Accepted Accounting Practice.

Statements on internal control

Monitor's system of internal control is designed to support the achievement of Monitor's policies, aims and objectives. In relation to preparing these accounts, Monitor has established the following processes to ensure these accounts provide a true and fair view of the state of affairs of the NHS foundation trust sector:

- obtaining expertise in accounts preparation for the consolidation;
- provision of guidance to the NHS foundation trusts and their auditors, including consolidation processes. This has been approved by HM Treasury;
- establishment of the Technical Issues Forum to ensure consistent financial reporting and audit;
- reliance on the work of the auditors of NHS foundation trusts over the truth and fairness of each set of accounts that have been consolidated into the consolidated accounts presented in this report. The board of governors of each NHS foundation trust is responsible for appointing external auditors. These auditors have undertaken an audit in accordance with the *Audit Code for NHS Foundation Trusts*, issued by Monitor;
- the appointment of the Quality Assurance Directorate of the Institute of Chartered Accountants in England and Wales to undertake a review of the quality of the work of these auditors;
- the appointment of the Comptroller and Auditor General to undertake an audit of the consolidated accounts presented in this report; and
- consideration by management and Monitor's audit committee of the consolidated account and the processes established to derive them.

The Board of Monitor is not accountable for the internal control of NHS foundation trusts; this is the remit of the board of each individual NHS foundation trust. The chief executive as accounting officer of each NHS foundation trust has the responsibility for maintaining a sound system of internal control that supports the achievement of that NHS foundation trust's policies, aims and objectives. In addition the chief executives have responsibility for safeguarding the public funds and the organisation's assets as set out in the *NHS Foundation Trusts' Accounting Officer Memorandum*.

Each NHS foundation trust's annual report and accounts, presented to Parliament directly, included a statement on internal control for the year ended 31 March 2005. These statements confirmed that all the NHS foundation trusts had systems of internal control in place for the financial year 2004-05 and up to the dates of approval of their annual reports and accounts. Each individual statement on internal control explains how the accounting officer has reviewed the effectiveness of internal control during the period and highlights any significant control issues, where the risk cannot be effectively controlled.

Highlights of NHS foundation trusts' statements on internal control

As reported in the individual statements, the NHS foundation trusts have faced a challenging year with the adjustment to a new regulatory regime as well as the implementation of a variety of Government initiatives including Agenda for Change, consultants' contract and Payment by Results. In addition to these challenges, many NHS foundation trusts have been implementing new systems, in particular electronic patient records to enhance data capture and improve patient care.

Whilst not highlighted as significant control issues, several NHS foundation trusts noted concerns in relation to financial deficits. Monitor will review progress against these control issues through the compliance regime.

Many NHS foundation trusts reported improvements to their internal control systems during the year, including:

- increased emphasis on a risk based approach to control including more widespread risk management training;
- the establishment of assurance frameworks linked to performance management to enhance the system of internal control; and
- more stringent financial monitoring and the alignment of financial and business objectives.

The focus for the system of internal control for 2005-06 for many of the NHS foundation trusts is on:

- further development of the risk based approach to internal control;
- implementation of systems to further advance data capture; and
- maximising the benefits of the Patient Choice initiative as well as the initiatives introduced in 2004-05.

Significant controls issues

Two of the twenty-five NHS foundation trusts disclosed significant control issues in their statements on internal control.

Bradford Teaching Hospitals NHS Foundation Trust

In 2004-05 Bradford Teaching Hospitals was subject to a significant control issue with regard to its financial position. As it approached mid-year, a year-end deficit of approximately £11m was predicted. Monitor intervened using its powers under the Act in October 2004. Since this date the trust has been under monthly monitoring and a financial recovery plan has been implemented to address the issues noted above. By the year-end the deficit had reduced to £8m.

Homerton University Hospital NHS Foundation Trust

As noted in the 2003-04 statement on internal control, the implementation of the electronic patient records system presented a number of operational and financial challenges. A detailed project plan has been established and significant additional resources have been invested in the system to ensure that its benefits are fully maximised in future years and that all material risks identified have been mitigated.

William Moyes
Executive Chairman
21 October 2005

The Certificate of the Comptroller and Auditor General to the Independent Regulator of NHS Foundation Trusts

Consolidated accounts of NHS foundation trusts

I certify that I have audited the financial statements on pages 38 to 56, in accordance with the letter of engagement dated 19 August 2005. These financial statements have been prepared under the historical cost convention as modified by the revaluation of certain fixed assets and the accounting policies set out on pages 41 to 46.

Respective responsibilities of the Independent Regulator of NHS Foundation Trusts and the Auditor

The Independent Regulator of NHS Foundation Trusts (Monitor) is responsible under the Health and Social Care (Community Health and Standards) Act 2003 for preparing a report which provides an overall summary of the accounts of NHS foundation trusts. As described on page 34, in discharging his responsibilities under Section 11(3) of Schedule 2 of the Act, Monitor has prepared a consolidated account on a basis consistent with the individual foundation trust accounts, and consolidated in accordance with UK Generally Accepted Accounting Practice. Monitor is also responsible for the preparation of the other contents of the Annual Report. In discharging my responsibilities as independent auditor, I have regard to the standards and guidance issued by the Auditing Practices Board and the ethical guidance applicable to the auditing profession.

