Annual Report & Accounts 2009/10

Choose Chelsea and Westminster

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

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Chelsea and Westminster Hospital NHS Foundation Trust

Annual Report & Accounts 2009/10

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Introduction

About this report

Our annual report follows 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.

The structure of the report is as follows:

- **Introduction**
  Statements by the Chairman and Chief Executive

- **Strategy**
  Our strategic vision, performance against corporate objectives 2009/10 and details of our corporate objectives 2010/11

- **Quality Report**
  Articulating our commitment to providing quality care for all patients and reporting back on our performance against priorities for quality improvement agreed by the Trust Board of Directors

- **Performance Report**
  Including our performance against national targets

- **Governance Report**
  Including details of the Board of Directors, Council of Governors and Foundation Trust membership

- **Statutory Information**
  Other information required to be included in the annual report by Monitor, the independent regulator of Foundation Trusts, including this year for the first time major new sections on Sustainability/Climate Change, Equality & Diversity, Staff Survey and Regulatory Ratings

- **Finance**
  Including the accounts

A commitment to quality and quality improvement underpins our corporate objectives 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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The Quality Report was written by Catherine Mooney, Director of Governance & Corporate Affairs, with contributions from a wide range of staff throughout the Trust.

Chairman's statement

Everyone knows that, despite the political commitment of the new Government to protect the NHS, the economic downturn will place major pressures on healthcare in the years ahead.

However, as a Foundation Trust with a proven track record of providing high quality care in new ways, we are well placed to rise to this challenge.

The active involvement of our 15,000 patient, public and staff Foundation Trust members—as well as their elected representatives on our Council of Governors—is vital to our future success and it was pleasing to see how we made this aspiration a reality in 2009/10.

56 Dean Street, our new HIV and sexual health centre in Soho, was made possible because as a Foundation Trust we could retain our financial surplus and invest it in the development of this state-of-the-art modern facility.

A user group including patients and Governors helped plan the development of this centre and it is now delivering services where and when patients want them—including at weekends and during the evening.

Little more than a year since it opened in March 2009, 56 Dean Street is now the busiest HIV and sexual health centre in London.

Governors and Foundation Trust members also supported the Trust's successful bid to be designated as a stroke unit. A capital scheme has expanded its capacity and our stroke services are ranked third best in the country by the National Sentinel Stroke Audit.

Parents and children who use our paediatric services were involved before, during and after our successful bid to be designated as the lead centre for neonatal and specialist paediatric surgery in North West London.

Chelsea and Westminster is a provider of specialist services for patients from all over London, South East England and beyond and general acute services for our local community. It is also a centre for teaching and research.

As a clinician and academic, I was delighted that we led a successful bid to establish and host the North West London Health Innovation and Education Cluster (HIEC). This new partnership aims to ensure that patients receive better treatment by promoting innovation, quality and productivity through training and education of healthcare staff.

We also host the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Northwest London which aims to enable the rapid introduction of new, effective treatments for a wide range of medical conditions.

Finally, I would like to congratulate Trust Chief Executive Heather Lawrence who was awarded an OBE in the New Year's Honours list for services to healthcare.

Heather has been key to the success of Chelsea and Westminster as Chief Executive since 2000 and she has also made an outstanding contribution to the wider NHS, most recently as a member of the Prime Minister's Nursing and Midwifery Commission.

Few deserve recognition more than Heather who has guided the Trust to financial stability, Foundation Trust status in 2006, and a reputation as one of the consistently best performing NHS organisations in England.

I am confident that, with Heather's strong and visionary leadership of our outstanding team, Chelsea and Westminster has a bright future despite the challenging economic times that undoubtedly lie ahead for the NHS.

Professor Sir Christopher Edwards
Chairman

Chief Executive's statement

2009/10 was a successful year for the Trust thanks to the commitment of all our staff.

We achieved a double 'Excellent' rating for both 'Quality of Services' and 'Quality of Financial Management' in the 2009 NHS annual performance ratings, placing us among the top 9% of NHS trusts. We expect to retain a double 'Excellent' rating for our performance in 2009/10 when the Care Quality Commission publishes the 2010 ratings in October.

Chelsea and Westminster was rated as the fourth best performing hospital in England for patient safety in the Dr Foster Hospital Guide 2009 and we continued to treat 95% of outpatients and 90% of inpatients within 18 weeks of GP referral.

We met, and indeed exceeded, Care Quality Commission targets to minimise MRSA bacteraemia and *Clostridium difficile* infections—no patient admitted for planned surgery in 2009/10 contracted MRSA—while the National Patient Safety Agency's Patient Environment Action Team (PEAT) assessment rated our hygiene standards as 'Excellent'.

However, we are not complacent and we recognise that from time to time there are shortcomings in the care and treatment that some patients receive—90% of respondents to the 2009 national inpatient survey rated their experience at Chelsea and Westmisnter as 'Excellent', 'Very good' or 'Good' but we want 100% of patients to have 'Excellent' care.

I believe passionately that the litmus test of any hospital is for every member of staff to ask themselves—would I want my loved ones treated here? If the answer is yes, we know that we are getting it right.

In 2009/10 we introduced the Patient Experience Tracker to gather 'real-time' patient feedback and rolled out the *Releasing Time to Care—The Productive Ward* programme to ensure that our frontline clinical staff spend more time with patients.

Over the last year we have also worked with staff and women to improve our maternity services and we are proud of the improvements that our midwives, obstetricians and the rest of the team have made by working together and listening to women who use our service—87% of women now rate our maternity care as 'Excellent', 'Very good' or 'Good'.

This year we are focusing on our medical wards to ensure that we communicate well and deliver compassionate care to our often very frail patients at all times.

Strategically we have anticipated changes to the NHS in London by repositioning ourselves as a high performing organisation that not only provides high quality specialist services and popular local services but also has the flexibility to provide services in the community.

In 2009/10 we won competitive tenders to provide community dermatology and gynaecology services in Westminster, established 56 Dean Street as a cutting edge HIV and sexual health centre in the heart of Soho, and were named as the 'preferred provider' for a new Urgent Care Centre co-located with Chelsea and Westminster A&E.

NHS organisations will need to be flexible and adapt to a very different political and economic environment by delivering services in new and innovative ways and so I am delighted that Chelsea and Westminster has a strong track record in doing just that.

We are making 10% cost savings in 2010/11 to ensure that we retain the financial stability that has underpinned our success while at the same time investing in a major redevelopment of the hospital.

This redevelopment will enhance our reputation as a provider of specialist services by delivering state-of-the-art facilities for children, HIV patients and outpatients.

Despite the economic downturn, I believe we have an opportunity to create an exciting future for the Chelsea and Westminster 'brand' as a guarantee of excellence in clinical care and patient experience—wherever we provide services and whatever new partnerships and alliances we forge with other providers and GPs.

I look forward to working with colleagues on the Board of Directors and staff at Chelsea and Westminster to help build that future.

Heather Lawrence

Heather Lawrence OBE
Chief Executive

Strategy

Our strategic vision

Strategic approach 2009/10

The Trust's strategic vision in 2009/10 was as follows:

"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."

Our strategic service objectives in 2009/10 were as follows:

- To be a provider of specialist services, building on our existing excellent reputation in HIV, burns care and high risk maternity, and developing our role as a designated centre for neonatal and specialist paediatric surgery, and stroke

- To be a provider of local services for our local population, including delivering more community-based services in specialties such as dermatology, musculoskeletal and diabetes, in collaboration with our primary, community and secondary care colleagues

Strategic developments 2009/10

The Trust developed its reputation as a provider of specialist services in 2009/10:

- Following a competitive tender process, we were designated as the hub of complex paediatric and neonatal surgery in North West London and lead organisation for the specialist paediatric surgical network in the sector—we have developed a federated model of care with key partner organisations including Great Ormond Street Hospital, Guy's and St Thomas' NHS Foundation Trust and Royal Brompton & Harefield NHS Foundation Trust

- In support of this expansion of paediatrics, the Trust was granted planning permission for a £39 million redevelopment of the main hospital site to improve the patient environment for children, HIV patients and outpatients in particular—work started on site in April 2010

- We achieved NHS Litigation Authority risk management standards in Maternity at Level 2 following an assessment in February 2010

- We refurbished our Neonatal Intensive Care Unit to expand its capacity to 42 cots in support of our high risk maternity and complex specialist paediatric patients

- The Assisted Conception Unit was refurbished to improve the environment for patients

- We were designated as a Stroke Unit by Healthcare for London and a capital scheme has expanded the unit to 22 beds

- 56 Dean Street, our new HIV and sexual health centre in Soho—which was officially opened in May 2009—has cemented the Trust's reputation as a leader in this field and is now the busiest HIV and sexual health centre in London

The Trust developed its reputation as a provider of local services, including delivering more community-based services in 2009/10:

- We successfully bid to become the provider of community dermatology and gynaecology services in Westminster—both services are now operational and proving popular with GPs and patients by offering the Trust's expertise in community settings closer to where people live

- An innovative new community mobile health clinic was launched in 2009/10, providing a range of health screening in a purpose-built mobile unit on matchdays at Chelsea Football Club—this initiative was initially targeted at men, who traditionally seek health advice less than women, but the aim is for the mobile health clinic to be used in a variety of community settings targeted at different patient groups

- We have worked closely with NHS Kensington & Chelsea in support of the national and regional drive to reduce inappropriate and unnecessary A&E attendances, and we have been designated as the 'preferred provider' for an Urgent Care Centre—this new facility, which will be co-located with the A&E department at Chelsea and Westminster, is due to open during 2010/11

Refreshing our strategic vision

The Trust's strategic vision was formed during our application for Foundation Trust status in 2006.

Not only has the landscape of the NHS environment within which we operate changed markedly since 2006 but also we require a robust strategy to cope with the effects of the economic downturn on the public sector.

During 2009/10 the Board of Directors engaged with the Council of Governors—elected representatives of patients, members of the public living in our four local boroughs, and staff, and nominated representatives of stakeholder organisations—to refresh our strategic vision.

The Trust's strategic vision for the next three years is as follows:

"To provide high quality patient-centred care for our local population and those using our specialist services, delivered by a modern workforce in a range of settings along integrated pathways of care."

Our strategic objectives to support the vision

Strategic objectives in support of our updated strategic vision are as follows:

- To improve quality—patient safety, clinical effectiveness and patient experience
- To streamline our administrative processes—for example, the use of technology to deliver our vision of an 'airport' style facility to enhance the patient experience in outpatients
- To foster an environment of strong clinical leadership
- To work collaboratively through networks and in partnership with other providers
- To provide world class teaching and research
- To deliver more care in community-based settings in close liaison with GPs and other primary and community care colleagues
- To challenge traditional ways of working to ensure an efficient and 'fit for purpose' organisation that is financially sustainable

The Trust is operating in challenging economic times for the NHS—we have established the *Fit for the Future* programme to make 10% cost savings in 2010/11 by encouraging our staff to work in different ways in order to deliver greater efficiency and productivity without compromising quality.

We have also implemented an organisational restructure which has established three clinical divisions, each with a Divisional Medical Director and a Divisional Director of Operations, to enhance clinical leadership in the Trust.

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 2009/10

Corporate Objective 1: Improve patient safety and clinical effectiveness

- We were rated as the fourth best performing hospital in England for patient safety in the Dr Foster Hospital Guide 2009
- We were rated 'Excellent' for 'Quality of Services' in the NHS annual performance ratings 2009
- We met a national target to treat 95% of outpatients and 90% of inpatients within 18 weeks of GP referral and we also met a national target to treat 98% of A&E patients within four hours
- We met targets for the reduction of MRSA bacteraemia and Clostridium difficile—10 cases of MRSA (against a target of 19 cases set by the Care Quality Commission) and 32 cases of *C. difficile* (against a target of 109 cases set by the Care Quality Commission)
- We achieved NHS Litigation Authority risk management standards for Maternity at Level 2

Corporate Objective 2: Improve the patient experience

- 90% of patients in the annual NHS inpatient survey 2009 rated their care as 'Excellent', 'Very good' or 'Good'
- We demonstrated a progressive improvement in key issues identified by the annual NHS inpatient survey 2009, performing significantly better on 16 questions compared with the 2008 survey and significantly worse on no questions
- We implemented the use of a 'real-time' electronic patient feedback tool, the Patient Experience Tracker (PET), and by the end of 2009/10 76% of patients on inpatient wards were giving their views on their care using the PET
- We rolled out the *Releasing Time to Care—The Productive Ward* programme to 14 wards in 2009/10 to improve ward processes and environments so that staff are able to spend more time caring directly for patients
- Administrative processes have been improved by centralising most medical secretaries and all appointment bookings and admissions staff in a new purpose-built area of the hospital—this has led to a significant reduction in patient complaints relating to appointments and admissions
- 65% of staff took part in the annual NHS staff survey 2009 (compared with 61% in 2008 and 53% in 2007)—we improved or maintained our performance for 83% of the survey's 36 key findings

Corporate Objective 3: Deliver excellence in teaching and research

- We led a successful bid to establish and host the North West London Health Innovation and Education Cluster (HIEC) which aims to ensure that patients receive better treatment as a result of promoting innovation, quality and productivity through training and education of healthcare staff
- We continued to participate actively in the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Northwest London which is hosted at Chelsea and Westminster
- The Trust developed its Research Strategy which is due to be approved and implemented in 2010/11

Corporate objectives 2010/11

Corporate Objective 1: Improve patient safety and clinical effectiveness

Patient safety

- Reduce hospital acquired preventable venous thromboembolism (VTE) by 20%
- Reduce the incidence of falls resulting in moderate or major harm by at least 25%
- Ensure that no elective patient is infected with MRSA bacteraemia while in the hospital

Clinical effectiveness

- Meet agreed targets based on National Confidential Enquiry into Patient Outcome & Death (NCEPOD) recommendations for emergency surgery
- Reduce the Trust's Hospital Standardised Mortality Ratio (HSMR) by 5%
- Be at or below the national average of patients with an indwelling urinary catheter and reduce the number of urinary catheter days, excluding patients who need a lifelong urinary catheter

Corporate Objective 2: Improve the patient experience

- Achieve performance above the national average on five selected questions in the 2010 NHS inpatient survey in order to be more responsive to the personal needs of patients
- Improve the patient experience for women and children by:
    - Achieving a 90% satisfaction score for patient experience on the postnatal ward, as measured by the Patient Experience Tracker (PET)
    - Reducing the waiting time for an appointment in the antenatal clinic to no longer than 15 minutes
    - Achieving a 90% satisfaction score for patient experience in children's outpatients, as measured by the PET
- Reduce the number of complaints relating to appointments and admissions by 30%
- Increase staff satisfaction by achieving the upper quartile scores for appraisals and Personal Development Plans (PDPs) in the national staff survey and make a year-on-year improvement in sickness absence rates, vacancy rates and uptake of mandatory training

Corporate Objective 3: Deliver excellence in teaching and research

- Deliver an agreed improvement in students' overall rating of their teaching
- Implement the Research Strategy including the CLAHRC programme
- Achieve Year One priorities for the Health Innovation Education Cluster (HIEC)

Corporate Objective 4: Ensure financial and environment sustainability

- Deliver the financial plan for 2010/11
- Improve performance on environmental sustainability by:
    - Completing a programme to install automatic meter reading for gas and electricity usage
    - Improving our overall rating for the Corporate Good Citizen Assessment model with the intention of achieving at least the London average by March 2011
    - Increasing recycling rates in 2010/11 from their current level of 29% to 40% of all waste

The Trust has agreed targets for emergency surgery

Quality Report

The Trust achieved NHS Litigation Authority risk management standards for Maternity at Level 2 following an assessment visit in February 2010

Statement on quality from the Chief Executive

The Trust Board of Directors is committed to providing high quality care for our patients.

This commitment to meeting the challenge of delivering quality and efficiency underpins our corporate objectives for 2010/11:

- Improve patient safety and clinical effectiveness
- Improve the patient experience
- Deliver excellence in teaching and research
- Ensure financial and environmental sustainability

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

I am very grateful to our stakeholders for contributing to the development of this Quality Report, in particular our staff and Governors, to ensure that we are reflecting and addressing the concerns that matter to patients and the public.

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

- The Trust was registered without conditions by the Care Quality Commission (CQC) from 1 April 2010 when a new system for regulating standards in the NHS became law—to be registered, the Trust needed to show it could meet new essential standards of quality and safety which the CQC will monitor

- Chelsea and Westminster was named as one of the best hospitals in the country for patient safety by the Dr Foster Hospital Guide in November 2009—Chelsea and Westminster was fourth best in England and the best performing hospital in North West London

- The Trust achieved NHS Litigation Authority risk management standards for Maternity at Level 2 following an assessment visit in February 2010—we were already at Level 2 for the general Trustwide standards

- We significantly outperformed national targets for the reduction of both MRSA bacteraemia and *Clostridium difficile* in 2009/10

- Chelsea and Westminster was given a clean bill of health by the CQC following an unannounced inspection in May 2009 to assess whether the Trust adequately protects patients, staff and visitors from infection

We are proud of these achievements and we are committed to improving quality further—our performance against our priorities for quality improvement in 2009/10 and the priorities for quality improvement that we have set for 2010/11 are outlined in this Quality Report.

The Board of Directors is committed to maintaining and improving quality and the Trust is in a strong position to rise to this challenge in partnership with staff, patients and other stakeholders.

To the best of my knowledge, the information in this report is accurate.

Heather Lawrence

Heather Lawrence OBE
Chief Executive

Priorities for quality improvement 2010/11

Following consultation with key stakeholders the Trust Board of Directors has agreed the following priorities for quality improvement in 2010/11:

Priority 1: Patient safety

To reduce hospital acquired preventable venous thromboembolism (VTE) by 20%

Why is this a priority?

Deep vein thrombosis (DVT) is a common medical condition that occurs when a blood clot forms in a deep vein, usually in the leg or the pelvis. A DVT can block off or reduce the flow of blood in the vein. Sometimes it breaks off and travels to the arteries of the lung where it will cause a pulmonary embolism (PE). DVT and PE are known collectively as venous thromboembolism (VTE).

PE is a major cause of preventable death and a DVT may result in lifelong disability with painful leg swelling, varicose veins and leg ulcers. Reducing the incidence of VTE is a national priority for the NHS.

Approximately half of all cases of VTE occur in patients who have had a recent stay in hospital. VTE is one of the most common preventable causes of hospital deaths. It is estimated that in England each year more than 25,000 people die from preventable VTE contracted in hospital.

About one third of patients will develop VTE despite the best care but we can help prevent VTE occurring in two thirds of patients by providing appropriate preventative treatment.

What did we do in 2009/10?

The Trust has established a multi-disciplinary committee to tackle this priority. We have introduced a number of measures to raise awareness among patients and staff to ensure that all patients admitted to hospital are assessed for their risk of VTE and treated appropriately:

- We have published a patient information leaflet on DVT and PE and a pocket guide for staff which includes guidance on assessing risk factors for VTE and treatment to prevent VTE in at-risk patients

- We have designed an electronic VTE risk assessment for use with adult inpatients which highlights what preventative treatment may be required, supported by an electronic prescribing alert which appears if an at-risk patient has not been prescribed preventative anticoagulant drugs

How did we perform in 2009/10?

We set ourselves an initial target in 2009/10 to reduce preventable VTE by 15%. We wanted to measure the number of DVTs and PEs diagnosed at this hospital that occurred during an admission or within three months of an admission in order to establish a baseline.

Nationally it is recognised that data accuracy for VTE is a problem and so an audit was undertaken to assess the accuracy of the reported data for a four-month period from 1 September to 31 December 2009.

We identified 58 patients who were coded as having had a VTE of whom nine had been coded incorrectly—they did not have a VTE although it was considered as a possible diagnosis. Of the 49 patients who did have a VTE, 12 had a recent admission to Chelsea and Westminster Hospital and three had a recent admission to another hospital. The remaining 34 patients had a VTE unrelated to a hospital admission. Now that we have established an approximate number of cases for a four-month period, we can measure progress towards our target and have decided to increase it to a 20% reduction in 2010/11.

We have undertaken audits on the wards to establish the number of patients who receive appropriate anticoagulant drugs to prevent DVT and PE. An audit on an orthopaedic ward in 2008 showed that only 32% of patients were receiving appropriate preventative anticoagulant drugs despite the introduction of electronic prescribing pop-up alerts reminding doctors to prescribe the drugs, if they had not already been prescribed.

However, this figure rose to 69% in 2009 following the introduction of revised guidelines and clearer wording in the pop-up alerts. An audit of patients undergoing planned hip and knee replacement surgery performed for two weeks in March 2010 showed that 83% of patients were offered an information leaflet on DVT and PE at the pre-assessment clinic and 83% of patients were wearing stockings to prevent DVT.

What actions are we planning to improve our performance?

We are changing the VTE risk assessment in line with the new Department of Health VTE risk assessment tool. We will extend the risk assessment to include maternity and day case patients as well as all inpatients. We plan to make the risk assessment mandatory to ensure that all patients will be risk assessed. We will undertake a root cause analysis of all cases of DVT and PE occurring during a hospital admission or within three months of admission. This will help us identify areas where we can make improvements to prevent VTE in other patients.

How will improvement be measured and monitored?

We will monitor cases of preventable VTE bi-monthly and rates of VTE risk assessment completion for all adult patients monthly. We will audit on a regular basis whether appropriate preventative treatment is being provided Trustwide.

How will progress be reported?

Progress will be reported at the multi-disciplinary Thrombosis and Thromboprophylaxis Committee every two months and at the Quality Committee and the Assurance Committee on a quarterly basis.

Priority 2: Patient experience

To achieve a progressive improvement in issues identified in the annual national inpatient survey relating to communication, information and responsiveness to the personal needs of patients

Why is this a priority?

Improving the patient experience is a key Trust corporate objective and issues relating to communication and information have been highlighted as areas for improvement in the Trust's national inpatient survey results.

In addition, there is a national focus in 2010/11 on responsiveness to the personal needs of patients.

What did we do in 2009/10?

We used a 'real-time' electronic patient feedback tool called the Patient Experience Tracker (PET) to ask five questions relating to the inpatient survey questions we wished to address:

1. Were you kept well informed about your care and treatment by staff during your stay?
2. Did you feel involved in decisions made regarding your care and treatment?
3. Did staff answer your questions in a way that you could understand?
4. Were the staff friendly and approachable?
5. Overall how would you rate your experience on the ward?

A total of 13 inpatient adult wards, including the postnatal ward, have been using the PET since June 2009 and this was extended to other clinical areas during 2009/10.

How did we perform in 2009/10?

Obtaining sufficient responses from patients to ensure the validity of the PET results has been a key challenge since its introduction in the Trust. However, by March 2010 the Trust achieved a 76% response rate for inpatient ward areas.

Overall in 2009/10 patients using the PET reported a satisfaction score of 86% against a target score of 90%.

National inpatient survey results

The PET questions relate to the inpatient survey questions as shown in the table below which also compares the Trust's performance in the 2008 and 2009 surveys and the national average for 2009.

The results are expressed as problem scores—a low score is a good score. Different questions have different responses and the problem score combines these categories. A problem score shows the percentage of patients for each question who, by their response, indicated that a particular aspect of their care could have been improved.

PET question reference	Inpatient survey reference	Inpatient survey question	2008	2009	National average 2009
1	E3	How much information about your condition or treatment was given to you?	18%	**18%**	21%
2	E2	Were you involved as much as you wanted to be in decisions about your care and treatment?	49%	**40%***	46%
3	C1+	When you had important questions to ask a doctor, did you get answers you could understand?	29%	**23%***	31%
	D1+	When you had important questions to ask a nurse did you get answers that you could understand?	45%	**38%**	35%
4	C3	Did doctors talk in front of you as if you were not there?	29%	**24%**	27%
	D3	Did nurses talk in front of you as if you were not there?	33%	**25%**	23%
5	H3	Overall, how would you rate the care you received?	6%	**5%***	7%
	H6	During your hospital stay, were you ever asked to give your views on the quality of your care?	77%	**75%**	79%

The Trust has improved its performance against all of the above questions when comparing the 2009 and 2008 survey results, except E3 for which performance remained the same as the 2008 survey. The Trust performed significantly better than the national average in the 2009 survey for those questions marked with (*).

What are our objectives in 2010/11?

This year we will continue our work on information and communication but will focus on improving responsiveness to the personal needs of patients. Our target is to be above the national average on five questions from the inpatient survey as outlined in the table below. This indicates how the Trust currently compares to the national average as well as a historical comparison—a low score is a good score.

