Annual Report & Accounts 2011/12

Choose Chelsea and Westminster

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Chelsea and Westminster Hospital NHS Foundation Trust

Annual Report & Accounts 2011/12

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

Contents

Introduction

About this report

Our annual report sets out our strategy, reports back on our performance against strategic objectives and national targets, and presents information about our service and financial performance transparently and honestly. The structure is as follows.

- **Introduction**
  Statements by the Chairman and Chief Executive and an Executive Summary
- **Our Values**
  'Who do you think WE are?'—developing and defining our values

  'It's who we are'—embedding and living our values
- **Strategy**
  Including our vision, values, performance against corporate objectives 2011/12, and details of our corporate objectives 2012/13
- **Quality Report**
  Written in consultation with our Governors and other key local stakeholders
- **Directors' Report**
  Our performance against national targets and other quality measures
- **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
- **Finance**
  Including the Accounts

Credits

This annual report has been produced in-house by the Communications Department of Chelsea and Westminster Hospital NHS Foundation Trust.

The Quality Report section was compiled by Catherine Mooney (Director of Governance & Corporate Affairs) and Melanie Van Limborgh (Head of Quality & Assurance) with copywriting by Caroline White.

Thank you to staff throughout the Trust who contributed to the Quality Report.

Thank you also to members of the Council of Governors Quality Sub-Committee, including elected Governors and representatives of Kensington and Chelsea Local Involvement Network (LINk), who helped to shape it.

Chairman's statement

The last year was a busy and challenging one for the Trust but highly successful.

However, we must not be complacent, in particular because the proposed reconfiguration of NHS services in North West London is a potential threat to the future of Chelsea and Westminster.

We must redouble our efforts to make a compelling case for why we should retain a full A&E service and thus safeguard our future as a major hospital during the public consultation which is due to start in Summer 2012.

In March 2010 the Trust Board agreed a three-year *Fit for the Future* programme to maintain and improve the quality of patient care while making significant efficiency savings.

Quality can be divided into three areas—patient safety, clinical effectiveness and patient experience—with the aim of providing the best possible care to patients.

As a clinician, I am delighted that the Dr Foster Hospital Guide 2011 named us as the safest hospital in England. Chelsea and Westminster was the only hospital with low mortality rates across four mortality indicators in this independent healthcare guide.

The four indicators were overall mortality, mortality within 30 days of leaving hospital, post-operative deaths, and deaths in conditions where this is not expected such as asthma.

This independent recognition of the quality and safety of our services is a significant achievement of which our staff can be justly proud.

Our *Fit for the Future* programme aims to ensure that the Trust takes a planned, strategic approach to the challenges of the economic downturn and the need for the NHS in North West London to reduce its costs by £1 billion over three years.

We made 10% cost savings in 2010/11 and a further 9% cost savings in 2011/12.

I would like to thank Trust Chief Executive Heather Lawrence and the rest of the Executive team, as well as all staff, for achieving these cost savings to ensure that we retain the financial stability that has enabled us to invest in improvements to patient care.

Financially, things will be no easier this year as the Trust Board has agreed a further 8% cost savings.

Our 14,000 patient, public and staff Foundation Trust members—as well as their elected representatives on the Council of Governors—play an important role in the life of the hospital and have recently helped us develop our values.

The process of defining our values and the staff behaviours associated with them began at a joint Council of Governors and Board of Directors away day in November 2011.

It continued with the 'Who do you think WE are?' consultation in February 2012, which many Governors and members participated in. We launched our values at the hospital Open Day in May 2012 which was attended by more than 2,000 people.

Members also attended our Annual Members' Meeting in great numbers and our new 'Medicine for Members' seminars are proving popular.

All this activity demonstrates the important role that our hospital plays in the local community and the commitment of our patients, local community and staff to Chelsea and Westminster Hospital.

This year it is particularly important that I say thank you to some of the key individuals on the Board of Directors who have underpinned our success.

Our Chief Executive Heather Lawrence will be leaving us at the end of June 2012 after 12 hugely successful years during which she has demonstrated outstanding leadership, working with the Board and all staff to make Chelsea and Westminster one of the best performing and most highly regarded NHS trusts in the country.

It has been a pleasure for me to work with Heather since I joined the Trust as Chairman in November 2007. She is dedicated, caring and among the most competent and experienced leaders in the NHS, as at home talking to patients and staff on the wards as she is in the Boardroom.

Heather led the Trust to Foundation Trust status and we are now reaping the benefits thanks to investments in significant improvements to patient care which culminated this year with the opening of new facilities in the Chelsea Children's Hospital and HIV and Cancer Unit.

Heather led the Trust to Foundation Trust status and we are now reaping the benefits thanks to investments in significant improvements to patient care

We have appointed Heather's successor. He is Tony Bell OBE who is currently the Chief Executive of Liverpool and Broadgreen NHS Trust. His appointment was approved by the Council of Governors in May 2012 and he will join the Trust in September 2012.

Tony comes to us with a track record of success as Chief Executive of two major NHS trusts in Liverpool and 30 years' experience of working in healthcare, having originally trained as a nurse.

Deputy Chief Executive Amanda Pritchard left the Trust in April 2012 to take up a new post as Chief Operating Officer at Guy's and St Thomas' NHS Foundation Trust. Amanda played a key role in the success of the Trust since her appointment in September 2006. I would like to thank her for that contribution and wish her well in the future.

Our Deputy Chair Charlie Wilson's term of office as a Non-Executive Director came to an end in October 2011. He made an outstanding contribution to the Board and, as an ex-Editor of *The Times*, his expertise in communications and the media was invaluable. I would like to thank Charlie for all he did for the Trust over many years.

Two other Non-Executive Directors, Colin Glass and Andrew Havery, also left the Trust Board. I thank them for their help and expert input over several years.

We have been very fortunate to recruit three outstanding replacements in Sir John Baker, Sir Geoffrey Mulcahy and Jeremy Loyd. Sir John has also been appointed Vice Chair and Senior Independent Director.

I am sure that you will want to join me in welcoming our new Non-Executive Directors and our new Chief Executive.

I have every confidence that Tony Bell will be able to build on Chelsea and Westminster's reputation as one of the best NHS trusts in the country, together with our Executive team.

I believe that the Trust has a very bright future under Tony's leadership despite the challenges we face due to the planned reorganisation of services in North West London and the continued need to make significant cost savings and improve our efficiency.

Professor Sir Christopher Edwards
Chairman

Chief Executive's statement

After 12 rewarding and hugely enjoyable years as Chief Executive, I will be leaving Chelsea and Westminster at the end of June 2012.

This was not a decision that I took lightly because on a personal level I feel a strong attachment to Chelsea and Westminster.

I feel very privileged to have been able to work with so many talented and dedicated staff who have succeeded in making Chelsea and Westminster one of the best NHS trusts in the country.