I report my opinion as to whether the financial statements give a true and fair view. I also report if, in my opinion, the Foreword is not consistent with the financial statements, if Monitor has not kept proper accounting records, or if I have not received all the information and explanations I require for my audit.

I read the other information contained in the Annual Report and consider whether it is consistent with the audited financial statements. I consider the implications for my certificate if I become aware of any apparent misstatements or material inconsistencies with the financial statements. I am not required to form an opinion on the effectiveness of the corporate governance procedures or risk and control procedures operated by Monitor or the individual NHS foundation trusts.

Basis of audit opinion

I conducted my audit in accordance with United Kingdom Auditing Standards issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures of financial transactions included in the financial statements. It also includes an assessment of the significant estimates and judgements made by Monitor in the preparation of the financial statements, and of whether the accounting policies are appropriate to the circumstances of the NHS foundation trust sector, consistently applied and adequately disclosed.

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

Opinion

In my opinion the financial statements give a true and fair view of the state of affairs of the NHS foundation trust sector at 31 March 2005 and of the deficit, total recognised gains and losses and cash flows for the year then ended.

John Bourn
Comptroller and Auditor General
4 November 2005

National Audit Office
157-197 Buckingham Palace Road
Victoria, London SW1W 9SP

Financial statements and notes

Consolidated income and expenditure account – year ended 31 March 2005

	Note	2005 £ million
Income from activities	2.1	3,376.8
Other operating income	2.2	715.1
Operating expenses	3.1	(4,038.3)
Operating surplus		**53.6**
Loss on disposal of fixed assets	5	(1.3)
Surplus before interest		**52.3**
Interest receivable		9.4
Interest payable	6	(0.6)
Other finance costs – unwinding of discount	15	(0.8)
Surplus for the year		**60.3**
PDC dividends payable	16	(97.2)
Retained deficit for the year		**(36.9)**

All operations are continuing.

Consolidated statement of total recognised gains and losses – year ended 31 March 2005

	Note	2005 £ million
Surplus for the financial year before dividend payments		60.3
Fixed asset impairment losses	18	(5.6)
Unrealised surplus on fixed assets and current asset investments revaluations	18	252.3
Increase in the donated asset/Government grant reserve due to receipt of donated/Government granted assets	18	49.5
Reductions in the donated asset/Government grant reserve due to depreciation, impairment, and/or disposal of donated/Government granted assets and other reserve movements	18	(19.2)
Total recognised gains and losses for the financial year		**337.3**

The notes on pages 41 to 56 form part of these accounts.

Consolidated balance sheet – as at 31 March 2005

	Note	£ million	2005 £ million
Fixed assets			
Intangible assets	7.1		6.1
Tangible assets	8.1		4,355.3
Total fixed assets			**4,361.4**
Current assets			
Stocks and work in progress	9	83.6	
Debtors	10	374.1	
Investments	11	36.4	
Cash at bank and in hand		117.2	
		611.3	
Creditors			
Amounts falling due within one year	12	(564.5)	
Net current assets			**46.8**
Total assets less current liabilities			**4,408.2**
Long term creditors			
Amounts falling due after more than one year	12		(14.5)
Provision for liabilities and charges	15		(81.4)
Total assets employed			**4,312.3**
Financed by taxpayers' equity			
Public dividend capital	17		2,485.3
Revaluation reserve	18		1,366.1
Donated asset reserve	18		395.0
Government grant reserve	18		16.8
Other reserves	18		7.2
Income and expenditure reserve	18		41.9
Total taxpayers' equity			**4,312.3**

The notes on pages 41 to 56 form part of these accounts.

William Moyes
Executive Chairman
21 October 2005

Consolidated cash flow statement – year ended 31 March 2005

	Note	2005 £ million
Net cash flow from operating activities	19.1	**296.9**
Returns on investment and servicing of finance		
Interest received		9.3
Interest paid		(0.3)
Interest element of finance lease rental payments		(0.3)
Net cash inflow from returns on investments and servicing of finance		**8.7**
Capital expenditure		
Payments to acquire tangible fixed assets		(249.8)
Receipts from sale of tangible fixed assets		22.0
Payments to acquire intangible assets		(1.6)
Net cash outflow from capital expenditure		**(229.4)**
Dividends paid		(112.0)
Net cash outflow before management of liquid resources and financing		**(35.8)**
Management of liquid resources		
Purchase of current asset investments		(23.9)
Sale of current asset investments		9.0
Net cash outflow from management of liquid resources		**(14.9)**
Net cash outflow before financing		**(50.7)**
Financing		
New public dividend capital received		137.5
Public dividend capital repaid (not previously accrued)	17	(53.9)
Loans received from Foundation Trust Financing Facility	13	6.0
Other loans received	13	3.1
Other capital receipts		36.5
Capital element of finance lease rental payments		(0.5)
Net cash inflow from financing		**128.7**
Increase in cash	19.2	**78.0**

The notes on pages 41 to 56 form part of these accounts.

