Annual Report & Accounts 2008/09

Choose Chelsea and Westminster

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

About this report

Our annual report aims to follow best practice in corporate reporting by articulating our strategy, reporting back on our performance against strategic objectives and national targets, and presenting information about our service and financial performance transparently and honestly to key stakeholders.

The report has a clear and simple structure:

- **Introduction**
  Statements by the Chairman and Chief Executive
- **Strategy**
  Including performance against corporate objectives 2008/09 and details of our corporate objectives 2009/10
- **Quality Report**
  Outlining our commitment to providing quality care for all patients
- **Performance Report**
  Including our performance against national targets
- **Statutory Information**
  Other information required for inclusion in the annual report in line with official guidance from Monitor, the independent regulator of Foundation Trusts
- **Finance**
  Including the accounts

This year for the first time Monitor requires all Foundation Trusts to include a Quality Report as a key element of the annual report and accounts.

A commitment to quality and quality improvement underpins our corporate strategy and this annual report. We hope you enjoy reading it.

Credits

This annual report has been produced in-house by Chelsea and Westminster Hospital NHS Foundation Trust:

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Chelsea and Westminster Hospital NHS Foundation Trust

Annual Report & Accounts 2008/09

Introduction

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Trust Chairman, Professor Sir Christopher Edwards and Chief Executive, Heather Lawrence pictured outside 56 Dean Street—our new HIV and sexual health centre in Soho—with Health Minister Lord Darzi at the official opening in May 2009

Chairman's statement

I believe passionately that Chelsea and Westminster Hospital belongs to patients who use its services, members of the public who live locally, and staff who work in the hospital.

This ethos is encapsulated by the slogan of our annual hospital Open Day—"Your hospital, your health, your say".

More than 1,500 people attended the Open Day in May 2009 which demonstrates that we already have a close relationship with our local community that I hope will develop further during the coming year.

Positive engagement with our community so that local people feel a sense of ownership over and pride in their hospital is vital to the future success of Chelsea and Westminster, especially at a time of economic uncertainty.

Our Members' Council and more than 15,000 patients, members of the public and staff who have chosen to be members of our Foundation Trust play an increasingly important role in the life of Chelsea and Westminster.

During 2008/09 Members' Council representatives provided strong support of the Trust's strategic aims including our successful bid to be recommended as the lead centre for neonatal and specialist paediatric surgery in North West London and our bid to be a 'hyper-acute' stroke unit.

Many Foundation Trust members and Members' Council representatives attended our Annual Members' Meeting in September 2008, our Seasonal Working Conference with Trust staff in March 2009, and the Open Day.

Strategically the Trust is not only a provider of general acute services for our local community but also a specialist centre for services including HIV and sexual health, paediatrics and burns, and a focal point for academic teaching and research.

The official opening in May 2009 of our new HIV and sexual health centre at 56 Dean Street by Health Minister Lord Darzi is indicative of what we are trying to achieve—a state-of-the-art modern facility providing healthcare where and when patients want it.

Another success story is the award to Chelsea and Westminster and its partners of £20 million to establish a Collaboration for Leadership in Applied Health Research and Care (CLAHRC) in North West London to enable the rapid introduction of new, effective treatments for a wide range of medical conditions.

Quality is the cornerstone of all that we are striving to achieve as a Foundation Trust in line with Lord Darzi's report *High Quality Care For All*. It underpins our 3 corporate objectives for 2009/10 and it is also the foundation of this annual report.

I look forward to working closely during the year ahead with patients, members of the public, and staff to achieve our aim of providing high quality care for all patients.

Professor Sir Christopher Edwards
Chairman

Chief Executive's statement

2008/09 was a successful year for the Trust. We treated 95% of outpatients and 90% of inpatients within 18 weeks of referral, saw 8% more patients than in 2007/08, and 94% of respondents to the annual NHS patient survey rated their care as 'Excellent', 'Very good' or 'Good'.

However, we recognise that our care is not always of a consistently high standard for all patients. We have invested in initiatives to improve the patient experience as a learning organisation committed to quality improvement.

These include the Patient Experience Tracker to get 'real-time' patient feedback, a patient experience improvement project run by Monitor and McKinsey which was piloted in maternity services, and the *Releasing Time to Care* programme to help frontline clinical staff spend more time with patients.

We met, and indeed exceeded, Healthcare Commission targets to reduce MRSA bacteraemia and *Clostridium difficile*. No patient admitted for planned surgery contracted MRSA bacteraemia. We will now focus on other infections by, for example, reducing the number of days that patients have urinary catheters because we know these are associated with infection.

We were disappointed that our 'Quality of Services' rating was reduced from 'Excellent' to 'Good' in the annual NHS performance ratings and we aim to regain an 'Excellent' rating this year through our strong performance in 2008/09.

The Trust believes that it was in the best interests of patients to safeguard patient confidentiality by delaying our rollout of the national Choose and Book programme following the discovery of a technical fault, even though this meant we 'failed' this target and lost our 'Excellent' rating.

Strategic changes to the NHS in London present us with opportunities to provide more services in the community and to reinforce our reputation as a provider of high quality specialist services.

Our new HIV and sexual health centre at 56 Dean Street—located in the heart of Soho—opened in March 2009 and we were recommended as the lead centre for neonatal and specialist paediatric surgery in North West London in May 2009.

The strategic 'provider landscape' work being undertaken by North West London Primary Care Trusts is likely to lead to a reduction in the number of providers and we are well placed to explore future opportunities as the only acute Foundation Trust in North West London.

We recognise that the economic downturn means we may need to reduce our expenditure by up to 15% over the next 3 years. We will expand the use of service line reporting and focus on increased productivity and efficiency to ensure that we continue to provide high quality patient care within the resources available to us.

I look forward to working with colleagues on the Trust Board and all staff at Chelsea and Westminster to achieve this goal.

Heather Lawrence

Heather Lawrence
Chief Executive

Strategy

Our strategic vision

Foundation Trust status—the first 3 years

The Trust's strategic vision was formed through consultation with the Board of Directors during our application for Foundation Trust status in May 2006:

"To deliver safe care of the highest quality for our local population and those using our specialist services, provided in a modern way by multi-disciplinary teams working in an excellent environment, supported by state-of-the-art technology and world class academic research."

The Trust has achieved a smooth transition from NHS Trust to Foundation Trust status following authorisation by Monitor in October 2006.

We have consistently met national performance targets, achieved financial surpluses to reinvest in patient care, and delivered high quality clinical services which are increasingly popular with patients.

Strategic developments 2008/09

The Trust reinforced its reputation as a provider of high quality specialist services in 2008/09, in particular as a centre of excellence in women's and children's health, HIV and sexual health services, and stroke care.

We secured the future of our specialist paediatric services by winning a competitive process. In May 2009 we were recommended as the lead centre for neonatal and specialist paediatric surgery in North West London.

This was an important milestone for paediatrics at Chelsea and Westminster and for the Trust as a whole because paediatrics is a core Trust service and fundamental to our strategic vision.

High quality maternity services are also vital to the success of the Trust's overall strategy as a centre of excellence in women's and children's health.

Our maternity services piloted a patient experience improvement project run by Monitor and McKinsey. The Trust Board has agreed that increasing the percentage of women who have an excellent experience of our maternity services to 90% in the next year should be among the Trust's top 3 priorities for quality improvement in 2009/10.

The opening of our new HIV and sexual health centre at 56 Dean Street in March 2009 was a strategic milestone because, by locating the centre in Soho, we demonstrated our commitment to taking these services to the community.

The Trust operates the only HIV and sexual health services in London that offer Saturday clinic opening times—56 Dean Street and the West London Centre for Sexual Health at Charing Cross Hospital—which demonstrates that we aim to provide what patients want at a time convenient to them in an accessible location.

Our stroke service is now recognised as a leading centre after being ranked 3rd best nationally in the National Sentinel Stroke Audit which was published in March 2009.

Healthcare for London recommended us for designation as a stroke unit and we expect the Joint Committee of Primary Care Trusts in London to make a decision in summer 2009 about the future location of 'hyper-acute' stroke units in London following a 3-month consultation in spring 2009.

We have submitted a bid to provide this 'hyper-acute' service.

Refreshing our strategic vision

We recognise that the landscape of the NHS environment within which we operate has changed markedly and we require a robust strategy to cope with the effects of the economic downturn on the public sector.

Therefore the Board of Directors will refresh the Trust's current strategic vision during 2009/10 and we expect to engage with the Members' Council, Foundation Trust members, and many other stakeholders during this process.

Our view of the future

The Trust is moving into challenging economic times for the NHS. We will work with our staff to deliver greater efficiency and productivity while focusing on quality, in line with Lord Darzi's report *High Quality Care for All*.

We will continue to pursue our strategic vision to be a provider of specialist services, as outlined above in our review of strategic developments during 2008/09.

We recognise that there are likely to be less acute providers in North West London and that more care will move into the community.

We will explore collaborations with other providers and look to work across the hospital and community sectors, particularly in order to tackle chronic long-term conditions.

We believe the Trust is well placed to face the tough challenges of the years ahead and develop its reputation as a hospital of choice.

Performance against corporate objectives 2008/09

Corporate Objective 1: Focus on patient safety & quality

- We met targets for the reduction of MRSA bacteraemia and *Clostridium difficile*—5 cases of MRSA (against a target of 19 cases set by the Healthcare Commission) and 41 cases of *C. difficile* (against a target of 114 cases set by the Healthcare Commission)
- We achieved NHS Litigation Authority risk management standards at Level 2
- We introduced clinical quality benchmarks, starting with monthly monitoring of Sentinel audit data for stroke care which resulted in improved patient outcomes
- Directorates identified clinical quality indicators at specialty level which will be monitored and reported in 2009/10

Corporate Objective 2: Deliver effective & efficient pathways of care

- We met a national target to treat 95% of outpatients and 90% of inpatients within 18 weeks of GP referral by March 2009 (this target was achieved by December 2008)
- We achieved a bigger financial surplus than predicted—£9.6 million—which will be reinvested to improve patient care, largely due to increased demand for clinical services
- We worked closely with PCTs, including our host commissioner NHS Kensington & Chelsea, to implement recommendations from Lord Darzi's report *Healthcare for London: A Framework for Action* including a public consultation on the future of stroke services in London

Corporate Objective 3: Be the provider & employer of choice

- 94% of patients in the annual NHS patient survey 2008 rated their care as 'Excellent', 'Very good' or 'Good' (compared with 90% in 2007)
- We agreed contracts for the provision of a 'real-time' electronic patient feedback tool, the Patient Experience Tracker, and the formation of a Patients' Panel—both projects will be rolled out Trustwide in 2009/10
- We were selected as a pilot site for a patient experience improvement project run by Monitor and McKinsey—the project was piloted in maternity services and will be rolled out Trustwide in 2009/10
- 61% of staff took part in the annual NHS staff survey 2008 (compared with 53% in 2007)—we improved or maintained our performance for 85% of the survey's 26 key findings
- We were 95% compliant with the European Working Time Directive of a maximum 48-hour week for all doctors in training by March 2009—we expect to be 100% compliant by the deadline of August 2009

Corporate Objective 4: Deliver excellence in teaching & research

- 70% of medical students who spent time with the Trust rated their experience as 'Excellent' after an internal system for gaining feedback was introduced
- We agreed a new partnership with King's College London and London South Bank University to provide clinical placements for undergraduate nursing and midwifery students
- We were actively involved in the implementation of the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) in North West London, based at Chelsea and Westminster, through participation in Round 1 research projects
- A Research Strategy Board was formed to drive forward delivery of the Trust's Research & Development Strategy

Corporate Objective 5: Create a robust infrastructure for the future

- We undertook infrastructure mapping leading to increased investment in service line reporting information and a review of corporate structure
- We revised our governance structure by, for example, creating a single Assurance Committee to provide a more rigorous, streamlined assurance system in conjunction with the Audit Committee
- We brought in-house ownership of the Lastword electronic patient record system and its team of support staff to allow us to maintain the system until a national programme is agreed

Corporate objectives 2009/10

Corporate Objective 1: Improve patient safety & clinical effectiveness

Cause no avoidable harm to patients

- Define patient safety indicators with local targets and design a measurement system

Reduce healthcare associated infections

- No elective patient to be infected with MRSA bacteraemia whilst in the hospital

Achieve consistent improvement in key indicators of clinical effectiveness

- Define clinical indicators with local targets and design a measurement system

Corporate Objective 2: Improve the patient experience

Develop methods to understand and improve the patient experience

- Ensure that 90% of women have an 'Excellent' experience of maternity services
- Achieve a progressive improvement in key issues identified by the annual NHS patient survey

Provide excellent administrative processes for all patients

- Deliver an improvement in key areas of administrative efficiency, as measured by a reduction in complaints relating to appointments and admissions

Develop a motivated, trained, capable and competent workforce

- Increase staff satisfaction by achieving 100% of staff completing appraisals and personal development plans and a year-on-year improvement in sickness absence, vacancy rates and uptake of mandatory training

Corporate Objective 3: Deliver excellence in teaching and research

Deliver excellence in teaching

- Deliver an agreed improvement in students' overall rating of their teaching
- Develop at least 2 further simulation training programmes linked to Trust priorities

Achieve status as a hub for a Health Innovation Education Cluster (HIEC)

- Achieve status as a hub for a Health Innovation Education Cluster (HIEC)

Deliver the Research Strategy including the CLAHRC programme

- Complete the Research Strategy to include how to enhance the Trust's research profile and income, and to deliver the CLAHRC programme

These corporate objectives to be underpinned by a strong financial and performance position

Quality Report

Sister Lesley-Anne Marke with patient Josephine Sinclair on David Erskine Ward which was chosen to pilot the *Releasing Time To Care—The Productive Ward* initiative to help frontline staff spend more time on direct patient care

Introduction

The Trust Board is committed to providing quality care for all patients and to quality improvement.

This commitment to quality underpins our 3 corporate objectives for 2009/10:

- Improve patient safety and clinical effectiveness
- Improve the patient experience
- Deliver excellence in teaching and research

We welcome the fact that this year for the first time Monitor, the independent regulator of Foundation Trusts, requires all Foundation Trusts to publish a Quality Report.

This Quality Report is as important as the Finance section of the Annual Report and Accounts.

Our longstanding focus on quality improvement has ensured that we have set high standards for quality:

- Chelsea and Westminster was named as one of the safest hospitals in the country by the Dr Foster Hospital Guide in November 2008—it highlighted us in the top 20% of NHS trusts nationally with significantly lower than expected Hospital Standardised Mortality Ratios (HSMRs)

- The Trust achieved NHS Litigation Authority risk management standards at Level 2 following an assessment visit in December 2008—we passed 48 out of 50 criteria in 5 areas of risk management

- We have reduced our MRSA bacteraemia rate by 90% in the last 5 years and in 2008/09 we significantly outperformed both targets for the reduction of both MRSA bacteraemia and *Clostridium difficile*

We are proud of these achievements and we are committed to improving quality further—our 3 priorities for quality improvement in 2009/10 are outlined in this Quality Report.

Other quality objectives include:

- Reviewing the detailed data behind the overall HSMR statistics to ensure that we reduce avoidable mortality

- Building on our success in achieving NHS Litigation Authority risk management standards at Level 2 by ensuring that processes are embedded in the Trust and that systems set up to monitor compliance are effective in delivering further improvements in safety for patients and staff

- Maintaining our focus on best practice in infection prevention and control to drive down healthcare associated infections still further

- Ensuring that directorates identify clinical quality indicators at specialty level, monitor performance against these indicators, and report on this performance—in line with the Indicators for Quality Improvement published by the NHS Information Centre in May 2009

- Improving our performance against the patient experience indicators in the annual NHS patient survey through more frequent monitoring—including 'real-time' patient feedback using an electronic Patient Experience Tracker and the formation of a Patients' Panel to be used as a sounding board by the Trust

We are committed to ensuring that a culture of continuous quality improvement is embedded in the Trust and we will work closely with all our staff to make addressing these issues a priority in 2009/10 and beyond.

Heather Lawrence

Heather Lawrence
Chief Executive

Quality

Indicators to measure the Trust's performance 2009/10—selected by the Trust Board

Patient safety

1. Reduce our preventable venous thromboembolism (VTE) rate by 15% in the next year (Data source: Internal Trust data and national Dr Foster data).