It is thanks to the hard work and expertise of these staff, including our contractors, that the Trust consistently ranks as one of the best providers of high quality clinical care nationally. This was demonstrated by the Dr Foster Hospital Guide 2011 naming Chelsea and Westminster as the safest hospital in England.

However, like every other public and private sector organisation, we face the challenge of how to do more for less. We must maintain and improve our services for patients while making efficiency savings.

Our financial stability enabled us to become a Foundation Trust in 2006 which in turn has given us the flexibility to invest in significant improvements to patient care. This culminated in the opening during 2011/12 of our state-of-the-art new Paediatrics and HIV and Cancer facilities.

Meeting the challenge of doing more for less is a team effort and we have tried to foster a culture of innovation that encourages staff at all levels and from all professions to come forward with ideas that improve patient care.

Our new staff initiative Directors' Den received a tremendous response from staff when it was launched in October 2011 and the panel of judges awarded funding for five schemes ranging from a children's website to training for staff in ultrasound-guided biopsy skills.

Our Star Awards for staff, which were launched in March 2012 thanks to sponsorship by Chelsea and Westminster Health Charity, demonstrated the high esteem in which our staff are held with almost 800 nominations from staff, patients and Governors.

The Star Awards presentation evening at Chelsea Football Club in May 2012 was a celebration of all that is best about Chelsea and Westminster.

Thanks to our staff, we met all major national performance targets. We treated 95% of outpatients and 90% of inpatients within 18 weeks, saw and treated 98% of A&E patients within four hours, and reduced rates of MRSA bacteraemia and *Clostridium difficile*.

Although the vast majority of patients taking part in the latest national inpatient, outpatient, maternity and paediatric surveys rated their treatment as 'Excellent', 'Very good' or 'Good', I want all patients to have an excellent experience at Chelsea and Westminster.

We must improve the patient experience and our efforts continue to be focused on the key areas of communication, discharge and care of older people.

Amanda Pritchard, the Trust's Deputy Chief Executive, left us in April 2012 to become Chief Operating Officer at Guy's and St Thomas' NHS Foundation Trust. This was testament to her abilities and a reflection of the fact that Chelsea and Westminster has been able to attract staff of a very high calibre.

I was sad to see Amanda go but I would like to congratulate her on her appointment and to say thank you for all her support during our time working together.

I am proud to have led Chelsea and Westminster over the last 12 years and I know that the Trust will go from strength to strength under the leadership of a new Chief Executive, Tony Bell, who inherits from me an excellent Executive team, a supportive and highly respected Chairman, and most importantly a fantastic team of talented staff.

Heather Lawrence

Heather Lawrence OBE
Chief Executive

Executive Summary

Who we are

Chelsea and Westminster Hospital NHS Foundation Trust became a Foundation Trust in 2006 and is a major London acute teaching hospital trust.

We treat more than 360,000 patients every year and more than 3,000 people work at Chelsea and Westminster including staff employed directly by the Trust, facilities staff employed by contractors, and hospital volunteers.

The Trust provides specialist services including paediatric and neonatal surgery, HIV and sexual health, high risk obstetrics, burns, bariatric surgery and many more to patients from London, the South East and beyond, general services for the local community, and an increasing number of services provided in the community.

Independent assessments and national awards

Chelsea and Westminster was assessed by the independent Dr Foster Hospital Guide 2011 as the safest hospital in England because we were the only hospital in England with low mortality rates across all four mortality indicators measured by this annual independent healthcare guide—see case study on the next page for more information.

The quality of the patient environment at Chelsea and Westminster was confirmed by our 'Excellent' ratings for hygiene, hospital food, and privacy and dignity in the Patient Environment Action Team (PEAT) annual assessment 2011.

We earned national recognition for the quality of our clinical services in the *Health Service Journal* Awards 2011, winning an award as a key partner in the North West London Integrated Care Pilot, being highly commended for our Acute Oncology Service, and shortlisted for Research Culture.

We also won independent recognition as an employer. The Trust was named Best Employer for Carers and in the top 30 employers in the UK by the Top Employers for Working Families Awards 2011 and shortlisted for Best Internal Communications in the HR Excellence Awards 2011.

The work of our staff was recognised by other national awards:

- Our staff flu vaccination campaign 'I've had mine. Have you had yours?' won a Flu Fighter Award from NHS Employers in November 2011 and was shortlisted for the Chartered Institute of Public Relations (CIPR) Excellence Awards 2012
- The Trust website www.chelwest.nhs.uk was shortlisted for the Chartered Institute of Public Relations (CIPR) Excellence Awards 2012
- The Trust was shortlisted for the CHKS Patient Safety Award in 2011 and 2012 based on indicators including infection and mortality rates
- A campaign run by 56 Dean Street, the Trust's HIV and sexual health centre in Soho, to encourage people to have an HIV test on World AIDS Day 2011 won the 'Health Communication Campaign of the Year' category of the *British Medical Journal* Improving Health Awards 2012
- 56 Dean Street's 'HIV—Closer Than You Think' campaign to increase the uptake of HIV testing won the 'Public Sector, Value for Money' category of the Public Relations Consultants Association (PRCA) Awards 2011 and the 'Best Budget Campaign' category in the Chartered Institute of Public Relations (CIPR) Excellence Awards 2011
- The Trust was shortlisted in the 'Rewards and Benefits' category of the *Personnel Today* Awards 2011

Key Fact

Chelsea and Westminster is the safest hospital in England, as measured by four mortality indicators included in the Dr Foster Hospital Guide 2011

- Chelsea and Westminster and our partners in the Fulham Road Collaborative were highly commended in the 'Procurement Initiative of the Year' category for health and social care organisations of the National Government Opportunities Excellence in Public Procurement Awards 2012 for the shared services contract for 'Soft Facilities Management (FM)' services including catering, cleaning and portering
- Chelsea and Westminster surgeons Mr Naresh Joshi and Mr Andy Williams were named in *The Times* 'Britain's Top Surgeons' list published in December 2011
- Internationally renowned HIV expert Professor Brian Gazzard was awarded a CBE for services to healthcare in the Queen's Birthday Honours published in June 2011

Case Study

Trust receives special award from Dr Foster

Tim Baker, Chief Executive of Dr Foster International, visited Chelsea and Westminster Hospital in January 2012 to present a special award following the Trust's strong performance in the Dr Foster Hospital Guide 2011, an annual independent healthcare survey.

Chelsea and Westminster was the only hospital in England with low mortality rates across all four mortality indicators in this independent healthcare survey.

The Hospital Guide said: "This is an impressive achievement and warrants a special mention."

Heather Lawrence, Chief Executive of Chelsea and Westminster Hospital NHS Foundation Trust, said: "I want to thank every member of staff at Chelsea and Westminster who has played their part in helping us to earn this independent recognition of our commitment to quality and safety."