Notes to the accounts

1. Accounting policies

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

Basis of consolidation
This account aggregates the accounts of all NHS foundation trusts, using the principles of UK Generally Accepted Accounting Practice (UK GAAP) for consolidation. It presents the consolidated results of the NHS foundation trust sector, eliminating all inter-NHS foundation trust balances and transactions. Monitor is not the parent undertaking for NHS foundation trusts, and its results are not incorporated within these accounts, but were laid separately before Parliament (HC 195, 18 July 2005).

NHS foundation trusts have been included within these accounts using the acquisition method of accounting as if they were wholly owned subsidiaries even though Monitor is not the parent undertaking. Accordingly, the income and expenditure and the statement of cashflows include the results and cashflows of the NHS foundation trusts from the date of authorisation for each organisation. There are therefore no comparative figures and the opening balance is nil, with the assets and liabilities being brought into the balance sheet on the day of transfer at the carrying value accounted for by the predecessor NHS trust, unless materially different to fair value. No such adjustments were necessary in 2004-2005.

Monitor has directed NHS foundation trusts, in accordance with Section 25 of Schedule 2 to the Health and Social Care Act 2003, to apply the accounting requirements of the NHS foundation trusts' Manual for Accounts, which has been approved by HM Treasury. The accounting policies contained within the manual are broadly consistent with those specified in HM Treasury's *Resource Accounting Manual* (RAM), which itself follows UK GAAP, to the extent that it is meaningful and appropriate in the public sector context. The divergences from the RAM are listed on Monitor's website, and have been designed to ensure an appropriate financial reporting framework for the NHS foundation trust sector. HM Treasury's Financial Reporting Advisory Board have approved these limited divergences. The Manual for Accounts has also been used in preparing this consolidated account.

NHS foundation trusts are not required to comply with FRS 3 regarding historical profits and losses.

Acquisitions and discontinued operations
Activities are considered to be 'discontinued' where they meet all of the following conditions:

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

Operations not satisfying all these conditions are classified as continuing. Activities are considered to be 'acquired' whether or not they are acquired from outside the public sector.

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

Tangible and intangible fixed assets
Intangible assets are capitalised when they are capable of being used in a trust's activities for more than one year; they can be valued; and they have a cost of at least £5,000. Intangible fixed assets held for operational use are valued at historical cost and are depreciated over the estimated life of the asset on a straight line basis. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Purchased computer software licences are amortised over the shorter of the term of the licence and the useful economic life.

Tangible assets are capitalised if they are capable of being used for a period which exceeds one year and they:

- individually have a cost of at least £5,000; or
- form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Tangible fixed assets are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost (for leased assets, fair value) including any costs such as installation directly attributable to bringing them into working condition. They are restated to current value each year. The carrying values of tangible fixed assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable.

All land and buildings are restated to current value using professional valuations in accordance with FRS 15 every five years. A three yearly interim valuation is also carried out. Professional valuations are conducted by the District Valuers of the Inland Revenue Government Department. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. The last asset valuations were undertaken in 2004 as at the prospective valuation date of 1 April 2005. The revaluation undertaken at that date has been accounted for on 31 March 2005. The valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property, including land for existing use. Additional alternative Open Market Value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal. All impairments resulting from price changes are charged to the statement of total recognised gains and losses. If the balance on the revaluation reserve is less than the impairment, the difference is taken to the income and expenditure account. Assets in the course of construction are valued at cost and are included as part of the valuation exercise once they are brought into use. Residual interests in off-balance sheet private finance initiative properties are included in assets under construction within tangible fixed assets at the amount of unitary charge allocated for the acquisition of the residual with an adjustment. The adjustment is the net present value of the change in the fair value of the residual as estimated at the start of the contract and at the balance sheet date. Operational equipment is valued at net current replacement cost. Equipment surplus to requirements is valued at the net recoverable amount.

Depreciation, amortisation and impairments
Tangible fixed assets are depreciated at rates calculated to write them down to estimated residual value on a straight-line basis over their estimated useful lives. No depreciation is provided on freehold land, and assets surplus to requirements. Assets in the course of construction and residual interests in off-balance sheet PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively. Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as advised by the District Valuer. Leaseholds are depreciated over the primary lease term. Equipment is depreciated on the current cost evenly over the estimated life.

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

Investments
Investments in subsidiary undertakings, associates and joint ventures are treated as fixed asset investments and valued at cost less any amounts written off. Deposits and other investments that are readily convertible into known amounts of cash at or close to their carrying amounts are treated as liquid resources in the cash flow statement.

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

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. Where the Government grant is used to fund revenue expenditure it is taken to the income and expenditure account to match that expenditure. Where the grant is used to fund capital expenditure the grant is taken to the Government Grant reserve and released to the income and expenditure account over the life of the asset on a basis consistent with the depreciation charge for that asset.