Inpatient survey reference	Inpatient survey question	2008	2009	National average 2009
E2	Were you involved as you wanted to be in decisions about your care and treatment?	49%	**40%***	46%
E5	Did you find someone to talk to about your worries and concerns?	60%	**59%**	57%
E6	Were you given enough privacy when discussing your condition or treatment?	32%	**27%***	29%
G7	We you told about medication side effects to watch out for when you went home?	46%	**48%**	47%
G12	Were you told who to contact if you were worried about your condition after you left hospital?	24%	**24%**	22%

The Trust performed significantly better than the national average in the 2009 survey for those questions marked with (*).

What actions are we planning to improve our performance?

We will work with our staff and other Foundation Trust members through our Council of Governors to identify how we can improve the experience of patients in these five areas.

We will also look at our patient feedback from surveys, comment cards and complaints. We will develop further our information campaign for staff and patients telling people what we are doing in each area and what patients should expect.

How will improvement be measured and monitored?

We will judge our success by what our patients tell us in the annual national inpatient survey. We will also review how we are doing by regularly asking patients using our Patient Experience Tracker.

How will progress be reported?

Progress will continue to be reported quarterly through the Patient Experience Steering Group and will be overseen by the Assurance Committee, a sub-committee of the Board. The Council of Governors will also receive regular updates on progress in understanding and responding to patients' experience.

Improving the patient experience in Maternity and Children's & Young People's Services

In addition to the general Trustwide objective to improve the patient experience, the Trust also had a specific objective to improve the patient experience for women using our maternity services and for children and young people.

Maternity

We set ourselves a priority in 2009/10 of specifically improving women's experience of our maternity services to contribute to our overall strategy of being a centre of excellence in women's and children's health.

Our Maternity Unit was chosen as a pilot site in 2008/09 for a patient experience project run by Monitor, the independent regulator of Foundation Trusts, and McKinsey, an external management consultancy, to help better understand and action patients' concerns.

Senior clinical staff, community representatives, Governors and managers worked in small groups to drive forward this work. The themes for improvement that were identified and the actions that we have taken are as follows:

Communication with patients
We have improved our maternity services website and reviewed most of the patient information leaflets. We have recruited midwifery matrons who visit the wards and clinics daily and pick up any concerns there and then. In addition, the senior midwife on Labour Ward now speaks to every woman after she has had her baby to answer any questions or concerns immediately.

Women using our maternity services told us that they found it difficult to identify different staff groups and so we have introduced new uniforms, using different colours for different staff groups with their relevant designation (eg midwife, doctor) embroidered on the front.

Environment for staff and patients
We have improved the 24-hour cleaning on Labour Ward, replaced all Labour Ward beds, and the refurbishment and redecoration of all bathrooms is due to start shortly. In addition, the refurbishment of the Antenatal Clinic is due to start in summer 2010.

Staffing
In April 2009 the midwifery establishment was increased by 15%. A successful recruitment strategy was implemented and this has meant that the use of agency staff has decreased significantly over the course of the year and is now rarely required. In order to support further the service and staff,

all senior managers (midwives) are now on a rota to work a percentage of their time on the wards in clinical practice.

1:1 care in labour
We know that it is important to women that they have 1:1 care during their labour (where care is received from a designated midwife throughout labour) and we have made excellent progress in implementing this, with daily audits demonstrating 100% compliance over the past year.

Patient Experience Tracker (PET)

The Patient Experience Tracker (PET) has been used on the postnatal ward since June 2009 and in the Antenatal Clinic since January 2010.

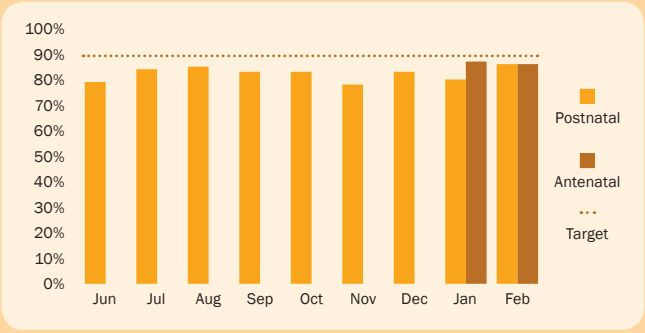
The patient experience project run by Monitor and McKinsey highlighted the areas we wished to measure and specific questions were devised as follows:

Postnatal ward
- Did you get information you could understand?
- Did you feel the ward was clean enough?
- Were the staff kind and caring?
- Did you feel welcomed when you arrived?
- Overall how would you rate your experience on this ward?

Antenatal Clinic
- How would you rate the level of waiting time for your appointment today?
- Were staff friendly and approachable?
- How would you rate the process of booking your appointment?
- Were you satisfied with the information supplied about your schedule of care?
- Overall how would you rate your care on the unit?

How did we perform in 2009/10?

Maternity Services satisfaction
Jun 2009–Feb 2010



The postnatal ward reported an overall patient satisfaction score of 82% and the Antenatal Clinic reported an overall satisfaction score of 85%. The target score for both areas was 90%.

The area of most dissatisfaction in the Antenatal Clinic was appointment waiting time.

Children's and Young People's Services

In January 2010 we introduced the PET into our Children's and Young People's Services—in Children's Outpatients.

The overall satisfaction score in Children's Outpatients was 74% but this masks variable performance, for example the satisfaction score for waiting times during the child's appointment was only 56% and the satisfaction score for the process of booking an appointment was 71%.

However, the satisfaction score for information giving was 82% and the satisfaction score for staff being friendly and approachable was 86%.

What are our objectives in 2010/11 for Maternity and Children's and Young People's Services?

- To achieve a 90% satisfaction score for patient experience on the postnatal ward, as measured by the PET
- To reduce the waiting time for an appointment in the Antenatal Clinic to no longer than 15 minutes
- To achieve a 90% satisfaction score for patient experience in Children's Outpatients, as measured by the PET

What actions are we planning to improve our performance?

While our performance on the postnatal ward, as measured by the PET, has improved, it is a slight increase and our focus this year will be on understanding more about the areas of concern through engagement with users of the service in order to make a more substantial improvement.

The Trust Board approved capital to improve the Antenatal Clinic environment, taking into account ways to improve the patient journey to make it more efficient and reduce waiting times. For example, we will introduce touch screens for patients to check in.

The refurbishment is due to take place in late summer 2010.

In Children's Outpatients, we will implement the improvement plan which includes increasing consultation time and space, revising the booking policy and improving communication about delays.

How will improvement be measured and monitored?

We will use the PET to monitor progress on patient satisfaction in each area.

How will progress be reported?

Progress will be reported quarterly through the Maternity Services Management Board, Children's Services Management Board and the Patient Experience Steering Group, and will be overseen by the Assurance Committee, a sub-committee of the Board.

The Council of Governors will also receive regular updates on progress in understanding and responding to patients' experience.

Priority 3: Clinical effectiveness
To meet agreed targets based on National Confidential Enquiry into Patient Outcome & Death (NCEPOD) recommendations for emergency surgery

Our target in 2009/10 was to reduce delays of more than 24 hours to selected non-elective urgent surgery. We needed to define delays and introduced new measurements as described below. This has enabled us to be more specific about what we are trying to achieve.

Why is this a priority?

Senior surgeons had expressed concerns about delays for some patients needing urgent surgery. No empirical measures or data were available to use as a baseline but there was significant anecdotal evidence that some patients were experiencing delays to emergency surgery.

What did we do in 2009/10?

Typically a patient needing acute surgery is admitted to a ward by the responsible surgical team. Once a decision to operate is made, the surgical team books the patient on the emergency operating list. The period we are measuring is the time from booking to the anaesthetic start time.

We adopted the NCEPOD classification of surgical priority which outlines four levels of surgery:

- **Immediate**—immediate life, limb or organ saving intervention
- **Urgent**—normally within hours of decision to operate
- **Expedited**—normally within days of decision to operate
- **Elective**—routine admission for planned surgery at a time convenient for the patient

The first three levels apply to emergency surgical cases. However, by definition the first level always has almost instant access to theatre and so we decided to focus on urgent and expedited cases. The times for these categories were not defined and so the Trust adopted the following definition:

- **Urgent**—within 24 hours of booking
- **Expedited**—within 4 working days of booking

The information to measure our performance was either not available or incomplete on the electronic theatre booking system and so a paper-based method had to be implemented. We will include routine measurement as part of the implementation of the new electronic theatre booking system which is due to take place in September 2010.

We designated one of the theatres as the emergency theatre to increase the capacity for emergency surgery and introduced a daily review of the waiting emergency cases by the anaesthetists and surgical specialties to agree priorities.

How did we perform in 2009/10?

The problems with data collection meant that we were unable to collect data until December 2009 and so our results are a reflection of the work undertaken so far.

Performance against standards for emergency surgery 1–7 December 2009

Classification	N° of cases	Outcomes	% achieving target
Immediate	3	All 3 to theatre immediately	**100%**
Urgent	27	26 within 24 hours,1 in 26 hours	**96%**
Expedited	24	22 within 4 days, 2 within 7 days	**91%**
Total	**54**		**94%**

Performance against standards for emergency surgery 1–7 March 2010

Classification	N° of cases	Outcomes	% achieving target
Immediate	3	All 3 to theatre immediately	**100%**
Urgent	46	42 within 24 hours, 3 in 36 hours, 1 case 55 hours (delay with Imaging)	**91%**
Expedited	20	19 within 4 days, 1 within 7 days	**95%**
Total	**69**		**93%**

What actions are we planning to improve our performance?

We wish to continue to focus on this target so that the initiatives become fully embedded and we can be assured through better data collection that we are meeting the targets we have set. The planned upgrade to the electronic theatre booking system will help achieve this.

We also wish to look in more detail at particular diagnoses, for example time to surgery for patients with fractured neck of femur.

How will improvement be measured and monitored?

Improvement will be measured as it is currently until the electronic theatre booking system is functioning when data collection will be much easier. Performance will be monitored through the Theatre Emergency Group.

How will progress be reported?

Progress will be reported to the Quality Committee and the Assurance Committee on a quarterly basis.

Priority 4: Patient Safety
To reduce the incidence of falls resulting in moderate or major harm by at least 25% in 2010/11

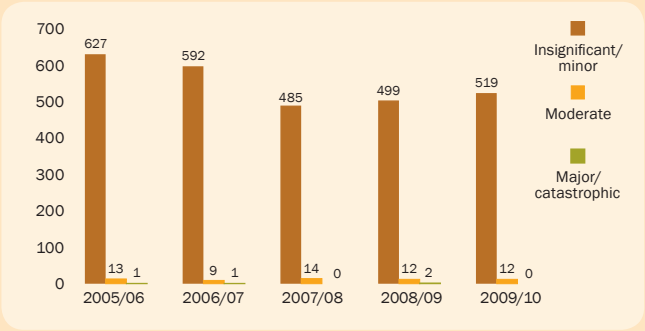
Why is this a priority?

Nationally falls are the most reported safety incident and are consistently among the Trust's top three most reported incidents. Approximately 10–30% of falls result in harm to the patient, of which 10% of injuries are moderate or serious.

We know from feedback and complaints how a fall can cause distress to a patient and their family and can lead to a longer stay in hospital than expected. We have therefore decided to add this to our priorities for quality improvement in 2010/11.

How did we perform in 2009/10?

Patient falls per year, 2005–10



What actions are we planning to improve our performance?

We already have a Falls Group and we plan to strengthen this by having more senior clinical membership and changing the reporting lines to give the Group a higher profile.

The Group will adopt the Patient Safety First campaign interventions. These include a wide range of measures such as identifying training requirements, developing and implementing a plan for falls prevention training, and instigating a rolling programme of environmental risk assessments.

We will also focus on achieving consistent and good quality reporting.

In addition, a standing panel for the investigation of falls will be established which will allow consistency in investigation and ensure that learning is embedded. A patient Governor will be invited to be part of this panel.

We are grateful to the Friends of Chelsea and Westminster Hospital for supporting our pilot of falls alarms on our medical wards which will be rolled out to other areas if successful.

This alarm indicates when 'at risk' patients are moving (eg standing up) and will allow prompt help to be provided.

How will improvement be measured and monitored?

Improvement will be measured and monitored through the current incident reporting system and through indicators to be developed by the Falls Group.

How will progress be reported?

Progress will be reported to the Quality Committee and the Assurance Committee on a quarterly basis.

Statements relating to quality of NHS services provided

Statements of assurance from the Trust Board

During 2009/10 Chelsea and Westminster Hospital NHS Foundation Trust provided and/or sub-contracted 54 NHS services.

The Trust has reviewed all the data available to us on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2009/10 represents 100% of the total income generated from the provision of NHS services by the Trust in 2009/10.

Review of data on quality of care

The Trust has systems and processes in place to review data on quality regularly. Directorate specific quarterly clinical governance reports are provided which cover a wide range of data including complaints, concerns, claims and incidents. Incident trends and the outcomes of more serious incident investigations are reviewed to ensure that actions are followed through and changes implemented.

The reports also include risks on the risk register and progress on actions, data on the incidence of MRSA and *C. difficile*, the results of monthly hand hygiene audits, progress on updating clinical guidelines, progress on clinical audits, legal claims and research activity. The results of Trustwide audits in areas including documentation and consent are reported at directorate level.

Patient experience is addressed through reviewing complaints and concerns as well as progress on completion rates and satisfaction scores from the Patient Experience Tracker (PET), and national inpatient survey results.

Problems identified using this data are addressed at local level through the directorate management systems or, if appropriate, escalated to the Executive team. All the data available at local level is also monitored at corporate level through the Trust Executive for Clinical Governance. An internal audit on the use and value of the quarterly clinical governance reports is in progress to provide assurance on this element of our quality system.

The Trust Executive has the responsibility to drive up quality. Additional challenge and scrutiny is provided by the Assurance Committee which is a sub-committee of the Board. The annual business planning process seeks to involve staff at all levels in the organisation to identify issues to be addressed. A number of key areas for improvement have been identified by this process and are included in our quality improvement plan for 2010/11.

We have also undertaken an in-depth review of some of our services. Paediatric high dependency care and paediatric surgery were reviewed as part of our successful bid for designation as a hub for paediatric and neonatal surgery in North West London. We assessed ourselves against the Royal College of Paediatrics and Child Health and other national standards as part of this process and this led to changes in our proposed service including strengthening the staffing for the Paediatric High Dependency Unit.

As part of the bid for Stroke Unit designation we reviewed our services against national guidelines and Healthcare for London quality standards. We were subsequently accredited for providing the required levels of care. We also reviewed our maternity services in detail, partly in response to a Healthcare Commission review and partly in response to concerns raised by patients through complaints. We are currently undertaking a review of the medicine directorate.

A quality improvement plan has been agreed by the Board. This includes a commitment to undertake more in-depth reviews, a focus on clinical audit as a tool for improvement and assurance, the development of a Board dashboard to include our quality indicators, work on further indicators, and further development of our engagement and feedback processes.

Participation in clinical audits

During 2009/10, 29 national clinical audits and eight national confidential enquiries covered NHS services that the Trust provides. During 2009/10 the Trust participated in 83% of national clinical audits and 87% of national confidential enquiries that it was eligible to participate in.

See below for full details including:

- National clinical audits and national confidential enquiries that the Trust was eligible to participate in
- National clinical audits and national confidential enquiries that the Trust participated in and for which data collection was completed
- Number of cases submitted to each audit or enquiry as a percentage of the number of registered cases indicated/ required by the terms of that audit or enquiry

National Clinical Audits—Continuous (with no planned end date)

Topic	Eligible to participate	Participated	Cases indicated/ required	Cases submitted	% cases submitted
NNAP: Neonatal Care	Yes	Yes	574	574	100
NDA: National Diabetes Audit	Yes	Yes	41	41	100
ICNARC CMPD: Adult Critical Care Units	Yes	No			
National Elective Surgery PROMs: Hip Replacements*	Yes	Yes	111	10	9
National Elective Surgery PROMs: Knee Replacements*	Yes	Yes	163	18	11
National Elective Surgery PROMs: Varicose Veins*	Yes	Yes	131	23	18
National Elective Surgery PROMs: Hernia*	Yes	Yes	378	41	10
CEMACH: Perinatal Mortality 2009: Neonatal Deaths	Yes	Yes	20	20	100
CEMACH: Perinatal Mortality 2009: Stillbirths	Yes	Yes	28	28	100
NJR: Hip and knee replacements	Yes	Yes	239	239	100
NLCA: Lung Cancer	Yes	Yes	53	52	98
NBOCAP: Bowel Cancer	Yes	Yes	62	88	100
MINAP (including ambulance care): AMI & other ACS	Yes	Yes	20	20	100
Heart Failure Audit	Yes	Yes	143	10	7
NHFD: Hip Fracture	Yes	Yes	60	48	80
TARN: Severe Trauma	Yes	Yes	5	5	100
NHS Blood & Transplant: Potential Donor Audit	Yes	No			

*Note: PROMs data is for period up to December 2009

National Clinical Audits—Intermittent (samples recruited according to time period or sample size; one-off, with no plan to repeat patient recruitment in the future)

Topic	Eligible to participate	Participated	Cases indicated/ required	Cases submitted	% cases submitted
National Sentinel Stroke Audit	Yes	Yes	20	26	100
National Audit of Dementia	Yes	Yes	40	Data entry to 16 Jul 2010	n/a (ongoing study)
National Falls & Bone Health Audit	Yes	Yes	60	60	100
National Comparative Audit of Blood Transfusion	Yes	Yes	40	27	68
National Comparative Bedside Transfusion Audit	Yes	Yes	40	27	68
British Thoracic Society: Respiratory Diseases—Adult Community Acquired Pneumonia, NIV (Adult), Paediatric Pneumonia	Yes	No			
College of Emergency Medicine: Asthma	Yes	Yes	50	41	82
College of Emergency Medicine: Fractured NOF	Yes	Yes	50	39	78
College of Emergency Medicine: Pain in children	Yes	No			
College of Emergency Medicine: Pain in children	Yes	No			

National Clinical Audits—One-Off (all patients)

Topic	Eligible to participate	Participated	Cases indicated/ required	Cases submitted	% cases submitted
National Mastectomy & Breast Reconstruction Audit	Yes	Yes	3	3	100
National Oesophago-Gastric Cancer audit	Yes	Yes	33	33	100
RCP Continence Care Audit	Yes	No			

National Confidential Enquiries

Topic	Eligible to participate	Participated	Cases indicated/ required	Cases submitted	% cases submitted
NCEPOD: Peri Operative Care	Yes	Yes	Prospective data collection so n° of cases unknown	Data collection from Mar 2010 to Mar 2011	n/a—ongoing study
NCEPOD: Surgery in Children	Yes	Yes	48	Data collection ongoing until end of Jun 2010	Not available currently
NCEPOD: Emergency Elective Surgery in the Elderly	Yes	Yes	8	8	100
NCEPOD: Cosmetic Surgery	Yes	Yes	None that met criteria during study period	n/a	n/a
NCEPOD: Parenteral Nutrition	Yes	No	Did not participate	0	0
CEMACE: Maternal and Perinatal Surveillance	Yes	Yes	48	48	100
CEMACE: Obesity in Pregnancy	Yes	Yes	Prospective data collection so n° of cases unknown	Data entry to 2011	n/a—ongoing study
CEMACE: Head Injury in Children	Yes	Yes	32	20	63

The reports of 11 national clinical audits were reviewed by the Trust in 2009/10. See below for details of actions that we intend to take to improve the quality of care.

National audit	Actions to be taken
NNAP: Neonatal Care	No actions required—Trust standards exceed National Comparators.
CEMACH: Perinatal Mortality 2009: Neonatal Deaths	No actions required—Trust standards exceed National Comparators.
CEMACH: Perinatal Mortality 2009: Stillbirths	No actions required—Trust standards exceed National Comparators.
NLCA: Lung Cancer	To improve data completeness by submitting data prospectively and using the cancer waiting times database.
NBOCAP: Bowel Cancer	Data within the National Audit report conflicts with annual local service review, therefore to focus on the improvement of information submission for staging of disease.
Heart Failure Audit	Further develop inpatient services for heart failure through the use of an Integrated Care Pathway.
National Sentinel Stroke Audit	No actions required—Trust standards exceed National Comparators.
National Comparative Audit of Blood Transfusion	No action required—Trust standards exceed National Comparators.
National Comparative Bedside Transfusion Audit	No action required—Trust standards exceed National Comparators.
College of Emergency Medicine: Asthma	A review of the audit report findings and proposed action plan will be presented at the clinical governance half day in June 2010.
College of Emergency Medicine: Fractured NOF	To introduce fast tracking of patients to the ward. To improve speed of pain relief. Each patient is pain assessed (reflected on the casualty card) and the optimum time period is pain relief within 20 minutes of arrival.

The reports of 74 local clinical audits were reviewed by the Trust in 2009/10 and we intend to take actions to improve the quality of care. Details are available on request from Dr Mike Anderson, Trust Medical Director at mike.anderson@chelwest.nhs.uk.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Chelsea and Westminster Hospital NHS Foundation Trust in 2009/10 who were recruited during that period to participate in research approved by a research ethics committee was 3,000.

In 2009/10 the Trust was involved in conducting 121 multi-disciplinary clinical research studies, 16 of which were supported by the National Institute of Health Research (NIHR) and its research networks.

During 2009/10 there was a 27% increase in patient recruitment into NIHR studies compared with 2008/09. This increasing level of participation in clinical research demonstrates our commitment to increase patient access to high quality research.

In the last three years, 600 publications have resulted from our involvement in research, helping to improve patient outcomes and experience across the NHS.

Of the 121 studies given permission to start in 2009/10, 50% were given permission by an authorised person less than 30 days from receipt of a valid complete application and 80% of these studies were established and managed under national model agreements outlined by the Department of Health.

Goals agreed with commissioners

A proportion of Trust income in 2009/10 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2009/10 and for the following 12-month periods are available from the Foundation Trust Secretary at ftsecretary@chelwest.nhs.uk.

In 2009/10, 0.5% of our main acute contract income, which covers most of our NHS services, was conditional upon achieving CQUIN goals agreed with our host commissioner, NHS Kensington and Chelsea. We also agreed CQUIN payments linked to our more specialist work in HIV and Neonatal Intensive Care, which are commissioned by specialist commissioners, and for our community services in Paediatrics, Dermatology and Gynaecology.

We achieved 93% of our CQUIN-related goals in 2009/10 and will therefore receive a payment of £1.35m linked to these achievements, compared with a maximum payment of £1.45m. The breakdown of our payments by contract is as follows:

Contract	Value (£000)
Main acute contract	1,120.8
HIV specialist contract	204.5
Neonatal Intensive Care specialist contract	23.3
Total	**1,348.6**

The unachieved CQUIN of £0.1m relates to missed stretch targets on MRSA bacteraemia, *C. difficile* and prescribing performance for anti-microbials prescribed on discharge. We agreed and delivered on a wide range of quality indicators to underpin these payments—a few examples of CQUIN-related goals are listed below:

Area of improvement	Indicator chosen	Rationale for inclusion
Patient Safety	Zero Elective MRSA Bacteraemia	MRSA bloodstream infections can be a major complication of surgery. Although the Trust strives to avoid all MRSA bacteraemia and has reduced its rate of MRSA by 90% in the last five years, there are still occasional situations where an infection does occur. However, with elective surgical cases, the Trust believes patients should expect to avoid hospital acquired infections and so we have agreed and achieved a target to have zero elective patients infected by MRSA bacteraemia.
Clinical Effectiveness	Patients' electronic discharge summary includes indication for treatment and intended duration of treatment for hospital initiated proton pump inhibitors therapy and for antimicrobials.	To enhance continuing care, where patients were being discharged with a course of treatment of either proton pump inhibitors or antimicrobials, the Trust agreed to ensure electronic discharge summaries provided GPs with information on how long patients should stay on these treatments and why the treatment was initiated. This information was agreed to be important to GPs in their ongoing care of patients after hospital discharge, including ensuring that patients did not stay on courses of treatment unnecessarily.
Patient Experience	Accelerated rollout of the Trust's Patient Experience Trackers (PETs)	The Trust introduced PETs in 2009/10 to enable the collation of 'realtime' patient feedback, which is in turn fed back to individual wards on a weekly basis. As a key part of the Trust's efforts to understand and improve on patients' hospital experience, we agreed a target with commissioners to ensure at least 40% of our patients were being surveyed by the end of 2009/10.
Enhanced Communications	Rollout of electronic discharge summaries to GP surgeries in neighbouring PCTs	The Trust had already successfully rolled out electronic discharge summaries to GP surgeries in NHS Kensington and Chelsea in 2008/09. The transfer of discharge information electronically sped up the process of getting information about discharged patients to their GPs and helps to reduce the unnecessary administrative costs of dealing with paper discharge summaries. This system has now been rolled out to GP surgeries in NHS Hammersmith and Fulham and NHS Westminster.