2. Reduce in-hospital cardiac arrest and mortality through earlier recognition and treatment of the deteriorating patient (Data source: Internal Trust data in line with measures recommended by the national Patient Safety First Initiative).

3. Reduce the risk of selected high risk medicines (Data source: Internal Trust data in line with measures recommended by the national Patient Safety First Initiative).

Patient experience

4. Ensure that 90% of women have an 'Excellent' experience of our maternity services (Data source: Internal Trust data and Healthcare Commission [now the Care Quality Commission] maternity patients survey).

5. Achieve a progressive improvement in key issues identified in the annual NHS patients survey relating to communication, information and customer service (Data source: Healthcare Commission [now the Care Quality Commission] annual NHS patients survey).

6. Reduce the number of complaints relating to appointments and admissions (Data source: Internal Trust data).

Clinical effectiveness

7. Reduce delays of more than 24 hours to selected non-elective urgent surgery (Data source: Internal Trust data).

8. Reduce Hospital Standardised Mortality Ratio (HSMR) by 10% (Data source: National Dr Foster data).

9. Reduce the number of urinary catheter days, ie the number of days that patients in the Trust have a urinary catheter—excluding patients who require lifelong urinary catheters (Data source: Internal Trust data).

Priorities for quality improvement 2009/10—agreed by the Trust Board

Priority 1: Patient safety

To reduce our preventable venous thromboembolism (VTE) rate by 15% in the next year.

Why is this a priority?

VTE is a major cause of preventable death and reducing its incidence is a national priority for the NHS.

It is estimated that in England each year more than 25,000 people die from VTE contracted in hospital and 1 in 3 patients undergoing surgery in hospital can develop VTE if no preventative measures are taken.

In addition, non-fatal VTE can require treatment with anticoagulant drugs at doses with a significant risk of bleeding, causes delays in patients' discharge home from hospital, and often results in readmissions to hospital.

What actions are we planning to improve our performance?

The Trust has established a multi-disciplinary committee to oversee implementation of the recommendations of the Chief Medical Officer's expert working group on the prevention of VTE in hospitalised patients, implementation of National Institute for Health and Clinical Excellence (NICE) guidance, and adherence to Trust guidelines on VTE prevention including the use of an electronic risk assessment tool and audit of prescribing.

How will improvement be measured?

Rates of hospital acquired VTE will be measured with the aim of reducing preventable VTE by 15% in the first year.

Priority 2: Patient experience

Ensure that 90% of women have an 'Excellent' experience of our maternity services.

Why is this a priority?

High quality maternity services are vital to the success of the Trust's overall strategy as a centre of excellence in women's and children's health. Most women have a positive experience of maternity services at Chelsea and Westminster, as evidenced by the fact that 86% of women who took part in the Healthcare Commission's maternity review 2008 rated their care as 'Excellent', 'Very good' or 'Good'.

However, there are known areas for improvement as a result of feedback from incidents and complaints and the Trust wants to ensure that all women have a positive experience of our maternity services.

What actions are we planning to improve our performance?

The Trust's maternity services were chosen as a pilot site for a patient experience project developed by Monitor, the independent regulator of Foundation Trusts, and McKinsey in 2008/09 to understand our patients and act on their concerns. In 2009/10 we will look to implement fully the recommendations from this project and embed a culture of continuous patient feedback and improvement in our maternity services.

The Trust focused considerable resources on improving maternity services during 2008/09 through the Monitor/McKinsey project and its own Maternity Services Improvement Review. This focus will continue in 2009/10.

How will improvement be measured?

'Real-time' patient feedback monitoring tools, in particular the Patient Experience Tracker, will be used to measure and track improvements.

Priority 3: Clinical effectiveness

To reduce delays of more than 24 hours to selected non-elective urgent surgery.

Why is this a priority?

Senior Trust surgeons have expressed concerns that a number of factors may be exacerbating delays for some patients requiring non-elective urgent surgery.

These factors include a drive to meet the national 18 week target from GP referral to treatment, increased numbers of patients requiring surgery, and implementation of National Confidential Enquiry into Patient Outcome & Death (NCEPOD) guidelines restricting out-of-hours operating unless life is at stake.

The Trust is responding directly to these concerns by making the reduction of delays to selected non-elective urgent operations a priority for quality improvement in 2009/10.

This work will complement existing initiatives to improve the effectiveness and efficiency of the use of operating theatres.

What actions are we planning to improve our performance?

Each surgical speciality is reviewing arrangements for non-elective urgent operating. Initiatives include the appointment of a dedicated consultant emergency surgeon for general surgery, appointment of a trauma nurse to focus on improving the pathway for patients with fractured neck of femur, and a review of the plastic surgery trauma service including the 'hand room' and dedicated hand trauma theatre.

In addition, a theatre improvement group has been established which will include a focus on creating clear leadership and efficient management of non-elective surgery.

How will improvement be measured?

Time to operation from decision to operate will be measured to establish a baseline for each selected surgical procedure. Individual targets will be set with the aim of a progressive improvement towards a target of 100% of non-elective urgent surgery being undertaken within 24 hours.

Response to reports from regulators & concerns raised by organisations representing the public 2008/09

Annual performance ratings

The Trust met all national targets in the annual performance ratings 2008 with a single exception, resulting in a reduction of our 'Quality of Services' rating from 'Excellent' in 2007 to 'Good' in 2008.

This was due to the fact that the Trust did not fully meet a national target relating to the Choose and Book system after uncovering a technical fault during the pilot stage which may have compromised patient confidentiality.

The Trust therefore 'failed' this target by delaying the rollout of Choose and Book to other specialties until September 2007.

We believe it was right to put the best interests of patients above the requirements of meeting a target. On average 85–90% of our services are now directly bookable via Choose and Book.

Kensington & Chelsea Residents' Panel

In February 2009 the Royal Borough of Kensington & Chelsea published the results of the healthcare section of its 2009 Residents' Panel questionnaire.

A total of 440 local residents took part in the survey, of whom 53% had visited their local hospital as a patient in the previous year—of these respondents, 61% had visited Chelsea and Westminster Hospital.

Residents rated us more highly than other local hospitals on 5 key questions:

- 73% agreed that the person they were referred to had all the information about their condition
- 82% said they were treated with dignity and respect
- 85% agreed information they were given was easy to understand
- 59% said standards of hygiene were adequate
- 73% would recommend the hospital to friends and family

The Trust is encouraged by these results. However, we are concerned about the dissonance between these results and annual NHS patient survey results. The Trust will use the Patient Experience Tracker to test out patient views and help improve its performance further.

Performance against regulatory requirements and national targets

Regulatory requirements

The Trust declared full compliance to the Healthcare Commission (now the Care Quality Commission) with all 24 core standards contained within Standards for Better Health for 2008/09—with 1 exception.

This exception was standard 13c ('Healthcare organisations have systems in place to ensure that staff treat patient information confidentially, except where authorised by legislation to the contrary').

The Trust had a significant lapse against this standard during 2008/09 but achieved full compliance by the end of the financial year. See page 35 for full details.

National targets
(excluding cancer waiting time targets)

Requirement/target	2008/09 performance	Target
Incidence of Clostridium difficile	**41**	114
Incidence of MRSA bacteraemia	**5**	19
18-week maximum waiting time from point of referral to treatment (admitted patients—inpatients)	**92.07%**	90%
18-week maximum waiting time from point of referral to treatment (non-admitted patients—outpatients)	**98.29%**	95%
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	**98.75%**	98%
People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack)	**n/a**	n/a

Cancer waiting time targets
1 Apr–31 Dec 2008 (Q1–Q3)

Requirement/target	Performance	Target
Maximum waiting time of 2 weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	**99.7%**	98%
Maximum waiting time of 31 days from decision to treat to start of first definitive treatment for cancer	**100%**	98%
Maximum waiting time of 62 days from all referrals to first definitive treatment for cancer	**100%**	95%

Cancer waiting time targets
1 Jan–31 Mar 2009 (Q4)

Requirement/target	Performance	Target
Maximum waiting time of 2 weeks from receipt of urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	**97.3%**	93%
Maximum waiting time of 31 days from decision to treat to start of first definitive treatment for all cancers (admitted and non-admitted)	**95.7%**	97%
Maximum waiting time of 31 days from decision to treat to start of subsequent treatment or recurrence (surgery and drug therapy)	**100%**	97%
Maximum waiting time of 62 days from all referrals to first definitive treatment for all cancers	**100%**	85%
Maximum waiting time of 62 days from date patient is upgraded by consultant onto urgent cancer pathway	**100%**	85%
Maximum waiting time of 62 days from all referrals received by national screening programme (breast, bowel, cervical)	**100%**	85%

Performance Report

A panoramic view from the roof of the hospital

Key facts

There was increased demand for Trust services in 2008/09:

Number of patients treated

	2008/09	2007/08
Inpatients	**40,836**	39,405
Outpatients	**395,919**	357,907
Day cases	**19,410**	17,955
A&E	**97,640**	97,685
Total	**553,805**	**512,952**

There were increased levels of satisfaction with Trust services among patients and independent assessors in 2008/09:

- 94% of patients rated their care at Chelsea and Westminster as 'Excellent', 'Very good' or Good' in the annual NHS patient survey 2008 (compared with 90% in 2007)
- Stroke services at Chelsea and Westminster were rated as the 3rd best nationally in the National Sentinel Stroke Audit 2008 (compared with 6th best in 2006)
- Standards of hospital hygiene and food were both rated 'Excellent' in the National Patient Safety Agency's Patient Environment Action Team (PEAT) assessment 2008 (compared with ratings of 'Good' and 'Excellent' in 2007)

Principal activities of the Trust

The Trust is a Central London teaching hospital, providing general acute hospital services to the local population and specialist tertiary services in a range of specialties including HIV, Burns and Paediatrics to patients from a wider area. It is a main campus of Imperial College School of Medicine.

Most services are at Chelsea and Westminster Hospital but HIV/GUM services are provided at the St Stephen's Centre next to the hospital, 56 Dean Street, W1 (services transferred from the Victoria Clinic, SW1—March 2008), and the West London Centre for Sexual Health, Charing Cross Hospital.

Clinical services are divided into 5 directorates, each led by a General Manager and Clinical Director. Support services include pharmacy, therapy services, and facilities management. Facilities services are contracted out to ISS Mediclean and Balfour Beatty.

Review of financial performance

In 2008/09 the Trust reported a maximum financial risk rating of 5 out of 5, where 5 is 'low risk', and delivered a surplus of £9.6 million which was well ahead of the planned surplus of £7.9 million—the Trust expects to be 'Excellent' for 'Use of Resources' in the annual performance ratings published in October 2009. The Trust's annual income and expenditure performance is set out in Table 1.

Table 1: Summary 2008/09 Income and Expenditure Outturn vs Plan (£m)

	Plan 2008/09	Actual 2008/09	Variance 2008/09
Income			
Clinical Income	223.6	**233.2**	9.6
Non-Clinical Income	43.5	**47.5**	4
Total Income	**267.1**	**280.7**	**13.6**
Expenses			
Pay Costs	-141.2	**-148.1**	-6.9
Non-Pay Costs	-101.7	**-106.1**	-4.4
Total Expenses	**-242.9**	**-254.2**	**-11.3**
EBITDA	**24.2**	**26.6**	**2.4**
Depreciation	-8.7	**-8.7**	0
Dividend on PDC	-8.7	**-8.7**	0
Interest	1.2	**0.6**	-0.6
Net surplus	**7.9**	**9.6**	**1.7**
CIPs	**6.4**	**5.4**	**-1.0**

56 Dean Street—our new HIV and sexual health centre in Soho which was funded by our financial surplus in 2007/08

Key variances from plan in 2008/09

1. NHS clinical income was £9.6 million above plan because of increased clinical activity due to unplanned increases in referrals across most specialties not included in contracts with PCTs.

2. Non-clinical income was £4 million above plan because of income from private maternity services which were retained under the Trust's management, increased income from facilities charges to recover higher energy costs, and additional income from research and development and education and training.

3. Pay costs were £6.9 million higher than plan because of increased spending on agency staff, £11.4 million in total. This was partly due to increased clinical activity which was in excess of plans. This resulted in the use of short-term staffing solutions. The Trust has put in place plans to ensure that managers maintain robust day-to-day controls on temporary staffing expenditure and to provide up-to-date information on staffing to ensure that services are delivered cost effectively.

4. Non-pay costs were £4.4 million higher than plan because of the costs of increased clinical activity and higher energy charges.

5. Net interest received was £0.6 million less than plan because of falling interest rates associated with the economic downturn.

6. 84% of the planned cost improvement programme was delivered. This shortfall was offset by the release of balance sheet provisions no longer required. The Trust has put in place plans to ensure that managers monitor and deliver cost improvements.

There were no exceptional items charged to the accounts in 2008/09.

The Trust's cash balances at the end of the financial year were £15.28 million ahead of plan due to the following factors:

- Planned loan drawdown of £6.8 million deferred until after the conclusion of the Trust's bid to be the lead centre for neonatal and specialist paediatric surgery in North West London

- Working capital improvement of £7.7 million during 2008/09

- Capital expenditure of £15.3 million unspent in 2008/09 as a result of planned deferral of capital schemes

- Net interest receivable of £0.6 million below plan in 2008/09 as a result of the economic downturn

The capital plan of £37.2 million underachieved by £17.7 million (48%) because of significant capital slippage in 2008/09, mostly relating to large building schemes such as the planned development of specialist paediatrics and provision of single room ward accommodation.

Review of non-financial performance

The Trust was rated 'Good' for 'Quality of Services' in the annual performance ratings published by the Healthcare Commission in October 2008.

We met all core standards and met all national targets with a single exception, resulting in a reduction of our rating from 'Excellent' in 2007 to 'Good' in 2008.

The Trust did not fully meet a national target relating to the national Choose and Book system after uncovering a technical fault during the pilot stage in April 2007 which could have compromised patient confidentiality.

The Trust therefore 'failed' this target by delaying the rollout of Choose and Book to other specialties until September 2007.

We believe it was right to put the best interests of patients above the requirements of meeting a target.

The Trust met all national targets in 2008/09 including the challenging target to treat 95% of outpatients and 90% of inpatients within 18 weeks of GP referral by March 2009.

The Trust also significantly outperformed key targets to treat 98% of A&E patients within 4 hours and to reduce healthcare associated infections.

The increasing popularity of the Trust's services was confirmed by the results of the annual NHS patient survey—94% of patients rated our services as 'Excellent', 'Very good' or 'Good' (compared with 90% in the previous year).

However, the Trust is striving to improve its services so that all patients have a consistently excellent experience at Chelsea and Westminster.

Improving the patient experience is a corporate objective for 2009/10.

Developments since the end of 2008/09 financial year

There have been a number of key developments affecting paediatric services since 31 March 2009:

- North West London PCTs recommended Chelsea and Westminster as the lead centre for neonatal and specialist paediatric surgery, and associated critical care, in North West London—subject to approval by NHS London and possible public consultation, the new arrangements will be in place from April 2010
- We will work with, and be supported by, our partners at Great Ormond Street Hospital and the Evelina Children's Hospital at St Thomas'
- A planning application for an extension to the hospital was approved by the local authority, which is intended to house a new paediatric centre including 4 new paediatric operating theatres, an extended High Dependency Unit, and 18 day surgery bays, in a child-friendly environment

Future developments

Future developments in paediatric services are outlined in the previous section.

Potentially another key service development for the Trust in 2009/10 is designation as a 'hyper-acute' stroke unit (HASU), as well as a stroke unit and transient ischaemic attack (TIA) centre.

A 3-month public consultation by Healthcare for London (HfL) about proposed centralisation of stroke and major trauma services ended in May 2009 and the Joint Committee of PCTs in London is due to make a final decision about the future configuration of services in July 2009.

We were recommended by HfL as a stroke unit and TIA centre. Charing Cross Hospital, part of Imperial College Healthcare NHS Trust, was recommended as a HASU due to geographical location and neurosurgery links.

However, if St Mary's Hospital—also part of Imperial College Healthcare NHS Trust—was designated as a major trauma centre by HfL, the HASU would be located at St Mary's rather than Charing Cross.