Private finance initiative (PFI) transactions
The NHS follows HM Treasury's Technical Note 1 (Revised) "How to Account for PFI transactions" which provides definitive guidance for the application of Application note F to FRS 5. Where the balance of the risks and rewards of ownership of the PFI property are borne by the PFI operator, the PFI payments are recorded as an operating expense. Where the trust has contributed land and buildings, a prepayment for their fair value is recognised and amortised over the life of the PFI contract by charge to the income and expenditure account. Where, at the end of the PFI contract, a property reverts to the trust, the difference between the expected fair value of the residual on reversion and any agreed payment on reversion is built up over the life of the contract by capitalising part of the unitary charge each year, as a tangible fixed asset. Where the balance of risk and rewards of ownership of the PFI property are borne by the trust, it is recognised as a fixed asset along with the liability to pay for it which is accounted for as a finance lease. Contract payments are apportioned between an imputed finance lease charge and a service charge.

Stocks and work-in-progress
Stocks and work-in-progress are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to current cost due to the high turnover of stocks. Work-in-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress.

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

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

Expenditure so deferred is limited to the value of future benefits expected and is amortised through the income and expenditure account on a systematic basis over the period expected to benefit from the project. It is revalued on the basis of current cost. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. Where possible, NHS foundation trusts disclose the total amount of research and development expenditure charged in the income and expenditure account separately. However, where research and development activity cannot be separated from patient care activity it cannot be identified and is therefore not separately disclosed.

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

Provisions
NHS foundation trusts provide 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 the Treasury's discount rate of 3.5% in real terms.

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which NHS foundation trusts pay 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 NHS foundation trusts. The total value of clinical negligence provisions carried by the NHSLA on behalf of NHS foundation trusts is disclosed in Note 15 to the Accounts.

Non-clinical risk pooling
NHS foundation trusts participate in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trusts pay an annual contribution to the NHS Litigation Authority and in return receive 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.

Pension costs
Past and present employees are covered by the provisions of the NHS Pensions Scheme. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. As a consequence it is not possible for NHS foundation trusts to identify their share of the underlying scheme liabilities. The Scheme is subject to a full valuation every four years by the Government Actuary. The last published valuation relates to the period 1 April 1994 to 31 March 1999. The valuation as at 31 March 2003 has not yet been published. Between valuations, the Government Actuary provides an update of the scheme liabilities. 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 Agency website at www.nhspa.gov.uk. Copies can also be obtained from The Stationery Office. The notional surplus of the scheme is £1.1 billion as per the last scheme valuation by the Government Actuary for the period 1 April 1994 to 31 March 1999. The conclusion of the valuation was that the scheme continues to operate on a sound financial basis. Employers pension cost contributions are charged to operating expenses as and when they become due. Employer contribution rates are reviewed every four years following the scheme valuation, on advice from the actuary. At the last valuation on which contribution rates were rebased (31 March 1999) employer contribution rates from 2003-04 were set at 14% of pensionable pay. Employees pay contributions of 6% (manual staff 5%) of their pensionable pay. 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 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 pensionable pay for death in service, and up to five times their annual pension for death after retirement is payable. 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 employees can make contributions to enhance their pension benefits. The benefits payable relate directly to the value of the investments made. Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the income and expenditure account at the time the trust commits itself to the retirement, regardless of the method of payment.

The pension payments for the period are charged to the income and expenditure account. Details are included in Note 5 to the Accounts.

Value added tax
Most of the activities of NHS foundation trusts 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.

Foreign exchange
Transactions that are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the income and expenditure account.

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 trusts have no beneficial interest in them. However, they are disclosed in Note 26 to the Accounts in accordance with the requirements of the Resource Accounting Manual.

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

Protected assets
Section 16 of the Health and Social Care (Community Health and Standards) Act 2003 provides that:

"An NHS foundation trust may not dispose of any protected property without the approval of the Regulator. Disposing of property includes disposing of part of it or granting an interest in it."

Protected property is property designated as protected in the Terms of Authorisation (ToA) of an NHS foundation trust. Condition 9 of the ToA defines property as protected if it is required for the purposes of providing either the mandatory goods and services or the mandatory education and training as defined in the ToA ('mandatory goods and services'). Note 9.2 provides details of the protected assets of NHS foundation trusts as at 31 March 2005.

Losses and special payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments, are divided into specific categories and separately reported and disclosed in the accounts to draw them to the attention of Parliament and other stakeholders.

"Losses" include both real stock and cash losses as well as bookkeeping losses; including losses arising from overpayments to staff or suppliers due to miscalculation, misinterpretation of regulations or other errors, and any improperly authorised payments. "Losses" can also arise from the failure to make adequate charges or collect payments for the use of public property or services; including fruitless payments (for which liability ought not to have been incurred) and constructive losses (arising due to changes in policy or standards) as well as Claims on others waived or abandoned. "Special payments" refer to extra-contractual and ex-gratia payments to suppliers, contractors or members of the public, for example, injury, damage or loss where no liability is accepted; other ex-gratia payments; compensation payments (including those decided in court) and extra-statutory and extra-regulatory payments. Note 22 provided details of losses and special payments incurred by NHS foundation trusts.