Independent surveys of patients and staff

Independent national surveys show high levels of patient satisfaction with our services:

- 89% of adult inpatients rate their care as 'Excellent', 'Very good' or 'Good'
- 96% of women using our maternity services during pregnancy say their care is 'Excellent', 'Very good' or 'Good'
- 96% of parents rate their child's outpatient care as 'Excellent', 'Very good' or 'Good' and 93% rate their child's inpatient care as 'Excellent', 'Very good' or 'Good'

Our staff also rate us highly in the NHS staff survey:

- 80% of staff would recommend the Trust to family and friends for treatment
- 70% of staff would recommend the Trust to family and friends as a place to work

Public support and interest—the Chelsea and Westminster brand

More than 10,000 patients and members of the public have chosen to become members of our Foundation Trust and we engaged with them to define the Trust's values through our 'Who do you think WE are?' consultation campaign in February 2012.

The Trust's annual Open Day is a major public event which attracts more than 2,000 people, our website has 70,000 'hits' a month, and more than 1,300 people now follow us on Twitter.

Our profile in the media was raised this year by the BBC3 documentary series *Junior Doctors: Your Life in Their Hands* which was filmed at Chelsea and Westminster—2.5 million people watched each episode.

Financial stability—*Fit for the Future*

The Trust achieved a Cost Improvement Programme of £19.7 million (9% of controllable costs) in 2011/12 and delivered a surplus of £13.6 million.

Our financial stability is due to the success of our three-year *Fit for the Future* programme to improve the quality of patient care while delivering significant cost savings.

Research and innovation

Chelsea and Westminster is a key partner in the new Academic Health Science Partnership for North West London (Imperial College Health Partners) which aims to develop innovative solutions and translate research into practice to improve the quality of healthcare and health outcomes for patients.

The Trust recruited more than 5,000 patients into clinical research studies in 2011/12. We also host three organisations that drive research and innovation:

- **National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Northwest London**—aims to embed research findings into clinical practice as quickly as possible
- **North West London Health Innovation and Education Cluster (HIEC)**—enables the quick uptake of innovative technologies and services through education and training
- **Training for Innovation (TFI)**—helps to create and disseminate innovative training tools to accelerate the adoption of new healthcare technologies in the NHS

Key Fact

Our services are increasingly popular with parents and children

Our children's services treated 80,299 patients in 2011/12 compared with 74,876 in 2010/11

Redevelopment of Chelsea and Westminster Hospital—*Putting Patients First*

The *Putting Patients First* programme has used our surplus and financial freedoms as a Foundation Trust to invest in a major redevelopment to improve services for patients and secure our future as a specialist hospital.

Prime Minister David Cameron and Deputy Prime Minister Nick Clegg both visited our new Outpatients department in 2011.

Secretary of State for Health Andrew Lansley called it "a new development which encapsulates the spirit of the modern NHS" when he officially opened the new facility.

Other key milestones have included the opening of four new paediatric theatres and a paediatric High Dependency Unit—as part of the development of the new Chelsea Children's Hospital—and the opening of a new HIV and cancer unit.

Case Study

New services for children now open

The latest stage in the development of the new Chelsea Children's Hospital at Chelsea and Westminster was reached in February 2012.

Two new children's operating theatres opened—bringing the total to four new theatres for children—together with an extended High Dependency Unit, day surgery ward and expanded surgical recovery area.

This was the second phase in the development of the new Chelsea Children's Hospital following the opening of two children's operating theatres and surgical admissions and pre-assessment areas in September 2011.

Mr Simon Eccles, Clinical Director for Children's, Neonatal and Young People's Services, said:

"The opening of these new facilities is a hugely significant landmark in our development of the new Chelsea Children's Hospital.

"Over the next 18 months an integrated paediatric service will be created on the 1st Floor of the hospital including upgraded wards and a relocated outpatients department. Our aim is that by the end of 2013 the 1st Floor will be home to what amounts to a new children's hospital."

In recognition of the scale of the development we have renamed our children's services as Chelsea Children's Hospital. The name and logo were chosen following a consultation exercise with patients, parents and staff.

Our Values

‘Who do you think WE are?’—developing and defining our values

The Trust developed and defined its values so that patients know what to expect when they are cared for at Chelsea and Westminster and staff know what is expected of them in terms of how we treat patients and each other as staff colleagues.

We began the process of developing our values with a joint Council of Governors and Board of Directors away day in November 2011, led by Non-Executive Director Jeremy Loyd and Chief Nurse and Director of Patient Experience and Flow, Thérèse Davis.

An initial ‘longlist’ of 30 values was reduced to a shortlist of 12 to be consulted on with our key stakeholders.

In February 2012 the Trust launched its ‘Who do you think WE are?’ consultation during which staff, patients and the public people were invited to vote for their top four values and to take part in focus groups and drop-in sessions in the hospital.

A total of 130 people attended 10 focus groups and 802 people voted for their values.

The results were analysed and a recommendation for the Trust’s four chosen values was presented at the Board of Directors meeting in March 2012.

The Board of Directors agreed the Trust’s values should be:

- Safe
- Kind
- Excellent
- Respectful

Our chosen values ensure a balance between ‘hard’ and ‘soft’ values while retaining ‘patient-focused’ as being central to everything that we do as an organisation and as individual members of staff.

The Trust’s values were launched officially at the annual hospital Open Day on Saturday 12 May 2012 when visitors were invited to get involved by helping to create special graffiti artwork

‘It’s who we are’—embedding and living our values

Following agreement of the Trust’s values by the Board of Directors, they have been widely publicised through the ‘It’s who we are’ campaign.

Our values were launched officially at the annual Chelsea and Westminster Hospital Open Day on 12 May 2012 which was attended by more than 2,000 people.

Staff wore T-shirts emblazoned with the four values and visitors to the Open Day were invited to get involved in the creation of an original piece of art by a graffiti artist to bring the values to life.

Chelsea and Westminster Star Awards

The Trust presented its first Chelsea and Westminster Star Awards on 14 May 2012 to recognise the outstanding individuals and teams of staff who make the greatest difference to our patients and hospital.

Almost 800 nominations were received from staff, patients and Foundation Trust Governors in March 2012.

More than 170 staff attended the awards evening at Chelsea Football Club in May 2012 when BBC presenter Sophie Raworth presented 17 Staff Choice awards (staff nominated by staff), the Patient Choice Award (staff nominated by patients), the Council of Governors Special Award (staff nominated by Governors), and the Chief Executive’s Special Award.