The Trust launched a campaign urging patients, members of the public and staff to support our bid to be a HASU because this called into question the reasons why Charing Cross was recommended as a HASU.

St Mary's is only a mile away from another proposed HASU at University College Hospital and Chelsea and Westminster's excellent reputation for stroke care was confirmed by the National Sentinel Stroke Audit 2008, published in April 2009, which ranked our services as the 3rd best in the country.

As a result of our campaign, HfL has acknowledged that, if the HASU moves from Charing Cross to St Mary's, this change of service would require public consultation.

We have also bid to provide community musculoskeletal services in Hammersmith & Fulham. NHS Hammersmith & Fulham tendered for these services and the Trust expects a decision in June 2009.

Healthcare for London is expected to designate urgent care centres in 2009/10. We intend to bid to provide an urgent care centre in A&E at Chelsea and Westminster when a tender is issued. Reconfiguration of HIV inpatient services is expected in 2009/10—the Trust has a national and international reputation in this specialty and is in a strong position to bid to be designated as an inpatient facility if this approach is taken by the commissioners.

We will explore opportunities to work more closely with other providers in North West London, particularly as cuts in Government spending on the NHS are expected because of the economic downturn.

Principal risks & uncertainties facing the Trust

The Trust considers there are key performance risks in 2009/10 for 2 national targets:

- Maximum 14-day wait from decision to treat to start of treatment extended to cover cancer treatments
- 18-week wait from referral to treatment for 90% of inpatients and 95% of outpatients to be measured at specialty level

A risk assessment has been completed for both these key performance risks and plans are either in place or are being put in place to mitigate them. The Trust has effective mechanisms in place to manage risk, in accordance with its risk management policy and strategy, supported by 2 committees with Board accountability—the Audit Committee and the Assurance Committee.

In light of the economic downturn, the Trust has considered a number of downside scenarios for the period 2009–12 and developed mitigating options to ensure that the Trust can deliver 'Excellent' ratings for both 'Quality of Services' and 'Use of Resources'.

The transfer of services to the community is a risk to the Trust.

Trends & factors likely to affect the Trust's future performance

National trends

The need to ensure sustainability of shorter waiting times in line with the national 18 week referral to treatment target is a key focus, particularly because achieving this target at specialty level will be a significant challenge.

The Trust will redesign patient pathways to deliver streamlined care, ensure that patient referrals are as smooth as possible by improving administrative processes, and help specialties plan for peaks in demand.

The Trust is planning for a slowdown in public sector spending as a result of the economic downturn. It is developing mitigating options for a number of downside scenarios and making service line reporting information widely available to managers and clinicians to aid understanding of the economics of different specialties and scope for efficiency savings.

All NHS trusts must comply with a maximum 48-hour week for doctors in training by August 2009. We are confident that we will be fully compliant.

Regional trends

The ongoing implementation of Lord Darzi's report—*Healthcare for London: A Framework for Action*—will continue to have a significant impact.

The Joint Committee of PCTs in London is due to make a final decision about the future configuration of stroke services in July 2009.

Healthcare for London is also expected to designate urgent care centres in 2009/10 and the Trust intends to bid to provide this service at Chelsea and Westminster.

We expect that Londonwide reviews of cancer and cardiovascular services will have consequences for the Trust.

Local trends

Preparations to ensure that the Trust is ready to 'go live' as the provider of neonatal and specialist paediatric surgery in April 2010—subject to agreement by NHS London and possible public consultation—will be a key local focus this year.

We are well placed to explore future opportunities as the only acute Foundation Trust in North West London if the strategic 'provider landscape' work being undertaken by local Primary Care Trusts leads to a reduction in the number of providers.

The development of polyclinics and the transfer of services to the community is a growing trend that will affect the Trust.

Research & Development

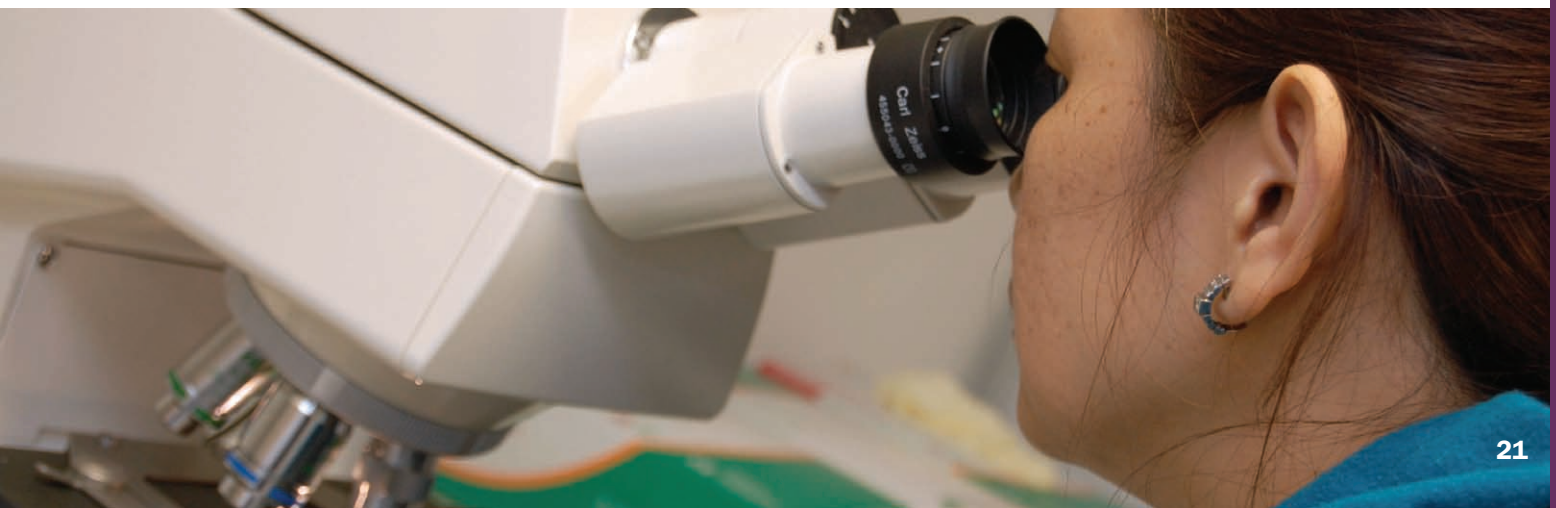
Delivering excellence in teaching and research was a key corporate objective in 2008/09 (as it is in 2009/10).

The focus of the Trust's research programme in 2008/09 was the implementation of the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) in North West London which is based at Chelsea and Westminster.

This £20 million project—£10 million from the National Institute for Health Research matched by £10 million from CLAHRC organisations in North West London—aims to lead to the rapid introduction of new, effective treatments for a wide range of medical conditions.

The Trust participated actively in round 1 research projects including chronic obstructive pulmonary disorder (COPD) discharge, pneumonia admissions to hospital, medicines management in acute care, case management in the community, and HIV/Hepatitis C testing in A&E and primary care.

The Trust held its inaugural Research & Development Open Day for patients, the public and staff in July 2008, and formed a Research Strategy Board to drive forward delivery of the Trust's Research & Development Strategy.



Our staff

The Trust employs more than 2,700 staff. The Trust's corporate objectives for 2008/09 included an objective to be not only a provider but also an employer of choice, as well as an objective to deliver excellence in teaching.

There was a marked increase in the response rate to the annual NHS staff survey—61% of staff took part in the survey which put the Trust in the top 20% of acute NHS trusts in England for response rates.

The Trust was ranked in the top 20% of NHS trusts nationally for a number of areas including good communication between senior management and staff, as well as staff recommending the Trust as an employer.

The Trust was also ranked in the top 20% of NHS trusts nationally for staff feeling able to contribute towards decisions that affect them and their services. This was an area of concern in the previous year's survey.

Areas for improvement included the number of staff who had an up-to-date appraisal and personal development plan.

The Trust is committed to learning lessons from the survey and communicating progress made towards implementing specific actions in response to the survey through Trustwide and directorate action plans and a "You Talked—We Listened" campaign in the monthly Team Briefing for staff.

The Trust has a commitment to staff development and celebrating the achievements of our staff. Customer service training is provided for all new staff joining the Trust at corporate induction. The Trust has an annual Christmas Cheer Awards and a monthly Team/Employee of the Month award to recognise the efforts of all staff.

We were delighted that Niamh Geoghegan, Paediatric Continence and Stoma Nurse Specialist, won a special award at the prestigious NHS Champions Awards in December 2008 in recognition of her outstanding care for children and their families.

We agreed a new partnership with King's College London and London South Bank University to provide clinical placements for undergraduate nursing and midwifery students as part of our role as a major London teaching hospital.

Patient care

Foundation Trust status

A key benefit of Foundation Trust status is that the Trust can retain its financial surplus—£14.6 million in 2007/08—to reinvest in services.

The surplus was used to develop 56 Dean Street, the Trust's new £2 million state-of-the-art HIV and sexual health centre which opened in March 2009.

56 Dean Street, which replaced services at the Victoria Clinic, SW1, offers Saturday and evening opening hours in an excellent environment and location.

Patient numbers have increased by approximately 20% as a direct result.

The Trust also invested part of its surplus in 2 new CT scanners which enable the Trust to provide a flexible service for both emergency patients who require instant diagnostic scans and patients with more routine imaging needs.

Performance against key patient targets

The Trust met all key national targets in 2008/09 and improved patient care by, for example, reducing waiting times and infection rates.

We met a challenging national target of treating 95% of outpatients and 90% of inpatients within 18 weeks of GP referral thanks to the hard work of staff.

We also achieved a national target of treating 98% of A&E patients within 4 hours—the Trust was asked by NHS London and NHS Kensington & Chelsea to treat 99% of A&E patients within 4 hours from January–March 2009 to help London as a whole achieve 97.9% for 2008/09.

The Trust consistently achieved weekly performance of 98.5–99.1% during this period, despite record attendances, to help London achieve 97.9%.

The Trust was thanked personally for its contribution and NHS London has asked to visit Chelsea and Westminster to understand how we achieve consistently high performance so that lessons can be shared with other hospitals.

The Trust significantly outperformed national targets for the reduction of MRSA bacteraemia and *Clostridium difficile*.

The Trust had just 5 cases of MRSA bacteraemia—against a target of 19 cases set by the Healthcare Commission—and 41 cases of *C. difficile*—against a target of 114 cases set by the Healthcare Commission.

Monitoring quality improvements

Progress towards meeting national and local targets is reported to the Board of Directors and any action required to meet targets is approved as appropriate.

For example, action plans were developed for approval by the Trust Board in response to the Trust's performance in the national patient and staff surveys.

New or significantly revised services

The Trust's new HIV and sexual health centre in Soho—56 Dean Street—opened in March 2009. It provides a wide range of services for patients in a modern environment utilising the latest technology and offering improved access to services including Saturday and evening opening hours. 56 Dean Street was officially opened by Lord Darzi, Health Minister, in May 2009.

The Trust's private maternity unit—The Kensington Wing—was significantly enlarged from 6 to 16 rooms and the patient environment enhanced.

The Kensington Wing was officially opened by Sophie Ellis-Bextor, singer-songwriter and service user, during the hospital Open Day in May 2009.

Service improvements following comments from patients

Our Patient Advice and Liaison Service (PALS) received 3,872 enquiries in 2008/09. Improvements made in response to comments received through PALS include:

- In the Treatment Centre 'quiet cubicles' have been introduced for patients suffering from anxiety and privacy booths have been introduced for patients undergoing sensitive procedures
- Amendments have been made to information on the Trust website in response to user feedback
- Font sizes have been enlarged on information posters as a direct response to clients who are partially sighted

Service improvements following complaints

The Trust received 458 formal complaints in 2008/09. 93% of complaints were responded to within 25 working days, as required by NHS guidelines. Improvements made in response to formal complaints include:

- All Trust laptops, Personal Digital Assistants, Blackberries and mobile devices have been encrypted
- The HIV & Sexual Health Directorate is developing a discharge summary for all patients who are travelling and might need to access healthcare whilst abroad
- Plans have been developed for a triage area on the antenatal ward to assess women in early labour

Improvements in patient/ carer information

An Information Zone has been developed on the ground floor of the hospital, incorporating an LCD screen and 2 electronic self-service kiosks, with news and useful information about the Trust. This project was funded by the Members' Council.

A DVD has been produced to be sent to children and young people before admission to hospital. This initiative was also funded by the Members' Council.

The Trust website was enhanced during 2008/09. A redesigned section for the new 56 Dean Street HIV and sexual health centre was developed. This design will be rolled out across the website in 2009/10.

Stakeholder relations

The Trust has maintained and strengthened its relationships with key stakeholders including PCTs, local authorities and education partners. These organisations are represented on the Members' Council.

We work closely with our host commissioner, NHS Kensington & Chelsea, and increasingly we look to forge strong links with the new acute commissioning alliance under development in North West London which is led by Michael Scott, Chief Executive of NHS Westminster.

The Trust works closely with the Royal Borough of Kensington & Chelsea, in particular the Health Overview and Scrutiny Committee.

In March 2009 a Memorandum of Understanding was signed between the Trust and the Royal Brompton & Harefield NHS Trust to explore opportunities for closer co-operation and collaboration in the future.

North West London PCTs recommended Chelsea and Westminster as the lead centre for neonatal and specialist paediatric surgery in the sector in May 2009 following a bidding process during the 2008/09 financial year. The new arrangements will start in April 2010 subject to approval by NHS London. The Trust bid proposed a federated network model involving Great Ormond Street Hospital, the Evelina Children's Hospital at St Thomas', and other hospitals throughout North West London.

The Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for North West London is hosted by Chelsea and Westminster and involves joint working with Imperial College London and all NHS organisations in North West London.

Statutory Information

Directors

The Trust has a Board of Directors including the Chairman, 5 other Non-Executive Directors and 5 Executive Directors.

Non-Executive Directors

The Chairman is Professor Sir Christopher Edwards.

The 5 other Non-Executive Directors are Colin Glass, Andrew Havery, Professor Richard Kitney, Karin Norman and Charles Wilson.

Charles Wilson is the Senior Independent Director.

Executive Directors

Executive Directors are Heather Lawrence (Chief Executive), Dr Mike Anderson (Medical Director), Lorraine Bewes (Director of Finance & Information), Andrew MacCallum (Director of Nursing) and Amanda Pritchard (Deputy Chief Executive/ Director of Service Integration & Modernisation—maternity leave December 2007–July 2008). Mariella Dexter joined the Trust from January–July 2008 as Interim Director of Service Integration & Modernisation to cover Amanda Pritchard's maternity leave. Catherine Mooney (Director of Governance & Corporate Affairs) attends Board meetings as Company Secretary.

Brief history of the Trust

Chelsea and Westminster Hospital opened in May 1993 on the former site of St Stephen's Hospital. It replaced 5 hospitals—St Stephen's, St Mary Abbots, Westminster Children's, Westminster and West London.

Chelsea and Westminster Hospital NHS Foundation Trust was founded on 1 Oct 2006 under the Health and Social Care (Community Health and Standards) Act 2003.

Environmental matters

The Trust pledged to reduce its carbon footprint by joining the Carbon Trust's NHS Carbon Management programme in May 2007. All staff are encouraged to help cut carbon emissions and reduce energy bills by taking simple steps to be more energy efficient.

Financial information

Disclosure of audit information

So far as the Directors are aware, there is no relevant audit information of which the auditors are unaware.

The Directors have taken all steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Better Payment Practice Code

The Better Payment Practice Code requires the Trust to pay all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later, unless other payment terms have been agreed with the supplier.

The Trust's compliance with the Code is set out in the Notes to the Accounts.

Remuneration Report
for the period 1 Apr 2008 to 31 Mar 2009

Remuneration Committee

This Trust Board Sub-Committee of the Board of Directors is appointed in accordance with the constitution of the Trust to determine the remuneration, allowances, pensions and gratuities or terms of service of the Executive Directors and rates for the reimbursement of travelling and other costs and expenses incurred by Directors.

The Board of Directors has delegated responsibility for agreeing remuneration, allowances, pensions and gratuities or terms of service for the Secretary and other Senior Managers. The Remuneration Committee does not determine the terms and conditions of office of the Chairman and Non-Executive Directors. These are decided by the Members' Council at a General Meeting.