Post-balance sheet events
From 1 April 2005 HM Treasury changed the discount rate used in calculating provisions from 3.5% to 2.2%. This change will result in an increase in provisions which will be charged to the income and expenditure account in 2005-06. National funding of NHS commissioners will be increased by the total estimated effect to offset this charge.

2.1 Income from activities

	2005
	£ million
Elective income	1,113.4
Non-elective income	924.5
Outpatient income	599.0
Other type of activity income	653.8
A & E income	112.9
PBR transitional relief	57.6
PBR clawback	(157.7)
Private patient income	73.3
Total	**3,376.8**

2.2 Other operating income

	2005
	£ million
Research and development	76.3
Education and training	279.6
Charitable and other contributions to expenditure	12.9
Transfers from donated asset reserve	17.0
Transfers from the Government grant reserve	2.1
Non-patient care services to other bodies	111.9
Other	215.3
Total	**715.1**

There are many elements making up the 'Other income' figure for the year ended 31 March 2005 across the 25 NHS foundation trusts. These are described in more detail in the 'analysis of consolidated accounts of NHS foundation trusts' section on pages 31 to 28, but significant sources include:

- car parking charges;
- accommodation & utility charges to external contractors or companies;
- staff accommodation rental income;
- catering, restaurant and concession income; and
- income from the Ministry of Defence.

3.1 Operating expenses

	2005
	£ million
Services from NHS trusts	53.9
Services from other NHS bodies	60.8
Purchase of healthcare from non-NHS bodies	15.0
Directors' costs	14.8
Staff costs	2,561.0
Drug costs	308.2
Supplies and services – clinical (excluding drug costs)	390.3
Supplies and services – general	77.0
Establishment	67.4
Transport	14.1
Premises	187.7
Bad debts	8.9
Depreciation and amortisation	154.8
Fixed asset impairments and reversals	7.9
Audit fees	2.4
Other auditors remuneration	0.1
Clinical negligence	37.9
Net increase in provisions	39.6
Other	36.5
Total	**4,038.3**

The audit fees disclosed represent the cost for the audit of the underlying financial statements and other work required by the *Audit Code for NHS Foundation Trusts* carried out by the auditors appointed by each NHS foundation trust.

3.2 Hire and operating lease rentals

	2005
	£ million
Hire of plant and machinery	7.4
Other operating leases	12.9

NHS foundation trusts are committed to make the following payments during the next financial year in respect of operating leases

	£ million	£ million
	Land and buildings	Other
Expiring within one year	0.6	2.3
Expiring between one and five years	4.1	10.0
Expiring after five years	37.2	9.1
Total	**41.9**	**21.4**

4.1 Staff costs

	2005 £ million
Salaries and wages	2,084.1
Social security costs	165.2
Employers' contribution to NHSPA	226.1
Other pension costs	0.1
Agency and contract staff	89.4
Seconded staff	9.9
Total	**2,574.8**

4.2 Average number of total staff

	2005
Medical and dental staff	10,790
Administration and estates staff	21,042
Healthcare assistants and other support staff	12,457
Nursing, midwifery and health visiting staff	35,969
Nursing, midwifery and health visiting learners	1,307
Scientific, therapeutic and technical staff	14,529
Social care staff	449
Bank and agency staff	1,336
Other	893
Total	**98,772**

4.3 Staff benefits

The amount spent on staff benefits during the year totalled £149,000.

4.4 Pensions

NHS foundation trusts participate in the NHS pension scheme. This is a statutory, defined benefit scheme, the provisions of which are laid down in the NHS Pension Scheme Regulations 1995 (SI 1995 No. 300). NHS foundation trusts pay contributions at rates specified from time to time by the Secretary of State, as advised by the Government Actuary and with the consent of HM Treasury. For 2004-2005, the contribution rate was 14%.

4.5 Retirements due to ill health

During 2004-05 there were 145 early retirements on the grounds of ill health. The estimated additional pension liability of these ill-health retirements (calculated on an average basis and borne by the NHS Pensions Scheme) will be £5.6 million.

5. Loss on disposal of fixed assets

	2005 £ million
Loss on disposal of intangible fixed assets	(0.1)
Profit on disposal of land and buildings	0.5
Loss on disposal of land and buildings	(0.7)
Loss on disposal of other tangible fixed assets	(1.0)
Total	**(1.3)**

6. Interest payable

	2005 £ million
Finance leases	(0.5)
Other	(0.1)
Total	**(0.6)**

7.1 Intangible fixed assets

	2005 £ million
Gross cost at start of period	9.7
Reclassifications	0.4
Additions – purchased	1.1
Additions – donated	0.3
Additions – Government granted	0.2
Disposals	(0.1)
Gross costs at 31 March 2005	**11.6**
Amortisation at start of period	4.1
Provided during the year	1.4
Amortisation at 31 March 2005	**5.5**
NBV – Purchased at start of period	5.3
NBV – Donated at start of period	0.3
Total at start of period	**5.6**
NBV – Purchased at 31 March 2005	5.4
NBV – Donated at 31 March 2005	0.5
NBV – Government granted at 31 March 2005	0.2
Total at 31 March 2005	**6.1**

All material intangible fixed assets consist of software licenses.