Statements from the Care Quality Commission

The Trust is required to register with the Care Quality Commission (CQC) and its current status is registration without conditions. We are not subject to periodic review by the CQC. The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Data quality

The Trust submitted records during 2009/10 to the Secondary Uses service for inclusion in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

- 90.8% for admitted patient care
- 73.6% for outpatient care
- 66.43% for Accident & Emergency (A&E) care

The percentage of records which included the patient's valid General Medical Practice Code was:

- 99.33% for admitted patient care
- 99.53% for outpatient care
- 100% for Accident & Emergency (A&E) care

Information Governance Toolkit attainment levels

The Trust's score for 2009/10 for Information Quality and Records Management, assessed using the Information Governance Toolkit, was 94.52%, exceeding our target of 90%.

Clinical coding error rate

The Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission. The error rate reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) was 7.3%—the national average is 9%.

The audit covered four areas—trauma and orthopaedics, general medicine, patients with a primary diagnosis affecting the nervous system, and cardiology (specifically arrhythmia or conduction disorders). The sample size was 300.

Due to the targeted nature of these audits and the small sample of activity audited it is not recommended that these results be extrapolated further than the actual sample audited.

Review of quality performance

How the Trust identifies local improvement priorities

The Trust is committed to understanding and responding to the patient experience and there are a number of ways in which we engage with our patients, staff and the public in determining priorities for quality.

As a Foundation Trust we have the benefit of a well-established and active Council of Governors which is an important source of views and experiences of people who use our services.

We seek clinicians' views through business planning sessions and Trust Executive for Clinical Governance meetings. We also have a number of mechanisms for more focused discussions. These include a maternity services steering group with patient and Governor representatives, which identified and then monitored the areas requiring improvement. As part of our plan to expand paediatric services we held a facilitated session which was attended by all grades of staff, patients and Governors to identify areas of concern and ideas for improvement.

There are also numerous patient forums in the Trust that represent specific areas including the Patient Environment Action Team, Maternity Services Liaison Committee and HIV Patient Forum. These forums influence how we design and deliver our services with an emphasis on quality.

To ensure we focus on equality and diversity we have developed a Single Equality Scheme in consultation with staff, patients and community groups. It identifies ways in which equality and diversity must be considered in the delivery of quality services. Our action plan includes improving the service that patients receive from the Appointments Office by, for example, printing letters in different languages or formats and using telephone translation services to communicate with patients who do not speak English.

The Trust has an Equality Impact Assessment toolkit, which is built into the Trust's business planning process, to ensure that equality and diversity issues are considered when making service changes.

There are two sub-committees of the Council of Governors that help to identify quality issues and prioritise and, in some cases, improve services. The Membership Sub-Committee focuses on not only increasing our membership but also engaging with and gaining feedback from our members. The Quality Sub-Committee has a specific remit to help identify priorities for quality and advise us on the content and focus of the Quality Report and quality improvement plan.

Staff Governors initiated a survey to ask staff and volunteers for their views on quality issues and what the Trust should be focusing on in 2010/11.

In order to help prioritise, the Trust identified areas in which we were aware of problems through complaints or incidents and areas in which there were evidence-based methods for improving care, and used these to discuss and agree priorities.

There was some consistency in issues raised. For example, the issues identified in the survey by Trust staff mirrored the key areas that the Governors had highlighted including discharge from hospital, waiting times for appointments, and falls. We have included reducing falls as an additional priority this year and will consider reviewing our indicators

and measurement for discharge in 2010/11 in conjunction with the Governors. The indicators selected for review outlined in the section below have been agreed as part of the engagement process.

The Trust is committed to working with Kensington and Chelsea Local Involvement Network (LINk) and this year we have embarked on a joint project looking at the nutritional and feeding support that patients receive in the hospital.

Performance indicators

Performance against local quality performance indicators 2009/10

The following table outlines performance against indicators for 2009/10 and includes new indicators selected by our stakeholders for monitoring in 2010/11.

Patient Safety	2008/09	2009/10	Target 2010/11	Comment
MRSA bacteraemia cases	5	10	3	
C. difficile cases	41	32	100	The nationally set target is 100 but we will aim for our local targets of 65 and 35, linked to financial incentives. We will aim towards the local targets but a more sensitive test for detecting *C. difficile* means that we will identify more cases.
Hand hygiene audit completion rates	57.7%	71%	90%	
Hand hygiene compliance rates	77%	80%	90%	
Patient falls resulting in moderate or major harm	14	12	9	This is one of our priorities for 2010/11. Data from local incident reporting system.
Incident reporting rate	6.6%	7.1%	8%	April to September data for 2008 and 2009 from the National Reporting and Learning System.
Never Events	0	0	0	Data from local incident reporting system.
% of observation charts completed accurately*	56.3	68 (Nov 2009)	80%	Local sampling audits. It is planned that this target will be increased further in 2011/2012.
Deaths from cardiac arrest*	23	12	12	This target refers to deaths where there is no return of spontaneous circulation.
% Patients with International Normalised Ratio (INR) less than 5*	No data	97.7% (Aug–Dec 2010)	At least 86%	Locally collected data. INR is a measure of the ability of the blood to clot.
Number of patients requiring opiate reversal*	No data	0% (1 week audit Aug 2009)	0%	Locally collected data. Plan to re-audit 1 week Aug 2010. Medication Safety Committee will monitor adverse events with opioids on an ongoing basis.
Ulcer prevalence (% of patients with pressure ulcers)	5.68	5.32	4	Measured by point prevalence.

Clinical Effectiveness	2008/09	2009/10	Target 2010/11	Comment
Mortality (HSMR)*	86.2	80.8	76.8	
% of patients with a catheter	28	17	12.5	Locally collected data.
Urinary catheter days*				Number of patient days that a catheter is in place (number of days multiplied by number of patients) excluding lifelong catheters—to be collected for 10/11. Local data.
% urgent surgery cases operated on within 24 hours of booking*		93.5% (Average of Dec 2009 and Mar 2009 data)	100%	Locally collected data.
% expedited surgery cases operated on within 4 days of booking*		93% (Average of Dec 2009 and Mar 2009 data)	100%	Locally collected data.

Patient Experience	2008/09	2009/10	Target 2010/11	Comment
PEAT scores	Excellent for food and the environment. Good for privacy and dignity	Excellent for food, the environment and privacy and dignity	Excellent for food, the environment and privacy and dignity	
Patient Experience Tracker completion rate*	n/a	75%	80%	See priority section. Locally collected data.
Patient Experience Tracker overall satisfaction scores*	n/a	85%	90%	See priority section. Locally collected data.
Complaints and concerns for admissions and appointments*	578	320	214	The target is a reduction of one third. Other indicators to be developed for measuring performance in this area this year—see corporate objectives.
Complaints responded to within target time (Formal complaints responded to in 25 working days)	92%	83%	90%	

*These indicators have been reviewed in detail this year, as part of our corporate quality objectives.

The data above is collected according to national definitions unless indicated otherwise.

Performance against key national priorities 2009/10

The Trust met all the national priority targets tracked by Monitor, the independent regulator of Foundation Trusts, as indicators of good governance.

Indicator Name	2009/10 Performance	Target
Incidence of *Clostridium difficile*	32	109
Incidence of MRSA Bacteraemia	10	19
18 Week Maximum Wait for Admitted Patients from Point of Referral to Treatment*	93.40%	90%
18 Week Maximum Wait for Non Admitted Patients from Point of Referral to Treatment*	98.97%	95%
Maximum time in A&E of 4 hours from arrival to admission, transfer or discharge	98.65%	98%
People suffering heart attack to receive Thrombolysis within 60 mins of call	n/a	n/a
All Cancer Two Week Wait**	96.63%	93%
Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)**	n/a	n/a
31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers**	98.51%	96%
31-Day Wait For Second Or Subsequent Treatment: Surgery**	98.13%	94%
31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments**	100.00%	98%
31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments**	n/a	94%
62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers**	93.01%	85%
62-Day Consultant Upgrade Wait For First Treatment: All Cancers**	100.00%	85%
62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers**	n/a	90%
Access to genito-urinary medicine clinics (48 hours)	100.00%	98%
Outpatients waiting longer than the 13 week standard	0.020%	0.03%
Inpatients waiting longer than the 26 week standard	0.028%	0.03%
Revascularisation waiting times (13 weeks)	n/a	n/a
Cancelled operations by the hospital for non-clinical reasons on the day of or after admission	0.52%	0.8%
Cancelled operations by the hospital for non-clinical reasons on the day of or after admission, who were treated within 28 days	4.52%	5%
Delayed transfers of care	1.20%	3.5%

* Predicted annual performance as published CQC performance is quarterly based only.

** Predicted annual performance as annual CQC performance will be published in June 2010.

Performance against Department of Health national core standards 2009/10

- Total number of Department of Health national core standards: **47**
- Total number of core standards against which the Trust declared itself as compliant to the Care Quality Commission: **47**

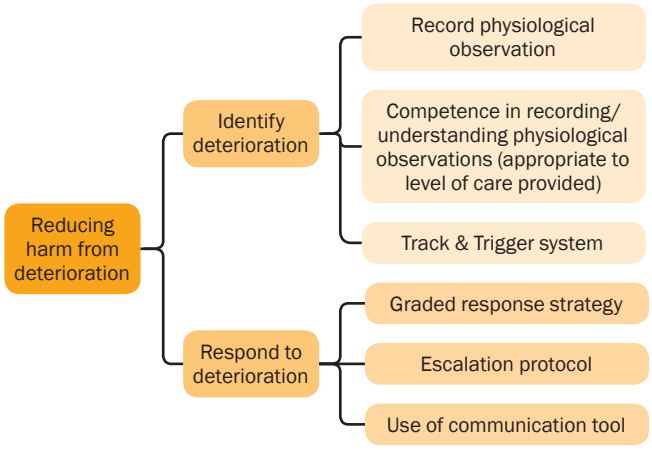
Progress on corporate quality objectives

In addition to our priorities for quality we set challenging corporate objectives for quality. Progress is described below.

Reduce in-hospital cardiac arrest and mortality through early recognition and treatment of the deteriorating patient

Ill patients can deteriorate while in hospital. It is important that this is recognised and appropriate, timely treatment is started. However, we also know from published evidence (www.patientsafetyfirst.nhs.uk) and our own experience that it does not always happen.

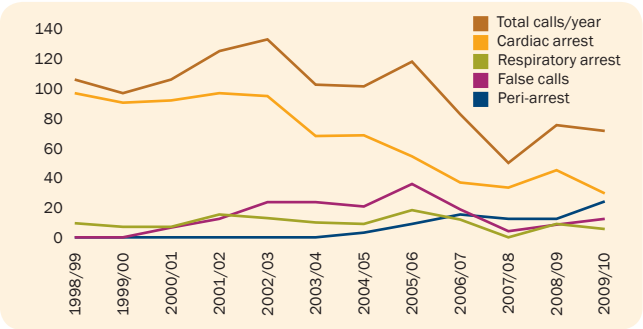
This indicator reflects the principles incorporated in the Patient Safety First (PSF) campaign intervention 'Reducing Harm from Deterioration' which can be summarised as follows:



Progress against this intervention in 2009/10 included:

- Improvement in the accuracy of completion of observations (heart rate, respiratory rate, blood pressure, temperature etc) from 56.3% in 2006 to 68% in 2009
- Introduction of a coloured observation chart in early 2010 to make it easier for staff to be alerted to changes in observations and potential deterioration (equivalent to the 'track and trigger' system in the PSF intervention)
- Reduction in resuscitation calls since 2003/04 as illustrated below
- Reduction in deaths at time of cardiac arrest from 23 deaths in 2008/9 to 12 deaths in 2009/10—these figures do not necessarily refer to survival but to patients who were resuscitated and had a pulse return at the time of resuscitation, as some of these patients would subsequently not survive

Resuscitation calls



In 2010/11 we plan to introduce a communication tool for all clinical staff and the Bedside Emergency Assessment Course for Healthcare Assistants (BEACH) course for support workers.

Reduce the risk of selected high risk medicines (warfarin and opioids) in line with measures recommended by the Patient Safety First campaign

Warfarin

Anticoagulants (including warfarin) are one of the classes of medicines most frequently identified as causing preventable harm to patients and admission of patients to hospital (National Patient Safety Agency—Patient Safety Alert 18—May 2007).

We carried out a one-week snapshot audit of all inpatients on warfarin in August 2009 to check the International Normalised Ratio (INR). This is a standard test that measures how long the blood takes to clot. It is important as it indicates whether warfarin is working properly. If it is too low there is a risk of blood clots and if it is too high (eg higher than five) there is a risk of serious bleeding. A performance standard of 95% was set for 2009/10 and the audit showed that 100% of inpatients had an INR of less than five during the one-week data collection period.

Guidelines for prescribing warfarin have been incorporated into the electronic prescribing system and systems put in place to ensure that reports of patients with INRs greater than five are regularly reviewed and individual patients followed up by the anticoagulant nurse. We also monitor adverse events related to anticoagulants on an ongoing basis and identify whether any further measures need to be implemented.

Opioids (including opiates and synthetic narcotics)

This group was chosen because of the frequency of involvement in reported incidents.

From April 2008 to March 2009, 701 incidents were documented on the Trust's Datix risk management database that involved a named medicine. Of these 701 incidents, the top 20 named medicines accounted for 140 incidents (20% of the total). Opioids accounted for 37 out of these 140 incidents (26%).

However, we found that during a one-week snapshot audit of all inpatients, no patient required reversal of opioid-related side effects with the reversal agent naloxone.

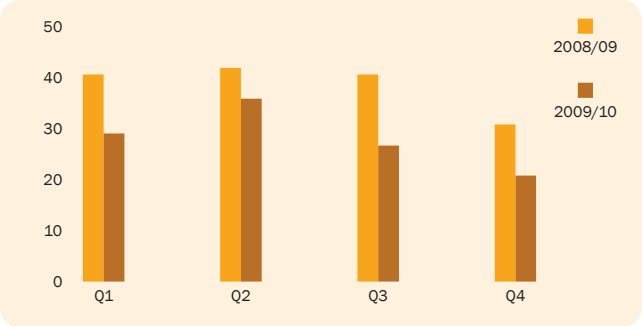
Reduce the number of complaints relating to appointments and admissions

We were concerned that complaints about the administrative pathway for our patients had increased—particularly during 2007/08 after the national 18-week referral to treatment target was introduced. Feedback from the Trust's Annual Members' Meeting in September 2009 also highlighted concerns relating to appointments for outpatient and elective (planned) surgery admissions.

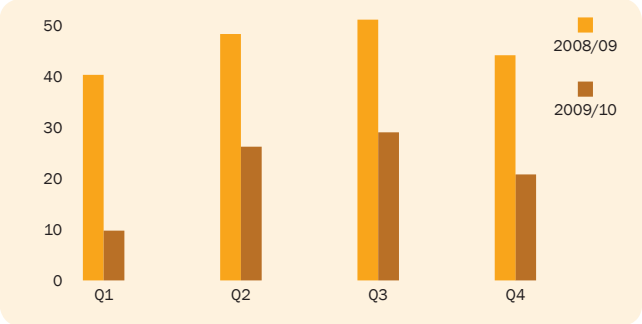
The administrative pathway is highly complex and so measuring improvement is challenging. We measure complaints in two key areas—the Appointments Office and the Admissions Office. The Appointments Office is responsible for booking all new outpatient appointments. The Admissions Office is responsible for booking nearly all adult elective surgical procedures.

In consultation with patients, our local PCTs and our own staff, we introduced much more flexibility into the Access Policy (which sets out the key principles of access to Trust clinical services). We upgraded the telephone system in February 2010 to enable a higher volume of calls to be answered in order to improve telephone waiting times, and the numbers of staff answering phones during the busiest times have been increased. We have also integrated the Admissions Office with the Appointments Office to provide a more efficient administrative pathway. These changes have had a significant impact as demonstrated by the tables below.

Complaints & concerns regarding Appointments Office



Complaints & concerns regarding Admissions Office



To improve the service further we are going to move the Admissions team onto the Appointments phone server and supply them with call centre phones. Phone calls can then be routed properly and the amount of calls taken can be monitored. We will encourage our patients to call us during less busy periods by including this information in patient letters. We will add a cancellation template to the Trust website so that patients can cancel appointments online. We will create a dedicated line for general enquiries in order to reduce the waiting times for patients calling.

Reduce Hospital Standardised Mortality Ratio (HSMR) by 5%

HSMR compares a Trust's number of actual deaths (mortality) with expected deaths. It is a calculation that takes into account a number of different factors that may affect mortality rates such as age, sex, diagnosis, length of stay and whether an admission was elective or emergency.

The factors are regularly reviewed and recalculated at intervals to take into account improvements in healthcare generally, for example to reflect the fact that people are on average living longer.

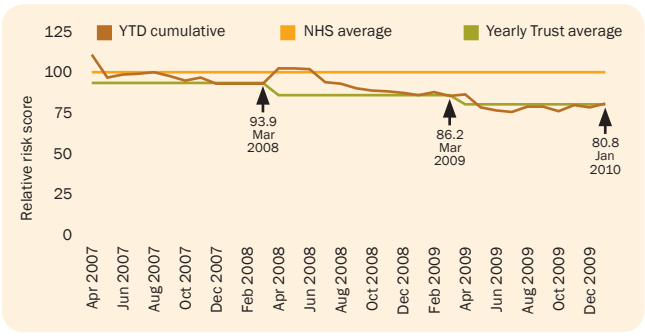
An HSMR of 100 means that the number of deaths is in line with expectations, an HSMR above 100 represents a higher mortality (death) rate, and an HSMR below 100 represents a lower mortality rate.

We have seen a steady reduction in our average HSMR over the past three years (see chart below) and we are currently ranked among the safest hospitals in England.

From a peak of 93.9 in March 2008, our cumulative HSMR in March 2009 was 86.2 and it reduced further to 80.8 in January 2010 (based on the most recent recalculation).

We did not achieve our planned 10% reduction for 2009/10, but we did achieve a 6% reduction, and we have set a target of a further 5% reduction this year.

HSMR year-to-date (YTD) cumulative historical performance (2008/09 benchmark)



This graph demonstrates the decrease in HSMR over the last three years using the current standardisation calculation and applying that retrospectively.

We have introduced a number of initiatives that have made a contribution to the reduction of our HSMR. These include the focus on identifying and responding to the deteriorating patient, reducing the incidence of venous thromboembolism (VTE), and reducing our infection rates in the Trust, most notably MRSA bacteraemia.

Our plans for 2010/11 include introducing a review of cases using the Institute for Healthcare Improvement (IHI) Global Trigger Tool (a tool for measuring adverse events) to identify areas for improvement, and a comparison of actual versus expected deaths by specialty.

HSMR as a comparator indicator between organisations is currently under national review and we will adapt our targets according to the outcome of this review.

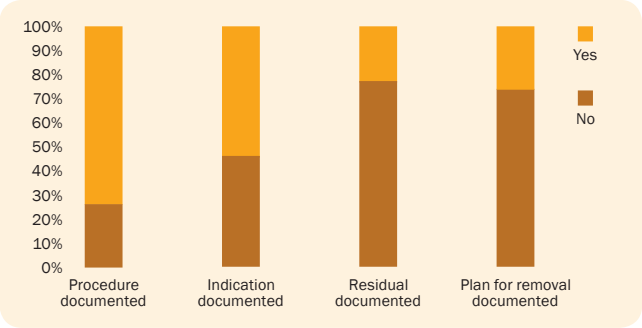
To be at or below the national average of patients with an indwelling urinary catheter and to reduce the number of urinary catheter days, excluding patients who need a lifelong urinary catheter

Urinary tract infections (UTIs) are one of the most frequently occurring hospital acquired infections—60–80% of UTIs are related to the presence of a urinary catheter. We know that approximately 20% of our patients will need a urinary catheter during their hospital stay and that the risk of developing a UTI increases by 5% each day a catheter remains in place. It is for this reason that we selected an indicator to reduce the number of catheter days within the Trust.

We undertook an audit of all adult wards in the Trust in 2009. A total of 264 patients were reviewed. We found that 17% of patients were catheterised and that the average length of time the catheter was in place was 10 days (range 1–25 days). The number of patients catheterised is an 11% reduction compared with our last audit in 2008 but is still higher than the national average of 12.5%.

The audit team found it difficult to establish an accurate baseline of the number of catheter days as there was a poor level of documentation of catheter information (see below). So although we have seen a significant reduction in the percentage of patients with a catheter, we do not know if we have seen a reduction in the number of associated catheter days.

Catheter documentation in patient records



We have introduced a number of initiatives with the aim of reducing the risks of developing a UTI and reducing the number of catheter days. The first of these initiatives was the introduction of short-term silver-alloy catheters in 2005. Silver-alloy reduces the risk of bacteria adhering to the catheter walls, which in turn reduces the risk of infection. In the past year we have introduced a new catheter policy which includes the use and introduction of bladder scanners. These are used to see if there is residual urine in the bladder before insertion. Catheters are then only inserted if urine is present in the bladder, leading to a reduction of unnecessary catheterisations.

We plan to continue auditing the frequency of use of urinary catheters and the number of urinary catheter days to establish a baseline. We will introduce the catheter care-bundle which is a set of interventions based upon Evidence Based Practice in Infection Control (EPIC) guidelines. These steps cover the insertion and ongoing management of a urinary catheter.

Quality and the business strategy

A commitment to quality is at the heart of what we do as an organisation. To ensure that our commitment to quality was embedded throughout the organisation in 2009/10 the Board explicitly set corporate objectives that reflected the quality imperative.

The Trust's corporate objectives to improve patient safety, clinical effectiveness and the patient experience mirror the three-part definition of quality in '*High quality care for all: NHS Next Stage Review final report*', published by Health Minister Lord Darzi in June 2008. As a Trust, we ensured that each of our directorates and departments showed how their local objectives were aligned with the Trust's corporate objectives in 2009/10.

For the 2010/11 financial year, the Trust Board has underlined its commitment to quality by maintaining the three corporate objectives from 2009/10 and adding a new objective to reflect the importance of financial and environmental sustainability:

- Improve patient safety and clinical effectiveness
- Improve the patient experience
- Deliver excellence in teaching and research
- Ensure financial and environmental sustainability

These corporate objectives are the basis for directorate and departmental objectives which ensure that there is alignment of objectives throughout the organisation so that quality is embedded in everything we do.

Workforce factors—how we embed quality

The NHS Constitution is integral to the Trust's workforce strategy. The Trust recognises that the four staff pledges identified in the NHS Constitution will help create and maintain a highly skilled and motivated workforce capable of meeting the Trust's corporate objective of improving the patient experience.

Pledge 1: Provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.

All staff should have an annual appraisal and personal development plan based on their objectives (which fit within directorate and departmental objectives)—the 2009 staff survey showed that 76% of staff had an appraisal in the past 12 months, giving the Trust one of the highest appraisal rates of any acute trust.

Pledge 2: Provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed.

The Trust runs more than 100 different learning courses and has a well-established first line management leadership course which includes a theme of managing quality running throughout the programme. All new staff attend the Trust's corporate induction and our Chief Executive leads a session

explaining the Trust's objectives, our approach to quality and what role staff can play in this.

This includes an outline of the Trust's vision which is 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.

Pledge 3: Provide support and opportunities for staff to maintain their health, well-being and safety.

Staff wellbeing is taken seriously and the Trust has a very low sickness absence rate (3.48%). Staff have access to fast-track musculoskeletal services and specialist counselling and we are actively pursuing further initiatives to support our staff to remain at work.

Pledge 4: Engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.

The Trust has developed a culture centred on quality. We have well-established methods of staff engagement including joint consultative frameworks and rigorous methods of communication, and the 2009 national staff survey confirms that we have significantly better communication between senior management and staff than most NHS trusts.

Leadership
We have recently completed an organisational restructure which increases clinical leadership, accountability, and shared responsibility with managers for delivery of services. It aims to empower clinical leaders at all levels in the Trust.