The membership of the Remuneration Committee includes the Trust Chairman, Professor Sir Christopher Edwards, and 5 Non-Executive Directors—Colin Glass, Andrew Havery, Professor Richard Kitney, Karin Norman and Charles Wilson.

The Remuneration Committee met once in 2008/09—in December 2008. Professor Sir Christopher Edwards, Karin Norman and Charles Wilson were in attendance. Colin Glass, Andrew Havery and Professor Richard Kitney were absent.

The meeting was attended by the Chief Executive, Heather Lawrence, and the Interim Director of Human Resources, Mark Gammage, for the purpose of providing advice or services to the Committee that materially assist the Committee in the consideration of the matters before them, other than the consideration of their own remuneration, allowances, pensions and gratuities or terms of service.

The Committee agreed to modest adjustments in the year under review having regard to the challenges facing the economy and in keeping with the standard pay inflation of 2.75% awarded to staff under Agenda for Change. The Committee was guided in its deliberations by background pay information including a comparative pay study, which benchmarks comparable roles in NHS trusts of similar size and complexity to ensure that rates of pay are competitive, represent value for money and provide stability in senior manager roles.

In order to assess whether performance conditions were met for those officers under the remit of the Committee, appraisals are conducted regularly and progress is assessed against personal and corporate objectives, long and short term.

Remuneration consists mainly of salaries and pension benefits in the form of contributions to the NHS Pension Fund which are not subject to performance conditions. Where performance bonuses are considered in exceptional circumstances, these are limited to 20% of the total salary. No bonuses were awarded in the year under review.

The Members' Council meeting on 23 November 2006 ratified the initial appointments of the Non-Executive Directors under powers outlined in item 27.2 of the Transition Schedule. Employment contracts for Executive Directors are not normally limited to a fixed duration, except where it is intended to cover an extended period of leave. The normal notice period ranges between 3 and 6 months.

The fixed term contract of Mariella Dexter, Interim Director of Integrated Service Delivery & Modernisation, expired in July 2008.

For a breakdown of salary and pension entitlements of senior managers, please see page 49.

Heather Lawrence

Heather Lawrence, Chief Executive
(on behalf of the Board)
4 Jun 2009

Singer-songwriter Sophie Ellis-Bexter with her baby son Kit and midwife Amy Pierce at the official opening of The Kensington Wing, our revamped and enlarged private maternity unit

NHS Foundation Trust Code of Governance

Chelsea and Westminster Hospital NHS Foundation Trust is committed to effective, representative and comprehensive governance which secures organisational capacity and the ability to deliver the mandatory goods and services. The Trust's governance arrangements reflect components of good practice distilled from consultation and widespread experience.

These disclosures give a clear and comprehensive picture of the Trust's governance arrangements and illustrate the application of the main and supporting principles of the Code as a criterion of good practice.

It is the responsibility of the Board of Directors to confirm that the Trust complies with the provisions of the Code or, where it does not, to provide an explanation which justifies departure from the Code in the particular circumstances.

For the year ending 31 March 2009 Chelsea and Westminster Hospital NHS Foundation Trust complied with all the provisions of the Code of Governance published by Monitor in September 2006 with the following exception which the Board of Directors considers to be sound and justified in the circumstances:

C.2.1: Approval by the Members' Council of the appointment of a Chief Executive should be a subject of the first general meeting after the appointment by a committee of the Chairman and Non-Executive Directors.

Reappointment by the Non-Executive Directors followed by re-approval by the Members' Council thereafter should be made at intervals of no more than 5 years.

All other Executive Directors should be appointed by a committee of the Chief Executive, the Chairman and Non-Executive Directors and subject to reappointment at intervals of no more than 5 years.

Response: The Trust does not comply with this provision in so far as the Chief Executive and other Executive Directors are not subject to reappointment at intervals of not more than 5 years.

The Chief Executive and other Executive Directors are permanent employees of the Trust with employment contracts in force prior to authorisation as a Foundation Trust.

The Board of Directors conducts robust annual appraisals of its Chief Executive and other Executive Directors and does not consider that 5-year contracts will be competitive and enable the Trust to recruit and retain the best talent.

On this page: Hospital staff and visitors at the Open Day in May 2009

Board of Directors

Composition of the Board

The Board has 6 Non-Executive Directors (including the Chairman) and 5 Executive Directors (including the Chief Executive)—the Director of Governance & Corporate Affairs attends Board meetings as Company Secretary.

The appointment of the Chairman and appointment/reappointment of Non-Executive Directors is approved by the Members' Council. The appointment of the Chief Executive is by the Non-Executive Directors, subject to approval by the Members' Council.

See below for details of the Board including each Director's name, role or job title, responsibilities, a brief description of their background and length of appointment (Non-Executive Directors only).

Balance of Board membership & independence

In anticipation of authorisation as a Foundation Trust in 2006, the Trust Board performed a comprehensive review of its skills, experience and attributes against Foundation Trust competencies. The Board updates its review as part of the appointments process. The most recent review was undertaken in July 2008. As a result of this review, the Board of Directors is satisfied that its balance of knowledge, skills and experience is appropriate to the Board and its sub-committees.

The Board has evaluated the circumstances and relationships of individual Non-Executive Directors which are relevant to the determination of the presumption of independence.

The Board determines all of its Non-Executive Directors to be independent in character and judgement. A Non-Executive Director is appointed as a representative of Imperial College London, the Trust's partner in medical education. However, the Board remains confident that, in spite of this relationship, this Director's judgement is not likely to be affected.

Performance evaluation

The annual appraisal of the Chairman involves collaboration between the Senior Independent Director and the Deputy Chairman of the Members' Council to seek the views of both Executive Directors and Council Members. Executive Directors have an annual appraisal with the Chief Executive. The performance of Non-Executive Directors is evaluated annually by the Chairman.

Access to register of Directors' interests

Members of the public can gain access to the register of Directors' interests by making a request to the Foundation Trust Secretary Chelsea and Westminster Hospital NHS Foundation Trust, 369 Fulham Road, London SW10 9NH, via email ftsecretary@chelwest.nhs.uk or on 020 8846 6716.

Board meetings

The Board meets regularly, on average once a month. Special meetings are convened as and when required.

There were 12 ordinary meetings and 1 special meeting in 2008/09.

Directors' attendance at Board meetings 2008/09

Non-Executive Directors	Ordinary Meetings	Special Meetings
Prof Sir Christopher Edwards	12/12	1/1
Colin Glass	11/12	1/1
Andrew Havery	12/12	0/1
Prof Richard Kitney	11/12	1/1
Karin Norman	7/12	1/1
Charles Wilson	10/12	1/1

Executive Directors	Ordinary Meetings	Special Meetings
Heather Lawrence, Chief Executive	11/12	1/1
Amanda Pritchard, Deputy Chief Executive (Director of Integrated Service Delivery & Modernisation) [1]	7/7	0/1
Dr Mike Anderson, Medical Director	9/12	1/1
Lorraine Bewes, Director of Finance & Information	11/12	1/1
Mariella Dexter, Interim Director of Integrated Service Delivery & Modernisation [2]	3/5	1/1
Andrew MacCallum, Director of Nursing	12/12	1/1
Catherine Mooney, Director of Governance & Corporate Affairs [3]	11/12	1/1

[1] On maternity leave until July 2008
[2] Interim Director of Integrated Service Delivery & Modernisation until July 2008
[3] Attends Foundation Trust Board meetings as Company Secretary

Significant commitments of the Trust Chairman

The Chairman is a Senior Research Fellow at Imperial College London and Chairman of Geothermal Plus. In December 2008 he was appointed as the first Chairman of a new organisation called NHS Medical Education England which provides independent advice to the Government on workforce planning, education and training for medicine, dentistry, pharmacy and healthcare sciences.

Board of Directors—Who's Who

Non-Executive Directors

Professor Sir Christopher Edwards, Chairman: Professor Edwards was appointed in November 2007. He was the first Principal of Imperial College School of Medicine from 1995 to 2000 before becoming Vice-Chancellor of the University of Newcastle upon Tyne where he led a major restructuring to make it one of the top universities in the UK. During a distinguished medical and academic career, Professor Edwards has held numerous senior positions including President of the Association of Physicians of Great Britain and Ireland and Chairman of the Council of Heads of Medical Schools. He was knighted in June 2008 and appointed as the first Chairman of NHS Medical Education England in December 2008. He chairs the Finance & Investment Committee.

Charles Wilson, Vice Chair: Charles was appointed in September 2000. He was reappointed for 4 years in October 2003. His term ended in October 2007 but the Members' Council voted to reappoint him for a further 2 years, his term ends in October 2009. He is the Senior Independent Director and Chair of the Assurance Committee. Charles spent 50 years in the newspaper industry, serving as editor of a number of papers including The Times. He retired as Managing Director of the Mirror Group plc.

Colin Glass: Colin was appointed for three years from 1 November 2007, his term ends in October 2010. Colin has nearly 30 years' experience of consumer business, having joined Boots as a graduate trainee and subsequently worked for some of the biggest retailers in the country. During his career Colin has been Managing Director of both Dixons Stores Group and PC World, Chief Executive of the food group Watson and Philip plc, and Chairman of online company PhotoBox Ltd. He founded and is actively involved in a social enterprise business which provides work-related training for under-privileged groups in south east Asia.

Andrew Havery: Andrew was reappointed for 3 years in November 2007, his term ends in November 2010. He has been a councillor in Westminster since 2002. A Non-Executive Director since December 2003, Andrew is a chartered accountant and worked for KPMG for 8 years before becoming a compliance officer to investment banks.

Professor Richard Kitney OBE: Professor Kitney was appointed for 4 years in May 2006, his term ends in April 2010. He is Professor of Biomedical Systems Engineering and Dean of the Faculty of Engineering at Imperial College. A leading authority on the use of IT in healthcare, Professor Kitney is Chairman and Director of Visbion Ltd.

Karin Norman: Karin was appointed for 4 years in July 2005, her term ends in October 2009. She worked in investment banking in London and New York as a fixed income specialist, advising on investments, risk and capital management, and structured finance. She was a Non-Executive Director of the NHS Pensions Agency and is currently a member of the Audit Committee for the Parkinson's Disease Society, and a Trustee of both the Nursing and Midwifery Council and My Generation, a community and youth charity that she co-founded.

Executive Directors

Heather Lawrence, Chief Executive: Heather has almost 20 years' experience at NHS Trust Board level, as Chief Executive of Hounslow and Spelthorne Community and Mental Health Trust and North Hertfordshire NHS Trust before being appointed Chief Executive at Chelsea and Westminster in May 2000. Her management experience spans all sectors of healthcare and includes major service change, including the development of innovative services, service re-design, developing an academic department, and closure of services. Heather chairs the North West London Critical Care Network and was NHS Employers' lead negotiator on the Staff and Associate Specialist doctors contract. Most recently she has been appointed as a member of the Government's Nursing and Midwifery Commission through which she and 15 other members will advise the Government on the future roles of nurses and midwives. Heather is a Chartered Fellow of the Institute of Personnel and Development.

Amanda Pritchard, Deputy Chief Executive (Director of Integrated Service Delivery & Modernisation): Prior to her appointment in September 2006, Amanda worked in the Prime Minister's Delivery Unit. She was previously Acting Director of Strategy & Service Development and General Manager for the Surgery and Anaesthetics & Imaging Directorates at Chelsea and Westminster, and Assistant Director of Critical Care & Ambulatory Services at West Middlesex Hospital. Amanda was an inaugural Health Foundation Leadership Fellow.

Dr Mike Anderson, Medical Director: Dr Anderson was appointed in Summer 2003. Previously, he was a Consultant Physician and Gastroenterologist at West Middlesex Hospital where he also held the post of Medical Director. He is an Honorary Clinical Senior Lecturer of Imperial College and continues in active clinical practice as a Consultant Gastroenterologist.

Lorraine Bewes, Director of Finance & Information: Prior to her appointment in May 2003, Lorraine was Director of Performance at University College London Hospitals NHS Foundation Trust and Deputy Director of Finance at Hammersmith Hospitals NHS Trust. She joined the NHS in 1991 following a successful commercial accountancy career, during which she worked at ITN and WH Smith Television Services.

Mariella Dexter, Interim Director of Integrated Service Delivery & Modernisation: Mariella provided interim cover during Amanda Pritchard's maternity leave from January–June 2008. Previously she was Chief Executive of Gloucestershire Royal NHS Trust and Chief Executive of Avon, Gloucestershire & Wiltshire Workforce Development Confederation.

Andrew MacCallum, Director of Nursing: Andrew was appointed in August 2003, having previously been Director of Nursing at Queen Mary's Sidcup NHS Trust and Deputy Director of Nursing at Guy's and St Thomas' NHS Trust.

Catherine Mooney, Director of Governance & Corporate Affairs: Before being appointed in March 2006, Catherine was Chief Pharmacist at St Mary's NHS Trust for 15 years until March 2004 when she joined Hammersmith Hospitals NHS Trust as Clinical Governance Director. She attends Foundation Trust Board meetings as Company Secretary.

Audit Committee

Membership & attendance

The Audit Committee is chaired by Andrew Havery, a Non-Executive Director, and includes 2 other Non-Executive Directors, Karin Norman and Charles Wilson. It met 5 times in 2008/09. Andrew Havery and Charles Wilson attended all meetings and Karin Norman attended 3 meetings.

How the Committee discharges its responsibilities

The Audit Committee assures the Board of Directors that probity and professional judgement are exercised in all financial matters.

It advises the Board on the adequacy and effectiveness of the Trust's systems of internal control and its arrangements for risk management, control and governance processes, and securing economy, efficiency and effectiveness (value for money). It prepares an annual report for the Board.

Policy for safeguarding the external auditors' independence

In so far as the Trust has not purchased work from its external auditors outside the audit code in 2008/09, the external auditors' objectivity and independence have been safeguarded.

Responsibility for preparing the annual accounts

The Chief Executive is the Trust's designated Accounting Officer with the duty to prepare the accounts in accordance with the National Health Service Act 2006.

Nominations Committees

Both the Board of Directors and the Members' Council have their own Nominations Committee:

Nominations Committee of the Members' Council for the appointment of Non-Executive Directors

The members of the Nominations Committee of the Members' Council are Professor Sir Christopher Edwards (Chair) and Professor Brian Gazzard (Staff: Medical & Dental).

There are now 2 vacancies on this Committee following the resignation from the Members' Council of an elected Council Member, Valerie Arends (Public: Kensington & Chelsea 2) and an appointed Council Member, Andrew Kenworthy (NHS Kensington & Chelsea).

This Nominations Committee identifies appropriate candidates for Non-Executive Director vacancies through a process of open competition which takes account of the policy maintained by the Members' Council and the skills and experience identified by the Board of Directors.

It makes recommendations about suitable candidates for approval by the Members' Council.

This Nominations Committee also reviews the policy for the size, structure and composition of Non-Executive Director membership of the Board of Directors. This takes account of relevant Trust strategies from time to time, and not less than every 3 years, and makes recommendations to the Members' Council.

There were no meetings of the Nominations Committee of the Members' Council in the 2008/09 financial year.

Nominations Committee of the Board of Directors for the appointment of Executive Directors

The Nominations Committee of the Board of Directors comprises permanent members who are the Chairman and the Chief Executive (except for consideration of his/her own appointment or reappointment), as well as temporary members drawn from a membership pool of the Board of Directors.

The Board agrees to temporary members joining the Committee for the consideration of each Executive Director vacancy. The temporary members shall be discharged immediately after the selection of the shortlisted candidates.

This Nominations Committee identifies appropriate candidates for Executive Director vacancies through a process of open competition which takes account of an evaluation of the balance of skills, knowledge and experience of the Board and makes recommendations for shortlisted candidates to the Board's Appointments Panel.

The Nominations Committee of the Board of Directors was constituted following the end of the 2008/09 financial year.

Members' Council

How the Board of Directors and the Members' Council operate

The Members' Council represents the interests of the local community—patients, public and staff who are Foundation Trust members—and shares information about key decisions with Foundation Trust members. The Members' Council is not responsible for the day-to-day management of the organisation which is the responsibility of the Board of Directors.