7.2 Analysis of intangible fixed assets

	2005 £ million
Net book value:	
– protected assets at 31 March 2005	3.0
– unprotected assets at 31 March 2005	3.1
Total	**6.1**

8.1 Tangible fixed assets

	2005								
	£ million	£ million	£ million	£ million	£ million	£ million	£ million	£ million	£ million
	TOTAL	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant and machinery	Transport equipment	Information technology	Furniture and fittings
Gross cost at start of period	**4,871.2**	656.3	2,938.9	56.7	208.3	828.9	8.4	134.7	39.0
Reclassifications	**0.0**	3.7	80.4	0.0	(103.7)	12.3	0.0	5.9	1.4
Impairments	**(10.6)**	0.0	(3.9)	(0.1)	(6.6)	0.0	0.0	0.0	0.0
Other revaluation	**10.5**	1.1	3.8	0.0	2.0	3.4	0.0	0.0	0.2
Additions – purchased	**213.5**	0.1	47.5	0.4	115.9	33.6	0.2	13.7	2.1
Additions – donated	**31.2**	0.1	3.8	0.0	21.6	4.8	0.0	0.8	0.1
Additions – Government granted	**11.3**	0.0	1.9	0.0	3.1	5.0	0.2	1.1	0.0
Disposals	**(62.1)**	(3.0)	(0.6)	(1.7)	(13.3)	(37.9)	(1.0)	(3.7)	(0.9)
National revaluation exercise	**68.2**	206.7	(150.2)	7.8	3.9	0.0	0.0	0.0	0.0
Gross costs at 31 March 2005	**5,133.2**	865.0	2,921.6	63.1	231.2	850.1	7.8	152.5	41.9
Depreciation at start of period	**836.7**	0.0	170.6	3.3	0.0	542.6	6.0	91.8	22.4
Provided during the year	**153.4**	0.0	91.5	1.3	0.0	47.6	0.6	9.8	2.6
Impairments	**3.1**	0.0	2.9	0.0	0.0	0.2	0.0	0.0	0.0
Reversal of impairments	**(0.2)**	0.0	(0.2)	0.0	0.0	0.0	0.0	0.0	0.0
Reclassifications	**0.4**	0.0	0.0	0.0	0.0	(0.4)	0.0	0.0	0.8
Other revaluation	**(173.6)**	0.0	(172.4)	(2.9)	0.0	1.7	0.0	0.0	0.0
Disposals	**(41.9)**	0.0	0.0	0.0	0.0	(36.3)	(1.0)	(3.7)	(0.9)
Depreciation at 31 March 2005	**777.9**	0.0	92.4	1.7	0.0	555.4	5.6	97.9	24.9
NBV – Purchased at start of period	**3,647.0**	623.8	2,543.4	51.9	139.9	229.4	2.1	40.9	15.6
NBV – Donated at start of period	**385.3**	32.5	222.9	1.5	68.4	56.9	0.3	1.8	1.0
NBV – Government granted at start of period	**2.2**	0.0	2.0	0.0	0.0	0.0	0.0	0.2	0.0
Total at start of period	**4,034.5**	**656.3**	**2,768.3**	**53.4**	**208.3**	**286.3**	**2.4**	**42.9**	**16.6**
NBV – Purchased at 31 March 2005	**3,951.4**	822.6	2,595.4	60.9	168.9	234.8	1.9	50.9	16.0
NBV – Donated at 31 March 2005	**394.5**	42.4	231.9	0.5	60.2	55.9	0.2	2.4	1.0
NBV – Government granted at 31 March 2005	**9.4**	0.0	1.9	0.0	2.1	4.0	0.1	1.3	0.0
Total at 31 March 2005	**4,355.3**	**865.0**	**2,829.2**	**61.4**	**231.2**	**294.7**	**2.2**	**54.6**	**17.0**

8.2 Analysis of tangible fixed assets

	2005
	£ million
Net book value	
– protected assets at 31 March 2005	**3,759.3**
– unprotected assets at 31 March 2005	**596.0**
Total at 31 March 2005	**4,355.3**

Net book value of assets held under finance leases and hire purchase contracts comprises £13.8 million of buildings excluding dwellings.

Depreciation charged in respect of assets held under finance leases and hire purchase contracts was £0.3 million.

8.3 Net book value of land, buildings and dwellings

	2005
	£ millions
Freehold	3,697.0
Long leasehold	58.2
Short leasehold	0.4
Total at 31 March 2005	**3,755.6**

9. Stock and work-in-progress

	2005 £ million
Pharmaceuticals and consumables	78.6
Finished goods	5.0
Total	**83.6**

10. Debtors

	2005 £ million
Debtors – amounts falling due within one year	
NHS Debtors	202.8
Provision for irrecoverable debts	(30.0)
Prepayments and accrued income	46.7
Other debtors	122.0
Total	**341.5**
Debtors – amounts falling due after one year	
NHS debtors	10.0
Provision for irrecoverable debts	(0.5)
Prepayments and accrued income	2.3
Other debtors	20.8
Total	32.6
Total debtors	**374.1**

11. Current asset investments

At 31 March 2005 four NHS foundation trusts held short term investments with a total value of £36.4 million. This amount consisted of £14.3 million cash on deposit and £22.1 million of interests in property and leases.