The winners of the Star Awards embody the Trust’s values, as demonstrated by the nominations they received:

Healthcare Assistant of the Year

Shanaz Khanom (Healthcare Assistant, Acute Assessment Unit)

“Shanaz is a shining example, she is so kind and caring to our patients and she is always polite and helpful”

Midwife of the Year

Emily Beonke

“As the lead for the vaginal birth after Caesarean service, Emily has helped to lower our planned Caesarean rate and improved the experience of women in our care”

Nurse of the Year

Marylin Joseph-Apple (Staff Nurse, Fracture Clinic)

“Marylin is a nurse who is dedicated to her job and I have seen many patients touched by her care”

Doctor of the Year

Dr Nick Fauvel (Consultant Anaesthetist)

“Nick works incredibly hard to improve quality of care for patients, often in areas that may go unnoticed such as the safe use of medical gases”

Diagnostic and Allied Health Professional of the Year

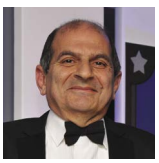
Tom McBride (Senior Orthopaedic Practitioner, Fracture Clinic)

“Tom is great with his patients, particularly the elderly and young children, and he has a unique ability to make them feel at ease—Tom is one in a million”

ISS Facility Services Healthcare Star of the Year

Manu Bahadur-Ghimire (Healthcare Cleaner, A&E Department)

“Manu takes real pride in his work in A&E, he is one of the team and well respected by everyone”



Scientist of the Year

Dr Berge Azadian (Director of Infection Prevention & Control)

“Berge is always supportive in times of crisis and encourages high standards... he is also approachable and easy to talk to”

Researcher of the Year

Professor Mark Bower (Consultant Medical Oncologist)

“Mark has improved the chances of patients with HIV-related cancers surviving by doing many research trials that have resulted in improved patient care—and he has also inspired a generation of young doctors to pursue a career in academic medicine”

Frontline Support Services Star of the Year

Aaron Frimley (Receptionist, Fracture Clinic)

"Aaron works hard and always cheers up the Prep Room"

Behind the Scenes Support Services Star of the Year

Graham Henry (Business Analyst, Finance)

"Graham is a financial star, not only does he keep us on top of managing our budget but he is always full of ideas about how we could do things differently"

Manager of the Year

Alan Kaye (Head of Diagnostics)

*"**A**—Amazing*
__L__—Loyal
__A__—Approachable
__N__—Never shies away from a challenge"

Team of the Year

Porters

"The Porters are the unsung heroes of the Trust, working hard to contribute to the smooth running of the hospital, and they are always cheerful even under pressure"

Most Improved Department of the Year

Edgar Horne Ward (Staff Nurse Grace Nabiryo accepted award)

"Ward Sister Sian Davies should be proud of how they are developing and growing as a team to improve care for patients"

Volunteer of the Year

Claudia Thompson (Volunteer, Intensive Care Unit)

"Claudia's contribution to our unit is invaluable, over the past 12 years she has so generously devoted her time to assist in the smooth running of the unit—she is our star!"

Educator/Mentor of the Year

Barry Jubraj (Lead Pharmacist for Academic Studies & Professional Development)

"Barry is a truly inspirational educator and mentor... he is empathetic and supportive to staff and someone who they can turn to in a crisis"

Outstanding Leadership Award

Mitch Haines (Matron, Medicine & Surgery)

"Mitch is a role model to other nurses, never afraid to deliver care himself, and visionary about the contribution that nurses can make in delivering high quality care"

Improving the Patient Experience Award

Vivien Bell (Head of Midwifery and General Manager, Maternity Services)

"Viv has led the Maternity service in consistently striving to improve the patient experience while engaging staff in continuing service improvements"

Patient Choice Award

Sacha Newman (Clinical Nurse Specialist, Gynaecology)

"When I had a potentially embarrassing and difficult examination, Sacha made it bearable and was kind and respectful at all times"

Council of Governors Special Award

Lesley-Anne Marke (Sister, David Erskine Ward)

"Lesley-Anne is very dedicated and caring, a special person, who has initiated many innovations on her ward including care rounds every two hours"

Chief Executive's Special Award

Dr Neil Soni (Consultant Anaesthetist)

Heather Lawrence presented her Special Award to Dr Soni to recognise his long service and outstanding contribution to patient care, teaching and research.

Strategy

Our strategic approach

Vision

The Trust's strategic vision in 2011/12 was:

"To deliver safe and sustainable care of the highest quality and to be the provider of choice 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."

Strategic priorities

Our strategic priorities in 2011/12 to support delivery of this vision were:

- To maintain and develop our key clinical specialties to secure our future both in terms of financial sustainability and reputation
- To explore opportunities for growth
- To ensure sustainability

Strategic developments

Developments in support of the Trust's strategic vision and priorities in 2011/12 included:

- A £40 million redevelopment of the hospital continued—it included the completion of the Netherton Grove extension which is a two-storey extension to the 1st and 2nd Floors of the hospital to help the Trust achieve its 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 HIV and oncology services
- A £9.8 million project to overhaul the hospital's energy infrastructure was undertaken and completed in April 2012—this transformation of the way in which electricity, heating and cooling is supplied to the hospital will reduce the Trust's carbon footprint, make us self-sufficient in terms of the power needed to keep services running smoothly, and significantly reduce our energy expenditure
- We continued to expand our portfolio of community services by winning a competitive tendering process to provide community musculoskeletal (MSK) services in Kensington and Chelsea in partnership with an independent sector provider, Connect Physical Health
- The North West London Integrated Care Pilot (ICP) to improve the care of diabetes patients and people aged over 75, won the 'Managing Long Term Conditions' category of the *Health Service Journal* Awards 2011
- We implemented a new senior nursing and management staffing structure, in line with the Trust's three clinical divisions, to improve multi-disciplinary clinical leadership and increase efficiency

Performance against corporate objectives

Corporate Objective 1: Improve patient safety and clinical effectiveness

- The Trust was named as the safest hospital in England in the Dr Foster Hospital Guide 2011, as the only hospital in England with low mortality rates across all four mortality indicators measured by this annual independent healthcare survey
- The Trust was shortlisted for the CHKS patient safety award 2012, a national award based on criteria including infection and mortality rates
- We met a national target to assess 90% of inpatients for their risk of venous thromboembolism (VTE) but we did not achieve our quality objective to have no hospital acquired preventable VTE—there were 10 cases in the measurement period of July 2011–January 2012
- The Trust achieved compliance with NHS Litigation Authority (NHSLA) risk management standards at Level 2—a key measure of patient safety
- We met Monitor's infection prevention targets of no more than three MRSA cases during the year (we had two cases) and no more than 31 cases of *Clostridium difficile* (we had 17 cases)
- We achieved our target to operate on 90% of emergency surgery patients within the agreed timescale for urgent (within 24 hours) and expedited (within four days) surgery