Key roles of the Members' Council are to:

- Appoint or remove the Chairman and other Non-Executive Directors and approve the appointment (by Non-Executive Directors) of the Chief Executive
- Decide the remuneration, allowances and other terms and conditions of office of Non-Executive Directors
- Appoint or remove the Foundation Trust's Financial Auditors
- Review the Trust's constitution and suggest changes
- Review and develop the Trust's Membership Development and Communication Strategy

Composition of the Members' Council

There are 35 Council Members including:

- Chairman (appointed)—also Chairman of the Board of Directors
- 6 Staff (elected)—1 each from 6 staff constituencies
- 8 Public (elected)—2 each from 4 local boroughs
- 10 Patients (elected)—patients treated at the hospital in the last 3 years or their carers
- 10 Nominated Representatives (appointed)—nominated from 10 partnership organisations

The Members' Council meets quarterly. There were 4 meetings in 2008/09.

Executive and Non-Executive Directors are invited to attend. Details of their attendance are in the table 'Directors' attendance at Members' Council meetings 2008/09'. Details of Council Members' attendance at meetings are in the table 'Council Members—Who's Who'.

Council Members' initial terms of office commenced on the day that the Foundation Trust was licensed, 1 October 2006. Both elected and appointed Council Members normally hold office for a period of 3 years and are eligible for re-election or reappointment at the end of that period. Council Members may not hold office for more than 9 consecutive years.

Elections held during 2008/09

An election was held in 2008/09 to fill a vacant seat in the constituency Public: Kensington & Chelsea Area 2. Sandra Smith-Gordon was elected.

Access to register of Council Members' interests

Members of the public can gain access to the register of Council Members' interests by making a request to the Foundation Trust Secretary, Chelsea and Westminster Hospital NHS Foundation Trust, 369 Fulham Road, London, SW10 9NH, via email ftsecretary@chelwest.nhs.uk or on 020 8846 6716.

How the Board have acted to understand the views of Council Members and Foundation Trust Members

Executive and Non-Executive Directors have attended Members' Council meetings to gain an understanding of the views of Council Members and the membership constituencies they represent.

A joint Away Day for the Board and the Members' Council was held in December 2008 and workshops on specific issues, for example development of the Trust's corporate objectives for 2009/10, have been arranged for the Board to gain the input of Council Members.

Council Members and Foundation Trust Members were invited to attend the Annual Members' Meeting in September 2008 and the Seasonal Working Conference with staff in March 2009 to give their views on the Trust.

Directors' attendance at Members' Council meetings 2008/09

Non-Executive Directors	Attendance
Prof Sir Christopher Edwards	4/4
Colin Glass	3/4
Andrew Havery	1/4
Prof Richard Kitney	1/4
Karin Norman	1/4
Charles Wilson	4/4

Executive Directors	Attendance
Heather Lawrence, Chief Executive	4/4
Amanda Pritchard, Deputy Chief Executive (Director of Integrated Service Delivery & Modernisation) [1]	3/3
Dr Mike Anderson, Medical Director	2/4
Lorraine Bewes, Director of Finance & Information	4/4
Mariella Dexter, Interim Director of Integrated Service Delivery & Modernisation [2]	0/1
Andrew MacCallum, Director of Nursing	4/4
Catherine Mooney, Director of Governance & Corporate Affairs [3]	4/4

[1] On maternity leave until July 2008
[2] Interim Director of Integrated Service Delivery & Modernisation until July 2008
[3] Attends Foundation Trust Board meetings as Company Secretary

Council Members—Who's Who

Name Constituency/Organisation	Date elected or appointed	Attendance at Council Meetings 2008/09*
Prof Sir Christopher Edwards (Chairman)	Nov 2007	4/4
Arana, Maria-Elena (Patient)	Mar 2006	2/4
Arends, Valerie (Public—Kensington & Chelsea 2)	Mar 2006 [1]	0/1
Balmford, Walter (Patient)	Dec 2007	4/4
Bennett, June (Patient)	Dec 2007	4/4
Billing, Nathan (Staff—Allied Health Professionals, Scientific & Technical)	May 2007 [2]	3/3
Birch, Chris (Patient)	May 2007	4/4
Blewett, Christine (Public—Hammersmith & Fulham 2)	Mar 2006	4/4
Bradford, Martin (Public—Hammersmith & Fulham 1)	Dec 2007	2/4
Browne, Nicky (The Royal Marsden NHS Foundation Trust)	Dec 2006	3/4
Delamare, Alison (Staff—Contracted)	Mar 2006	4/4
Fitzgerald, Hugo (Patient)	Mar 2006	1/4
Foulkes, Lionel (Public—Wandsworth 2)	Mar 2006	1/4
Gazzard, Prof Brian (Staff—Medical & Dental and Deputy Chairman)	Mar 2006	3/4
Henry, Michael (Patient)	Mar 2006	0/4
James, Cathy (Staff—Support, Admin & Clerical)	Mar 2006	3/4
Jowett, Prof Sandra (Thames Valley University)	Mar 2006 [3]	0/2
King, Jane (Patient)	Oct 2006	3/4
Levy, Mr Raymond (Public—Kensington & Chelsea 1)	Dec 2007 [4]	0/2
Lewis, Martin (Public—Westminster 2)	Dec 2007	3/4
Longworth, Catherine (NHS Westminster)	Oct 2006	4/4
Macrae, Dr Duncan (Royal Brompton & Harefield NHS Trust)	Oct 2006	2/4
Maze, Prof Mervyn (Imperial College London)	Oct 2006	2/4
Mills-Duggan, Ann (Public—Westminster 1)	May 2007	3/4
Molyneux, Peter (NHS Kensington & Chelsea)	Nov 2007 [5]	3/4
Rawaf, Prof Salman (Wandsworth Teaching PCT)	Oct 2006	0/4
Rowell, Martin (Patient)	Mar 2006	3/4
Smith, Jim (Patient)	Mar 2006	4/4
Smith, Sue (Staff—Nursing & Midwifery)	Dec 2007	1/4
Smith, Sue B (Patient)	Dec 2007	1/4
Smith-Gordon, Sandra (Public—Kensington & Chelsea 2)	Oct 2008	2/2
Symons, Mary (Public—Wandsworth 1)	Dec 2007	3/4
Taylor, Cllr Frances (Royal Borough of Kensington & Chelsea)	Oct 2006	3/4
Wood, Vivian (NHS Hammersmith & Fulham)	Mar 2007 [6]	0/2
Westmancott, Ben (NHS Hammersmith & Fulham)	Q2 (Jul–Sep 2008)	0/2

* If individuals joined or left the Members' Council during the financial year, the number of meetings has been adjusted accordingly

1 left the Council in Q1 (Apr–Jun 2008)
2 left the Council in Q3 (Oct–Dec 2008)
3 appointment terminated Nov 2008 when Foundation Trust constitution amended and constituencies changed
4 left the Council in Q2 (Jul–Sep 2008)
5 left the Council in Mar 2009
6 left the Council in Q2 (Jul–Sep 2008)

Foundation Trust membership

Who can be a member?

- **Patient constituency:** Any patient treated at the hospital in the last 3 years, or the carer of a patient
- **Public constituency:** Anyone living in the local boroughs of Kensington & Chelsea, Hammersmith & Fulham, City of Westminster, and Wandsworth—each borough is divided into 2 areas for Members' Council elections
- **Staff constituency:** Any member of staff—this constituency is divided into 6 staff groups which are Allied Health Professionals, Scientific & Technical; Contracted; Management; Medical & Dental; Nursing & Midwifery; Support, Administrative & Clerical

How many people are members?

Number of members	31 Mar 2009
Patients	6,136
Public	6,372
Staff	2,930
Total	**15,438**

How are we developing a representative membership?

The Membership Development and Communication Sub-Committee of the Members' Council develops and reviews the Membership Development and Communications Strategy.

Membership grew by 18% in 2008/09, largely due to a decision taken by the Members' Council to move to an 'opt-out' system for staff which means that all staff are automatically members unless they opt out—this resulted in staff membership increasing from 465 in March 2008 to 2,930 in March 2009.

Initiatives to increase membership recruitment in 2008/09 included publishing a membership application form in a booklet given to all adult patients discharged from hospital, recruitment campaigns in advance of the Annual Members' Meeting and the Open Day, and the development of an Information Zone including LCD screen and electronic kiosks in the hospital.

Analysis of the membership database by age, gender and ethnicity to ensure that it is representative of the community we serve identified 3 areas for development:

- Low penetration in the Public: Wandsworth Area 1 constituency
- Significantly lower membership in the under-40 age group
- Significantly lower membership in the highest socio-economic group

In 2009/10 the Trust aims to maintain the current level of public members and increase the number of patient members by 5%.

Members' Council representatives and Foundation Trust members were invited to attend the Annual Members' Meeting in September 2008 and the Seasonal Working Conference with staff in March 2009 to give their views on the Trust.

Get in touch

Members who wish to communicate with their representatives on the Members' Council or Executive Directors should contact the Foundation Trust Secretary, Chelsea and Westminster Hospital NHS Foundation Trust, 369 Fulham Road, London SW10 9NH, via email ftsecretary@chelwest.nhs.uk or on 020 8846 6716.

The Information Zone on the ground floor of the hospital—funded by the Members' Council

Public interest disclosures

Action to inform, involve & consult with staff

The Trust is committed to keeping staff fully informed about everything that has an impact on their working lives at Chelsea and Westminster by providing them with information, consulting them on key decisions, and listening to their concerns.

A range of initiatives are in place to provide staff systematically with information on matters of concern to them, consult staff or their representatives so that their views are taken into account in making decisions that are likely to affect their interests, encourage the involvement of staff in the Trust's performance, and raise staff awareness of financial and economic factors affecting the Trust's performance:

- Executive Directors meet Staffside (Trade Union) representatives at monthly meetings of the Joint Management and Trade Union Consultative Committee (JMTUC)
- Quarterly meetings of the Members' Council include elected staff representatives
- Communication with staff includes a monthly staff magazine, a monthly face-to-face Team Briefing with Executive Directors, Daily Noticeboard email bulletin, and one-off briefings on issues of importance
- Staff are invited to be involved in the annual business planning process and development of Trust objectives

The Trust was ranked among the top 20% of NHS trusts in the annual NHS staff survey for effective communication between senior managers and staff.

Policies in relation to equal opportunities

The Trust aims to be an employer of choice for all. We have an Equal Opportunities Policy to ensure there is no direct or indirect discrimination and to build a workforce whose diversity reflects the community we serve.

A draft Single Equality Scheme (SES) has been developed to demonstrate how the Trust intends to meet the duties placed upon it by equal opportunities legislation. It aims to promote equality of opportunity and prevent discrimination. Consultation on the draft SES has included drop-in sessions for staff from April–June 2009 and an information stand at the Open Day in May 2009.

The Trust has joined the Stonewall Workplace Diversity Champions Programme, and established a network of staff groups including a Disability Action Group, a Black and Minority Ethnic Staff Network, and a Gay, Lesbian, Bisexual and Transgender (GLBT) Staff Network.

Policies in relation to disabled staff

Policies for giving full and fair consideration to applications for employment from disabled people

The Trust has an Equal Opportunities Policy and a Recruitment and Selection Policy and Procedure so that applications by disabled candidates receive full and fair consideration. Support for Trust staff is provided by recruitment training days which are compulsory for staff who participate in recruitment panels.

Policies for continuing the employment of, and arranging appropriate training for, staff who have become disabled

Disabled staff, managers, Human Resources and Occupational Health staff advise on adjustments to support disabled staff including adjustments to job roles, working hours and environment, and additional training.

Policies for training, career development and promotion of disabled staff

Staff should have regular performance development reviews and training needs support through the Knowledge and Skills Framework.

Health & Safety performance

The number of incidents reported to the Health & Safety Executive reduced from 18 in 2007/08 to 9 in 2008/09.

Occupational Health performance

The Occupational Health department provides services including fitness for work assessments, screening for infectious and communicable diseases, and moving and

handling training. In 2008/09, the department contributed to the Trust's achievement of NHS Litigation Authority risk management standards at Level 2 by producing and monitoring implementation of new Trustwide policies for Stress Management, Moving and Handling, and the Prevention and Management of Body Fluid Exposures.

Counter-Fraud policies & procedures

The Trust has a Counter-Fraud Policy for dealing with suspected fraud and corruption, and other illegal acts involving dishonesty or damage to property.

If Trust staff suspect a fraudulent act they can contact the Director of Finance & Information or the Local Counter-Fraud Specialist.

Sickness absence data

The annual sickness absence level in the Trust in 2008/09 was 3.7%.

Serious Untoward Incidents involving data loss or confidentiality breach

A Serious Untoward Incident was reported to the Information Commissioner, Monitor, NHS London and NHS Kensington & Chelsea in August 2008 when a member of staff reported the loss of a data stick containing person identifiable information.

This incident identified the need to improve the Trust's data security.

Patients whose data was on the stick were informed and an investigation panel was established, chaired by the Chief Executive and including a Non-Executive Director, the Medical Director (Caldicott Guardian) and the Chairman of the relevant patient representative group.

As a result of this incident, the Trust has put in place additional data security initiatives and agreed a detailed action plan which is monitored by the Board. Actions completed include a programme of internal communications to remind staff about the importance of data security, encryption of hard disk drives on Trust laptops, encryption of USB data sticks, and the introduction of mandatory information governance training for all Trust staff.

Finance

Statement of Accounting Officer's responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of Chelsea and Westminster Hospital NHS Foundation Trust

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

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

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

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

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable her to ensure that the accounts comply with requirements outlined in the above mentioned Act.

The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Heather Lawrence,
Chief Executive and Accounting Officer
4 Jun 2009

Statement on Internal Control

Statement on Internal Control for the Period 1 April 2008 to 31 March 2009

1. Scope of Responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me.

I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.

2. Purpose of the System of Internal Control

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

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Chelsea and Westminster Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in Chelsea and Westminster Hospital NHS Foundation Trust for the year ended 31 March 2009 and up until the date of approval of the annual report and accounts.

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

3. Capacity to Handle Risk

The Trust has a risk management strategy and operational policies approved by the Trust Board. The accountability for clinical and corporate governance, including risk management, rests with the Director of Governance & Corporate Affairs. This post facilitates an integrated model of risk management.

All Directors working in the Trust take responsibility for risk mitigation within their areas of work and practice, in line with the management and accountability arrangements in the Trust. The delivery of risk management occurs through management action and accountability arrangements and risk mitigation is monitored through the Trust's Operational Risk Management Committee. This reports to the Trust Executive for Clinical Governance and also provides reports to the Assurance Committee (formerly the Clinical Governance Assurance Committee and Facilities Assurance Committee), which reports to the Board.

The risk management team within the Trust provides support to directorates and departments on all aspects of effective risk assessment and management. Directorates have an identified senior lead for risk management. The Trust risk management team maintains the Trust's incident/risk reporting system and risk and incident review registers. The team also has a vital role in training, the dissemination of good practice and lessons learned from incidents or near misses. This is also achieved through sharing incidents at relevant committees, for example the Risk Management Committee and Trust Executive for Clinical Governance.

Risk management training is given to staff on induction and regular training opportunities are provided within the hospital to staff at all levels, including root cause analysis training.

The Trust achieved CNST Level 2 in the maternity standards in January 2006. The Trust achieved Level 2 in the revised general NHS Litigation Authority Risk Management Standards in December 2008.

4. Risk and Control Framework

The risk management strategy identifies the key elements to managing risk. This includes reactive risk management through analysis of incidents, identification of trends, investigations of serious incidents, and identification of action plans to reduce risk. These actions are monitored through the incident monitoring database. Risk is identified in the Trust proactively in a number of different ways. Directorates and departments undertake an annual comprehensive risk review using a risk assessment tool. Key gaps in meeting risks are identified and action plans developed. Risks are also identified on an ad hoc basis and evaluated using the Trust risk assessment form. This captures risk information for clinical and non-clinical risks and supports risk evaluation and action planning. Risks may also be identified from incidents, complaints and claims.