The £22.1 million of interests in property was owned by University College Hospitals NHS foundation trust and represented a forward property transaction with another public sector body in connection with the NHS foundation trust's ongoing private finance initiative (PFI) scheme.

12. Creditors

	2005 £ million
Creditors – amounts falling due within one year	
Bank overdrafts	5.4
Loans	0.3
Payments received on account	5.5
NHS Creditors	212.7
Obligations under finance lease and hire purchase contracts	0.5
Other creditors	176.2
Accruals and deferred income	163.9
Total	**564.5**
Creditors – amounts falling due after one year	
Loans	5.7
Obligations under finance lease and hire purchase contracts	6.8
Other	2.0
Total	**14.5**

13. Prudential borrowing limit

	2005
	£ million
Long term borrowing limit set by Monitor	234.3
Working capital limit set by Monitor	156.5
Total borrowing limit set by Monitor	**390.8**
Actual borrowing in the year – long term	6.0
Actual borrowing in the year – working capital	3.0

14. Finance lease obligations

	2005
	£ million
Leases payable:	
Within one year	0.8
Between one and five years	3.1
After five years	8.1
Finance charges allocated to future periods	(4.7)
Net obligations	**7.3**

15. Provisions for liabilities and charges

	2005				
	£ million	£ million	£ million	£ million	£ million
	Total	Pensions relating to former directors	Pensions relating to other staff	Other legal claims	Other
At start of period	**66.9**	1.0	27.9	5.9	32.1
Arising during the year	**44.5**	0.0	0.6	2.4	41.5
Utilised during the year	**(25.9)**	(0.1)	(1.4)	(1.4)	(23.0)
Reversed unused	**(4.9)**	0.0	(1.3)	(1.4)	(2.2)
Unwinding of discount	**0.8**	0.0	0.7	0.0	0.1
At 31 March 2005	**81.4**	**0.9**	**26.5**	**5.5**	**48.5**
Expected timing of cash flows					
Within one year	**47.7**	0.1	3.4	4.1	40.1
One to five years	**11.6**	0.4	8.3	0.6	2.3
Over five years	**22.1**	0.4	14.8	0.8	6.1
Total	**81.4**	**0.9**	**26.5**	**5.5**	**48.5**

£215.9 million is included in the accounts of the NHS Litigation Authority for clinical negligence liabilities in NHS foundation trusts.

Notes to the accounts (continued)

16. Movement in taxpayers' equity

	2005
	£ million
Taxpayers' equity at start of period	3,989.6
Surplus for the financial year	60.3
Public dividend capital dividends	(97.2)
Fixed asset impairments	(5.6)
Gain from revaluation of purchased fixed and current asset investments	252.3
New public dividend capital received	137.0
Public dividend capital repaid in year	(53.9)
Public dividend capital repayable	(2.2)
Other movements in public dividend capital in year	1.6
Additions to donated asset reserve	16.2
Additions to Government grant reserve	14.2
Taxpayer's equity at 31 March 2005	**4,312.3**

17. Movement in public dividend capital

	2005
	£ million
Public dividend capital at start of period	2,402.8
New public dividend capital received	137.0
Public dividend capital repaid in year	(53.9)
Public dividend capital repayable	(2.2)
Other movements in public dividend capital in year	1.6
Public dividend capital at 31 March 2005	**2,485.3**

18. Movement in reserves

	2005					
	£ million	£ million	£ million	£ million	£ million	£ million
	Total	Revaluation reserve	Donated asset reserve	Government grant reserve	Other reserves	Income and expenditure reserve
At start of period	**1,586.9**	1,130.2	385.6	2.2	7.2	61.7
Transfer from income and expenditure account	**(36.9)**	0.0	0.0	0.0	0.0	(36.9)
Fixed asset impairments	**(5.6)**	(5.4)	(0.2)	0.0	0.0	0.0
Surplus on revaluations of fixed asset and current asset investments	**252.3**	258.2	(4.0)	(1.9)	0.0	0.0
Transfer of real profit to the income and expenditure reserve	**0.0**	(6.4)	0.0	0.0	0.0	6.4
Receipt of donated assets or Government grants	**49.5**	0.0	33.2	16.3	0.0	0.0
Transfer to the income and expenditure account for Government assets	**(19.1)**	0.0	(17.0)	(2.1)	0.0	0.0
Other transfers between reserves	**(0.1)**	(10.5)	(2.6)	2.3	0.0	10.7
At 31 March 2005	**1,827.0**	**1,366.1**	**395.0**	**16.8**	**7.2**	**41.9**