Student placements

The Trust provides placements for undergraduate medical, nursing, midwifery, physiotherapy, dietetics and occupational therapy students, as well as some volunteer placements for NVQ students.

Evaluations of all placements are carried out by our educational partners and results are fed back to the Trust via the programme and academic boards of the various universities at the end of each academic year. This feedback is then reviewed, necessary actions taken, and ideas for further development agreed. The Trust also organises its own local evaluations at the end of each placement for physiotherapy and is trialling this for midwifery with a view to expanding it to nursing.

A Trustwide placement group enables multi-professional placement data to be recorded which helps plan student capacity in order to provide learners with the best and most appropriate experience possible.

The Trust runs its own university co-ordinated mentorship course to train approximately 80 mentors annually for nursing and midwifery.

Innovation

We have a track record of innovation to improve quality—see below for three examples.

Medicines management

The rollout of electronic inpatient prescribing to reduce medicines-related risks continued in 2009/10—it now involves 24 out of 27 wards and it has had positive results. From October 2007 to May 2008 the following was demonstrated in the surgical wards:

- 52% increase in allergy documentation
- 77% decrease in medicines prescribed for patients to which they had a documented allergy on the medication chart
- 74% increase in compliance with the Trust's post-operative nausea and vomiting clinical guidelines
- 11% reduction in the severity of prescribing errors

We have demonstrated a sustained improvement in appropriate thromboprophylaxis prescribing from 32% in 2008/09 to 70% in 2009/10 due to an electronic trigger warning.

Since the rollout of electronic prescribing to medical and gynaecological wards we are confident these improvements will be realised across the Trust. In 2009/10 we continued to perform well and better than 2007/08 in all cases of allergy documentation and adherence to guidelines.

Antibiotic stewardship

We have a dedicated specialist pharmacy team working with microbiology, infection control nurses and clinicians to form the Antibiotic Management Team (AMT). The AMT reviews antibiotic prescriptions daily and provides advice to clinicians on antibiotic prescribing.

Antibiotic prescribing continued to improve in 2009/10 and, together with strong infection control practices, resulted in a 22% reduction in hospital associated *C. difficile* diarrhoea cases compared to 2008/09, substantially overachieving on Department of Health targets.

The Trust can demonstrate strong adherence to antibiotic guidelines through regular audits of antibiotic prescribing, with adherence consistently remaining above 90%. We have also exceeded the minimum target set by the PCT relating to antibiotic prescribing on discharge from hospital.

We introduced a user-friendly antibiotic pocket guideline for staff in August 2008 which has contributed to year-on-year reductions in the use of intravenous antibiotics—a 43% reduction from 2007/08 to 2008/09 and a further 13% reduction from 2008/09 to 2009/10.

The guide has also helped to reduce the risk of a patient receiving a penicillin-containing medication inappropriately by colour coding the medications according to whether they are a penicillin antibiotic or not.

Radiology

Since the installation of two new CT scanners, we have tried to improve the patient pathway and imaging experience. We have used the combination of advanced CT technology and innovative contrast injector software technology to optimise vascular opacification during the CT examination. This approach not only allows us to use lower strength contrast media but also to reduce the total contrast volume delivered to the patient. It has had a two-fold benefit for us in that not only does the patient benefit from reduced iodine volumes being administered but the department has seen financial benefit through reduced contrast use.

We have presented the benefits of using such innovative techniques at local and national conferences.

Our environment

We are fortunate to have a modern, well-designed hospital which is pleasant to work in. We benefit from an extensive range of art which contributes to a relaxed and pleasant environment for patients and visitors.

The Trust has an excellent reputation for cleanliness and infection control, reflected in consistently high Patient Experience Action Team (PEAT) scores and low rates of MRSA bacteraemia and *C. difficile*.

In order to maintain consistently high performance, the Trust runs internal PEAT visits on a regular basis involving clinical and non-clinical staff as well as patient representatives. These visits monitor cleanliness, patient dignity and food quality against the national PEAT standards and the results are reported quarterly to the Trust's PEAT Committee which is chaired by the Director of Nursing.

Additionally, all areas within the hospital are audited jointly on a monthly basis, with representatives from the Trust and the Trust's Facilities contractor who review and score the quality of the patient environment in clinical areas. Our internal target is that 90% of all clinical areas are jointly audited and performance is reported to the monthly PEAT Committee and the quarterly Facilities Committee.

The Trust also runs regular FEAT (Facilities Environment Action Team) visits to monitor non-clinical areas in the hospital. These are run every other month and results are reported to the Trust's Health, Safety and Fire Committee. The visits concentrate on monitoring and improving 'back of house' areas such as plant rooms and stairwells.

Annex 1: Statements from key stakeholders

NHS Kensington and Chelsea

The national Quality Account Toolkit defines the structure for NHS trusts to follow in preparing the Quality Account.

Chelsea and Westminster Hospital NHS Foundation Trust has followed this structure and the Quality Account is therefore consistent with the requirements.

Despite the curtailed timescales for comments, Chelsea and Westminster Hospital NHS Foundation Trust has consulted with NHS Kensington and Chelsea as regards to the content and the targets set within the Quality Account and has integrated the comments into their final Quality Account document.

The priorities that the Trust has set are broadly in line with the strategic priorities for the PCT for 2010/11 defined within its annual Business Plan, and on that basis the PCT is happy to endorse the targets that have been set.

Chelsea and Westminster Hospital NHS Foundation Trust has undertaken a long development process to agree and refine its proposals within the Quality Account, working closely with its Council of Governors who have taken a keen interest in the priority-setting and giving a users' perspective on the proposals.

The priorities include some areas where there is already work in place and some areas where there is separate monitoring as the priority is already a CQUIN target.

The Trust has considered priorities in each of the three key areas of clinical quality—safety, patient experience and effectiveness—showing a commitment to continuous improvement in standards of care across the board.

The priorities that the Trust has chosen are not viewed in isolation but in the context of the much wider work that the Trust is undertaking to improve patient care within the Trust. This is a consistently high performing Trust with an 'Excellent' rating from the Care Quality Commission for quality of care.

In the future, the PCT would seek to have a much less generic response to quality improvement and some sense that the Trust is understanding the segments of its user population and the differential impact that its quality improvement schemes may have.

The reduction in the inequalities experienced in some segments of the population within the Royal Borough of Kensington and Chelsea is a key priority for the PCT and all providers will be required to play their part in that.

The PCT will continue to work with the Trust to monitor the delivery of the proposed priorities and to assure itself that there is safe, effective care in place.

The Trust has a stated commitment to a focus on clinical audit as a tool for improvement and assurance. This focus would be fully endorsed by the PCT as a means of demonstrating outcomes of care as an integral part of the continuous improvement in quality.

Royal Borough of Kensington and Chelsea—Overview and Scrutiny Committee (OSC) on Health

The Overview and Scrutiny Committee was invited to comment on the Quality Report but was unable to do so within the available timescale because it ceased to exist on the day of the General Election, Thursday 6 May, and was

not reconvened until the Council's Annual General Meeting on Wednesday 26 May when it was created anew with many changes in membership.

Kensington and Chelsea Local Involvement Network (K&C LINk)

Kensington and Chelsea Local Involvement Network (K&C LINk) welcomes the opportunity to comment on Chelsea and Westminster Hospital NHS Foundation Trust's Quality Account.

We appreciate that this is the first year of Quality Accounts for the Trust and that the process was a steep learning curve for us all. The LINk would like to thank Trust staff for their support over the three-week consultation period and we look forward to more strategic partnership working in the coming year.

The LINk found the draft, in parts, difficult to read, lacking in data and unsuitable for the target audience. The LINk has received feedback from the Trust on a number of the issues raised in our full response but unfortunately this information was not timely for the consultative period available to us.

To summarise, the main issues of concern to K&C LINk in Chelsea and Westminster Hospital are:

- Stocking usage
- Patient satisfaction and complaint handling
- The administrative pathway including the 'Choose and Book' system
- Medicines management
- 'Mixed' wards
- Catheter usage

However, K&C LINk is looking forward to carrying out our 'dignity champion' assessments of nutrition and protected mealtimes on the wards in Chelsea and Westminster Hospital this summer.

Now that the project has been agreed, we are keen to ensure it has the full support of the Trust and continues to roll out in an efficient and effective manner.

As advised in previous communications, the K&C LINk wishes to strengthen the relationship it has with the Trust and has suggested establishing a formal liaison arrangement. We are happy to share the information and intelligence we collect and to offer our support to the Trust with patient and public involvement.

We suggest that we meet with a nominated representative in the near future to discuss joint-working possibilities, to share with you our LINk work-plan for 2010/11 and to discuss LINk involvement on public engagement committees.

We strongly recommend that the Trust considers its approach to the Quality Account process for 2010/11 now. Engagement with the public and patients, including the LINk, should be continuous throughout the year. Then the public, the target audience for the Quality Account, will have the opportunity to feedback in a timely and effective way throughout the year and to finalise feedback during the 30-day consultation period.

The Quality Account should also be more reflective of local priorities as a result. We look forward to hearing from you.

The Trust publicises protected mealtimes for patients

Annex 2: Glossary

Abbreviation	Meaning/definition
ABO	ABO blood group system (A, B, O, AB)
AMT	Antibiotic Management Team
BEACH	Bedside Emergency Assessment Course for HCAs (Healthcare Assistants)
CABG	Coronary Artery Bypass Graft
CEMACE	Centre for Maternal & Child Enquiries
CEWSS	Chelsea Early Warning Scoring System
CIN	Cervical Intra-Epithelial Neoplasia
CQUIN	Commissioning for Quality and Innovation
CXR	Chest X-Ray
DAHNO	Data for Head & Neck Oncology
DAT	Direct Antiglobulin Test
DEBM	Donor Expressed Breast Milk
EPIC	Evidence Based Practice in Infection Control
FBS	Fetal Blood Sampling
HSIL	High-grade Squamous Intraepithelial Lesions
HSMR	Hospital Standardised Mortality Ratio
ICNARC CMP	Intensive Care National Audit & Research Centre—Case Mix Programme
IHI Global Trigger Tool	An international tool developed by the Institute for Health Improvement which uses triggers or clues to identify adverse events/incidents and is effective for measuring the overall level of harm in a healthcare organisation.
IMB	Inter-Menstrual Bleeding
LINk	Kensington and Chelsea Local Involvement Network
MDT	Multi Disciplinary Team
MEBM	Maternal Expressed Breast Milk
MINAP	Myocardial Ischaemia National Audit Project
NAPTAD	National Audit of Psychological Therapies for Anxiety and Depression
National inpatient survey problems score	A tool used for admitted patients to assess their satisfaction levels against an agreed criteria. It is used to assist healthcare organisation to identify areas for improvement.
NBOCAP	National Bowel Cancer Audit Programme
NCEPOD	National Confidential Enquiries into Patient Outcome and Death
NDA	National Diabetes Audit
NEC	Necrotizing Enterocolitis
Never Events	Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
NHFD	National Hip Fracture Database
NHS CSP	NHS Cervical Screening Programme
NICE	National Institute for Clinical Excellence
NICU	Neonatal Intensive Care Unit
NIHR	National Institute of Health Research
NJR	National Joint Registry
NLCA	National Lung Cancer Audit
NNAP	National Neonatal Audit Programme

Abbreviation	Meaning/definition
NPSA	National Patient Safety Agency
PALS	Patient Advice & Liaison Service—a department found in every NHS hospital with the responsibility of attending to any concerns by patients and/or carers.
PCB	Postcoital Bleeding
PCEA	Patient Controlled Epidural Analgesia
PEAT	Patient Environment Action Team
PET	Patient Experience Tracker
PMB	Post Menopausal Bleeding
Problem scores	Problem scores are an interpretation of the data made by the Picker Institute. Any comparisons made within the Trust (internal benchmarks, historic comparisons) or between trusts (external benchmarks) are made using these scores. The problem score shows the percentage of patients for each question who, by their response, indicated that a particular aspect of their care could have been improved. They are calculated by combining response categories. For example, for the following question 'Did you have confidence and trust in the doctors treating you?' the responses 'Yes, sometimes' and 'No', have been combined to create a single problem score.
PROMs	Patient Reported Outcomes Measures—measures of health status or health-related quality of life that come directly from patients.
PSF intervention	Patient Safety First intervention—see www.patientsafetyfirst.nhs.uk
RCP	Royal College of Physicians
Secondary Uses service	Provides anonymous patient-based information for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.
SCJ	Squamocolumnar Junction
TARN	Trauma Audit & Research Network
Proton Pump Inhibitors	Drugs that reduce the secretion of gastric (stomach) acid
Revascularisation waiting time	The length of time a patient waits before having a surgical procedure for the provision of a new, additional, or augmented blood supply to a body part or organ.
Peri-arrest	A type of cardiac arrest related to irregular heart beats (arrythmias) due to malfunction of the heart.
Stretch targets	Set beyond average, achievable target through attaining extremely high standards.
Urinary catheter care bundles	A documentation tool with an outlined sequential care plan which ensures that all significant interventions for the care and management of patients with urinary catheters are not missed. This enables implementation of standardised best practice and prevent/reduce adverse events.

One of the hospital atriums

Performance Report

A member of staff helps a patient use the Trust's new Patient Experience Tracker (PET) to give feedback on our services

Key facts

There was increased demand for Trust services in 2009/10:

Number of patients treated

	2009/10	2008/09	2007/08
Inpatients	**38,751**	37,644	36,729
Outpatients	**262,116**	259,916	247,525
Day cases	**17,790**	16,821	15,962
A&E	**100,905**	97,640	97,685
Total	**419,562**	**412,021**	**397,901**

In particular, there was increased demand for our specialist services:

- 5,497 deliveries in Maternity in 2009/10, compared with 5,311 in 2008/09 and 5,177 in 2007/08
- 86,922 children treated in 2009/10 as inpatients, outpatients, in Paediatric A&E or as day case patients, compared with 83,921 in 2008/09 and 82,478 in 2007/08
- 6,005 people living with HIV on our caseload in 2009/10, compared with 5,481 in 2008/09 and 5,444 in 2007/08

There were also high levels of satisfaction with Trust services:

- 90% of patients rated their care at Chelsea and Westminster as 'Excellent', 'Very good' or Good' in the annual NHS inpatient survey 2009
- Chelsea and Westminster was rated as the fourth best performing hospital in England for patient safety in the Dr Foster Hospital Guide 2009
- Standards of hospital hygiene (environment), privacy and dignity, and food were all rated 'Excellent' in the National Patient Safety Agency's Patient Environment Action Team (PEAT) assessment 2010

Principal activities of the Trust

The Trust is a Central London teaching hospital, providing specialist services in a range of specialties including Paediatrics, HIV & Sexual Health and Burns, and general hospital services to the local population.

Chelsea and Westminster is a campus of Imperial College London School of Medicine.

Most services are at Chelsea and Westminster Hospital but HIV & sexual health services are provided at the St Stephen's Centre next to the main hospital building, 56 Dean Street in Soho, and the West London Centre for Sexual Health at Charing Cross Hospital.

The Trust is also increasingly providing community-based services—for example, in 2009/10 we won competitive tendering exercises to provide community gynaecology and community dermatology services in Westminster.

Clinical services are divided into three divisions, each led by a Divisional Clinical Director and a Divisional Director of Operations. Facilities services are contracted out to ISS Mediclean and Norland Managed Services.

Review of financial performance

In 2009/10 the Trust's financial performance was given a financial risk rating of 4 out of 5 by Monitor, where 5 is 'low risk', and delivered a surplus of £7.0 million which was ahead of the planned surplus of £6.4 million—the Trust expects to be 'Excellent' for 'Quality of Financial Management' in the annual performance ratings published in October 2010. This will be the fourth successive year that the Trust has delivered an 'Excellent' financial rating since becoming a Foundation Trust in October 2006.

The Trust's annual income and expenditure performance is set out in Table 1.

Table 1: Summary 2009/10 Income and Expenditure Outturn vs Plan (£m)

	Plan 2009/10	Actual 2009/10	Variance 2009/10
Income			
Clinical Income	265.2	**267.3**	2.1
Non-Clinical Income	38.4	**41.2**	2.8
Total Income	**303.6**	**308.5**	**4.9**
Expenses			
Pay Costs	-157.0	**-159.1**	-2.1
Non-Pay Costs	-120.4	**-125.8**	-5.4
Total Expenses	**-277.4**	**-284.9**	**-7.5**
EBITDA	**26.2**	**23.7**	**-2.6**
Depreciation	-10.0	**-7.4**	2.6
Dividend on PDC	-9.2	**-8.6**	0.6
Interest	-0.7	**-0.5**	0.2
Loss on Disposal of Asset		**-0.2**	-0.2
Net surplus	**6.4**	**7.0**	**0.6**
Cost Improvement Porgramme (CIP)	**10.5**	**8.7**	**-1.8**

Key variances from plan in 2009/10

1. NHS clinical income was £2.1 million above plan due to activity over-performance across most specialties.

2. Non-clinical income was £2.8 million above plan mainly due to increased income from facilities charges and education and training.

3. Pay costs were £2.1 million higher than plan, primarily due to increased clinical activity which was in excess of plan, resulting in short-term staffing solutions and increased spend on temporary staffing. During the year the Trust put in place robust management controls on temporary staffing and the usage of nurse agency hours was reduced by 37% from the start of the year.

4. Non-pay costs were £5.4 million higher than plan because of increased costs of drugs, other clinical supplies and increased use of high-cost laparoscopic (keyhole) surgical techniques.

5. Depreciation and dividend costs were underspent by £2.6 million and £0.6 million respectively due to recognition of 50% residual value of Trust assets in line with independent valuations.

6. Net interest received was £0.2 million less than plan due to lower interest rates than originally planned as a result of the economic downturn.

7. 84% of the planned cost improvement programme was delivered during 2009/10. This shortfall was offset partly by increased levels of income and partly by the reduction in depreciation and dividend costs previously stated.

Panoramic view from the roof of the hospital

Review of non-financial performance

The Trust was rated 'Excellent' for both 'Quality of Services' and 'Quality of Financial Management' in the annual performance ratings published by the Care Quality Commission in October 2009 which measured performance in 2008/09.

Only 37 out of 392 NHS trusts in England achieved a double 'Excellent' rating which meant we were ranked among the top 9% of NHS trusts in England.

NHS Chief Executive, David Nicholson, and Care Quality Commission Chairman, Barbara Young, wrote a letter of congratulations to staff which named Chelsea and Westminster among 41 trusts nationally that had performed strongly in the performance ratings for two years in a row.

We were compliant with 43 of 44 core standards, met seven of eight indicators measuring performance against long-standing government targets mainly concerned with waiting times and access to services, and met all 13 indicators measuring performance against the government's national priorities including overall patient experience, MRSA bacteraemia rates, cancer targets and stroke care.

In 2009/10, the Care Quality Commission rated the Trust's quality of care against 21 indicators and we were able to measure how we performed against 19 of the 21 indicators throughout the year—on the basis of this ongoing monitoring, we predict we will achieve a maximum score for all 19 indicators when annual performance ratings are published in October 2010.

The Care Quality Commission will allocate scores for the remaining two indicators (staff satisfaction and patient experience) based on the results of the national staff survey and the national inpatient survey before confirming our overall 'Quality of Services' rating.

The Trust is therefore hopeful of retaining its 'Excellent' rating for 'Quality of Services' in this year's NHS performance ratings.

The popularity of the Trust's services was confirmed by the results of the annual NHS inpatient survey 2009 which were published in May 2010—90% of patients rated our services as 'Excellent', 'Very good' or 'Good'.

Developments since the end of 2009/10 financial year

Developments since 31 March 2010 have been focused on three main areas:

- *Putting Patients First*—redevelopment of Chelsea and Westminster Hospital
- *Fit for the Future*—10% cost improvement programme in 2010/11 as agreed by the Board of Directors
- Other developments

Putting Patients First

A £39 million redevelopment of the hospital aims to improve services for patients and secure our future as a specialist hospital.

A two-storey extension to the first and second floors of the hospital will help us to achieve the Trust's vision of providing world class children's services following our designation as the lead centre for specialist paediatric and neonatal surgery in North West London, while also developing further our HIV services.

As part of the redevelopment, many outpatients services will be moved to the lower ground floor of the hospital and other departments will need to move off-site, in order to maximise space on the hospital site for clinical care.

Key developments since the end of the 2009/10 financial year include:

- BAM Construction, the Trust's building contractor on the redevelopment to improve children's services and HIV services, started work on site on 26 April 2010
- The Preoperative Assessment Centre moved from the first floor to the lower ground floor on 4 May 2010, the first stage of the relocation of most outpatients services to create an integrated, 21st century service

Fit for the Future

The Trust has launched a structured internal communications campaign called *Fit for the Future* with staff about why the Trust must maintain and improve the quality of patient care while delivering 10% cost savings in 2010/11.

This campaign builds on engagement with staff to help identify Trustwide cost savings since the need to save 10% in 2010/11 was identified in autumn 2009.

Our challenge, in common with all other NHS organisations, is how to achieve savings without compromising quality—in other words, how to make Chelsea and Westminster *Fit for the Future*.

A key development since the end of the 2009/10 financial year was the implementation of the *Fit for the Future* approach in the newly created Medicine and Surgery Division.

The divisional management team, led by the Divisional Clinical Director and the Divisional Director of Operations, invited all staff to an open meeting in April 2010.

The main aim is to promote closer working across the emergency and elective pathways in Medicine and Surgery including:

- A new combined Acute Assessment Unit to provide acute care for medical and surgical patients, replacing the current Acute Medical Unit
- An enhanced Weight Loss Surgery recovery area on a ward
- An emergency surgery taskforce to improve patient access to emergency surgery and reduce length of stay
- A day case procedure taskforce focusing on increased use of the Surgical Admissions Lounge
- Development of closer collaborative working arrangements with partner organisations including Social Services to improve transfers and prevent unnecessary admissions

This closer working—as well as the national policy drive to provide more care in the community rather than in acute hospitals—means less inpatient beds are needed and so St Mary Abbots Ward will close with effect from 1 July 2010.

A formal consultation with staff directly affected by the proposal to shut the ward is underway. Due to the number of staff vacancies across the Division, it is anticipated that no redundancies will be necessary.

Other developments

- The Trust's new organisational structure of three clinical divisions, each led by a Divisional Clinical Director and a Divisional Director of Operations, came into full effect on 1 April 2010—it aims to ensure doctors are in positions of leadership and responsibility
- Our revamped Assisted Conception Unit was officially opened on 8 May 2010 by the BBC presenter and journalist Sophie Raworth—she praised the quality of care she received on the Maternity Unit while having her three children at Chelsea and Westminster
- More than 1,500 people attended the hospital Open Day on 8 May 2010—97% of visitors who used our Patient Experience Tracker (PET) devices to give feedback rated the Open Day as 'Excellent' or 'Good'

Future developments

Putting Patients First

The redevelopment of the hospital will continue in 2010/11.

Work on converting space on the lower ground floor of the hospital into a new location for most outpatients services is due to start after staff who are currently based in this area vacate the space in August 2010. The new area is due to open in February 2011.

The Trust's vision for this new 21st century outpatients service is to maximise the use of technology, provide patients with an 'airport' style facility in which bookings and appointments are easy and logical, and ensure that clinical teams work to standardised, efficient administrative processes.

Some staff who currently work on the lower ground floor will be required to move from the main hospital site to off-site office accommodation in order to facilitate the redevelopment.

Off-site options are currently being explored by the Trust. The Trust is committed to communicating information to all staff affected as soon as possible.

Fit for the Future

Changes in the Medicine and Surgery division will be implemented in 2010/11 including the development of an Acute Assessment Unit and increased use of the Surgical Admissions Lounge.

Trustwide in 2010/11 there is a cost improvement programme target of £22.6 million which equates to a need to make 10% cost savings.

Maintaining and improving the quality that patients experience from the Trust while delivering significant cost savings during these difficult economic times will have a major impact on all areas of the organisation.