A coloured risk matrix is used to rate risks. Risk assessments are peer reviewed to include an assessment of the risk rating to ensure validity. Risks that are red or orange are entered into the centrally held risk register, which is managed by the corporate risk team. This register is reviewed at the Operational Risk Management Committee and if appropriate by other committees, for example those with capital implications are reviewed at the Capital Board. Current Assurance Framework risks are monitored by the Board. Leads for risk areas provide updates either as risks are mitigated or by default every 3 months. Risk assessments and the directorate risk register are part of the quarterly Clinical Governance Reports which are reviewed by the directorates. Risks that are red are notified to the Trust Board and these are monitored quarterly.

Risk management is embedded in the activity of the organisation in a number of ways. The strategy describes

local risk management processes which reflect the overall strategy of the Trust. In addition, directorates and departments are required to identify risks associated with objectives; risk identification is part of the business planning template; and risk identification is included in application forms for capital expenditure. The capital plan is regularly compared with the risk register to ensure significant risks requiring funding are prioritised.
Risks which may prevent the Trust from achieving its corporate objectives are identified during the development of the Trust's Assurance Framework.

The Board reviewed the systems and procedures for securing personal data in 2008/09, including patient data in transit, and was satisfied that these have been and remain compliant with relevant information governance guidance and the Data Protection Act 1998, with some exceptions. These exceptions have largely been addressed:

- In outpatient and ward areas, paper medical records are potentially accessible to the public during clinics. Lockable trolleys have been installed and training in information governance for all staff is being monitored regularly by the Information Governance Committee.

- The medical records library is open and security has been improved by the addition of CCTV.

- There is a software problem with the national PACS system which affects the security of passwords. The resolution of this is outside the Trust's control.

A serious incident in August 2008 involving the loss of a data stick containing person identifiable information was reported to the Information Commissioner and Monitor. As a result of this incident, additional data security initiatives have been put in place and there is a detailed action plan which is monitored by the Board. Actions completed include encryption of disk drives on portable PCs in accordance with NHS guidance; PointSec for encryption of USB storage devices has been installed with strong password authentication; IT security in the Trust has been investigated through ethical security testing and found to be of a high standard.

The Audit Committee now receives a regular update on information governance at each meeting and will assure the Board through reports to the Board.

The lead PCT is involved in risks which affect them through negotiation on the contract. In addition there is liaison and partnership work with relevant bodies on risks which affect them or which they can mitigate, for example ISS Mediclean for transport, Balfour Beatty for estates, the local safeguarding children's board for children's issues and various organisations for safeguarding vulnerable adults. The Trust also works with local agencies on emergency and business continuity planning.

Risk appetites are determined by the Board. This is usually based on risk assessments as part of a business case. The definition of consequences as part of the risk rating tool outlines risk levels and what the Trust considers major and extreme. Red risks are notified to the Board and progress on mitigation reported quarterly.

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

The development and reporting of patient level costing and service level reporting ensures that the Board is cognisant of relative profitability and efficiency.

Monthly finance and performance reports are provided to the Board. The Trust has exceeded the target for EBITDA and generation of surplus.

It is within Internal Audit's remit to make recommendations on the effective use of resources and they have undertaken a review of cost improvement processes.

The Audit Committee reviews performance against the Auditors' Local Evaluation despite being a Foundation Trust as the Trust considers it is good practice. Operational efficiency indicators are set at the top quartile of performance.

6. Review of Effectiveness

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

The Board ensures the effectiveness of the system of internal control through clear accountability arrangements.

The Audit Committee is a formal sub-committee of the Board and is accountable to the Board for reviewing the establishment and maintenance of an effective system of internal control and risk management. The committee meets at least 5 times per year. The Audit Committee approves the annual audit plans for internal and external audit activities and ensures that recommendations to improve weaknesses in control arising from audits are actioned by executive management.

The Audit Committee ensures the robustness of the underlying process used in developing the Assurance Framework. The Board monitors the Assurance Framework and objectives quarterly, ensuring actions to address gaps in control and gaps in assurance are progressed.

The Finance and Investment Committee conducts an objective review of financial and investment policy issues and reports to the Board.

The Assurance Committee is a formal sub-committee of the Board and has replaced the Clinical Governance Assurance Committee and Facilities Assurance Committee from December 2008. This committee is accountable for the assurance of the organisation's clinical governance and

associated risk arrangements, including infection control and for assurance of the maintenance of a safe, clean hospital environment. The Trust Executive committees report into the Assurance Committee.

Internal Audit services are outsourced to RSM Bentley Jennison Risk Management Ltd, who provide an objective and independent opinion to the Chief Executive, the Board and the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisation's agreed objectives. Each assignment is discussed with the appropriate line manager or Director and a report including management responses and proposed action plan is presented to the Audit Committee. Internal Audit routinely follows up action with management to establish the level of compliance and the results are reported to the Audit Committee.

Executive Directors are accountable to the Board, the Audit Committee and the Assurance Committee (formerly the Clinical Governance and Facilities Assurance Committees) for ensuring management arrangements are in place to develop relevant strategies, policies, systems and procedures to maintain internal control and to take action to address any gaps identified from the review of these systems. Executive Directors are responsible for setting team objectives to ensure the delivery of corporate objectives and the management of risk. Any need to change priorities or controls is clearly recorded and actioned as appropriate. There is a quarterly report to the Board on progress on objectives, including a review of the risks.

The Trust declared full compliance with the Standards for Better Health for 2008/09 with one exception. The exception was standard 13c ('Healthcare organisations have systems in place to ensure that staff treat patient information confidentially, except where authorised by legislation to the contrary') where the Trust had a significant lapse in year, but achieved full compliance by year end.

A significant internal control issue was highlighted by a serious incident involving the loss of a data stick containing person identifiable information. The incident was reported to the Information Commissioner and Monitor. Actions have been taken as outlined above in section 4 and the action plan is being monitored by the Board.

A risk relating to maternity services has been identified recently, linked to the high use of agency staff. Recruitment, training and levels of usage of temporary staff will be a key issue in 2009/10.

The initial concerns about data quality have been addressed, with significant improvements in timeliness, completeness and accuracy of data. There is however a remaining risk related to high levels of agency staff in an environment of recruitment difficulties for coders.

7. Conclusion

Other than the control issues specified above, of which all have been mitigated or robust plans are in place to do so, there are no other significant control issues.

Heather Lawrence

Heather Lawrence,
Chief Executive
4 Jun 2009

Independent Auditors' Report

Independent Auditors' Report to the Members' Council and Board of Directors of Chelsea and Westminster Hospital NHS Foundation Trust

We have audited the financial statements of Chelsea and Westminster Hospital NHS Foundation Trust for the year ended 31 March 2009 under the National Health Service Act 2006 ("the Act") which comprise the Income and Expenditure Account, Balance Sheet, Statement of Total Recognised Gains and Losses, Cash Flow Statement and the related notes 1 to 26. These financial statements have been prepared in accordance with the accounting policies set out therein.

This report is made solely to the Members' Council and Board of Directors ("the Boards") of Chelsea and Westminster Hospital NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditors' report and for no other purpose. To the fullest extent permitted by law, we do not, in giving our opinion, accept or assume responsibility to anyone other than the Trust and the Boards, as a body, for this report, or for the opinions we have formed.

Respective Responsibilities of the Accounting Officer and Auditors

The Accounting Officer's responsibilities for preparing the financial statements in accordance with directions issued by Monitor, the independent regulator of NHS Foundation Trusts, are set out in the Statement of Accounting Officer's Responsibilities.

Our responsibility is to audit the financial statements in accordance with relevant legal and regulatory requirements (including statute and the Audit Code of NHS Foundation Trusts) and International Standards on Auditing (UK and Ireland).

We report to you our opinion as to whether the financial statements give a true and fair view in accordance with the accounting policies directed by Monitor, the independent regulator of NHS Foundation Trusts. We also report to you whether in our opinion the information given in the Directors' Report is consistent with the financial statements.

In addition, we report to you if, in our opinion, the financial statements have not been prepared in accordance with directions made under paragraph 25 of Schedule 7 of the Act, the financial statements do not comply with the requirements of all other provisions contained in, or having effect under, any enactment applicable to the financial statements, or proper practices have not been observed in the compilation of the financial statements.

We review whether the statement on internal control reflects compliance with the requirements of Monitor contained in the NHS Foundation Trust Financial Reporting Manual. We report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information we are aware of from our audit of the financial statements. We are not required to consider, nor have we considered, whether the statement on internal control covers all risks and controls. We are also not required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

We read the other information contained in the Annual Report as described in the contents section and consider whether it is consistent with the audited financial statements. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the financial statements. Our responsibilities do not extend to any further information outside the Annual Report.

Basis of Audit Opinion

We conducted our audit in accordance with the Audit Code for NHS Foundation Trusts issued by Monitor, which requires compliance with International Standards on Auditing (UK & Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements. It also includes an assessment of the significant estimates and judgements made by the Directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

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

Opinion

In our opinion:

- The financial statements give a true and fair view of the state of affairs of Chelsea and Westminster Hospital NHS Foundation Trust as at 31 March 2009 and of its income and expenditure for the year then ended in accordance with the accounting policies directed by Monitor, the independent regulator of NHS Foundation Trusts
- The information given in the Directors' Report is consistent with the financial statements.

Certificate

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

Heather Bygrave
5 June 2009

Heather Bygrave FCA BA (Hons)
(Senior Statutory Auditor)
For and on behalf of Deloitte LLP
Chartered Accountants
St Albans
5 Jun 2009

Foreword to the accounts

These accounts for the year ended 31 March 2009 have been prepared by Chelsea and Westminster Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

Heather Lawrence

Heather Lawrence,
Chief Executive
4 Jun 2009

Income and expenditure account for the year ended 31 March 2009

	Note	2008/09 £000	2007/08 £000
Income from activities	3	**243,355**	221,636
Other operating income	4	**37,370**	36,574
Operating expenses	5	**(262,911)**	(235,414)
Operating surplus		**17,814**	22,796
Loss on disposal of fixed assets		**(118)**	0
Operating surplus		**17,696**	22,796
Finance income	9.1	**1,438**	2,018
Finance costs—interest expense	9.2	**(813)**	(880)
Surplus for the financial year		**18,321**	23,934
Public Dividend Capital dividends payable	15.1	**(8,687)**	(9,309)
Retained surplus for the year		**9,634**	14,625

The notes on pages 43 to 55 form part of these accounts. All income and expenditure is derived from continuing operations.

Balance sheet as at 31 March 2009

	Note	31 Mar 2009 £000	31 Mar 2008 £000
Fixed assets			
Tangible assets	10	**289,240**	278,701
Current assets			
Stocks and work in progress	11	**6,588**	6,002
Debtors	12	**11,418**	9,990
Cash at bank and in hand	16.3	**32,053**	35,894
Total current assets		**50,059**	51,886
Creditors: amounts falling due within one year	13.1	**(36,524)**	(32,376)
Net current assets		**13,535**	19,510
Total assets less current liabilities		**302,775**	298,211
Creditors: Amounts falling due after more than one year	13.1	**(11,705)**	(13,222)
Provisions for liabilities and charges	14	**(440)**	(4,212)
Total assets employed		**290,630**	280,777
Financed by:			
Taxpayers' equity			
Public dividend capital	15.2	**162,549**	162,549
Revaluation reserve	15.3	**91,320**	91,040
Donated asset reserve	15.3	**7,472**	7,533
Income and expenditure reserve	15.3	**29,289**	19,655
Total taxpayers' equity		**290,630**	280,777

Heather Lawrence

Heather Lawrence, Chief Executive
4 Jun 2009

Statement of total recognised gains and losses for the year ended 31 March 2009

	2008/09 £000	2007/08 £000
Surplus for the financial year before dividend payments	**18,321**	23,934
Unrealised surplus on fixed asset revaluation	**280**	0
Increase in the donated asset reserve due to receipt of donated assets	**240**	0
Reductions in the donated asset reserve due to depreciation, impairment and/or disposal of donated assets	**(301)**	(310)
Total recognised gains for the financial year	**18,540**	23,624

Cash Flow Statement for the Year Ended 31 March 2009

	Note	Year ended 31 Mar 2009 £000	Year ended 31 Mar 2008 £000
Operating activities			
Net cash inflow from operating activities	16.1	**27,845**	27,841
Returns on investments and servicing of finance			
Interest received		**1,493**	1,977
Interest paid		**(717)**	(800)
Interest element of finance leases		**(100)**	(80)
Net cash inflow from returns on investments and servicing of finance		**676**	1,097
Capital expenditure			
Payments to acquire tangible fixed assets		**(19,231)**	(10,694)
Net cash outflow from capital expenditure		**(19,231)**	(10,694)
Dividends paid		**(8,687)**	(9,309)
Net cash inflow before financing		**603**	8,935
Financing			
New public dividend capital received		**0**	2,151
Public dividend capital repaid		**0**	(2,204)
Loans received from Foundation Trust Financing Facility		**0**	4,706
Loans repaid to Foundation Trust Financing Facility		**(1,470)**	0
Other loans repaid		**(3,124)**	(3,126)
Other capital receipts		**197**	0
Capital element of finance lease rental payments		**(47)**	(37)
Net cash (outflow)/inflow from financing		**(4,444)**	1,490
(Decrease)/increase in cash		**(3,841)**	10,425

Notes to the accounts

1. Accounting policies and other information

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the *NHS Foundation Trust Financial Reporting Manual* which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2008/09 *NHS Foundation Trust Financial Reporting Manual* issued by Monitor. The accounting policies contained in that manual follow UK generally accepted accounting practice for companies (UK GAAP) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of tangible fixed assets at their value to the business by reference to their current costs. NHS foundation trusts, in compliance with HM Treasury's Financial Reporting Manual, are not required to comply with the FRS 3 requirements to report "earnings per share" or historical profits and losses.

1.2 Income Recognition

Income is accounted for by applying the accruals convention. The main source of income for the Trust is from commissioners in respect of healthcare services. Income is recognised in the period in which services are provided. Income relating to episodes of care which are partially complete at the end of an accounting period is divided pro rata across the periods in which episodes take place. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

1.3 Expenditure

Expenditure is accounted for by applying the accruals convention.

1.4 Tangible fixed assets

Capitalisation

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

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

1.5 Valuation

Tangible fixed assets are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost (for leased assets, fair value) including any costs such as installation directly attributable to bringing them into working condition. The carrying values of tangible fixed assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable. The costs arising from financing the construction of the fixed asset are not capitalised but are charged to the income and expenditure account in the year to which they relate.

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

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The last asset valuations were undertaken in 2006 as at the prospective valuation date of 1 April 2006. The revaluation undertaken at that date was accounted for on 1 April 2006. The next valuation will take place on 31st March 2010.

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

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

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

1.6 Depreciation, amortisation & 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 assessed by the NHS Foundation Trust's professional valuers. Leaseholds are depreciated over the primary lease term.

Equipment is depreciated on current cost evenly over the estimated life of the asset. The useful economic life for equipment assets is deemed as 5 years for short life assets, 10 years for medium life assets and 15 years for long life assets.

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.

1.7 Donated fixed assets

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the donated asset reserve and each year an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the income and expenditure account.

Similarly, any impairment on donated assets charged to the income and expenditure account is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value of the donated asset is transferred from the donated asset reserve to the income and expenditure reserve.

1.8 Government Grants

Government grants are grants from Government bodies other than income from Primary Care Trusts or NHS Trusts for the provision of services. Any grant from the Department of Health is accounted for as Government grant. Where the Government grant is used to fund revenue expenditure it is taken to the Income and Expenditure account to match that expenditure. Where the grant is used to fund capital expenditure the grant is held as deferred income and released to the income and expenditure account over the life of the asset on a basis consistent with the depreciation charge for that asset.

1.9 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 accounted for as NHS debtors and not work-in-progress.

1.10 Cash, bank and overdrafts

Cash, bank and overdraft balances are recorded at the current values of these balances in the Trust's cash book. These balances exclude monies held in the Trust's bank account belonging to patients (see "third party assets" below). Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases overdrafts are disclosed within creditors. Interest earned on bank accounts and interest charged on overdrafts is recorded respectively as "interest receivable" and "interest payable" in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

1.11 Research and development

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

- there is a clearly defined project;
- the related expenditure is separately identifiable;
- the outcome of the project has been assessed with reasonable certainty as to its technical feasibility and its likelihood of resulting in a product or services that 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, the Trust discloses 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.