19.1 Reconciliation of operating surplus to net cash inflow from operating activities

	2005 £ million
Total operating surplus	**53.6**
Depreciation and amortisation	154.8
Fixed asset impairments and reversals	7.9
Transfer from donated asset reserve	(17.0)
Transfer from Government grant reserve	(2.1)
Increase in stocks	(4.6)
Decrease in debtors	48.4
Increase in creditors	41.8
Increase in provisions	14.1
Net cash inflow from operating activities	**296.9**

19.2 Reconciliation of net cash flows to movement in net funds

	2005 £ million
Net funds at start of period	**46.6**
Increase in cash in the period	78.0
Cash inflow from new debt	(6.0)
Cash outflow from debt repaid and finance	0.4
Cash outflow from increase in liquid resources	14.9
Change in net funds resulting from cash flows	**87.3**
Non-cash changes	1.0
Net funds at 31 March 2005	**134.9**

19.3 Analysis of changes in net funds

	£ million At start of period	£ million Cash changes in year	£ million Non-cash changes in year	2005 £ million At 31 March 2005
Commercial cash at bank and in hand	6.0	56.0	0.1	62.1
OPG cash at bank	29.7	25.4	0.0	55.1
Bank overdrafts	(2.0)	(3.4)	0.0	(5.4)
Debt due within one year	(0.4)	(0.3)	0.4	(0.3)
Debt due after one year	0.0	(5.7)	0.0	(5.7)
Finance leases	(8.2)	0.4	0.5	(7.3)
Current asset investments	21.5	14.9	0.0	36.4
Total	**46.6**	**87.3**	**1.0**	**134.9**

20. Capital commitments

NHS foundation trusts have entered into £178.7 million of capital commitments at 31 March 2005.

21. Contingent liabilities

Potential net contingent liabilities totalling £19.9 million have not been accrued as the outcome of these cases is uncertain. These do not include cases of clinical litigation which are accounted for by the NHS Litigation Authority.

22. Losses and special payments

In the year there were 4,445 cases of loss with a total value of £1.5 million and 788 cases of special payments with a total value of £1.0 million.

There were no individual losses or special payments made in excess of £100,000.

Note: The total costs included in this note are on a cash basis and will not reconcile to the amounts in the notes to the accounts which are prepared on an accruals basis.

23. Related party transactions

NHS foundation trusts are public benefit corporations established under the Health and Social Care (Community Health and Standards) Act 2003. The Department of Health is regarded as a related party. During the period the NHS foundation trusts had a significant number of material transactions with the Department and with other entities for which the Department is regarded as the parent department, i.e. all strategic health authorities, NHS trusts, primary care trusts, NHS agencies and all special health authorities. In addition, the NHS foundation trusts had a significant number of material transactions with other Government departments including central and local Government bodies. NHS foundation trusts had some transactions with a number of charitable funds and certain of the trustees are also members of the NHS foundation trusts' boards. Details of all the NHS foundation trust related party transactions are shown in the individual NHS foundation trusts' accounts.

24. Post balance sheet events

As at 31 March 2005 there were 25 NHS foundation trusts. With effect from 1 April 2005, six NHS trusts became NHS foundation trusts and with effect from 1 June 2005, one NHS trust became a NHS foundation trust.

The value of post balance sheet events disclosed in the individual NHS foundation trust accounts represented a net increase in income of £21 million.

25. Financial instruments

The NHS foundation trust consolidated account includes the accounts of 25 underlying NHS foundation trusts. It is within the underlying accounts of these 25 bodies that detailed FRS13 disclosures have been made. The following paragraphs provide an overview of the major financial risks for NHS foundation trusts and how they are managed at the individual level.

Financial instruments
FRS 13, Derivatives and Other Financial Instruments, requires disclosure of the role which financial instruments have had during the period in creating or changing the risk an entity faces in its underlying activities. Because of the largely non-trading nature of NHS foundation trusts' activities and the way in which they are financed, the NHS foundation trusts are not exposed to the degree of financial risk faced by business entities. Moreover, financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which FRS 13 mainly applies. Financial assets and liabilities are primarily generated by day-to-day operational activities and are not held to change the risks facing NHS foundation trusts in undertaking their activities.

Liquidity risk
NHS foundation trusts' net operating expenses are primarily met by income generated under annual service agreements with primary care trusts, which are financed from sources voted annually by Parliament. NHS foundation trusts also largely finance their capital expenditure from the funds made available from Government under agreed borrowing limits. NHS foundation trusts are not therefore exposed to significant liquidity risks.

Interest rate risk
The majority of NHS foundation trusts' financial assets and financial liabilities carry nil or fixed rates of interest. NHS foundation trusts are not, therefore exposed to any significant interest rate risk.

Foreign currency risk
NHS foundation trusts have no or negligible foreign currency income or expenditure and therefore are not exposed to significant foreign currency risk.

Fair values
The fair values of financial assets and financial liabilities for NHS trusts approximates to their book values.

26. Third party assets

The balance of patients' money held within the NHS foundation trusts' bank accounts at 31 March 2005 was £17,419. This has been excluded from the balance sheet as they are not assets of the NHS foundation trusts but are held on trust on behalf of patients.

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