Other developments

- The Trust is bidding to provide community dermatology services in Kensington and Chelsea following the success in 2009/10 of the Trust's bids to provide community dermatology and gynaecology services in Westminster
- We will explore opportunities to bid to provide other community services in order to expand the Trust's portfolio of 'out of hospital' care
- The Trust will also consider possible future opportunities to bid to take over the running of a PCT's provider function or to explore the possibility of acquiring another provider organisation (hospital)
- We are working jointly with NHS Kensington and Chelsea on a 'preferred provider' basis to develop a model of care and an implementation plan for an Urgent Care Centre, co-located with the A&E at Chelsea and Westminster, to which non-emergency patients will be redirected
- The London and South East of England Burns Network has announced a strategic review of burns care, to be undertaken by Commissioning Support for London—development of the Burns Unit at Chelsea and Westminster is aligned with our strategic positioning as a specialist hospital and the Trust intends to bid if services are formally tendered following the review process

Principal risks & uncertainties facing the Trust

The Trust has effective mechanisms in place to manage risk, in accordance with its risk management policy and strategy, supported by two committees with Board accountability—the Audit Committee and the Assurance Committee.

The Trust has a very challenging cost improvement programme target of £22.6 million (10%) in 2010/11 to ensure that the Trust can maintain an 'Excellent' rating for 'Quality of Financial Management' in the Care Quality Commission's annual performance ratings for 2010/11.

The main reasons for this are:

- Expected losses in income due to tariff changes and a reduction in the Market Forces Factor
- Impact of demand management schemes as commissioners shift routine outpatient work into the community
- Funding for the Trust's capital development programme of c. £100 million over the next three years

A risk is that, if £22.6 million of savings are not identified, the Trust will have to underspend in other areas to compensate.

Uncertainties are future economic conditions and their impact on public sector spending under a new coalition government.

A major uncertainty is that as yet there is no confirmed strategy for the reconfiguration of services within North West London. The Trust is working closely with the North West London Commissioning Partnership to support its work and mitigate risks to the Trust's activity, particularly relating to any review of paediatric inpatients activity or adult emergency surgery.

The drive to move services from acute settings to community-based polysystems is a risk to the Trust although it is mitigated in part by the Trust's success in bidding to provide community services and its strategic aim to continue to bid for tenders to provide other community services.

The setting up of an Urgent Care Centre to take on a large amount of activity from A&E is also a risk to the Trust but it is mitigated by our 'preferred provider' status for providing the service and by the fact that the anticipated impact on A&E activity may not be realised in full, at least in the short-term.

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 will continue to be a key focus, particularly because achieving this target at specialty level remains a significant challenge.

The Trust is planning for a slowdown in public sector spending as a result of the economic downturn. The impact of this trend on the Trust will be a key focus in 2010/11 and beyond.

Regional trends

We expect the North West London Commissioning Partnership to finalise its strategy for the reconfiguration of services within the sector in 2010/11 in line with the principles of Lord Darzi's report *Healthcare for London: A Framework for Action*—this strategy will have a significant impact on the Trust.

As a Foundation Trust, we are considered a 'fixed point' in North West London and therefore options are being explored about potentially acquiring another NHS trust or taking over the management of a PCT's provider function.

The Board of Directors is clear that any potential acquisition needs to be explored carefully to ensure that it benefits patient care and the NHS trusts involved. Any potential acquisition would receive due diligence from the outset.

Reconfiguration of HIV inpatient services in London 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.

Local trends

The development of polysystems and the transfer of services to the community is a growing trend that will affect the Trust. We are bidding in partnership with The Royal Marsden NHS Foundation Trust for community services in Richmond and Hounslow.

The Trust is also currently bidding to provide community dermatology services in Kensington and Chelsea and we plan to bid to provide community cardiology, sexual health, musculoskeletal and older people's services in Kensington and Chelsea if, as expected, they are tendered in 2010/11.

The £39 million redevelopment of the main hospital will be a key local focus this year—the new location for outpatients services on the lower ground floor is due to open in February 2011.

The Trust will aim to expand its Maternity Unit further this year with the aim of increasing the number of deliveries to 6,000 by 2012/13, in line with our strategic positioning as a specialist provider.

The opening of the Urgent Care Centre at Chelsea and Westminster, for which the Trust is the 'preferred provider', will have an impact on activity in the A&E Department.

Research & Development

Delivering excellence in teaching and research was a key corporate objective in 2009/10 (as it is in 2010/11).

In 2009/10, the Trust led a successful bid to establish and host the North West London Health Innovation and Education Cluster (HIEC).

HIECs are partnerships between NHS organisations, universities, voluntary organisations and industry to promote innovation, quality and productivity in the NHS through training and education of healthcare staff. They aim to ensure that patients see the benefits of research and innovation through better care and treatment.

North West London HIEC is hosted at Chelsea and Westminster and partner organisations include the Royal Marsden and Royal Brompton hospitals, Imperial College London, other NHS trusts, and Macmillan Cancer Care.

Since it was announced that the Trust's bid had been successful in December 2009, two initial projects have been scoped—the use of telemonitoring to support heart failure patients in the community and how best to support staff working with cancer patients in the community.

The Trust also continues to host the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Northwest London.

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 is participating actively in CLAHRC research projects including hospital discharges of patients with chronic obstructive pulmonary disorder (COPD) and HIV/Hepatitis C testing in A&E and primary care.

The Trust Chairman, Professor Sir Christopher Edwards, chairs the Trust's Research Strategy Board. The Trust's Research Strategy, *Improving Patients' Lives Through Research and Innovation*, was developed in 2009/10 and is due to be approved and implemented in 2010/11.

Our staff

The Trust employs more than 2,700 staff. The Trust's corporate objective for 2009/10 of improving the patient experience included an aim to develop a motivated, trained, capable and competent workforce.

There was a marked increase in the response rate to the annual NHS staff survey—65% of staff took part in the survey. See the 'Staff survey' section on page 58 for full details of the survey results.

The Trust is committed to staff development and celebrating the achievements of our staff. Customer service training is provided for all new staff joining the Trust.

We also have an annual Christmas Cheer Awards and a monthly Team/Employee of the Month Award which gives staff and patients an opportunity to nominate staff who go the extra mile in their working lives.

Patient care

Foundation Trust status

A key benefit of Foundation Trust status is that the Trust can retain its financial surplus to reinvest in services.

Part of the Trust's surplus in 2007/08 helped develop 56 Dean Street, a new £2 million HIV and sexual health centre in Soho which opened to patients in March 2009.

56 Dean Street is now the busiest sexual health centre in London, according to Department of Health statistics for the three months from December 2009 to February 2010.

The centre also diagnoses 20% of all new HIV cases among gay men in London.

Another key benefit of Foundation Trust status is financial flexibility.

Funding of £39 million for the first major redevelopment of Chelsea and Westminster Hospital since it opened in 1993 was secured through the Foundation Trust Finance Facility.

The redevelopment aims to enable the Trust to provide world class children's services following our designation as the lead centre for specialist paediatric and neonatal surgery in North West London, develop further our internationally renowned HIV services, and create a 21st century outpatients facility.

Another benefit of Foundation Trust status is the positive engagement with our local community engendered by our 15,000 members and the Governors who they elect as their representatives.

Our members and Governors played an important role in supporting our successful campaign to be designated as a stroke unit during a three-month public consultation by Healthcare for London which ended in May 2009.

Governors were involved in development of the Trust's strategy in 2009/10, both at their quarterly meetings and at workshops and sessions with the Executive team.

The Annual Members' Meeting in September 2009 was both well-attended and a valuable forum for discussion of important issues, while the continued popularity of our annual Open Day demonstrates a high level of public interest in the hospital.

Performance against key patient targets

The Trust met all key national targets in 2009/10 and improved patient care by, for example, treating a record number of people and reducing infection rates.

We met a challenging national target of treating 95% of outpatients and 90% of inpatients within 18 weeks of GP referral, not only Trustwide but also at specialty level.

This achievement was made possible by the hard work and expertise of staff, despite increasing patient numbers—419,562 in 2009/10 compared with 397,901 in 2007/08—and the harshest winter for many years.

We also achieved a national target of treating 98% of A&E patients within four hours, again following the busiest year on record—100,905 patients were treated in A&E during 2009/10 including 32,295 in our dedicated 24-hour Paediatric A&E which continues to be increasingly popular with parents.

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

The Trust had just 10 cases of MRSA bacteraemia—against a target of 19 cases set by the Care Quality Commission—and 32 cases of *C. difficile*—against a target of 109 cases set by the Care Quality Commission.

Targets agreed with local commissioners

In 2009/10, 0.5% of the value of our main acute contract income was conditional upon goals agreed with our host commissioner, NHS Kensington and Chelsea, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

These targets included zero MRSA bacteraemia infections for elective surgery patients, an accelerated rollout of the Trust's Patient Experience Tracker (PET) to collate real-time patient feedback, and the rollout of electronic discharge summaries to GPs in Hammersmith and Fulham, and Westminster.

CQUIN payments were also agreed for specialist work in HIV and neonatal intensive care, and for community services in paediatrics, dermatology and gynaecology.

The Trust achieved 93% of CQUIN-related goals in 2009/10.

In 2010/11, five key questions from the national inpatient survey relating to the need to be more responsive to the personal needs of patients have been chosen as national indicators under the CQUIN payment framework.

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 inpatient and staff surveys.

New or significantly revised services

The Trust's new HIV and sexual health centre in Soho—56 Dean Street—was officially opened in May 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.

Statistics for 2009/10 show that relocating the centre from Vincent Square, SW1 to Soho has been a huge success. There was a 40% year-on-year increase in sexual health clinic attendances and the number of infections diagnosed also rose sharply, for example a 103% increase in chlamydia diagnoses and a 185% increase in gonorrhoea diagnoses.

A new community mobile health clinic was launched in February 2010, initially providing health screening and advice targeted at men attending Chelsea Football Club home games at Stamford Bridge.

The Surgical Admission Lounge was officially opened in October 2009 by patient Patricia Rowley—the new facility aims to improve the experience of patients being admitted to the hospital for elective surgery.

The Trust successfully bid to provide, and implemented, community gynaecology and dermatology services in Westminster.

In addition, a number of services have been significantly revised or improved:

- Following the Trust's designation as a stroke unit, after Healthcare for London's public consultation in 2009, a capital scheme has expanded the unit to 22 beds to support the provision of the service at the required level
- An extensive refurbishment of the Neonatal Intensive Care Unit was completed to expand its capacity to 42 cots to support the Trust's high risk maternity and complex specialist paediatrics activities
- The Trust's Assisted Conception Unit has been revamped to provide an enhanced environment for patients and was officially opened in May 2010

Service improvements following patients' concerns and complaints

In April 2009 a new two-stage complaints process for health and social care comments, concerns and complaints was implemented nationally.

All complaints and concerns are logged and reported to the Board of Directors on a quarterly basis. Previously concerns raised via M-PALS were reported separately to concerns raised as formal complaints.

There is also a greater emphasis on local resolution of concerns raised in clinical directorates to ensure a timely and local response rather than immediately referring them to the Complaints or M-PALS team.

The quarterly report to the Board of Directors captures all concerns raised through both M-PALS and Complaints and analyses the data to ensure any trends or areas of concern are identified and an appropriate action plan is in place.

An important aspect of handling complaints is listening to patients' views, observing what and where things are going wrong, and changing practice to improve services. It is important that lessons learned from complaints are shared across the Trust and used to enhance the quality of services for the future.

The following are examples of improvements that have been made to services in response to concerns and complaints:

Medicine

- An additional staff member for the secretarial team in Neurology will be recruited to ensure there are no delays in the typing and sending of discharge summaries and clinic letters

Surgery

- The Emergency Hand Trauma pathway has recently been reviewed with the Clinical Nurse Specialist playing a key link role between the surgical team and the A&E Department

Women's & Children's Services

- Measures have now been put in place to ensure that specific dietary requirements for unplanned admissions can be ordered directly with the Trust's catering provider when a dietitian is not available (eg weekends and Bank Holidays)

Anaesthetics & Imaging

- New signs have now been put up in the Phlebotomy Department to inform parents that if their child is under 5 they should report to Paediatrics for blood tests

Pharmacy

- New posters have been put up in the Pharmacy Department informing staff and patients that representatives of patients who are waiting for medication, following a discharge, can collect it on behalf of the patient if permission is sought from the pharmacy staff on the discharging ward.

Improvements in patient/carer information

The Trust's Patient Experience Tracker (PET) to collect real-time patient feedback was rolled out to inpatient and outpatient areas in 2009/10—by March 2010 the Trust had achieved a 76% response rate for inpatient areas.

New sponsored electronic patient information screens were installed in three locations in the hospital in March 2010. They provide useful health information and they also benefit the Trust financially because we receive a percentage of the sponsorship revenue.

The Trust improved information for people with learning disabilities, in line with a Care Quality Commission performance indicator.

A 'Patient Passport' was produced to support people with learning disabilities who come to Chelsea and Westminster—copies were distributed to wards and departments for staff to use with patients who have learning disabilities.

As part of its ongoing commitment to reducing accessibility barriers, the Trust enabled an innovative new product called BrowseAloud on its website.

BrowseAloud helps people who have literacy problems, learning difficulties, dyslexia, mild visual impairments or who speak English as a second language by reading aloud all website content. There is no charge for users.

Redevelopment of the Trust website was rolled out during 2009/10 to improve the quality of information available about our services to patients and carers online. The website project will be completed in 2010/11.

Children's Services staff pictured with one of the Trust's new sponsored electronic patient information screens

Stakeholder relations

The Trust has maintained and strengthened its relationships with key stakeholders including NHS, local authority and education partners.

Key stakeholders have nominated representatives on the Council of Governors which also includes elected representatives of patients, members of the public living in our four local boroughs, and Trust staff.

Key stakeholder organisations are invited to take part in the annual hospital Open Day—teams of staff from 17 partner organisations and nine charities associated with the Trust took part in the Open Day in May 2010.

Both our local MPs, Greg Hands and Sir Malcolm Rifkind, have taken a keen interest in the hospital and also attended the Open Day for the last two years.

We work closely with our host commissioner, NHS Kensington and Chelsea, and increasingly with the North West London Commissioning Partnership.

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

In 2009/10 the Trust worked in partnership with its neighbouring NHS organisations on Fulham Road—Royal Brompton & Harefield NHS Foundation Trust and The Royal Marsden NHS Foundation Trust—on specific project workstreams with the aim of realising 'back office' efficiencies.

North West London PCTs designated Chelsea and Westminster as the hub for neonatal and specialist paediatric surgery in the sector in May 2009 following a bidding process during the 2008/09 financial year.

Our focus in 2009/10 was on mobilising the specialist paediatric surgical network across North West London by, for example, hosting stakeholder events and launching the clinical network board.

The Trust has developed a federated model of care along defined clinical pathways with key partners including Great Ormond Street Hospital, Guy's and St Thomas' NHS Foundation Trust, and Royal Brompton & Harefield NHS Foundation Trust.

The Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Northwest London and the North West London Health Innovation and Education Cluster (HIEC) are both hosted at Chelsea and Westminster.

Both the CLAHRC and HIEC involve partnership working with key stakeholders in the NHS and other sectors.

The CLAHRC aims to facilitate the rapid introduction of new, effective treatments for a wide range of medical conditions while the HIEC promotes innovation, quality and productivity in the NHS through training and education of healthcare staff so that patients benefit from better care and treatment.

Staff and patients from the children's and young people's engagement forum held in April 2010 to consult about the redevelopment of our Children's Services

Governance Report

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 2010 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 Council of Governors 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 Council of Governors thereafter should be made at intervals of no more than five 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 five 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 five 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 five-year contracts will be competitive and enable the Trust to recruit and retain the best talent.

Board of Directors

Composition of the Board

The Board has six Non-Executive Directors (including the Chairman) and five 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 Council of Governors. The appointment of the Chief Executive is by the Non-Executive Directors, subject to approval by the Council of Governors.

See page 46 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

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 Council of Governors to seek the views of both Executive Directors and Governors. 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, 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 10 ordinary meetings and one special meeting in 2009/10.

Directors' attendance at Board meetings 2009/10

Non-Executive Directors	Ordinary Meetings	Special Meetings
Prof Sir Christopher Edwards	10/10	1/1
Colin Glass	8/10	0/1
Andrew Havery	9/10	1/1
Prof Richard Kitney	7/10	1/1
Karin Norman	9/10	0/1
Charles Wilson	10/10	1/1

Executive Directors	Ordinary Meetings	Special Meetings
Heather Lawrence, Chief Executive	10/10	1/1
Amanda Pritchard, Deputy Chief Executive (Director of Integrated Service Delivery & Modernisation)*	8/8	1/1
Dr Mike Anderson, Medical Director	10/10	0/1
Lorraine Bewes, Director of Finance & Information	10/10	1/1
Mark Gammage, Interim Deputy Chief Executive**	2/2	n/a
Andrew MacCallum, Director of Nursing	10/10	1/1
Catherine Mooney, Director of Governance & Corporate Affairs ***	10/10	1/1

* On maternity leave since December 2009
** Interim Deputy Chief Executive since December 2009
*** 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, Chairman of the Council of the British Heart Foundation, Chairman of GeothermalPlus and Deputy Chairman of CluffGeothermal. In December 2008 he was appointed as the first Chairman of NHS Medical Education England which provides independent advice to the government on education, training and workforce planning 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 is also Chairman of the Council of the British Heart Foundation. He chairs the Finance & Investment Committee.

Charles Wilson, Vice Chair: Charles was appointed in September 2000. He was reappointed for four years in October 2003. His term ended in October 2007 but the Members' Council (now called the Council of Governors) voted to reappoint him for a further two years until October 2009, and then for a further year, and therefore his term ends in October 2010. 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 underprivileged groups in south east Asia.

Andrew Havery: Andrew was reappointed for three 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 eight years before becoming a compliance officer to investment banks.

Professor Richard Kitney OBE: Professor Kitney was appointed for four years in May 2006, his term ends in October 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 reappointed for three years in September 2009, her term ends in October 2012. A Non-Executive Director since July 2005, 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 and the Investment Committee for Parkinson's UK, a Trustee of the Nursing and Midwifery Council and Chair of My Generation, a community and youth charity that she co-founded.

Executive Directors

Heather Lawrence OBE, Chief Executive: Heather has almost 20 years' experience at NHS Trust Board level, having served 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 for the three-year pay deal for staff on Agenda for Change. Most recently she was a member of the Government's Nursing and Midwifery Commission through which she and 15 other members advised the Government on the future roles of nurses and midwives.

Heather is a Fellow of the Chartered Institute of Personnel and Development. She was awarded the OBE in the New Year's Honours 2009 list for services to healthcare.

Amanda Pritchard, Director of Integrated Service Delivery & Modernisation (Deputy Chief Executive): 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. Amanda has been on maternity leave since December 2009.

Dr Mike Anderson, Medical Director: Dr Anderson was appointed in 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.

Mark Gammage, Interim Deputy Chief Executive and Director of Human Resources: Mark is providing interim cover during Amanda Pritchard's maternity leave which started in December 2009. He is also the Interim Director of Human Resources. Since 2002 Mark has been Managing Director of Dearden Consulting, a well-established healthcare consultancy firm, and his consultancy work has included working as a Director of HR in a number of different NHS organisations. Mark has also coached a wide range of individuals and worked as an accredited coach with the NHS National Institute for Innovation and Improvement, the Department of Health and others. Mark is a Fellow of the Chartered Institute of Personnel and Development.

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. Andrew is leaving the Trust at the end of May 2010 to take up a new post as Pro-Vice Chancellor and Dean of Nursing and Human Sciences at Thames Valley University.

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 and was the Clinical Governance Manager at Hammersmith Hospitals NHS Trust from October 2003. She attends Foundation Trust Board of Directors meetings as Company Secretary.

Audit Committee

Membership & Attendance

The Audit Committee is chaired by Andrew Havery, a Non-Executive Director, and includes two other Non-Executive Directors—Karin Norman and Charles Wilson. It met six times in 2009/10—Andrew Havery attended all meetings, Charles Wilson and Karin Norman attended four meetings each.

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 purchased work from its external auditors outside the audit code in 2009/10, 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.


A baby receives treatment on the Neonatal Intensive Care Unit

Nominations Committees

Both the Board of Directors and the Council of Governors have a Nominations Committee:

Nominations Committee of the Council of Governors for the appointment of Non-Executive Directors

The Nominations Committee of the Council of Governors comprises the Chairman of the Foundation Trust (or the Vice Chair when a Chairman is being appointed, unless the Vice Chair is applying for appointment as Chairman, in which case another Non-Executive Director), two elected Governors and one appointed Governor.

Another person nominated by the Nominations Committee is invited to act as an independent assessor to the Nominations Committee of the Council of Governors.

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 Council of Governors and the skills and experience identified by the Board of Directors.

It makes recommendations about suitable candidates for approval by the Council of Governors.

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 three years, and makes recommendations to the Council of Governors.

There were no meetings of the Nominations Committee of the Council of Governors in the 2009/10 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, reappointment or removal), 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 which consists of the Chairman, Chief Executive (except for his/her own appointment) and other Non-Executive Directors.

There were no meetings of the Nominations Committee of the Board of Directors in the 2009/10 financial year.

BBC presenter and journalist Sophie Raworth unveils a plaque to officially open the revamped Assisted Conception Unit in May 2010

Council of Governors

How the Board of Directors and the Council of Governors operate

The Council of Governors 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 Council of Governors 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 Council of Governors 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 Communications Strategy

Composition of the Council of Governors

There are 35 Governors 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 Council of Governors meets quarterly. There were four meetings in 2009/10.

Executive and Non-Executive Directors are invited to attend. Details of their attendance are in the table 'Directors' attendance at Council of Governors meetings 2009/10'. Details of Governors' attendance at meetings are in the table 'Foundation Trust Governors—Who's Who'.

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

Elections held during 2009/10

An election was held in 2009/10 in the Patient constituency. Cass J Cass-Horne, Alan Cleary, Edward Coolen, Susan Maxwell, Wendie McWatters and Taryn Youngstein were elected. Jim Smith was re-elected.

An election was also held in 2009/10 in the constituency Public: Hammersmith & Fulham Area 2—Christine Blewett was re-elected.

An election was also held in 2009/10 in a number of the Staff constituencies. In the constituency Staff: Allied Health Professionals, Scientific & Technical, Lucy Ball was elected. In the constituency Staff: Contracted, Jacinto Jesus was elected. In the constituency Staff: Management, Carol Dale was elected. In the constituency Staff: Medical & Dental, Professor Brian Gazzard was re-elected. In the constituency Staff: Support, Administrative & Clerical, Sinead Jones was elected.

Access to register of Governors' interests

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

How the Board has acted to understand the views of Governors and Foundation Trust members

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

Governors attended the hospital Open Day in May 2009 to meet Foundation Trust members and discuss the work of the Council. Governors and Foundation Trust members were also invited to attend the Annual Members' Meeting in September 2009 to give their views on the Trust.

Governors were invited to attend a strategy seminar led by the Trust Chief Executive and Chairman in September 2009. Following this seminar, Governors' views were taken into account and the Chief Executive gave a final strategy and business planning presentation to Governors at the Council of Governors meeting in February 2010.