Corporate Objective 2: Improve the patient experience

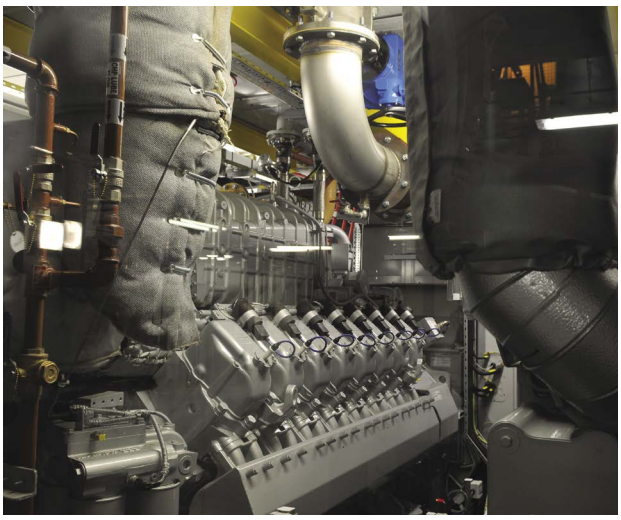
- Divisional action plans to improve the patient experience focused on the three key areas of communication, discharge and care of older people:
    - **Communication**
      We produced new patient information leaflets about common conditions and treatments, and new patient information booklets for inpatient wards, and we also introduced a 'patient passport' for people with learning disabilities
    - **Discharge**
      We introduced weekly meetings where clinical staff, the discharge team and staff from community teams plan the discharge from hospital of patients with more complex needs
    - **Care of older people**
      We piloted individual 'wellbeing rounds' by senior nursing staff on a medical ward, provided specialist training for 200 clinical staff to recognise the signs of dementia and meet the needs of patients with this condition, and introduced a 'Request a volunteer' service for patients to be befriended and supported by volunteers
- We achieved our targets of remaining in the top 20% of acute trusts nationally for staff engagement and being in the top 20% for well-structured staff appraisals, as measured by the national staff survey, but we were not in the top 20% for the proportion of staff appraised or for the proportion of appraised staff with personal development plans

Corporate Objective 3: Deliver excellence in teaching and research

- The Trust is a founder partner of the Academic Health Science Partnership (AHSP) for North West London which aims to bring together providers of primary, secondary, tertiary, community and mental healthcare to work with Imperial College London to pursue higher quality care for patients
- We raised the profile of Chelsea and Westminster as a teaching hospital and increased public understanding of the ongoing education of junior medical staff by participating in the BBC3 documentary *Junior Doctors: Your Life in Their Hands*
- We continued to implement the Trust's Research Strategy and developed synergies and joint working between the National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Northwest London and the North West London Health Innovation and Education Cluster (HIEC)
- We reduced the average length of time taken to grant permission for new clinical research studies from an average of 70 days in July 2011 to 13 days in March 2012

Corporate Objective 4: Ensure financial and environmental sustainability

- We achieved the financial plan for 2011/12 by delivering a Cost Improvement Programme of £19.7 million and achieving a surplus for the year of £13.6 million which was £5.2 million ahead of plan
- We improved our performance on environmental sustainability by:
    - Undertaking a £9.8 million Infrastructure Project, completed in April 2012, to reduce our carbon footprint and improve our energy efficiency
    - Gaining Trust Board approval of a Carbon Purchasing Strategy so that sustainability is considered in the evaluation of products and services purchased by the Trust



We have modernised our engineering infrastructure to make the hospital more energy efficient

Our strategic approach

Vision

The Trust's strategic vision in 2012/13 is the same as in 2011/12:

"To deliver safe and sustainable care of the highest quality and to be the provider of choice 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."

Values

The Trust Board approved our values following consultation with Governors, Foundation Trust members, patients, staff and other key stakeholders:

- Safe
- Kind
- Excellent
- Respectful

Our values define what patients should expect when they are cared for at Chelsea and Westminster and how all staff can help meet these expectations.

Strategic priorities

Maintaining and developing our key clinical specialties

- Maintain our key specialties to secure our future both in terms of financial sustainability and reputation
- Engage fully in the *Shaping a healthier future* public consultation on service reconfiguration in North West London and develop the Trust's response to ensure the best outcome for Chelsea and Westminster
- Support services that are subject to externally driven opportunities and challenges including HIV, Cancer and Burns because there is a drive in North West London and across London for greater centralisation of specialist services
- Influence the review of tertiary Paediatrics in North West London to secure a positive outcome for patients and Chelsea Children's Hospital
- Develop a high quality clinical space to accommodate diagnostic services in a single location in the hospital—the Diagnostic Centre will be developed this year with capacity to accommodate the anticipated growth in demand for endoscopy services

Exploring opportunities for growth

- Work in collaboration with partners in North West London on a number of priority projects through the Academic Health Science Partnership
- Proactively develop business propositions in areas that are likely to grow in the years to come including community services
- Grow private patient income through short-term and long-term opportunities, following changes to the cap on private patient activity
- Respond to tenders from commissioners and initiate service developments in line with our strategic priorities, with the aim of growing and strengthening our service portfolio

Ensuring sustainability

- Develop and embed our values through the 'It's who we are' project to improve the patient and staff experience
- Maintain financial and environmental sustainability through initiatives such as the Infrastructure Project and focus on the potential sharing of 'back office' functions with other partner organisations
- Drive efficiency by building on the successful first wave of service line reviews in 2011/12

Corporate objectives

Corporate Objective 1: Improve patient safety and clinical effectiveness

- Have no hospital acquired preventable venous thromboembolism (VTE)
- Ensure that at least 75% of emergency general medical and surgical patients are seen by a consultant within 12 hours of the decision to admit or within 14 hours of their arrival at the hospital
- Achieve the Trust's and commissioner's quality indicators targets including further reductions in the levels of healthcare acquired infections

Corporate Objective 2: Improve the patient experience

- Continue to focus on communication, discharge and the care of older people
- Remain in the top 20% of acute trusts nationally for staff engagement and staff appraisals, as measured by the national NHS staff survey, and ensure that our agreed Trust values inform everything that we do
- Further improve our facilities through the creation of a Diagnostic Centre and the rest of our capital refurbishment programme
- Continue to focus on ensuring that we meet waiting time targets for all our patients

Corporate Objective 3: Deliver excellence in teaching and research

- Join the Academic Health Science Partnership (AHSP) for North West London to improve patient care by benefiting from greater co-ordination of research, training and education
- Work closely with the new Local Education and Training Board (LETB) to retain our place as a leading provider of education and training
- Foster synergies between the National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Northwest London, the North West London Health Innovation and Education Cluster (HIEC) and Training for Innovation (TFI)
- Implement the Trust's Research Strategy and continue to build upon the Trust's research capacity and capability to support improved patient outcomes

Corporate Objective 4: Ensure financial and environmental sustainability

- Deliver a financial risk rating of 4 (where 0 is 'high risk' and 5 is 'low risk') and a Cost Improvement Programme (CIP) of £16.2 million
- As part of the CIP work:
    - Ensure a significant focus on improvements in productivity and efficiency through the application of new ways of working, operating at top quartile/decile productivity levels and implementing improvements in clinical pathway management (eg the management of long term conditions)
    - Deliver minimum cost savings of 1% of turnover through improved procurement
    - Improve our environmental sustainability by exceeding the NHS national target of 10% carbon reduction by 2015

Quality Report

About this report

What is a Quality Report?