1.12 Provisions

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

1.13 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 19, where an inflow of economic benefits is probable.

Contingent liabilities are provided for where a transfer of economic benefits is probable. Otherwise, they are not recognised, but are disclosed in note 19 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

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

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

1.14 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 14.

Since financial responsibility for clinical negligence cases transferred to the NHSLA at 1 April 2002, the only charge to operating expenditure in relation to clinical negligence in 2008/09 relates to the Trust's contribution to the Clinical Negligence Scheme for Trusts.

1.15 Non-clinical risk pooling

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

1.16 Pension costs

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

The Scheme is subject to a full actuarial valuation every four years (until 2004, based on a five year valuation cycle), and a FRS17 accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

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

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

b) FRS17 Accounting valuation

In accordance with FRS17, a valuation of the Scheme liability is carried out annually by the Scheme Actuary as at the balance sheet date by updating the results of the full actuarial valuation.

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

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

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

Pension Scheme Provisions

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

On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

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

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the income and expenditure account at the time the Trust commits itself to the retirement, regardless of the method of payment.
The Scheme provides the opportunity to members to increase their benefits through money purchase Additional Voluntary Contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee/member can make contributions to enhance an employee's pension benefits. The benefits payable relate directly to the value of the investments made.

Scheme provisions from 1 April 2008
From 1 April 2008 changes were made to the NHS Pension Scheme contribution rates and benefits. Further details of these changes can be found on the NHS Pensions website www.pensions.nhsbsa.nhs.uk.

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

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

1.19 Third Party Assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in note 16.4.

1.20 Leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the 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.

1.21 Public Dividend Capital (PDC) and PDC Dividend
Public dividend capital (PDC) is a type of public sector equity finance.

A charge, reflecting the forecast cost of capital utilised by the Trust, is paid over as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average relevant net assets less the value of all liabilities, except for donated assets, assets funded by external finance and cash with the Office of the Paymaster General. The average relevant net assets are calculated as a simple mean of opening and closing relevant net assets.

1.22 Financial instruments
Financial instruments are defined as contracts that give rise to a financial asset of one entity and a financial liability or equity instrument of another entity. The Trust will commonly have the following financial assets and liabilities: trade debtors (but not prepayments), current asset investments, cash at bank and in hand, trade creditors (but not deferred income), finance lease obligations, loans, provisions.

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described above.

Regular way purchases or sales are recognised and de-recognised, as applicable, using the trade date.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risk and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement
Financial assets are classified into the following specified categories:

- Financial assets 'at fair value through Income and Expenditure' or
- 'Loans and receivables' or
- 'Available-for-sale' financial assets or
- 'Held-to-maturity' investments.

Financial liabilities are classified as either:

- Financial liabilities 'at fair value through Income and Expenditure' or
- 'Other financial liabilities'.

There are no financial assets classified as 'at fair value through Income and Expenditure', 'Available for sale' or 'Held to maturity' investments. There are no financial liabilities classified as 'at fair value through income and expenditure'.

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

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

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

The Trust's loans and receivables comprise: cash at bank and in hand, NHS debtors, accrued income and 'other debtors'.

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

Interest on loans and receivables is calculated using the effective interest method and credited to the income and expenditure account, except for short-term receivables when the recognition of interest would be immaterial.

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

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

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

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

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the income and expenditure account and the carrying amount of the asset is reduced through the use of an allowance account/ bad debt provision.

2. Segmental analysis

The Board of Directors is of the opinion that the Trust's operating activities fall under the single heading of healthcare for the purposes of segmental reporting.

3. Income from Activities

3.1 Income from activities by type

	2008/09 £000	2007/08 £000
Elective income	**38,112**	34,058
Non elective income	**61,524**	56,835
Outpatient income	**60,679**	47,038
Other NHS clinical income	**63,129**	73,353
Accident & Emergency income	**9,979**	9,843
Payment by results (clawback)	**0**	(6,428)
Private patient income	**7,969**	6,937
Other non-protected clinical income	**1,963**	0
Total	**243,355**	221,636

3.2 Private patient income

	Base year 2002/03 £000	2008/09 £000	2007/08 £000
Private patient income	5,498	**7,969**	6,937
Total patient related income	157,015	**243,355**	221,636
Proportion (as percentage)	3.50%	**3.27%**	3.13%

3.3 Income from activities by source

	2008/09 £000	2007/08 £000
NHS Trusts	**22**	1,331
Primary Care Trusts	**189,447**	176,207
Department of Health—other	**43,673**	35,516
Non NHS: Private patients	**7,969**	6,937
Non NHS: Overseas patients (non-reciprocal)	**1,026**	718
NHS injury scheme	**838**	692
Non NHS: Other	**380**	235
Total	**243,355**	221,636

4. Other Operating Income

	2008/09 £000	2007/08 £000
Research and development	**2,691**	3,029
Education and training	**22,257**	21,629
Charitable and other contributions to expenditure	**121**	122
Transfers from donated asset reserve in respect of depreciation	**301**	310
Non-patient care services to other bodies	**710**	608
Other income	**11,290**	10,876
Total	**37,370**	36,574

5. Operating Expenses

	2008/09 £000	2007/08 £000
Services from NHS Trusts	**187**	1,191
Purchase of healthcare from non-NHS bodies	**376**	643
Executive directors costs	**736**	727
Non executive directors costs	**116**	116
Staff costs	**147,236**	133,177
Drug costs	**42,240**	36,994
Supplies and services—clinical (excluding drug costs)	**29,060**	25,782
Supplies and services—general	**2,777**	3,697
Establishment	**4,600**	2,931
Transport	**1,446**	601
Premises	**17,120**	17,353
Bad debts	**13**	(1,278)
Depreciation and amortisation	**8,734**	7,587
Audit fees	**105**	106
Clinical negligence	**2,873**	3,015
Other	**5,292**	2,772
Total	**262,911**	235,414

5.2 Operating leases

5.2/1 Operating lease rentals

	2008/09 £000	2007/08 £000
Hire of plant and machinery	**278**	559
Other operating lease rentals	**1,284**	718
Total	**1,562**	1,277

5.2/2 Operating Lease Commitments

Land & Buildings Operating leases which expire:	2008/09 £000	Restated 2007/08 £000
Within 1 year	**0**	0
Between 1 and 5 years	**166**	166
After 5 years	**703**	186
Total	**869**	352

Other Operating leases which expire:	2008/09 £000	Restated 2007/08 £000
Within 1 year	**37**	42
Between 1 and 5 years	**146**	165
After 5 years	**139**	139
Total	**322**	346

2007/08 reflected outstanding lease commitment therefore restated to reflect annual lease commitment

6. Staff costs and numbers

6.1 Staff costs

	2008/09 £000	2007/08 £000
Salaries and wages	**114,416**	107,009
Social security costs	**10,040**	9,713
Employers' contributions to NHS Pension Scheme	**12,113**	10,979
Agency/contract staff	**11,403**	6,203
Total	**147,972**	133,904

6.2 Average number of persons employed

	2008/09 n°	2007/08 n°
Medical and dental	**515**	490
Administration and estates	**535**	519
Healthcare assistants and other support staff	**207**	188
Nursing, midwifery and health visiting staff	**985**	965
Nursing, midwifery and health visiting learners	**4**	9
Scientific, therapeutic and technical staff	**278**	288
Bank and agency staff	**470**	419
Other	**27**	27
Total	**3,021**	2,905

6.3 Employee benefits

During 2008/09 there were no material non-pay benefits which are not attributable to individual employees exceeding £0.1m (year ended 31 March 2008 - nil).

6.4 Retirements due to ill-health

During 2008/09 there were no (year ended 31 March 2008—3) early retirements from the Trust agreed on the grounds of ill-health. (The estimated additional pension liabilities of ill-health retirements year ended 31 March 2008—£0.1m.)

Notes to table 6.5

1. Medical Director moved to the new consultant contract in 2008/09
2. Salary is part year in 2007/08 and 2008/09 due to maternity leave
3. Salary is part year in 2007/08 and 2008/09
4. Salary for part year in 2007/08
5. Salary for part year in 2008/09
6. Salary for Interim Directors reported as full cost to the Trust

As non executive directors do not receive pensionable remuneration there are no entries in respect of pensions for them.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figure shown relates to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures include the value of any pension benefits in another scheme or arrangement in which the individual has transferred to the NHS pension scheme. They also include any additional pension benefits accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV—this reflects the increase in CETV effectively funded by the employer . It takes account of the

increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Real increase in CETV for current year may be significantly different from prior year. This is due to a change in the factors used to calculate CETVs, which came into force on 1 October 2008 as a result of the Occupational Pension Scheme (Transfer Value Amendment) regulation. These placed responsibility for the calculation method for CETVs (following actuarial advice) on Scheme Managers or Trustees. Further regulations from the Department for Work and Pensions to determine cash equivalent transfer values (CETV) from Public Sector Pension Schemes came into force on 13 October 2008.

6.5 Salary and Pension Entitlements of Senior Managers

	a) Remuneration		b) Pension				
	Salary for the year ended 31 Mar 2009 bands of **£5,000**	**Salary for the year ended 31 Mar 2008** bands of **£5,000**	**Accrued pension and related lump sum at age 60 as at 31 Mar 2009** bands of **£2,500**	**Real increase/ (decrease) in pension and related lump sum at age 60 as at 31 Mar 2009** bands of **£2,500**	**CETV at 31 Mar 2008** **(£000)**	**CETV at 31 Mar 2009** **(£000)**	**Real increase/ (decrease) in CETV for the year ended 31 Mar 2009** **(£000)**
Executive Directors							
Heather Lawrence, Chief Executive	**170–175**	165–170	**292.5–295.0**	**(10.0)–(7.5)**	1,343	**1,826**	**268**
Mike Anderson, Medical Director [1]	**155–160**	135–140	**275.0–277.5**	**75.0–77.5**	858	**1,651**	**474**
Lorraine Bewes, Director of Finance & Information	**125–130**	120–125	**107.5–110.0**	**7.5–10.0**	352	**487**	**76**
Amanda Pritchard, Deputy Chief Executive (Director of Service Integration & Modernisation) [2]	**85–90**	100–105	**57.5–60.0**	**0–2.5**	125	**158**	**18**
Andrew MacCallum, Director of Nursing	**95–100**	90–95	**125.0–127.5**	**2.5–5.0**	383	**547**	**97**
Mariella Dexter, Interim Director of Service Integration & Modernisation [3, 6]	**20–25**	25–30	**0**	**0**	0	**0**	**0**
Non-Executive Directors							
Professor Sir Christopher Edwards, Chairman [4]	**40–45**	15–20	**0**	**0**	0	**0**	**0**
Andrew Havery, Non-Executive Director	**15–20**	15–20	**0**	**0**	0	**0**	**0**
Karin Norman, Non-Executive Director	**10–15**	10–15	**0**	**0**	0	**0**	**0**
Charles Wilson, Non-Executive Director	**10–15**	10–15	**0**	**0**	0	**0**	**0**
Professor Richard Kitney, Non-Executive Director	**10–15**	10–15	**0**	**0**	0	**0**	**0**
Colin Glass, Non-Executive Director [4]	**10–15**	0–5	**0**	**0**	0	**0**	**0**
Directors							
Catherine Mooney, Director of Governance & Corporate Affairs	**80–85**	80–85	**107.5–110.0**	**2.5–5.0**	361	**496**	**79**
Alex Geddes, Director of Information Management & Technology	**90–95**	90–95	**30.0–32.5**	**2.5–5.0**	0	**0**	**0**
Neil Callow, Deputy Director of Finance [5]	**70–75**	0	**77.5–80.0**	**17.5–20.0**	169	**293**	**66**
Alan Bramhall, Interim Deputy Director of Finance [3, 6]	**35–40**	70–75	**0**	**0**	0	**0**	**0**
Amit Khutti, Director of Strategy & Service Planning	**80–85**	75–80	**7.5–10.0**	**2.5–5.0**	9	**23**	**9**
Mark Gammage, Interim Director of Human Resources [5, 6]	**85–90**	0	**0**	**0**	0	**0**	**0**

7. Better Payment Practice Code

7.1 Better Payment Practice Code—measure of compliance

	2008/09 n°	2008/09 £000	2007/08 n°	2007/08 £000
Total bills paid in the year	**70,804**	**143,549**	65,669	124,372
Total bills paid within the target	**62,628**	**128,136**	61,743	110,805
Percentage of bills paid within target	**88.5%**	**89.3%**	94.0%	89.1%

The Better Payment Practice Code requires the Trust to aim to pay 95% of all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

7.2 The Late Payment of Commercial Debts (Interest) Act 1998

There were no amounts included within interest payable (note 9.2) arising from claims made under this legislation (2007/08—nil).

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

The loss on disposal of fixed assets was £0.12m (2007/08—nil) consisting of various pieces of medical equipment decommissioned.

9.1 Finance Income

	2008/09 £000	2007/08 £000
Interest receivable on cash deposits	**1,438**	2,018
Total	**1,438**	2,018

9.2 Finance Costs—Interest Expense

	2008/09 £000	2007/08 £000
Loans from the Foundation Trust Financing Facility	**587**	504
Finance leases	**104**	80
Other Loans	**122**	296
Total	**813**	880

10. Tangible Fixed Assets

10.1 Elements of tangible fixed assets at the balance sheet date

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 Apr 2008	50,000	214,914	1,269	2,237	35,617	65	11,462	471	316,035
Additions—purchased	0	3,430	0	8,050	4,551	0	2,774	66	18,871
Additions—donated	0	0	0	0	240	0	0	0	240
Reclassifications	0	4,592	0	(5,031)	439	0	0	0	0
Other revaluations	0	0	0	0	0	0	280	0	280
Disposals	0	0	0	0	(1,513)	0	0	0	(1,513)
Cost or valuation at 31 Mar 2009	**50,000**	**222,936**	**1,269**	**5,256**	**39,334**	**65**	**14,516**	**537**	**333,913**
Depreciation at 1 Apr 2008	0	11,088	188	0	18,862	63	6,681	452	37,334
Provided during the year	0	5,423	111	0	2,300	2	879	19	8,734
Disposal	0	0	0	0	(1,395)	0	0	0	(1,395)
Depreciation at 31 Mar 2009	**0**	**16,511**	**299**	**0**	**19,767**	**65**	**7,560**	**471**	**44,673**
Net book value									
Purchased at 1 Apr 2008	50,000	196,856	1,081	2,237	16,192	2	4,781	19	271,168
Donated at 1 Apr 2008	0	6,970	0	0	563	0	0	0	7,533
Total at 1 Apr 2008	**50,000**	**203,826**	**1,081**	**2,237**	**16,755**	**2**	**4,781**	**19**	**278,701**
Net book value									
Purchased at 31 Mar 2009	50,000	199,688	970	5,256	18,836	0	6,956	66	281,772
Donated at 31 Mar 2009	0	6,737	0	0	731	0	0	0	7,468
Total at 31 Mar 2009	**50,000**	**206,425**	**970**	**5,256**	**19,567**	**0**	**6,956**	**66**	**289,240**
Net book value									
Protected assets at 31 Mar 2009	50,000	203,068	970	0	0	0	0	0	254,038
Unprotected assets at 31 Mar 2009	0	3,357	0	5,256	19,567	0	6,956	66	35,202
Total at 31 Mar 2009	**50,000**	**206,425**	**970**	**5,256**	**19,567**	**0**	**6,956**	**66**	**289,240**

10.2 Assets held at open market value:

As at 31 March 2009, £50m related to land, £206m related to buildings, excluding dwellings, and £0.97m related to dwellings.