Directors' attendance at Council of Governors meetings 2009/10

Non-Executive Directors	Attendance
Prof Sir Christopher Edwards	4/4
Colin Glass	1/4
Andrew Havery	2/4
Prof Richard Kitney	2/4
Karin Norman	2/4
Charles Wilson	4/4

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

* On maternity leave since December 2009
** Interim Deputy Chief Executive since December 2009
*** Attends Foundation Trust Board meetings as Company Secretary


Trust Chairman, Professor Sir Christopher Edwards launches the hospital Open Day in May 2010

Foundation Trust Governors—Who's Who

Council of Governors—Who's Who

Name (Constituency/Organisation)	Date elected or appointed	Attendance at Council Meetings 2009/10*
Prof Sir Christopher Edwards (Chairman)	Nov 2007	4/4
Ball, Lucy (Staff — Allied Health Professionals, Scientific & Technical)	Nov 2009	1/2
Balmford, Walter (Patient)	Dec 2007	4/4
Bennett, June (Patient)—left the Council in Feb 2010	Dec 2007	3/4
Birch, Chris (Patient)	May 2007	4/4
Blewett, Christine (Public—Hammersmith & Fulham 2)	Nov 2009	4/4
Bradford, Martin (Public—Hammersmith & Fulham 1)—term of office expired in Nov 2009	Dec 2007	2/2
Browne, Nicky (The Royal Marsden NHS Foundation Trust)	Dec 2006	4/4
Cass-Horne, Cass J (Patient)	Nov 2009	2/2
Cleary, Alan (Patient)	Nov 2009	1/2
Coolen, Edward (Patient)	Nov 2009	1/2
Dale, Carol (Staff—Support, Admin & Clerical)	Nov 2009	1/2
Delamare, Alison (Staff—Contracted)—term of office expired in Mar 2009	Mar 2006	2/2
Finch, Dr David (NHS Wandsworth)	May 2009	2/4
Gazzard, Prof Brian (Staff—Medical & Dental and Deputy Chairman)—Lead Governor	Nov 2009	4/4
Glazebrook, Rosie (NHS Hammersmith and Fulham)	Nov 2009	2/2
James, Cathy (Staff—Support, Admin & Clerical)—term of office expired in Mar 2009	Mar 2006	1/2
Jesus, Jacinto (Staff—Contracted)	Nov 2009	2/2
Jones, Sinead (Staff— Support, Admin and Clerical)—left the Council in Jan 2010	Nov 2009	0/1
King, Jane (Patient)—term of office expired in Oct 2009	Oct 2006	2/2
Lewis, Martin (Public—Westminster 2)	Dec 2007	2/4
Longworth, Catherine (NHS Westminster)	Oct 2006	1/4
Macrae, Dr Duncan (Royal Brompton & Harefield NHS Trust)	Oct 2006	2/4
Maxwell, Susan (Patient)	Nov 2009	2/2
Maze, Prof Mervyn (Imperial College London)—left the Council in Sep 2009	Oct 2006	0/2
McWatters, Wendie (Patient)	Nov 2009	2/2
Mills-Duggan, Ann (Public—Westminster 1)	May 2007	4/4
Moyo, Edgar (NHS Kensington and Chelsea)	Jun 2009	3/3
Nemeth, Cllr Cyril (Westminster City Council)	Nov 2009	1/2
Smith, Jim (Patient)	Nov 2009	4/4
Smith, Sue (Staff—Nursing & Midwifery)	Dec 2007	3/4
Smith, Sue B (Patient)—left the Council in Jun 2009	Dec 2007	0/1
Smith-Gordon, Sandra (Public—Kensington & Chelsea 2)	Oct 2008	4/4
Symons, Mary (Public—Wandsworth 1)	Dec 2007	3/4
Taylor, Cllr Frances (Royal Borough of Kensington and Chelsea)	Oct 2006	3/4
While, Alison (Major Education Provider)	Oct 2009	2/2
Youngstein, Taryn (Patient)	Nov 2009	1/2

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

Foundation Trust membership

Who can be a member?

- **Patient constituency:** Any patient treated at the hospital in the last three years, or the carer of a patient
- **Public constituency:** Anyone living in the local boroughs of Kensington and Chelsea, Hammersmith and Fulham, City of Westminster, and Wandsworth—each borough is divided into two areas for Council of Governors elections
- **Staff constituency:** Any member of staff—this constituency is divided into six 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 2010
Patients	6,010
Public	6,130
Staff	3,046
Total	**15,186**

How are we developing a representative membership?

The Membership Sub-Committee of the Council of Governors develops and reviews the Membership Development and Communications Strategy and the Membership Development Work Plan.

Initiatives to increase membership recruitment and develop a representative membership in 2009/10 included the amalgamation of membership activity with the Patient Advice and Liaison Service (PALS) to create M-PALS which provides the Trust with more opportunities to promote membership.

The M-PALS team supports the promotion of membership by giving membership application leaflets to all visitors to the M-PALS office in the hospital and by sending out membership application leaflets with all letters responding to comments received by the M-PALS service.

Other initiatives in 2009/10 included:

- Membership recruitment campaigns in advance of the Annual Members' Meeting and the Open Day
- Development of a new membership application leaflet including an Easyread version for people with a learning disability
- Use of the Trust's new community mobile health clinic to undertake health screening and recruit new Foundation Trust members at Chelsea Football Club and other community venues

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

- Low penetration in the Public: Wandsworth Area 1 constituency
- Significantly lower membership in the under-40 age group
- Lower membership in Black and Asian ethnic groups

In 2010/11 the Trust aims to maintain the current level of both public and patient members. An 'opt-out' system for staff means that all staff are automatically members unless they choose to opt out of membership and therefore proactive recruitment of staff members is not necessary.

Council of Governors' representatives and Foundation Trust members were invited to attend the Annual Members' Meeting in September 2009 to give their views on the Trust.

Get in touch

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

Hospital volunteers on the Welcome Desk at this year's Chelsea and Westminster Open Day which was sponsored by the Council of Governors

Statutory Information

Directors

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

Non-Executive Directors

The Chairman is Professor Sir Christopher Edwards.

The five 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 since December 2009). Mark Gammage has been the Interim Deputy Chief Executive since December 2009 while Amanda Pritchard is on 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 five 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 October 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. See page 55 for more information on sustainability/climate change.

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.

TV presenter Chris Hollins (left) and his father, ex-Chelsea FC legend John Hollins at the official launch of the new Chelsea and Westminster Hospital community health clinic in February 2010 with Sian Nelson (Membership & Engagement Manager) and Heather Lawrence (Chief Executive)

Remuneration Report

Remuneration Committee

The Remuneration Committee is a Standing Committee of the Board of Directors which 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 Council of Governors at a General Meeting.

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

The Remuneration Committee met in April 2010. Professor Sir Christopher Edwards, Andrew Havery and Karin Norman were in attendance. Colin Glass, Professor Richard Kitney and Charles Wilson 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 implement the national pay inflation award of 2.25% for staff on Agenda for Change contracts, and to support national recommendations for pay inflation increases for junior doctors.

In line with national recommendations, no pay inflation award was given to consultant medical staff.

The Committee also agreed that, in light of the current economic position, Executive Directors would receive no pay inflation increase.

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.

For a breakdown of salary and pension entitlements of senior managers, please see page 77.

Heather Lawrence

Heather Lawrence OBE
Chief Executive (on behalf of the Board)
27 May 2010

Burns patient Katie Piper, pictured with her surgeon Mr Mohammad Jawad—her recovery from horrific acid burns was the subject of a BAFTA-nominated Channel 4 documentary that highlighted the expertise of staff at Chelsea and Westminster

Sustainability/climate change

Commentary

The NHS has a carbon footprint of 18 million tonnes of CO_2 per year and has made a commitment to reducing this in line with government targets.

Chelsea and Westminster Hospital NHS Foundation Trust is committed to playing its part in this overall reduction both as a good corporate citizen and for sound financial reasons.

The Trust has appointed a Board Director to take the lead on sustainability and has recently produced a Sustainable Development Management Plan to support the work to reduce our carbon footprint.

A Sustainable Development Committee has been established to lead on the implementation of the Sustainable Development Management Plan. A number of sub-groups have been set up to work on specific areas of carbon reduction strategy.

To support and enhance the Sustainable Development Management Plan, the Trust has signed up to the Good Corporate Citizen Assessment Scheme.

The initial assessment has identified a number of areas to focus on.

Summary performance

The Trust achieved an overall reduction in energy consumption in 2009/10 of 6.5% compared to the previous year. The total expenditure on all utilities fell by 24% compared with 2008/09 largely as a result of falls in gas and electricity tariffs—see table below for details.

Future priorities and targets

The Trust will be required to register as a participant in the Carbon Reduction Commitment (CRC) by September 2010. As part of the early action metrics for CRC we will be completing a programme to install automatic meter reading and will be working to obtain the Carbon Trust Standard.

The Trust is looking to install a combined heat and power plant which will significantly reduce the Trust's total energy consumption.

The Trust will work to improve its overall rating for the Corporate Good Citizen Assessment Scheme with the intention of achieving at least the London average by March 2011.

The Trust has recently introduced new recycling bins and will be looking to increase recycling rates in 2010/11 from their current level to 40% of all waste.

Area		Non-financial data (applicable metric) 2008/09	Non-financial data (applicable metric) 2009/10		Financial data 2008/09 (£000)	Financial data 2009/10 (£000)
Waste minimisation and management	**Waste produced (tonnes)**	1,360	**1,390**	**Expenditure on waste disposal**	407	**496**
Finite resources	**Water (tonnes)**	184,213	**192,953**	**Water**	254	**282**
	Electricity (kWh)	24,048,300	**22,651,900**	**Electricity**	2,514	**1,846**
	Gas (kWh)	28,452,642	**26,434,984**	**Gas**	883	**632**

Equality & diversity

Commentary

Statement of approach to equality & diversity

The Trust's Deputy Chief Executive is the Executive lead for equality and diversity and Chair of the Equality & Diversity Steering Group which leads the Trust's work on addressing equality and diversity issues in the workforce and service provision for patients. The Trust also employs a full-time Equality & Diversity Manager.

In order to maintain progress with the equality and diversity agenda, the Group has refreshed its terms of reference and its membership to reflect the Trust's organisational restructure which came into effect on 1 April 2010.

The Equality & Diversity Steering Group monitors performance against key internal targets such as training or Equality Impact Assessments and progress of the Single Equality Scheme (SES).

Statement of compliance with publication duties

The Equality Bill received Royal Assent in April 2010 and formally become the Equality Act 2010. In anticipation of the Bill becoming an Act, the Equality & Diversity Manager developed a draft SES and action plan which was consulted upon with staff, equality staff networks, the Council of Governors, and external groups and charities such as Action Disability Kensington and Chelsea.

The Equality & Diversity Manager and a group of volunteers participated in the hospital Open Day in May 2009 to seek views from members of the public on the proposed SES and action plan. The final SES and action plan was approved by the Trust Board of Directors in October 2009.

The provisions in the Act will come into force in stages. Existing legislation has been replaced with a single Act which will form the basis of straightforward practical guidance for

employers, service providers and public bodies covering duties on age, sexual orientation, religion or belief as well as the existing duties on race, disability and gender. The overriding duties to promote equality of opportunity and eliminate harassment will remain the same. Prior to October 2009 the Trust had three separate statutory equality schemes for race, disability and gender.

The Trust produces an equality and diversity annual report that is submitted to the Trust Board of Directors. It includes analysis of workforce monitoring as well as a report on the progress of the SES. Equality Impact Assessments are also published.

Action plans and timeframe to address any shortfalls

The SES was implemented before the Equality Bill received Royal Assent. In 2010/11 the Equality & Diversity Manager will review the Equality Act to ensure that the Trust's SES complies with legislation. The action plan will then be amended to reflect any changes, if required. Key objectives from the action plan will be reviewed and, if they have not been completed in the specified timeframe, an amended timeframe will be agreed to ensure the objective is met.

The equality and diversity pages on the Trust website pages are currently being updated. All completed Equality Impact Assessments will be uploaded on the website as a matter of priority.

Summary of performance—workforce statistics

Trust workforce profile 2009/10

The Trust's ethnic profile compared with the local population shows that Black and Minority Ethnic (BME) staff are well represented, particularly in the clinical directorates. When comparing the ethnic profile of the Trust's workforce with the ethnic profile of London, we employ more staff from White Irish, Black African, Black Caribbean, Chinese and 'Any Other' ethnic or 'Mixed' backgrounds. In contrast we employ fewer staff from White British, Bangladeshi, Pakistani and 'Any Other' Black backgrounds. The ethnic composition of our workforce has marginally changed since last year.

The Trust has a younger workforce than other Foundation Trusts. The largest group of staff come from the 30–34 age bracket which amounts to almost 20% of the workforce. Within this age bracket most staff are employed in Nursing & Midwifery or Medical & Dental staff groups.

According to our Electronic Staff Record (ESR) database, the Trust workforce is 75% female and 25% male. No transgender staff are noted by the ESR database. This has not changed for the last three years and reflects the gender split across the NHS.

Only 0.67% of staff have declared that they have a disability but recent staff survey results indicated that we have a higher percentage of staff with a declared disability than indicated by the ESR database. The Trust is actively exploring ways to encourage staff to report their disability status so that we can ensure we are meeting their needs accordingly.

Trust membership profile 2009/10

The Membership Sub-Committee of the Council of Governors develops and reviews the Membership Development and Communications Strategy and the Membership Development Work Plan including initiatives to develop a representative membership.

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

- Low penetration in the Public: Wandsworth Area 1 constituency
- Significantly lower membership in the under-40 age group
- Lower membership in Black and Asian ethnic groups

Priorities and targets going forward

Statement of key priority areas

These key priority areas from the action plan will provide a focus for the Trust to concentrate its efforts on addressing equality and diversity issues over the next three years:

- Leadership, corporate commitment and governance
- Equality Impact Assessments
- Partnership working, consultation and involvement
- Accessibility and communications
- Workforce and training
- Commissioning and procurement
- Monitoring data, reporting and publishing
- Complaints

Performance against key priority areas

Performance will be monitored periodically by the Equality & Diversity Steering Group. Internal Trust targets for training and Equality Impact Assessments will also be monitored by the Equality & Diversity Steering Group.

Monitoring arrangements

The requirement for equality monitoring is enshrined in law and is assessed annually by the Care Quality Commission. In addition, NHS trusts have to demonstrate their compliance with equality and diversity standards set by the Care Quality Commission.

The purpose of collecting equality data is to enable organisations to ensure that they are not intentionally or unintentionally discriminating against any particular group of people and to enable them to develop appropriate and equitable services for service users and career development opportunities for staff.

We have included information in our SES about all the diversity strands. Each year we will produce a report detailing the progress we have made.

We will publish the results of our Equality Impact Assessments and any action plans or improvements we will be making. This will ensure that we share best practice in all our equality work.

Each year we will produce an annual report for the Trust Board that includes workforce monitoring data as well as a report on the progress of the SES. The Trust's Equality & Diversity Steering Group will monitor the progress of the SES.

Future priorities and how they will be measured

During 2010/11, a priority is for 33% of all staff to attend equality and diversity training. All departments will be required to submit an action plan for completing Equality Impact Assessments in 2010/11. The Equality & Diversity Steering Group will monitor both targets.

Summary of Trust workforce and Foundation Trust membership diversity data

Workforce	Staff 2008/09	% 2008/09	Staff 2009/10	% 2009/10
Age				
<20	9	0.30%	4	0.13%
20-24	159	5.67%	156	5.25%
25-29	516	18.40%	550	18.51%
30-34	553	19.00%	556	18.71%
35-39	443	15.79%	486	16.36%
40-44	380	13.55%	380	12.79%
45-49	304	10.83%	320	10.77%
50-54	194	6.92%	249	8.38%
55-59	147	5.24%	142	4.78%
60-64	80	2.85%	98	3.30%
65-69	14	0.50%	21	0.71%
70+	6	0.21%	9	0.30%
Ethnicity				
White British	1,234	44.0%	1,312	44.2%
White Irish	122	4.3%	118	4.0%
White Other	335	11.9%	368	12.4%
White & Black Caribbean	24	0.9%	26	0.9%
White & Black African	9	0.3%	12	0.4%
White & Asian	23	0.8%	18	0.6%
Mixed—Other	37	1.3%	36	1.2%
Asian/Asian British Indian	149	5.3%	165	5.6%
Asian/Asian British Pakistani	32	1.1%	25	0.8%
Asian/Asian British Bangladeshi	9	0.3%	12	0.4%
Asian/Asian British—Other	162	5.8%	170	5.7%
Black/Black British—Caribbean	177	6.3%	177	6.0%
Black/Black British—African	222	7.9%	246	8.3%
Black/Black British—Other	28	1.0%	32	1.1%
Other—Chinese	49	1.7%	55	1.9%
Other—Any Other Ethnic Group	112	4.0%	119	4.0%
Undisclosed	81	2.9%	80	2.7%
Gender				
Female	2,090	75%	2,229	75%
Male	715	25%	742	25%
Disability				
Declared disability	9	0.03%	20	0.67%

Membership	Membership 2008/09	% 2008/09	Membership 2009/10	% 2009/10
Age				
0-16	2	0.02%	2	0.02%
17-21	130	1.04%	150	1.21%
22+	8,443	67.50%	8,551	69.00%
Unknown	3,933	31.44%	3,671	29.67%
Ethnicity				
White	6,994	55.92%	7,021	56.73%
Mixed	327	2.61%	387	3.13%
Asian or Asian British	608	4.86%	641	5.18%
Black or Black British	473	3.78%	541	4.37%
Other	442	3.53%	445	3.60%
Unknown	3,664	29.29%	3,341	27.00%
Gender				
Female	7,314	58.47%	5,108	41.27%
Male	5,116	40.90%	4,300	34.74%
Unknown	78	0.62%	2,968	23.98%
Disability				
Declared disability	not recorded	not recorded	not recorded	not recorded

Staff survey

Commentary

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 with them on key decisions, and listening to their concerns.

A range of initiatives are in place to provide staff 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, raise staff awareness of financial and economic factors affecting the Trust's performance, and monitor and learn from staff feedback:

- Executive Directors meet Staffside representatives at monthly meetings of the Joint Management and Trade Union Consultative Committee (JMTUC) and the Director of Human Resources meets with the Staffside Chair on a fortnightly basis
- The Council of Governors, which includes elected staff representatives, meets quarterly
- Communication with staff includes a monthly staff magazine, a monthly face-to-face Team Briefing with Executive Directors which is disseminated through the line management structure to all staff, and a Daily Noticeboard email bulletin
- The Chief Executive holds ad hoc face-to-face staff briefings to engage staff with important strategic issues such as the redevelopment of the hospital and the need to make 10% cost savings in 2010/11 without compromising quality of care
- Executive Directors are allocated specific areas of the Trust on a monthly basis and are expected to visit these areas, engage with staff and feedback any issues to the Executive team

The Trust was ranked among the top 20% of trusts in the 2009 NHS staff survey for staff engagement and 37% of staff reported good communication between senior management and staff, which was the best performance of any Association of UK University Hospitals (AUKUH) Trust.

Summary of performance—results from the staff survey 2009

65% of staff completed the NHS staff survey 2009 (compared with 61% in 2008). This rate was the highest among Acute Trusts in London, the highest among AUKUH Trusts, and the second highest among all Acute Trusts nationally.

The survey was structured around the four national pledges to staff given in the NHS Constitution and two additional themes around staff satisfaction and equality and diversity. These pledges and themes are reported under 40 key findings (KFs). There were 36 existing KFs and four new KFs for the 2009 staff survey.

For the first time this year the Care Quality Commission calculated a 'Staff Engagement Score', which includes staff's perceived ability to contribute to improvements at work, their willingness to recommend the Trust as a place to work or receive treatment, and the extent to which staff feel motivated and engaged with their work.

The Trust's staff engagement score places us in the top 20% of acute Trusts in the country.

The Trust improved or maintained its performance for 83% of the 36 key KFs.

The key area of improvement for this Trust was around Staff Pledge 2 which asks about appraisals, personal development, access to training and line management support.

All six KFs covered by this pledge saw an improvement on the Trust's 2008 results, and were higher than the national average for acute Trusts—five of the six KFs were in the highest (best) 20% of acute Trusts in the country.

Staff responding that they had had an appraisal within the previous 12 months increased by 18% on 2008, up to 76%.

The Trust also improved its performance on KFs including:

- Staff satisfaction with the quality of work/patient care they deliver
- Trust commitment to work-life balance
- Perceptions of effective action from the Trust towards violence and harassment
- Staff understanding where their role fits in

Areas of concern for the Trust focused on four KFs because our responses were lower than last year's survey and lower than the national average:

- KF10: % of staff using flexible working options
- KF20: % of staff saying hand washing materials are always available
- KF39: % of staff believing the Trust provides equal opportunities for career progression or promotion
- KF40: % of staff experiencing discrimination at work in the last 12 months

The results of the survey have been published and action plans to address these areas of concern and improve on other key findings will be produced by departments across the Trust.

NHS Staff Survey response rate 2009 & job satisfaction KF

Staff Survey	2008/09 Trust	2008/09 National Average	2009/10 Trust	2009/10 National Average	Trust improvement/ deterioration
Response rate	61%	55%	65%	55%	+4.0%
KF34:Staff job satisfaction (scored from 1–5, with 1 representing very unsatisfied and 5 representing very satisfied staff)	3.47	3.45	3.51	3.47	+0.4

Top and Bottom Ranking Scores

These KF scores show where the Trust compares most favourably with other acute trusts in England (top) and least favourably with other acute trusts in England (bottom).

Top 4 ranking score	2008/09 Trust	2008/09 National Average	2009/10 Trust	2009/10 National Average	Trust improvement/ deterioration
KF31: % of staff reporting good communication between senior management and staff	32%	25%	37%	26%	+4%
KF32: % of staff agreeing that they understood their role and where it fits in	55%	45%	62%	47%	+7%
K11: % of staff feeling there are good opportunities to develop their potential at work	48%	42%	51%	42%	+3%
KF36: % of staff who would recommend the Trust as a place to work or receive treatment	n/a	n/a	76%	70%	new measure in 2010

Bottom 4 ranking score	2008/09 Trust	2008/09 National Average	2009/10 Trust	2009/10 National Average	Trust improvement/ deterioration
KF10: % of staff using flexible working options	63%	71%	61%	70%	-2%
KF9: % of staff working extra hours (the lower score the better)	75%	68%	74%	65%	+1%
KF20: % of staff saying hand washing materials are always available	56%	69%	55%	69%	-1%
KF17: % of staff receiving health and safety training in last 12 months	55%	76%	61%	78%	+6%

Future priorities and targets

The Trust plans to engage with staff and improve staff feedback further in accordance with the NHS Constitution.

We carried out an internal communications survey in March 2010:

- 75% of staff said they found it 'Very easy' or 'Fairly easy' to get information about what is going on in the Trust
- 96% of staff rated the monthly staff magazine *Trust News* as 'Excellent' or 'Good'
- 91% of staff said the Daily Noticeboard email bulletin was 'Just right' in terms of the information it provides to staff each day
- 73% of staff said their manager discussed the monthly Team Briefing with them 'Every month' or 'Sometimes'

However, only 49% of staff said their manager discussed Team Briefing with them every month.

The Trust plans to undertake a detailed audit of Team Briefing to pinpoint areas in which line managers are not using it as intended.

The Trust will also be establishing 'employee circles' to involve staff in key decisions in the Trust.

The main mechanism in place to monitor performance against the key findings of the staff survey is the Trust's staff survey action plan which will focus on addressing areas of concern from this year's survey and building on areas of strength.

Each department and directorate will have their own plan to work on to address 'local' issues. Progress will be reported through the Trust's established communication systems.

Regulatory ratings

Commentary

Explanation of ratings

- **Financial risk rating**—when assessing financial risk, the Foundation Trust regulator Monitor assigns a risk rating using a scorecard which compares key financial metrics on a consistent basis across all NHS foundation trusts.

  The risk rating is intended to reflect the likelihood of a financial breach of the authorisation.

  The financial indicators used to derive the financial risk rating incorporate five individual ratings which are each rated 1 (high risk) to 5 (low risk)

- **Governance risk rating**—Monitor's assessment of governance risk is based predominantly on NHS foundation trusts' plans for ensuring compliance with the terms of their authorisation but will also reflect historic performance where this may be indicative of future risk.

  Monitor considers eight elements when assessing the governance risk rating—legality of constitution, growing a representative membership, appropriate Board roles and structures, service performance, clinical quality and patient safety, effective risk and performance management, co-operation with NHS bodies and local authorities, and provision of mandatory services.

  Monitor rates governance risk using a graduated system of green, amber/green, amber/red and red, where green indicates low risk and red indicates high risk.

Summary of performance

In 2009/10 the Trust was rated green for both the governance risk rating and the mandatory services rating in each quarter.

The financial risk rating was planned at 4 but varied from plan in the second quarter when it was rated 3 although the overall rating for 2009/10 was 4.

This performance was in line with expectation in the annual plan.

Performance in 2008/09 was also green for both the governance risk rating and the mandatory services ratings and 5 for the financial risk rating.

Financial risk rating performance

The Trust planned to achieve an overall financial risk rating of 4 at the end of each quarter of 2009/10, on the cumulative position. This was achieved in the first, third and fourth quarters, resulting in an overall rating of 4 for the financial year. In the third quarter the rating reduced to 3 overall—the reasons for this are discussed below.

The overall financial risk rating reflects the weighted average of five individual ratings—two of the five ratings were below plan, Achievement of Plan and Return on Assets.

The Achievement of Plan rating assesses EBITDA achieved against EBITDA planned and this was 83% at the end of the second quarter which is a 3 rating.

This position recovered in the third quarter and at the end of the fourth quarter EBITDA achieved was 89% which provides a 4 rating.

The second rating below plan was Return on Assets which achieved a 3 rating in the third quarter when a 4 rating was planned. This was a consequence of lower EBITDA resulting in a lower surplus. The Trust achieved a 5.0% return on assets in the third quarter when it had planned for a 5.7% return.

This position recovered in the fourth quarter in line with the increase in EBITDA and the return on assets achieved at year end was 5.4% (a rating of 4).