All providers of NHS services in England have a statutory duty to produce an annual report to the public about the quality of services they deliver. This is called the Quality Report.

Quality Reports aim to increase public accountability and drive quality improvement within NHS organisations. They do this by getting organisations to review their performance over the previous year, identify areas for improvement, and publish that information, along with a commitment to you about how those improvements will be made and monitored over the next year.

Quality consists of three areas which are key to the delivery of high quality services:

- Patient safety
- How well the care provided works (clinical effectiveness)
- How patients experience the care they receive (patient experience)

> Quality Reports aim to increase public accountability and drive quality improvement within NHS organisations.

Some of the information in a Quality Report is mandatory but most is decided by patients and carers, Foundation Trust Governors, staff, commissioners, regulators, and our partner organisations, collectively known as our stakeholders.

denotes items explained in glossary

Scope and structure of the Quality Report

This report summarises how well Chelsea and Westminster Hospital NHS Foundation Trust did against the quality priorities and goals we set ourselves for 2011/12. It also sets out those we have agreed for 2012/13, and how we intend to achieve them.

This report is divided into four sections, the first of which includes a statement from the Chief Executive and looks at our performance in 2011/12 against the priorities and goals we set for patient safety, clinical effectiveness and patient experience.

If we have not achieved what we set out to do, we explain why, and outline how we intend to address these areas for improvement.

The second section sets out the quality priorities and goals for 2012/13 for the same categories, and explains how we decided on them, how we intend to meet them, and how we will track our progress.

The third section sets out how we identify our own priorities for improvement and provides examples of how we have improved services for patients. It also includes performance against national priorities and our local indicators.

The fourth section includes statements of assurance relating to the quality of services and describes how we review them, including information and data quality. It also includes a description of audits we have undertaken and our research work. We have also looked at how our staff contribute to quality.

The annexes at the end of the report include the comments of our external stakeholders including:

- Inner North West London Primary Care Trusts (PCTs)
- Kensington and Chelsea Local Involvement Network (LINk)
- Royal Borough of Kensington and Chelsea's Health, Environmental Health, and Adult Social Care Scrutiny Committee
- Council of Governors

This is where you will also find a glossary of terms used and information on the various committees and steering groups referred to throughout this report.

If you or someone you know needs help understanding this report, or would like the information in another format, such as large print, easy read, audio or Braille, or in another language, please contact our Director of Governance and Corporate Affairs by calling 020 3315 6599 or emailing cathy.mooney@chelwest.nhs.uk.

About the Trust

Chelsea and Westminster Hospital NHS Foundation Trust provides general and specialist services for half a million people living in the four local boroughs of Kensington and Chelsea, Westminster, Hammersmith and Fulham, and Wandsworth. In addition, the Trust also provides specialist tertiary services to patients from a wider area in a range of specialties.

The Trust is a modern, purpose-built facility with more than 3,000 staff. It has three clinical divisions which are outlined in more detail in Annex 6.

Most services are provided on the Chelsea and Westminster Hospital site, but the Trust also runs a highly successful network of community HIV and sexual health centres, dermatology clinics, and community maternity services across our four local boroughs. Additionally, we provide women's reproductive health (gynaecology) services in Richmond and Twickenham.

The hospital also has the busiest and most extensive HIV and sexual health service in Europe based in three different centres. As part of this, a new HIV and Cancer Unit opened in February 2012.

Chelsea Children's Hospital is a key part of the Trust, being the specialist children's centre for paediatric and neonatal surgery in North West London, leading the network of care for paediatric surgery. We admitted nearly 12,000 children last year, with a dedicated Children's A&E department and High Dependency Unit. High risk maternity patients are cared for in the Trust's Maternity Unit and our Neonatal Intensive Care Unit provides specialist neonatal services.

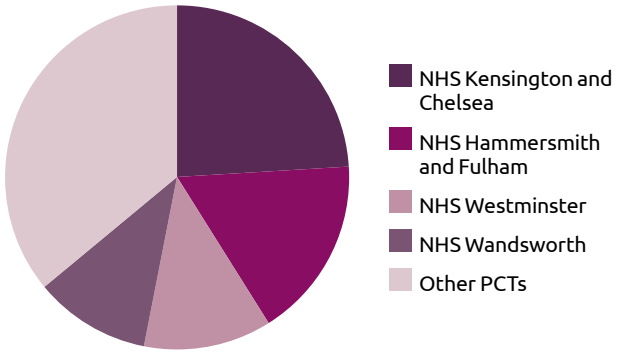
The Trust is one of two centres providing weight loss surgery services for London and the South East and we are the regional burns centre for London for adults, with a unit for children. Around 450 burns patients were admitted in 2011/12.

In 2011/12 there were approximately 446,000 outpatient consultations, including around 105,000 for HIV/sexual health services. There were approximately 46,800 admissions, 23,000 day cases and 5,900 births.

The Trust completed a major £9.8m Infrastructure Project in April 2012 to upgrade the main engineering system of the hospital and will start to deliver savings in 2012/13 as a result of energy efficiencies. Work to provide a new Diagnostic Centre will start in Summer 2012.

Monitor, the independent regulator of NHS Foundation Trusts, has given the Trust a rating of 'green' (the best rating) for governance, and a rating of 5 for financial risk (which is the lowest level of risk).

Outpatient attendances by local Primary Care Trusts



Chelsea and Westminster is the only hospital in the UK to gain official accreditation by the Museums, Libraries and Archives Council (MLA) for its art collection

Part 1: Our priorities for quality improvement 2011/12

Statement on quality from the Chief Executive

This Quality Report sets out the approach we are taking to improve quality at Chelsea and Westminster Hospital and how we are translating this into improvements in patient care and clinical outcomes.

We promote a safe environment for patients and staff and aim to be a learning organisation.

We are also working at a time of financial constraints in the NHS and it has never been more important to focus on our patients' experience of their care and evidence of clinical effectiveness to continually improve quality.

We must ensure that the quality of our clinical services is not compromised by the need to work more efficiently. Our commitment to this principle underpins our corporate objectives:

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

This year we were privileged to have our commitment to quality recognised with a number of achievements:

- We were the only hospital in England with low mortality rates across all four mortality indicators in the Dr Foster Hospital Guide, an annual independent healthcare survey published in November 2011
- We received an 'Excellent' rating for the three categories of Environment, Food, and Privacy and Dignity in the annual Patient Environment Action Team (PEAT) assessment
- We achieved our challenging targets to further reduce the number of cases of both MRSA bacteraemia and *Clostridium difficile*
- National surveys of inpatient, outpatient, maternity and paediatric care showed that levels of patient satisfaction with the quality of our services remained consistently high

Perhaps most telling of our commitment to quality were the results of the NHS staff survey published in March 2012. This showed that 80% of our staff (compared to a national average of 63% of NHS staff) would recommend the hospital to their family and friends as a place to be treated.