10.3 Net book value of assets held under finance leases and hire purchase contracts at the balance sheet date

	Dwellings £000
At 31 Mar 2009	**970**
At 31 Mar 2008	**1,081**

10.3/1 Total amount of depreciation charged to the income and expenditure account in respect of assets held under finance leases and hire purchase contracts

	Dwellings £000
Depreciation 31 Mar 2009	**111**
Depreciation 31 Mar 2008	**111**

10.4 Net book value of land, buildings and dwellings at 31 March 2009

	Total £000	Protected £000	Unprotected £000
Freehold	**256,425**	**253,068**	**3,357**
Long leasehold	**970**	**970**	**0**
Total at 31 Mar 2009	**257,395**	**254,038**	**3,357**

11. Stocks and Work in Progress

	31 Mar 2009 £000	31 Mar 2008 £000
Raw materials and consumables	**6,588**	6,002

12. Debtors

12.1 Debtors at the balance sheet date

Amounts falling due within one year:	31 Mar 2009 £000	31 Mar 2008 £000
NHS Debtors	**6,565**	6,026
Prepayments	**458**	684
Accrued income	**312**	766
Other debtors	**6,657**	5,016
Provision for irrecoverable debts	**(2,574)**	(2,502)
Total	**11,418**	9,990

Included in NHS debtors is a figure of £0.99m (31 Mar 2008—£0.71m) relating to partially completed spells of clinical activity at 31 Mar 2009.

12.2 Provision for Impairment of NHS Debtors

	31 Mar 2009 £000	31 Mar 2008 £000
At 1 April	**2,502**	3,956
Provision for debtors impairment	**195**	0
Debtors written off during the year as uncollectable	**(123)**	(425)
Unused amounts reversed	**0**	(1,029)
Total at 31 Mar 2009	**2,574**	2,502

12.3 Analysis of Impaired Debtors

Ageing of impaired debtors	31 Mar 2009 £000	31 Mar 2008 £000
Up to three months	**195**	0
In three to six months	**121**	148
Over six months	**2,258**	2,354
Total	**2,574**	2,502
Ageing of non-impaired debtors past their due date		
Up to three months	**3,206**	3,019
In three to six months	**979**	431
Over six months	**1,488**	0
Total	**5,673**	3,450

13. Creditors

13.1 Creditors at the balance sheet date

Amounts falling due within one year	31 Mar 2009 £000	31 Mar 2008 £000
Loans	**1,470**	4,594
NHS creditors	**7,798**	6,116
Other tax and social security costs	**3,182**	3,186
Obligations under finance leases and HP contracts	**47**	43
Capital Creditors	**1,076**	1,235
Other creditors	**7,255**	6,422
Accruals	**10,036**	6,186
Deferred income	**5,660**	4,594
Subtotal	**36,524**	32,376
Amounts falling due after more than one year		
Loans	**9,560**	11,030
Obligations under finance leases and HP contracts	**2,145**	2,192
Subtotal	**11,705**	13,222
Total	**48,229**	45,598

NHS creditors include outstanding pension contributions at 31 Mar 2009 of £1.65m (31 Mar 2008—£1.5m).

13.2 Loans—payment of principal falling due

Amounts falling due	31 Mar 2009 £000	31 Mar 2008 £000
In one year or less	**1,470**	4,594
Between one and two years	**1,470**	1,470
Between two and five years	**4,410**	4,410
Over 5 years	**3,680**	5,150
Total	**11,030**	15,624

13.3 Prudential Borrowing Limit (PBL)

	31 Mar 2009 £000 Authorised	31 Mar 2009 Actual £000	31 Mar 2008 £000 Authorised	31 Mar 2008 Actual £000
Total long term borrowing	**38,100**	**13,222**	29,900	17,859
Working capital facility	**20,000**	**0**	18,000	0
Total	**58,100**	**13,222**	47,900	17,859

13.3/1 Financial Ratios

	Prudential Borrowing Limits	2008/09 Approved PBL Ratio	2008/09 Actual PBL Ratio	2007/08 Approved PBL Ratio	2007/08 Actual PBL Ratio
Maximum debt/capital ratio (%)	**< 40%**	**6%**	**4%**	5%	5%
Minimum dividend cover (times)	**>1.0x**	**2.9x**	**3.1x**	2.2x	3.4x
Minimum interest cover (times)	**>3.0x**	**29.6x**	**34.4x**	25.0x	36.8x
Minimum debt service to revenue (%)	**>2.0x**	**4.8x**	**5.1x**	4.6x	8.0x
Maximum debt service to revenue (%)	**<3.0%**	**2.1%**	**1.9%**	1.9%	1.6%

The Trust is required to comply and remain within a prudential borrowing limit. This is made up of two elements:

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

Further information on the NHS Foundation Trust Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the independent Regulator of Foundation Trusts.

13.4 Finance Lease Obligations

	31 Mar 2009 £000	31 Mar 2008 £000
Within one year	**125**	121
Between two and five years	**537**	522
After five years	**2,470**	2,610
	3,132	3,253
Less: finance charges allocated to future periods	**(940)**	(1,018)
Net obligations	**2,192**	2,235

13.5 Finance Lease Commitments

	31 Mar 2009 £000	31 Mar 2008 £000
Minimum payments	**3,132**	3,253
Number of years of commitment (years)	**19**	20

14. Provisions for Liabilities and Charges

	Pensions relating to other staff £000	Agenda for Change payments £000	Total £000
At 1 April 2008	**408**	**3,804**	**4,212**
Arising during the year	**52**	**0**	**52**
Utilised during the year	**(20)**	**(220)**	**(240)**
Reversed unused	**0**	**(3,584)**	**(3,584)**
At 31 Mar 2009	**440**	**0**	**440**

14/1 Expected timing of cash flows

	Pensions relating to other staff £000	Agenda for Change payments £000	Total £000
Within one year	**12**	**0**	**12**
Between one and five years	**48**	**0**	**48**
After five years	**380**	**0**	**380**
Total	**440**	**0**	**440**

Clinical Negligence Liabilities

Amount included in provisions of the National Health Service Litigation Authority at 31 March 2009 in respect of clinical negligence of the Trust is £31.32m (31 March 2008—£27.6m).

15. Movements in Taxpayers' Equity and Public Dividend Capital

15.1 Movement in Taxpayers' Equity

	31 Mar 2009 £000	31 Mar 2008 £000
Taxpayers' equity at 1 April	**280,777**	266,515
Surplus for the financial period	**18,321**	23,934
Public dividend capital dividends	**(8,687)**	(9,309)
Surplus from revaluations of fixed assets	**280**	0
New public dividend capital received	**0**	2,151
Public dividend capital repaid in year	**0**	(2,204)
Reductions in donated asset reserve	**(61)**	(310)
Taxpayers' equity at 31 Mar	**290,630**	280,777

15.2 Movements in Public Dividend Capital

	31 Mar 2009 £000	31 Mar 2008 £000
Public dividend capital at 1 April	**162,549**	162,602
New public dividend capital received	**0**	2,151
Public dividend capital repaid in year	**0**	(2,204)
Public dividend capital at 31 Mar	**162,549**	162,549

15.3 Movements on Reserves

	Revaluation Reserve £000	Donated Asset Reserve £000	Income and Expenditure Reserve £000	Total Reserves £000
At 1 April 2008	**91,040**	**7,533**	**19,655**	**118,228**
Transfer from the income and expenditure account	**0**	**0**	**9,634**	**9,634**
Surplus on revaluations of fixed assets	**280**	**0**	**0**	**280**
Receipt of donated assets	**0**	**240**	**0**	**240**
Transfers to the income and expenditure account for depreciation, impairment and disposal of donated assets	**0**	**(301)**	**0**	**(301)**
At 31 Mar 2009	**91,320**	**7,472**	**29,289**	**128,081**

16. Notes to the Cash Flow Statement

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

	31 Mar 2009 £000	31 Mar 2008 £000
Total operating surplus	**17,814**	22,796
Depreciation	**8,734**	7,587
Transfer from the donated asset reserve	**(301)**	(310)
(Increase) in stocks	**(586)**	(429)
(Increase) in debtors	**(604)**	(1,116)
Increase/(decrease) in creditors	**6,559**	(909)
(Decrease)/increase in provisions	**(3,771)**	222
Net cash inflow from operating activities	**27,845**	27,841

16.2 Reconciliation of net cash flow to movement in net funds

	31 Mar 2009 £000	31 Mar 2008 £000
(Decrease)/increase in cash in the period	**(3,841)**	10,425
Cash (inflow) from new debt	**0**	(4,706)
Cash outflow from debt repaid and finance lease capital payments	**4,637**	3,164
Change in net debt resulting from cash flows	**796**	8,883
Net funds at start of period	**18,035**	9,152
Net funds at 31 Mar	**18,831**	**18,035**

16.3 Analysis of changes in net funds

	Net Funds at 1 Apr 2008 £000	Cash changes in year £000	Net Funds at 31 Mar 2009 £000
Commercial cash at bank and in hand	**16,815**	**(16,748)**	**67**
Office of Paymaster General cash at bank	**19,079**	**12,907**	**31,986**
Debt due within one year	**(4,594)**	**3,124**	**(1,470)**
Debt due after one year	**(11,030)**	**1,470**	**(9,560)**
Finance leases	**(2,235)**	**43**	**(2,192)**
Total	**18,035**	**796**	**18,831**

16.4 Third Party Assets

The Trust held £0.05m cash at bank and in hand at 31 March 2009 (31 March 2008—£0.05m) which relates to monies held by the Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts.

17. Contractual Capital Commitments

Commitments under capital expenditure contracts at 31 March 2009 were £0.97m (31 March 2008—£4.60m)

18. Post Balance Sheet Events

There have been no post balance sheet events since the balance sheet date.

19. Contingencies

There were no contingent liabilities at the balance sheet date.

20. Related Party Transactions

Chelsea and Westminster Hospital NHS Foundation Trust is a public benefit corporation established by the order of the Secretary of State for Health.

Government Departments and their agencies are considered by HM Treasury as being related parties. During the period the Trust has had a significant number of material transactions with the Department of Health and with other entities for which the Department is regarded as the parent department. The main commissioners include Kensington and Chelsea PCT, Hammersmith and Fulham PCT, Westminster PCT and Wandsworth PCT.

In addition, the Trust has had a significant number of material transactions in the ordinary course of its business with other Government Departments and other central bodies. Most of these transactions are with HM Revenue & Customs in respect of deduction and payment of PAYE, NHS Pension Scheme in respect of pension contributions, NHS Logistics Authority and NHS Litigation Authority.

Income and expenditure relating to the above mentioned commissioners and other Government Departments and other central bodies is as follows:

	Income £000	Expenditure £000
Main Commissioners:		
Kensington & Chelsea PCT	**81,416**	273
Hammersmith & Fulham PCT	**23,886**	20
Westminster PCT	**16,266**	239
Wandsworth PCT	**17,823**	
Other Government Departments and central bodies:		
HM Revenue & Customs		37,432
NHS Business Services Authority		17,034
NHS Logistics Authority		4,663
NHS Litigation Authority		2,836

The Trust has also received income from Chelsea and Westminster Health Charity as donations towards revenue and capital expenditure. No funds are held in trust by Chelsea and Westminster Hospital NHS Foundation Trust but are held by the Trustees, who prepare their own annual accounts, as they are independent from the Trust.

None of the Board Directors, Members' Councillors, members of the key management staff or parties related to them have undertaken any material transactions with the Trust.

21. PFI Schemes

The Trust is not party to any PFI Schemes.

22. Losses and Special Payments

There were 81 cases of losses and special payments (2007/08—332 cases) totalling £0.28m (2007/08—£0.8m) for the year ended 31 March 2009.

23. Financial Instruments

FRS 25 (Financial Instruments: Disclosure and Presentation) and FRS 29 (Financial Instruments: Disclosures), require disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The Trust does not have any complex financial instruments and does not hold or issue financial instruments for speculative trading purposes. Because of the continuing service provider relationship the Trust has with Primary Care Trusts and the way those Primary Care Trusts are financed, the Trust is not exposed to the degree of financial risk faced by business entities.

Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which FRS 25 mainly applies. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Finance and Investment Committee manages the Trust's funding requirements and financial risks in line with the Board approved treasury policies and procedures, and their delegated authorities.

The Trust's financial instruments comprise loans, finance lease obligations, provisions, cash at bank and in hand and various items, such as trade debtors and trade creditors, that arise directly from its operations. The main purpose of these financial instruments is to raise finance for the Trust's operations.

23.1 Categories of Financial Instruments

	31 Mar 2009 £000	31 Mar 2008 £000
Financial assets:		
Loans & receivables (including cash)	**43,013**	45,199
Assets at fair value through the I&E	**0**	0
Held to maturity investments	**0**	0
Total	**43,013**	45,199
Financial liabilities:		
Other financial liabilities (amortised cost)	**39,827**	40,796
Liabilities at fair value through the I&E	**0**	0
Total	**39,827**	40,796

23.2 Fair Values

	Book value £000	Fair value £000
Financial assets:		
Cash	**32,053**	**32,053**
Total	**32,053**	**32,053**
Financial liabilities:		
Finance leases obligation for more than 1 year	**2,145**	**0**
Provisions under contract	**440**	**440**
Loans due in more than 1 year	**9,560**	**9,560**
Total	**12,145**	**10,000**

As allowed by FRS 25, short term trade debtors and creditors measured at amortised cost may be excluded from the above disclosure as their book values reasonably approximate their fair values.

23.3 Liquidity and Interest Risk Tables

	Weighted ave. interest rate %	Less than 1 year £000	1–2 years £000	2-5 years £000	More than 5 years £000	Total £000
Financial assets:						
Non-interest bearing		**10,960**	**0**	**0**	**0**	**10,960**
Fixed interest rate instrument	**5.03%**	**32,053**	**0**	**0**	**0**	**32,053**
Variable interest rate instrument		**0**	**0**	**0**	**0**	**0**
Gross financial assets at 31 Mar 2009		**43,013**	**0**	**0**	**0**	**43,013**
Non-interest bearing		**9,305**	**0**	**0**	**0**	**9,305**
Fixed interest rate instrument	**5.59%**	**35,894**	**0**	**0**	**0**	**35,894**
Variable interest rate instrument		**0**	**0**	**0**	**0**	**0**
Gross financial assets at 31 Mar 2008		**45,199**	**0**	**0**	**0**	**45,199**
Financial liabilities:						
Non-interest bearing		**26,165**	**0**	**0**	**0**	**26,165**
Finance lease liability	**3.50%**	**125**	**129**	**408**	**2,470**	**3,132**
Fixed interest rate instrument	**4.74%**	**1,482**	**1,482**	**4,446**	**4,060**	**11,470**
Variable interest rate instrument		**0**	**0**	**0**	**0**	**0**
Gross financial liabilities at 31 Mar 2009		**27,772**	**1,611**	**4,854**	**6,530**	**40,767**
Non-interest bearing		**21,875**	**654**	**0**	**0**	**22,529**
Finance lease liability	**3.50%**	**121**	**125**	**397**	**2,610**	**3,253**
Fixed interest rate instrument	**4.92%**	**4,616**	**1,492**	**4,476**	**5,448**	**16,032**
Variable interest rate instrument		**0**	**0**	**0**	**0**	**0**
Gross financial liabilities at 31 Mar 2008		**26,612**	**2,271**	**4,873**	**8,058**	**41,814**

24. Interest-Rate Risk

100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. Chelsea & Westminster Hospital NHS Foundation Trust was not, therefore, exposed to significant interest-rate risk.

25. Liquidity risk

The Trust's net operating costs are mainly incurred under legally binding contracts with Primary Care Trusts, which are financed from resources voted annually by Parliament. This provides a reliable source of funding stream which significantly reduces the Trust's exposure to liquidity risk.

The Trust also manages liquidity risk by maintaining banking facilities and loan facilities to meet its short and long term capital requirements through continuous monitoring of forecast and actual cash flows.

In addition to internally generated resources the Trust finances its capital programme through a loan facility, while the working capital is backed by a committed facility of £20m, unused at 31 March 2009. Details are included in note 13.3.

26. Credit risk

Credit risk exists where the Trust can suffer financial loss through default of contractual obligations by a customer or counterparty.

Trade debtors consist of high value transactions with Primary Care Trusts under contractual terms that require settlement of obligation within a time frame established generally by the Department of Health. Other trade debtors include private and overseas patients, spread across diverse geographical areas. Credit evaluation is performed on the financial condition of accounts receivable and, where appropriate, sufficient prepayment is required to mitigate the risk of financial loss.

Credit risk exposures of monetary financial assets are managed through the Trust's treasury policy which limits the value that can be placed with each approved counterparty to minimise the risk of loss. The counterparties are limited to the approved financial institutions with high credit ratings. Limits are reviewed regularly by senior management.

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