Table of analysis

2008/09	Annual Plan	Q1	Q2	Q3	Q4
Financial risk rating	5	5	5	5	5
Governance risk rating	GREEN	GREEN	GREEN	GREEN	GREEN
Mandatory services	GREEN	GREEN	GREEN	GREEN	GREEN

2009/10	Annual Plan	Q1	Q2	Q3	Q4
Financial risk rating	4	4	3	4	4
Governance risk rating	GREEN	GREEN	GREEN	GREEN	GREEN
Mandatory services	GREEN	GREEN	GREEN	GREEN	GREEN

Public interest disclosures

Action to inform, involve & consult with staff

See the 'Staff survey' section on page 58 for details.

Policies in relation to equal opportunities

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

The Trust has joined the Stonewall Workplace Diversity Champions Programme, 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.

The Trust is a recognised '2 Ticks' employer. This status is awarded by Jobcentre Plus to employers that have made commitments to employ and develop the abilities of disabled staff.

Policies in relation to disabled staff

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

The Trust has an Equality & Diversity Policy and a Recruitment and Selection Policy and Procedure so that applications by disabled candidates receive full and fair consideration. Specific support for Trust staff and candidates is provided by recruitment training days which are compulsory for staff who participate in recruitment panels, as well as a policy for the recruitment and retention of staff with disabilities.

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 provide additional training in line with the policy for the recruitment and retention of staff with disabilities.

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

Due to improved levels of reporting, the number of incidents reported to the Health & Safety Executive increased from nine in 2008/09 to 36 in 2009/10.

Occupational Health performance

The Occupational Health department provides services including fitness for work assessments, screening for infectious and communicable diseases, support for staff and managers in relation to sickness absence and rehabilitation, and moving and handling training.

In 2009/10, the department led the Trust's Pandemic Flu Staff Protection Programme which included ensuring that all staff were kept informed about the best ways in which to protect themselves and their patients.

Approximately 1,756 staff were vaccinated by the Occupational Health team and 25 senior nurses which meant the Trust was among the best prepared nationally. A further 660 staff underwent 'fit testing' for high protection respirator facemasks in preparation for a possible pandemic, in line with Department of Health guidance.

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.

Nominated staff who Trust staff can contact confidentially if they suspect a fraudulent act are the Director of Finance & Information and the Local Counter Fraud Specialist (LCFS).

Sickness absence data

The annual sickness absence level in the Trust in 2009/10 was 3.48%.

Members of the Creating Excellence Together Network Group which supports Black and Minority Ethnic (BME) 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 NHS 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 the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS 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 Hospital NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

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

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

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable 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

Heather Lawrence OBE
Chief Executive and Accounting Officer
27 May 2010

Statement on Internal Control

Statement on internal control for the period 1 April 2009 to 31 March 2010

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 the 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 2010 and up until the date of approval of the annual report and accounts.

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.

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 and in addition other committees as appropriate eg the Health and Safety and Fire Committee, the Capital Programme Board and the Information Management and Technology Committee. The Operational Risk Management Committee reports to the Trust Executive for Clinical Governance and also provides reports to the 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 maintain 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 eg Operational 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 maintained Level 2 of the Clinical Negligence Scheme for Trusts (CNST) maternity standards following the assessment in February 2010. The Trust achieved Level 2 in the general NHS Litigation Authority Risk Management Standards in December 2008.

4. The 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 colour coded risk matrix is used to rate risks. Risk assessments are peer reviewed to include an assessment of the risk rating to ensure validity. All risks are entered into the centrally held risk register, which is managed by the corporate risk team. Risks that are red or orange are reviewed at the Operational Risk Management Committee and if appropriate by other committees eg those with capital implications are reviewed at the Capital Programme Board. Current Assurance Framework risks are monitored by the Board. Risks from previous objectives continue to be monitored through the executive team. 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 Trust manages its risks to data security through a number of different approaches. The Trust has a Board level Senior Information Risk Owner (SIRO). The SIRO chairs an Information Governance Committee (IGC) which is responsible for setting the framework for information governance standards in the Trust and ensuring delivery of action plans to improve compliance. A key part of the IGC's work is to review compliance against the Information Governance Toolkit and to ensure the evidence is externally assured through audit. The key strands of the Trust's management of risk to data security are:

- the development of appropriate information governance policies and staff procedures eg the Trust has an approved Information Risk policy which provides the framework for managing information risk in conjunction with an Information Governance Strategy and Policy, Information Security Policy and overall Risk Management Policy and Strategy

- developing a range of information governance training packages and literature, suitable to the needs of different staff groups and mandating this annually. The Trust has focused on areas of particular sensitivity eg HIV and sexual health services

- ensuring the Trust's IT systems are physically secure and have sufficient password protection and firewalls to prevent harm from malware or external hacking—this also includes provision of encrypted portable devices and provision of email encryption facilities

While the Trust has been externally assessed as green on its Information Governance toolkit, it has identified a few risk areas to improve as follows:

- Risk that not all staff complete their training and lack of assurance on staff competency in information governance awareness; this particularly relates to potential for lack of awareness of some staff and patients of the procedures to safeguard patient confidentiality and assure data protection

- Risk that not all flows of person identifiable information have been mapped

- Risk that the structure for managing information assets has not been fully embedded within the organisation to enable proactive risk assessment within each department

The Trust's plans for mitigating the above risks are:

- to conduct awareness surveys amongst staff and patients about the use of personal information

- to complete a comprehensive information flow mapping to analyse the type of information accessed by staff and their level of authorisation. The Trust's strategy is to implement an Electronic Document Management System which will help to address this risk

- to identify Information Asset Owners and Information Asset Administrators for each system and train them in their responsibilities for proactive information risk assessment

The outcomes of the above risk mitigation will be assessed as part of the Information Governance toolkit assessment for 2010/11 where all these areas will be targeted to improve from their current Level 2 status to Level 3.

The Trust reported a near miss to the Information Commissioner's Office where following the theft of two laptops from the Trust's premises, it was found that one was not encrypted. Whilst no loss of sensitive data occurred on this occasion, the Trust treated this as a serious incident with a full investigation and report to the Information Commissioner's Office and the Board. As a result, actions in relation to improving the physical security, completion of a full audit of the encryption of laptops and information governance training are being followed up by the Board.

The Audit Committee now receives a regular update on information governance and will assure the Board through the 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 eg ISS Mediclean for facilities management, Olympic South Limited for transport, and Norland 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.

The Foundation Trust is fully compliant with the core Standards for Better Health.

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.

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

The Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place. They need to more fully take account of emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Board received an account of the steps which have been put in place to ensure that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data. This was informed by a review of the standards for better data quality contained in the Audit Commission publication '*Figures you can trust: A briefing on data quality in the NHS 2009*'. This covers governance and leadership, policies, systems and processes, people and skills and data use and reporting. The Board also received a report of the quality assurance processes in place to prepare the report including external assurances where relevant.

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 aware of relative profitability and efficiency. This information is used proactively to identify opportunities for improving efficiency and profitability for each service. Service line reports have been developed to improve access to drill down reports to investigate cost variation.

Monthly finance and performance reports are provided to the Board. The Trust has exceeded the target net surplus. A new divisional structure to strengthen clinical accountability for resource use has been developed for implementation next year.

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 and procurement processes.

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, 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. This committee is accountable for seeking assurance that systems, processes and outcomes contribute to the Trust's aims and values and objectives, relating to patient safety and quality, safe and clean hospital environment and staff satisfaction and that there is evidence of robust governance and assurance processes in these areas. The Trust executive committees for clinical governance and general matters report into the Assurance Committee.

Internal Audit services are outsourced to RSM Tenon 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 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 Quality Report has been prepared in accordance with our normal systems of control with some additional processes as described above. A review of data quality processes resulted in three recommendations, which are concerned with individual accountability for data quality, a focus on getting data right the first time and integration of data arrangements into business planning and management processes.

A near miss incident involving the theft of a laptop which was not encrypted, but contained no person identifiable data, was treated as a serious incident. All actions from a previous incident were reviewed with an emphasis on assurance and this is an approach which will continue for all serious incidents reported to the Board. The near miss incident was reported to the Information Commissioner and Monitor. The action plan is being monitored by the Board.

A risk relating to maternity services was graded red and reviewed by the Board. The risk was mitigated due to improved recruitment and close monitoring of agency staff.

The Trust has identified a gap in the current risk assessments and Carbon Reduction Delivery Plans but actions are in place to ensure compliance with the Adaptation Reporting requirements of the Climate Change Act.

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 OBE
Chief Executive
27 May 2010

Independent Auditors' Report

Independent Auditors' Report to the Council of Governors 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 2010 under the National Health Service Act 2006 ("the Act") which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 36. These financial statements have been prepared in accordance with the accounting policies set out therein.

This report is made solely to the Council of Governors 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 Annual 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 2010 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
28 May 2010

Heather Bygrave FCA BA (Hons)
(Senior Statutory Auditor)
For and on behalf of Deloitte LLP
Chartered Accountants
3 Victoria Square, Victoria Street
St Albans AL1 3TF
28 May 2010

Foreword to the accounts

These accounts for the year ended 31 March 2010 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 OBE
Chief Executive
27 May 2010

Statement of comprehensive income for the year ended 31 March 2010

	Note	IFRS 2009/10 £000	IFRS Restatement 2008/09 £000
Operating income			
Operating income from operations	2	**308,519**	280,636
Operating expenses of operations	3	**(292,483)**	(260,668)
Operating surplus		**16,036**	19,968
Finance costs			
Finance income	7.1	**95**	1,438
Finance expense—financial liabilities	7.2	**(613)**	(856)
Public dividend capital dividends payable		**(8,557)**	(8,687)
Net finance costs		**(9,075)**	(8,105)
Surplus from operations	15.1	**6,961**	11,863
Surplus for the year		**6,961**	11,863
Other comprehensive income			
Revaluation (loss)/gain Property, Plant and Equipment		**(38,246)**	280
Increase in the donated asset reserve due to receipt of donated assets		**155**	240
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets		**(240)**	(212)
Total comprehensive (expense)/income for the year		**(31,370)**	12,171

Statement of financial position as at 31 March 2010

	Note	IFRS 31 Mar 2010 £000	IFRS Restatement 31 Mar 2009 £000	IFRS Restatement 1 Apr 2008 £000
Non-current assets				
Property plant and equipment	8	**265,939**	296,807	283,607
Total non-current assets		**265,939**	296,807	283,607
Current assets:				
Inventories	10	**6,045**	6,588	6,002
Trade and other receivables	11.1	**18,617**	11,418	9,990
Cash and cash equivalents	17	**19,861**	32,053	35,894
Total current assets		**44,523**	50,059	51,886
Current liabilities				
Trade and other payables	13.1	**(27,843)**	(29,347)	(23,146)
Borrowings	14.1	**(919)**	(1,621)	(4,746)
Provisions	16	**(1,896)**	(1,803)	(4,529)
Other liabilities	13.2	**(4,863)**	(2,560)	(4,593)
Total current liabilities		**(35,521)**	(35,331)	(37,014)
Total assets less current liabilities		**274,941**	311,535	298,479
Non-current liabilities				
Borrowings	14.2	**(6,624)**	(12,187)	(13,832)
Provisions	16	**(459)**	(470)	(1,040)
Other liabilities	13.2.1	**(3,450)**	(3,100)	0
Total non-current liabilities		**(10,533)**	(15,757)	(14,872)
Total assets employed		**264,408**	295,778	283,607
Financed by (taxpayers' equity)				
Public dividend capital		**162,549**	162,549	162,549
Revaluation reserve	19	**55,696**	91,320	91,040
Donated asset reserve		**4,986**	7,693	7,665
Income and expenditure reserve		**41,177**	34,216	22,353
Total taxpayers' equity		**264,408**	295,778	283,607

Heather Lawrence

Heather Lawrence OBE, Chief Executive
27 May 2010

Statement of changes in taxpayers' equity for the year ended 31 March 2010

Changes in taxpayers' equity 2009/10	Note	Total £000	Public Dividend Capital £000	Revaluation Reserve £000	Donated Assets Reserve £000	Income & Expenditure Reserve £000
Taxpayers' equity at 1 Apr 2009 as previously stated		**295,778**	162,549	91,320	7,693	34,216
Surplus for the year		**6,961**	0	0	0	6,961
Revaluation (losses) Property, Plant and Equipment		**(38,246)**	0	(35,624)	(2,622)	0
Increase in the donated asset reserve due to receipt of donated assets		**155**	0	0	155	0
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets		**(240)**	0	0	(240)	0
Taxpayers' equity at 31 Mar 2010		**264,408**	162,549	55,696	4,986	41,177
Changes in taxpayers' equity 2008/09						
Taxpayers' equity at 1 Apr 2008 as restated		**279,473**	162,549	91,040	7,533	18,351
Prior period adjustment	**36**	**4,134**	0	0	132	4,002
Taxpayers' equity at 1 Apr 2008—restated		**283,607**	162,549	91,040	7,665	22,353
Surplus for the year		**11,863**	0	0	0	11,863
Revaluation gains Property, Plant and Equipment		**280**	0	280	0	0
Increase in the donated asset reserve due to receipt of donated assets		**240**	0	0	240	0
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets		**(212)**	0	0	(212)	0
Taxpayers' equity at 31 Mar 2009		**295,778**	162,549	91,320	7,693	34,216

Cash flow statement for the year ended 31 March 2010

	IFRS 2009/10 £000	IFRS Restatement 2008/09 £000
Cash flows from operating activities		
Operating surplus from continuing operations	**16,036**	19,968
Non-cash income and expense		
Depreciation	**7,459**	6,121
Transfer from the donated asset reserve	**(240)**	(212)
Increase in trade and other receivables	**(7,199)**	(604)
Decrease/(increase) in inventories	**543**	(586)
Increase in trade and other payables	**1,529**	6,559
Other movements in operating cash flows	**238**	119
Increase/(decrease) in provisions	**82**	(3,344)
Net cash generated from operations	**18,448**	28,021
Cash flows from investing activities		
Interest received	**103**	1,493
Sale of Property, Plant and Equipment	**104**	0
Purchase of Property, Plant and Equipment	**(15,519)**	(19,231)
Net cash used in investing activities	**(15,312)**	(17,738)
Cash flows from financing activities		
Loans repaid	**(6,113)**	(4,594)
Capital element of finance lease rental payments	**(177)**	(180)
Interest paid	**(482)**	(717)
Interest element of finance leases	**(108)**	(143)
PDC dividends paid	**(8,448)**	(8,687)
Cash flows from other financing activities	**0**	197
Net cash used in financing activities	**(15,328)**	(14,124)
Decrease in cash and cash equivalents	**(12,192)**	(3,841)
Cash and cash equivalents at 1 Apr 2009	**32,053**	35,894
Cash and cash equivalents at 31 Mar 2010	**19,861**	32,053

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 Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the accounts and accompanying notes will be prepared in accordance with the 2009/10 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 New and revised standards and interpretations

The following standards, amendments and interpretations have been issued by the International Accounting Standards Board (IASB) and International Financial Reporting Interpretations Committee (IFRIC) but are not yet required to be adopted or are not yet effective.

- IAS 24 related party disclosures (revised 2009)
- IFRS 9 Financial Instruments

The Directors anticipate that the adoption of these standards and interpretations in future period will have no material impact on the financial statements. All other revised and new standards have not been listed here as they are not considered to have an impact on the Trust. Monitor does not permit the early adoption of accounting standards, amendments and interpretations that are in issue at the reporting date but effective at a subsequent reporting period.

1.2 Accounting convention

These accounts have been prepared under the historical cost convention, modified by the revaluation of properties, and, where material, current asset investments and inventories to fair value as determined by the relevant accounting standard.

1.3 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

In accordance with IAS 18, income relating to those spells which are partially completed at the financial year end is apportioned across the financial years on a pro rata basis.

1.4 Expenditure on employee benefits

1.4.1 Short-term employee benefits

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

1.5 Pension costs

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

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

1.6 Expenditure on other goods and services

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

1.7 Property, Plant and Equipment

1.7.1 Recognition

Property, Plant and Equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has a cost of at least £5,000
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost

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

1.8 Measurement

1.8.1 Valuation

All Property, Plant and Equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Properties in the course of construction are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value.

All assets are measured subsequently at fair value as follows:

(a) Land and non-specialised buildings—market value
(b) Specialised buildings—depreciated replacement cost
(c) Non-property assets—depreciated historic cost

The carrying values of Property, Plant and Equipment are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be fully recoverable.

All land and buildings are restated to fair value in accordance with IAS 16 and Monitor guidance, using professional valuations every five years and an interim valuation after three years to ensure that fair values are not materially different from the carrying amounts. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual based on modern equivalent assets.

A valuation of land, buildings and dwellings was carried out by Montagu Evans (Independent Chartered Surveyors, Registration number OC312072). Buildings were valued at depreciated replacement cost on a modern equivalent asset basis as at 31 March 2010. In order to derive relevant build costs, Montagu Evans gave regard to the RICS Build Cost Indices in consultation with their own building surveyor. In accordance with the RICS and Treasury's Financial Reporting manual valuation guidelines, an 'instant build' approach was assumed in that the modern equivalent assets would be constructed at the date of valuation without phasing or lead in periods. It also assumes the site is cleared and ready to take the new buildings and therefore there is no allowance for the demolition of any existing buildings or site preparation.

In arriving at the valuation of the land, Montagu Evans have considered the value for development sites reflecting the expectation that throughout the London Borough where the properties are located, land would be acquired in competition for predominantly residential led, mixed use development. Therefore land was valued having regard to prevailing land values in the vicinity of the existing site.

1.8.2 Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised.

1.8.3 Depreciation

Items of Property, Plant and Equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Property, Plant and Equipment are depreciated over the following useful lives:

- Property excluding land: Buildings, installations and fittings are depreciated on a straight line basis, after accounting for residual value, over the remaining useful economic life of 38 years
- Equipment is depreciated on a straight line basis over the useful economic life of the asset, deemed as 5 years for short life assets, 10 years for medium life assets and 15 years for long life assets

1.8.4 Revaluation and impairment

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income.

Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

1.9 De-recognition

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

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
- the sale must be highly probable ie:
  - (a) management are committed to a plan to sell the asset
  - (b) an active programme has begun to find a buyer and complete the sale
  - (c) the asset is being actively marketed at a reasonable price
  - (d) the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'
  - (e) the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it

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

Property, Plant and Equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.10 Donated assets

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

1.11 Private Finance Initiative (PFI) transactions

The Trust is not party to any PFI transactions.

1.12 Intangible assets

1.12.1 Recognition

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

1.12.2 Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

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

Expenditure which does not meet the criteria for capitalisation is treated as an operating expense in the year in which it is incurred. Where possible, the Trust discloses the total amount of research and development expenditure charged in the Statement of Comprehensive Income separately. However, where research and development activity cannot be separated from patient care activity it cannot be identified and is therefore not separately disclosed.

1.13 Software

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

1.14 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

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

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.15 Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.16 Government grants

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

1.17 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In, First Out (FIFO) method.

1.18 Cash and cash equivalents

Cash and cash equivalents comprise of cash on hand and demand deposits and other short term highly liquid investments that are readily convertible to a known amount of cash and are subject to an insignificant risk of changes in value. 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 payables. Interest earned on bank accounts and interest charged on overdrafts is recorded respectively as "finance income" and "finance cost" in the periods to which they relate. Bank charges are recorded as operating expense in the periods to which they relate.

1.19 Financial instruments and financial liabilities

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 receivables (but not prepayments), cash and cash equivalents, trade payables (but not deferred income), finance lease obligations, borrowings, provisions.

1.20 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 ie 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.

1.21 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.

1.22 Classification and measurement

Financial assets are classified into the following specified categories:

- Financial assets at 'Fair Value through Income and Expenditure'
- 'Loans and receivables'
- 'Available-for-sale' financial assets

Financial liabilities are classified as either:

- Financial liabilities at 'Fair Value through Income and Expenditure'
- 'Other financial liabilities'

The Trust has no financial assets classified as at 'Fair Value through Income and Expenditure' or 'Available for Sale'. There are also no financial liabilities classified as at 'Fair Value through Income and Expenditure'.

1.23 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 Statement of Comprehensive Income. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

The Trust has no financial assets classified as at 'Fair Value through Income and Expenditure', 'Available for Sale'. There are also no financial liabilities classified as at 'Fair Value through Income and Expenditure'.

1.24 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 and cash equivalents, NHS receivables, accrued income and 'other receivables'.

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 Statement of Comprehensive Income, except for short-term receivables when the recognition of interest would be immaterial.

1.25 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 non-current liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance Property, Plant and Equipment or intangible assets is not capitalised as part of the cost of those assets.

1.26 Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'Fair Value through Income and Expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred

after the initial recognition of the asset and which has an impact on the estimated future 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 Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of an allowance account/bad debt provision.

1.27 Leases

1.27.1 Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

1.27.2 Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

1.27.3 Leases of land and buildings

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

1.28 Provisions

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

1.29 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation 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 NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at notes to the accounts.

1.30 Non-clinical risk pooling

The NHS foundation 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.

1.31 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 the notes to the accounts where an inflow of economic benefits is probable. Contingent liabilities are not recognised but are disclosed in the notes to the accounts, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

(a) 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

(b) 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

1.32 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) net cash balances held with the Government Banking Services and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.33 Value Added Tax

Most of the activities of the NHS Foundation 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.

1.34 Corporation tax

Corporation tax is not applicable to foundation trusts until 2010/11.

1.35 Foreign exchange

The functional and presentational currencies of the Trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'Fair Value through Income and Expenditure') are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.36 Third party assets

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

2. Operating income from operations

2.1 Operating income (by classification)

Income from activities	Note	IFRS 2009/10 £000	IFRS restatement 2008/09 £000
Elective income		**18,790**	38,112
Non elective income		**64,066**	61,524
Outpatient income		**64,601**	60,679
Accident & Emergency income		**10,380**	9,979
Other NHS clinical income		**97,632**	63,129
Private patient income	2.3	**8,184**	7,969
Other non-protected clinical income		**1,604**	1,963
Total income from activities	2.4	**265,257**	243,355

2.2 Other operating income

	IFRS 2009/10 £000	IFRS restatement 2008/09 £000
Research and development	**4,329**	2,691
Education and training	**24,514**	22,257
Charitable and other contributions to expenditure	**92**	121
Transfers from donated asset reserve in respect of depreciation	**240**	212
Non-patient care services to other bodies	**649**	710
Profit on disposal of equipment	**4**	0
Other income	**13,434**	11,290
Total other operating income	**43,262**	37,281
Total operating income from operations	**308,519**	280,636

2.3 Private patient income

	Base year 2002/03 £000	IFRS 2009/10 £000	IFRS restatement 2008/09 £000
Private patient income	5,498	**8,184**	7,969
Total patient related income	157,015	**265,257**	243,355
Proportion (as percentage)	3.50%	**3.09%**	3.27%

2.4 Operating income (by type)

Income from activities	IFRS 2009/10 £000	IFRS restatement 2008/09 £000
NHS Foundation Trusts	**4**	0
NHS Trusts	**0**	22
Primary Care Trusts	**255,289**	189,447
Department of Health: Other	**176**	43,673
Non NHS: Private patients	**8,184**	7,969
Non NHS: Overseas patients (non-reciprocal)	**1,086**	1,026
NHS injury scheme	**414**	838
Profit on disposal of equipment	**4**	0
Non NHS: Other	**100**	380
Total	**265,257**	243,355

3. Operating expenses from operations

Operating expenses	IFRS 2009/10 £000	IFRS restatement 2008/09 £000
Services from NHS Trusts	**213**	187
Purchase of healthcare from non-NHS bodies	**708**	376
Executive directors costs	**743**	736
Non executive directors costs	**118**	116
Staff costs	**159,796**	147,663
Drug costs	**47,681**	42,240
Supplies and services—clinical (excl drug costs)	**34,944**	29,060
Supplies and services—general	**4,907**	2,777
Establishment	**4,872**	4,600
Research and development	**1,314**	0
Transport	**1,465**	1,446
Premises	**18,627**	16,945
Increase in bad debt provision	**216**	195
Depreciation on Property, Plant and Equipment	**7,459**	6,121
Audit fees:		
Audit services—statutory audit	**109**	105
Audit services—regulatory reporting	**0**	40
Other auditors remuneration—further assurance services	**12**	0
Other auditors remuneration—other services	**10**	0
Clinical negligence	**4,789**	2,873
Loss on disposal of other Property, Plant and Equipment	**168**	118
Other	**4,332**	5,070
Total operating expenses from operations	**292,483**	260,668

3.1 Operating leases

3.1.1 Arrangements containing an operating lease

	IFRS 2009/10 £000	IFRS restatement 2008/09 £000
Minimum lease payments	**1,988**	1,423
Less sublease payments received	**(28)**	(24)
Total	**1,960**	1,399

3.1.2 Arrangements containing an operating lease

Land & Building/Plant & Machinery	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000
Future minimum lease payments due:		
• not later than 1 year	**1,579**	1,052
• later than 1 year and not later than 5 years	**6,729**	3,176
• later than 5 years	**3,040**	2,646
Total	**11,348**	6,874
Total of future minimum sublease lease payments to be received at the balance sheet date	**0**	220

4. Employee expenses and numbers

4.1 Employee expenses

	IFRS 2009/10 £000	IFRS restatement 2008/09 £000
Salaries and wages	**125,233**	114,416
Social security costs	**10,669**	10,040
Employers' contributions to NHS Pension Scheme	**12,481**	12,113
Agency/contract staff	**13,078**	11,403
Total	**161,461**	147,972

4.2 Average number of persons employed (WTE Basis)

	2009/10 N°	2008/09 N°
Medical and dental	**538**	515
Administration and estates	**581**	535
Healthcare assistants and other support staff	**230**	207
Nursing, midwifery and health visiting staff	**1,012**	985
Nursing, midwifery and health visiting learners	**1**	4
Scientific, therapeutic and technical staff	**294**	278
Bank and agency staff	**523**	470
Other	**26**	27
Total	**3,205**	3,021

4.3 Employee benefits

	IFRS 2009/10 £000	IFRS restatement 2008/09 £000
Employee benefits	**69**	427

4.4 Retirements due to ill-health

During 2009/10 there were three (2008/09—nil) 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 2010—£0.2m).