The Care Quality Commission (CQC) undertook an unannounced visit of the Trust in February 2012. Their assessment was very positive and it was confirmed that the Trust is meeting all the essential standards of quality and safety. We were delighted and proud that the CQC reported that "people who use the service told us they were happy, felt that they were well looked after and that staff were attentive and caring".

I have said many times that the care we provide for our patients should be the same as we would expect for our loved ones and this endorsement of our services by the people who provide it speaks volumes.

The efforts of all of our staff have contributed to our achievements and my hope is that they feel proud of our collective success in our pursuit of excellence.

Of course there is always room for improvement and the pursuit of quality is a constant journey, but I hope you will agree that it is important to celebrate our successes.

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

Heather Lawrence

Heather Lawrence OBE
Chief Executive
28 May 2012

Priority 1 (Patient Safety):
To have no hospital associated preventable venous thromboembolism (VTE)

Venous thromboembolism, or VTE for short, is an umbrella term for potentially serious blood clots called deep vein thrombosis (DVT) and pulmonary embolism (PE). A DVT usually develops in the leg or pelvis. Sometimes part of the blood clot breaks off and ends up in the lung (PE) where it can block the blood supply. This can be fatal.

The risk of developing VTE is heightened after surgery and/or periods of immobility, and in certain conditions such as pregnancy or advanced cancer. Around half of all cases arise in patients who have recently been in hospital. Around one third of patients will develop VTE despite the best care, but in two thirds of these patients a VTE can be avoided with preventive treatment, including the use of compression stockings and appropriate medicine.

Although we have made improvements we have not yet achieved our target and we have kept this priority for 2012/13.

What we said we would do in 2011/12

- Set up a system for finding out which patients developed a VTE associated with their admission but who had not been given appropriate preventive treatment, and analyse the reasons (root cause analysis [RCA]).
- Produce guidance for doctors and nurses on the correct fitting of compression stockings, to ensure that patients who wear them are adequately monitored.

What we actually did

- From July 2011, for any patient with a VTE associated with a hospital admission (classified as during admission or within the preceding 90 days), we carefully reviewed all the steps we took to find out if the appropriate preventive actions had been taken (RCA).
- We produced new good practice guidelines for frontline staff on caring for patients wearing compression stockings, and provided extensive nurse training. We formally checked whether stockings were being fitted correctly and patients were being properly monitored.
- We introduced monthly audits on each of the adult wards to find out how many patients receive appropriate preventive treatment.
- We introduced monthly VTE ward rounds on the maternity wards to check that women had been screened and offered appropriate preventive treatment.
- We updated the online procedure for assessing VTE risk so that pregnant women could be screened during outpatient clinics.

> We monitor the number of patients who are screened for their risk of VTE, and since October 2010 we have achieved the national target of more than 90%

How did we do in 2011/12?

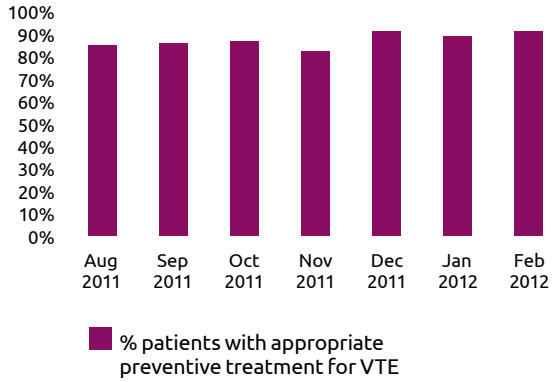
So far, we have measured the number of VTEs between July 2011 and January 2012 and we have identified 10 VTEs that we may have been able to prevent. Following an in-depth analysis (RCA) we found that most of these patients missed one or two days of their medication to prevent VTE.

We also learned from an RCA of the case of a pregnant woman who developed a deep vein thrombosis. Pregnant women are now screened for VTE at the outpatient clinics they attend.

We monitor the number of patients who are screened for their risk of VTE, and since October 2010 we have achieved the national target of more than 90%.

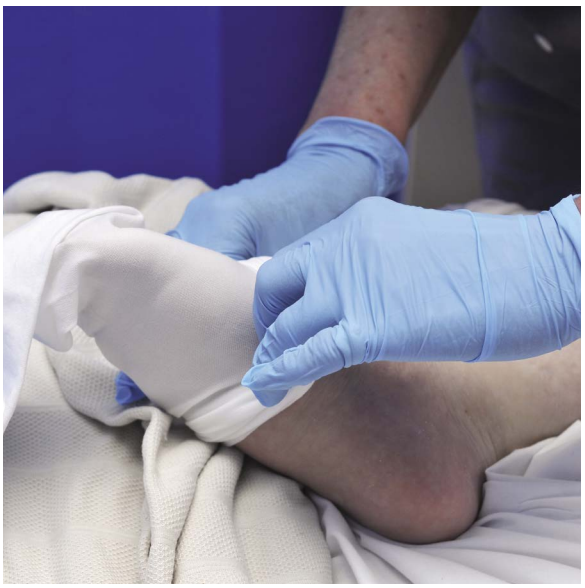
Since August 2011 we have performed monthly audits of medication on each ward to find out how many patients received appropriate preventive treatment and most did.

Monthly medication audit on VTE prevention



We did an audit to find out if patients were having their compression stockings fitted and checked daily. Of 15 patients wearing compression stockings on an orthopaedic surgery ward on a day in April 2012, 60% of patients had a completed stockings monitoring form. Of these patients, 100% had correct fitting recorded, more than 50% had their legs checked daily, and the remainder had them checked on average every other day.

Patients are also being told about the risks of VTE. An audit carried out between mid-June and the end of August 2011 to find out how many patients had been given an information leaflet on VTE at their preoperative assessment showed that all 20 patients had been.



Priority 2 (Patient Experience):
Focus on three key areas: communication, discharge planning, and care of older people

Analysis of responses to the national inpatient survey, and complaints and concerns raised by patients about aspects of their care, prompted us to focus on communication, discharge planning, and the care of older people. Despite some positive responses to the inpatient survey the areas where we did not do so well remain as communication and discharge. As a result, we will continue to focus on improvement in these areas. These themes will run through each of the divisional action plans for improving the patient experience.

What we said we would do in 2011/12

Communication

- Set up 'campaign groups' to monitor progress
- Make sure that patients are given clear and accurate information about their diagnosis and treatment

Discharge planning

- Look at setting up consultations with a senior member of staff immediately before discharge, and following up the next day by phone
- Look at how to reduce readmission rates

Care of older people

- Set up 'wellbeing' ward rounds for the over 75s
- Make sure that we detect dementia in patients when they are admitted so that their specific needs are met appropriately

What we actually did

Communication

- We established 'campaign groups' within each division to monitor progress
- We produced an additional 40 clearly and simply written patient leaflets on a range of conditions and treatments, as well as approximately 20 'easy read' versions for patients with learning disabilities

- We used 'patient diaries' on a general medical ward and in intensive care to record key information and events as a reference for patients
- We produced information booklets for wards, eg medicine and surgery wards have already produced leaflets on six out of eight of their wards, explaining who everyone is and what routinely happens on a ward
- We introduced a 'patient passport' for patients with a learning disability to make sure their needs are communicated effectively between different groups of staff—this has been extended to David Erskine Ward

Patient quote

"I cannot speak highly enough of the professional and kind care I received... in the ward and in the Pre-op assessment and Pre-surgery information group. This is such a good idea as it gives patients greater confidence about what is going to happen and the opportunity to ask questions."