4.5 Salary and pension entitlements of senior managers (table on following page)

Non executive directors do not receive pensionable remuneration therefore 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.

5. Better Payment Practice Code

5.1 Better Payment Practice Code—measure of compliance

	IFRS 2009/10		IFRS restatement 2008/09	
	N°	£000	N°	£000
Total bills paid in the year	**73,168**	**162,743**	70,804	143,549
Total bills paid within the target	**57,803**	**130,195**	62,628	128,136
Percentage of bills paid within target	**79.0%**	**80.0%**	88.5%	89.3%

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.

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

There were no amounts included within interest expense (note 7.2) arising from claims made under this legislation (2008/09—nil).

6. (Loss) on disposal of fixed assets

The loss on disposal of fixed assets was £0.16m (2008/09—£0.12m) consisting of various pieces of medical equipment decommissioned.

7.1 Finance income

	IFRS 2009/10 £000	IFRS restatement 2008/09 £000
Interest on loans and receivables	**95**	1,438

7.2 Finance costs—interest expense

	2009/10 £000	2008/09 £000
Loans from Foundation Trust Financing Facility	**482**	587
Finance leases	**131**	147
Other loans	**0**	122
Total	**613**	856

4.5 Table of salary and pension entitlements of senior managers

	a) Remuneration		b) Pension				
	Salary for the year ended 31 Mar 2010 bands of **£5,000**	**Salary for the year ended 31 Mar 2009** bands of **£5,000**	**Accrued pension and related lump sum at age 60 as at 31 Mar 2010** bands of **£2,500**	**Real increase/ (decrease) in pension and related lump sum at age 60 as at 31 Mar 2010** bands of **£2,500**	**CETV at 31 Mar 2009** **(£000)**	**CETV at 31 Mar 2010** **(£000)**	**Real increase/ (decrease) in CETV for the year ended 31 Mar 2010** **(£000)**
Executive Directors							
Heather Lawrence, Chief Executive	**170–175**	170–175	**305.0–307.5**	**(5.0)–(2.5)**	1,826	**0**	**0**
Mike Anderson, Medical Director	**150–155**	155–160	**270.0–272.5**	**(20.0)–(17.5)**	1,651	**1,675**	**24**
Lorraine Bewes, Director of Finance & Information	**125–130**	125–130	**120.0–122.5**	**5.0–7.5**	487	**564**	**77**
Amanda Pritchard, Director of Service Integration & Modernisation (Deputy Chief Executive)	**100–105**	85–90	**65.0–67.5**	**2.5–5.0**	158	**183**	**25**
Andrew MacCallum, Director of Nursing	**95–100**	95–100	**130.0–132.5**	**(2.5)–0.0**	547	**601**	**54**
Mark Gammage, Interim Deputy Chief Executive [1]	**35–40**	0	**0**	**0**	0	**0**	**0**
Non-Executive Directors							
Professor Sir Christopher Edwards, Chairman	**35–40**	40–45	**0**	**0**	0	**0**	**0**
Andrew Havery, Non-Executive Director	**15–20**	15–20	**0**	**0**	0	**0**	**0**
Charles Wilson, Non-Executive Director	**15–20**	10–15	**0**	**0**	0	**0**	**0**
Karin Norman, 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	**10–15**	10–15	**0**	**0**	0	**0**	**0**
Directors							
Mark Gammage, Interim Director of Human Resources	**120–125**	85–90	**0**	**0**	0	**0**	**0**
Catherine Mooney, Director of Governance & Corporate Affairs	**80–85**	80–85	**110.0–112.5**	**(2.5)–0.0**	496	**538**	**42**
Amit Khutti, Director of Strategy & Service Planning	**80–85**	80–85	**15.0–17.5**	**5.0–7.5**	23	**42**	**19**
Alex Geddes, Director of Information Management & Technology [2]	**55–60**	90–95	**32.5–35.0**	**0.0–2.5**	0	**0**	**0**
William Gordon, Acting Director of Information & Technology [3]	**45–50**	0	**0**	**0**	0	**0**	**0**
Kelda Alleyne, Deputy Director of Finance [4]	**60–65**	0	**0.0–2.5**	**0.0–2.5**	0	**11**	**11**
William Street, Deputy Director of Finance [5]	**55–60**	0	**0.0–2.5**	**0.0–2.5**	0	**10**	**10**
Neil Callow, Deputy Director of Finance [6]	**10–15**	70–75	**80.0–82.5**	**(2.5)–0.0**	293	**323**	**30**

Notes to senior managers' salary and pension table

[1] Started Interim Deputy Chief Executive position from January 2010. Salary for Interim Directors reported as full cost to the Trust.

[2] Left the Trust in November 2009

[3] Started acting position from September 2009

[4] Started employment with the Trust in June 2009

[5] Started July 2009 and left the Trust in February 2010

[6] Left the Trust in May 2009

8. Property, Plant and Equipment

8.1 Property, Plant and Equipment at the balance sheet date 31 March 2010

	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
Net book value at 1 Apr 2009									
Owned at 1 Apr 2009	50,000	206,314	0	5,256	18,881	0	6,956	66	287,473
Finance lease at 1 Apr 2009	0	0	1,014	0	627	0	0	0	1,641
Donated at 1 Apr 2009	0	6,958	0	0	735	0	0	0	7,693
NBV Total at 1 Apr 2009	**50,000**	**213,272**	**1,014**	**5,256**	**20,243**	**0**	**6,956**	**66**	**296,807**
Cost or valuation at 1 Apr 2009	50,000	222,936	1,269	5,256	40,330	65	14,516	537	334,909
Additions—purchased	0	5,809	108	4,074	1,963	1	2,868	128	14,951
Additions—donated	0	0	0	0	35	120	0	0	155
Impairments charged to revaluation reserve	0	(51,804)	0	0	0	0	0	0	(51,804)
Reclassifications	0	3,255	60	(4,936)	(414)	0	2,003	32	0
Other revaluations	0	0	564	0	0	0	0	0	564
Disposals	0	0	0	0	(1,168)	0	0	0	(1,168)
Cost or valuation at 31 Mar 2010	**50,000**	**180,196**	**2,001**	**4,394**	**40,746**	**186**	**19,387**	**697**	**297,607**
Accumulated depreciation at 1 Apr 2009 as restated	0	9,664	255	0	20,087	65	7,560	471	38,102
Provided during the year	0	3,040	34	0	2,780	0	1,594	11	7,459
Revaluation impairment/surplus	0	(12,704)	(289)	0	0	0	0	0	(12,993)
Disposal	0	0	0	0	(900)	0	0	0	(900)
Depreciation at 31 Mar 2010	**0**	**0**	**0**	**0**	**21,967**	**65**	**9,154**	**482**	**31,668**
Net book value									
Owned at 31 Mar 2010	50,000	176,005	0	4,394	17,614	1	10,233	215	258,462
Finance lease at 31 Mar 2010	0	0	2,001	0	490	0	0	0	2,491
Donated at 31 Mar 2010	0	4,191	0	0	675	120	0	0	4,986
NBV Total at 31 Mar 2010	**50,000**	**180,196**	**2,001**	**4,394**	**18,779**	**121**	**10,233**	**215**	**265,939**
Net book value at 31 Mar 2010									
Protected assets at 31 Mar 2010	50,000	180,196	2,001	0	0	0	0	0	232,197
Unprotected assets at 31 Mar 2010	0	0	0	4,394	18,779	121	10,233	215	33,742
Total at 31 Mar 2010	**50,000**	**180,196**	**2,001**	**4,394**	**18,779**	**121**	**10,233**	**215**	**265,939**

8.2 Property, Plant and Equipment at the balance sheet date 31 March 2009

	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
Net book value at 1 Apr 2008									
Owned at 1 Apr 2008	50,000	200,832	1,107	2,237	16,964	2	4,781	19	275,942
Finance lease at 1 Apr 2008	0	0	0	0	0	0	0	0	0
Donated at 1 Apr 2008	0	7,102	0	0	563	0	0	0	7,665
NBV Total at 1 Apr 2008	**50,000**	**207,934**	**1,107**	**2,237**	**17,527**	**2**	**4,781**	**19**	**283,607**
Cost or valuation at 1 Apr 2008	50,000	214,914	1,269	2,237	36,565	65	11,462	471	316,983
Additions—purchased	0	3,430	0	8,050	4,599	0	2,774	66	18,919
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**	**40,330**	**65**	**14,516**	**537**	**334,909**
Accumulated depreciation at 1 Apr 2008 as previously stated	0	11,088	188	0	19,038	63	6,681	452	37,510
Depreciation—prior period adjustment	0	(4,108)	(26)	0	0	0	0	0	(4,134)
Accumulated depreciation at 1 Apr 2008 as previously stated	0	6,980	162	0	19,038	63	6,681	452	33,376
Provided during the year	0	2,684	93	0	2,444	2	879	19	6,121
Disposal	0	0	0	0	(1,395)	0	0	0	(1,395)
Depreciation at 31 Mar 2009	**0**	**9,664**	**255**	**0**	**20,087**	**65**	**7,560**	**471**	**38,102**
Net book value									
Owned at 31 Mar 2009	50,000	206,314	1,014	5,256	19,512	0	6,956	66	289,118
Finance lease at 31 Mar 2009	0	0	0	0	0	0	0	0	0
Donated at 31 Mar 2009	0	6,958	0	0	731	0	0	0	7,689
NBV Total at 31 Mar 2009	**50,000**	**213,272**	**1,014**	**5,256**	**20,243**	**0**	**6,956**	**66**	**296,807**
Net book value at 31 Mar 2009									
Protected assets at 31 Mar 2009	50,000	209,915	1,014	0	0	0	0	0	260,929
Unprotected assets at 31 Mar 2009	0	3,357	0	5,256	20,243	0	6,956	66	35,878
Total at 31 Mar 2009	**50,000**	**213,272**	**1,014**	**5,256**	**20,243**	**0**	**6,956**	**66**	**296,807**

9. Net book value of assets held under finance leases contracts at the balance sheet date

9.1 Finance lease assets

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Dwellings	**2,001**	1,014	1,107
Plant and machinery	**490**	627	771

9.2 Total amount of depreciation charged to the income and expenditure account in respect of assets held under finance lease

	IFRS 2009/10 £000	IFRS restatement 2008/09 £000
Dwellings	**34**	93
Plant and machinery	**137**	144

10/10.1 Inventories

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Inventories			
Raw materials & consumables	**6,045**	6,588	6,002
Inventories recognised in expenses			
Write-down of inventories	**1,100**	0	0

11. Trade receivables and other receivables

11.1 Current receivables

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
NHS receivables	**13,483**	6,565	6,026
Provision for impaired receivables	**(2,736)**	(2,574)	(2,502)
Prepayments	**837**	458	684
Accrued income	**901**	312	766
Other receivables	**6,132**	6,657	5,016
Total current trade and other receivables	**18,617**	11,418	9,990

12. Provision for impairment of receivables

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
At 1 April	**2,574**	2,502	2,502
Increase in provision	**1,165**	195	0
Amounts utilised	**(54)**	(123)	0
Unused amounts reversed	**(949)**	0	0
At 31 March	**2,736**	2,574	2,502

12.1 Analysis of impaired receivables

Ageing of impaired receivables	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Up to three months	**133**	195	0
In three to six months	**678**	121	148
Over six months	**1,925**	2,258	2,354
Total	**2,736**	2,574	2,502

12.2 Ageing of non-impaired receivables past due date

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Up to three months	**9,184**	3,206	3,019
In three to six months	**913**	979	431
Over six months	**4,117**	1,488	0
Total	**14,214**	5,673	3,450

13. Trade and other payables

13.1 Current liabilities

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
NHS payables	**7,151**	7,798	6,116
Trade payables—capital	**395**	1,076	1,235
Accruals	**9,032**	10,036	6,187
Other payables	**5,277**	10,437	9,608
Other trade payables	**5,879**	0	0
PDC payable	**109**	0	0
Total current liabilities	**27,843**	29,347	23,146

13.2 Other liabilities

Current liabilities	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Deferred income	**4,863**	2,560	4,593
Total other current liabilties	**4,863**	2,560	4,593

13.2.1 Non-Current Liabilities

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Deferred government grant	**3,450**	3,100	0
Total other non-current liabilties	**3,450**	3,100	0

14. Borrowings

14.1 Current borrowings

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Loans from Foundation Trust Financing Facility	**756**	1,470	1,470
Obligations under finance leases	**163**	151	152
Other loans	**0**	0	3,124
Total current borrowings	**919**	1,621	4,746

14.2 Non-current borrowings

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Loans from Foundation Trust Financing Facility	**4,161**	9,560	11,030
Obligations under finance leases	**2,463**	2,627	2,802
Total non-current borrowings	**6,624**	12,187	13,832

15. Finance lease obligations

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Gross lease liabilities	**3,563**	3,827	4,124
of which liabilities are due:			
• not later than one year	**267**	264	260
• later than one year and not later than five years	**971**	1,093	1,114
• later than five years	**2,325**	2,470	2,750
	3,563	3,827	4,124
Less: finance charges allocated to future periods	**(937)**	(1,049)	(1,169)
Net lease liabilities	**2,626**	2,778	2,955
of which liabilities are due:			
• not later than one year	**163**	152	141
• later than one year and not later than five years	**646**	731	704
• later than five years	**1,817**	1,895	2,110

15.1 Finance lease commitments

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Minimum payments	**3,563**	3,827	4,124
Number of years of commitment	**18**	19	20

16. Provisions for liabilities and charges

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Pensions relating to other staff	**453**	440	408
Other provisions including short time employment benefit	**1,902**	1,833	5,161
Total provisions for liabilities and charges	**2,355**	2,273	5,569

	Pensions— other staff £000	Others including employee benefit £000	Total £000
At 1 Apr 2009	440	1,833	**2,273**
Arising during the year	29	69	**98**
Utilised during the year	(16)	0	**(16)**
Reversed unused	0	0	**0**
At 31 Mar 2010	**453**	**1,902**	**2,355**
Expected timing of cash flows:			
• not later than one year	41	1,855	**1,896**
• later than one year and not later than five years	48	0	**48**
• later than five years	364	47	**411**
Total	**453**	**1,902**	**2,355**

Clinical Negligence Liabilities

Amount included in provisions of the National Health Service Litigation Authority at 31 March 2010 in respect of clinical negligence of the Trust is £40.48m (2008/09—£31.32m).

17. Cash and cash equivalents

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Balance at 1 Apr 2009	**32,053**	35,894	35,894
Net change in year	**(12,192)**	(3,841)	0
Balance at 31 Mar 2010	**19,861**	32,053	35,894
17.1 Comprising:			
Commercial banks and cash in hand	**742**	67	16,815
Cash with Office of HM Paymaster General	**19,119**	31,986	19,079
Cash and cash equivalents as in statement of cash flows	**19,861**	32,053	35,894

18. Prudential Borrowing Limit (PBL)

	31 Mar 2010		31 Mar 2009	
	Authorised £000	Actual £000	Authorised £000	Actual £000
Total long term borrowing	**56,700**	**7,543**	38,100	13,222
Working capital facility	**20,000**	**20,000**	20,000	20,000
Total	**76,700**	**27,543**	58,100	33,222

		IFRS 31 Mar 2010		IFRS restatement 31 Mar 2009	
Financial ratios	**Prudential borrowing limits**	**Approved PBL ratio**	**Actual PBL ratio**	**Approved PBL ratio**	**Actual PBL ratio**
Minimum dividend cover (times)	>1.0x	**3.9x**	**2.7x**	2.9x	3.1x
Minimum interest cover (times)	>3.0x	**49.7x**	**38.5x**	29.6x	34.4x
Minimum debt service to revenue (%)	>2.0x	**5.7x**	**3.7x**	4.8x	5.1x
Maximum debt service to revenue (%)	<3.0%	**2.1%**	**2.0%**	2.1%	1.9%

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.

19. Revaluation Reserve

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Revaluation reserve at 1 Apr 2009—restated	**91,320**	91,040	91,040
Revaluation (losses)/gains and impairment losses on Property, Plant and Equipment	**(35,624)**	280	0
Revaluation reserve at 31 Mar 2010	**55,696**	91,320	91,040

20. Third party assets

The Trust held £0.05m cash at bank and in hand at 31 March 2010 (2008/09—£0.05m) which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

21. Contractual capital commitments

Commitments under capital expenditure contracts at 31 March 2010 were £0.5m (2008/09—£0.97m).

22. Post balance sheet events

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

23. Contingencies

There were no contingent liabilities at the balance sheet date.

24. 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.

25. Main commissioners

	IFRS 31 Mar 2010	
Main commissioners	**Income £000**	**Expenditure £000**
NHS Kensington and Chelsea	99,503	319
NHS Hammersmith and Fulham	37,637	64
NHS Westminster	23,883	29
NHS Wandsworth	27,255	396
Other government departments and central bodies:		
• HM Revenue & Customs	0	39,796
• NHS Business Services Authority	0	5,487
• NHS Litigation Authority	0	4,803

25.1 Main Commissioners	**Accounts Receivables £000**	**Accounts Payables £000**
NHS Kensington and Chelsea	3,301	30
NHS Hammersmith and Fulham	656	52
NHS Westminster	571	51
NHS Wandsworth	703	446
Other government departments and central bodies:		
• HM Revenue & Customs	0	3,449
• NHS Business Services Authority	0	425

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 the Charity's accounts independently of the Trust.

26. PFI schemes

The Trust is not party to any PFI schemes.

27. Losses and special payments

There were 68 cases of losses and special payments (2008/09—81 cases) totalling £0.06m (2008/09—£0.28m) for the year ended 31 March 2010.

28. Financial Instruments

IAS 32 (Financial Instruments: Disclosure and Presentation), IAS 39 (Financial Instrument Recognition and Measurement) and IFRS 7 (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 non NHS business entities.

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.

29. Categories of Financial Instruments

29.1 Financial assets

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Loans and receivables (including cash)	**37,642**	43,013	45,199
Total	**37,642**	43,013	45,199

29.2 Financial liabilities

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Other financial liabilities (amortised cost)	**34,262**	39,827	40,796
Total	**34,262**	39,827	40,796

30. Book values of financial assets & liabilites

	Book value		
	31 Mar 10 £000	**31 Mar 09 £000**	**1 Apr 08 £000**
Financial assets	**19,861**	32,053	35,894
Financial liabilities			
Finance leases obligation for more than 1 year	**2,463**	2,627	2,802
Loans due in more than 1 year	**4,161**	9,560	11,030
Total	**6,624**	12,187	13,832

30.1 Fair values of financial assets & liabilites

	Fair value		
	31 Mar 10 £000	31 Mar 09 £000	1 Apr 08 £000
Financial assets	**19,861**	32,053	35,894
Financial liabilities			
Finance leases obligation for more than 1 year	**2,463**	2,627	2,802
Loans due in more than 1 year	**4,161**	9,560	11,030
Total	**6,624**	12,187	13,832

As allowed by IFRS 7, 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.

31. Liquidity and interest risk tables

31.1 Financial assets

	Weighted avg interest rate (%)	Less than 1 year £000	1–2 years £000	2–5 years £000	More than 5 years £000	Total £000
Non-interest bearing		17,780	0	0	0	17,780
Fixed interest rate instrument	0.45%	19,861	0	0	0	19,861
Variable interest rate instrument		0	0	0	0	0
Gross financial assets at 31 Mar 2010		**37,641**	**0**	**0**	**0**	**37,641**
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 1 Apr 2009		**43,013**	**0**	**0**	**0**	**43,013**

31.2 Financial liabilities

	Weighted avg interest rate (%)	Less than 1 year £000	1–2 years £000	2–5 years £000	More than 5 years £000	Total £000
Non-interest bearing		24,441	0	0	0	24,441
Finance lease liability	3.50%	267	271	699	2,327	3,564
Fixed interest rate instrument	4.85%	756	756	756	2,649	4,917
Provisions under contract		1,867	42	42	327	2,278
Gross financial liabilities at 31 Mar 2010		**27,331**	**1,069**	**1,497**	**5,303**	**35,200**
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	4.92%	1,482	1,482	4,446	4,060	11,470
Gross financial liabilities at 1 Apr 2009		**27,772**	**1,611**	**4,854**	**6,530**	**40,767**

32. Interest rate risk

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

33. 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 2010. Details are included in note 18.

34. 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.

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.

35. Operating segments

The Board of Directors is of the opinion that the Trust's operating activities fall under the single heading of healthcare for the purpose of operating segments disclosure.

IFRS 8 requirements were considered and the Trust has determined that the Chief Operating Decision Maker is the Trust Board of Chelsea and Westminster Hospital NHS Foundation Trust.

It is the responsibility of the Trust Board to formulate financial strategy and approve budgets. Significant operating segments that are reported internally are the ones that are required to be disclosed in the financial statements.

There is no segmental reporting for revenue, assets or liabilities to the Trust Board. Expenditure is reported by segment to the Trust Board. However those segments fully satisfy the aggregation criteria to be one reportable segment as per IFRS 8.

Therefore all activities of the Trust are considered to be one segment, 'Healthcare', and there are no individual reportable segments on which to make disclosures.

36. Transition to IFRS

	Retained earnings £000	Revaluation reserve £000	Donated asset reserve £000	Government grant reserve £000	Total £000
Taxpayers' equity at 31 Mar 2009 under UK GAAP	**29,289**	**91,320**	**7,472**	**0**	**128,081**
Adjustments for IFRS changes:					
Leases	42				**42**
Employee benefits	(1,785)				**(1,785)**
Adjustments for:					
UK GAAP errors*	6,670		221		**6,891**
Taxpayers' equity at 1 Apr 2009 under IFRS	**34,216**	**91,320**	**7,693**	**0**	**133,229**

Surplus/(deficit) for 2008/09 under UK GAAP	9,634
Adjustments for:	
Leases	(12)
Employee benefits	(427)
Adjustments for:	
UK GAAP errors*	2,668
Surplus/(deficit) for 2008/09 under IFRS	**11,863**

* Depreciation of £6.891m relating to residual value of the buildings has been adjusted as a UK GAAP error in the Accounts. The adjustment has been reflected in the IFRS 2008/09 restatement and 1 April 2008 opening balance for the prior year element. £4.134m relates to prior year which has been adjusted in the 1 April 2008 opening balance as follows: increase to Income and Expenditure Reserve £4.002m; increase to Donated Assets Reserve £0.132m and increase to Property, Plant and Equipment £4.134m. The depreciation relating to 2008/09 was adjusted as follows: £2.668m in the restated 2008/09 Operating Surplus and £0.089m in Donated Assets Reserve.

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