—LCR, David Evans Ward

Patient Diaries on the Intensive Care Unit (ICU)

Patient diaries are started for patients who have been in ICU longer than 72 hours. All nurses caring for the patients document a daily diary of their progress, including visitors and even events outside the ICU.

It has shown to benefit the patients by filling in the gaps of their memory, as the majority do not remember their ICU experience. Many suffer with depression, nightmares and flashbacks after they leave hospital. The diary is a resource to help make sense of what they do remember and aids the recovery process.

When the patient has been discharged from hospital, they are invited back with their family members and are presented with the diary, and their primary nurse goes through it with them

Discharge planning

- Nurses are following up by phone with patients after they have been discharged in some areas but we need to focus on pre-discharge consultations

What defines a patient experience as good or bad?

The evidence shows that successful organisations in the healthcare sector devote considerable effort in understanding what defines a patient's experience as either good or bad. So we asked small teams of staff, patients and other interested parties to follow patients with common conditions throughout their journey of care looking for a range of clues that might signal a good or bad experience.

The findings have been fed back to each of the three divisions and linked to their action plans for improving the patient experience. Some of these clues relate to issues across the whole Trust, and will feed into projects such as the wayfinding project.

In February 2012, staff, patients and their relatives were also asked to help us identify a set of four key values and associated behaviours to inform everything we do at the Trust, with a view to improving the consistency of our approach.

- We have introduced weekly meetings, attended by clinical staff, the hospital discharge team, and representatives from the community team to plan the discharge of those with more complex needs

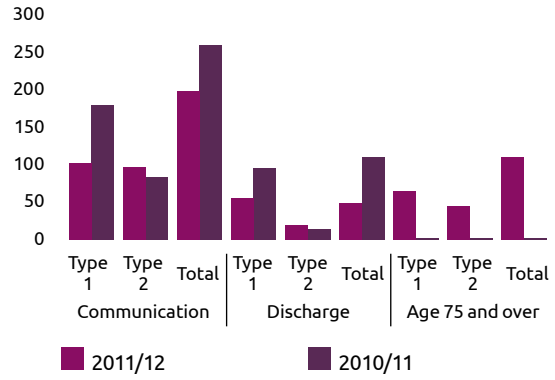
Care of older people

- We have conducted a trial of 'wellbeing' rounds on a medical ward to see whether this improves us being able to meet the needs of patients in a more timely way
- 200 staff including therapists, nurses and doctors have received training on recognising the signs of dementia and meeting the particular needs of patients with this condition
- We are now screening all A&E patients over 75 and also all patients over 75 who are admitted to hospital, for signs of dementia—patients are then referred to the memory assessment service in consultation with their GP or the older person's psychiatric liaison team and their care plan ensures that their stay in hospital is as safe and as comfortable as possible

How did we perform in 2011/12?

We measured our progress by looking at the number of complaints we received about communication, discharge planning, and those relating to the care of older patients. Type 1 complaints are also known as concerns and are raised informally through the Membership and Patient Advice & Liaison Service (M-PALS) while Type 2 complaints are managed through the Trust's formal complaints process.

Comparison of complaints, 2010/11–2011/12



This shows that complaints for communication have decreased by 24% and for discharge by 55%. The category for age 75 and over is new this year.

We also looked at responses to the national inpatient survey which showed that 89% of respondents rated their overall care as 'Good', 'Very Good', or 'Excellent'.

The table below shows the areas in which we have significantly improved since the 2010 survey, and it compares our performance with the average from 73 other trusts that conduct these particular surveys.

National Inpatient Survey—areas of significant improvement since 2010 (lower scores are better)

Reference	Question	2010	2011	Average
A4	A&E: not given enough privacy during examination or treatment	30%	23%	22%
A12	Planned admission: not given printed information about condition or treatment	26%	17%	20%
B2+	Hospital: mixed sex sleeping area	25%	9%	8%
B7+	Hospital: mixed sex bathing facilities	28%	17%	13%
B9	Hospital: bothered by noise at night from other patients	46%	40%	38%
B15	Hospital: no posters or leaflets asking patients to wash their hands or use disinfectant gels	8%	3%	5%
J9+	Religious beliefs: not always able to practice in hospital	27%	16%	17%

For discharge, the percentage of patients who said that they were not given completely clear written/printed information about medicines has reduced by 12% and is significantly better than average for all NHS trusts.

Also, the percentage of patients who would recommend this hospital to family and friends is significantly better than average.

"How can I help you?"

The M-PALS (Membership and Patient Advice & Liaison Service) team offers:

- Confidential advice and support to patients, families and their carers
- Information on NHS services and health related queries
- A place to hear and record concerns, suggestions, queries and compliments
- Confidential assistance to resolve concerns
- Explanations about the complaints procedure
- Information or patient leaflets in an alternative format or language

M-PALS act as a liaison between the patient, their relatives and friends with our hospital services to find solutions to concerns or queries. They aim to negotiate swift and prompt solutions to informal issues to contain and resolve these rapidly and to the patients' satisfaction.

Priority 3 (Patient Experience):

To remain in the top 20% of acute trusts nationally for staff engagement and to be in the top 20% for staff appraisals as measured by the NHS staff survey

A growing body of evidence shows that there is a direct link between a satisfied and engaged workforce and the quality of care that staff provide to patients.

Why do appraisals matter?

An appraisal provides the opportunity to reflect on how well individuals have met agreed targets and objectives over the past year and identify any training needs and areas for personal development, in a structured and supportive way.

We have made good improvements on this priority; although we did not achieve everything we set out to do, so we will be continuing our focus on our staff throughout 2012/13.

What we said we would do in 2011/12

- Continue to provide opportunities for staff to meet with the Chief Executive and senior management in face-to-face briefings and staff forums
- Introduce a competition to encourage staff to come up with innovative ideas to improve patient care
- Introduce a new standardised approach to improve the quantity and quality of appraisals and personal development plans

What we actually did

- We have continued to provide regular opportunities for staff to meet with the Executive team, members of whom visit specific areas of the Trust each month, and the Chief Executive holds monthly team briefings for all staff
- We launched the Directors' Den initiative in October 2011 to encourage frontline staff to come up with ideas to improve quality and efficiency with the best ideas funded to put them into practice with Director support
- We redesigned the appraisal form to make it easier to use and to be clearer about personal development planning

How did we perform in 2011/12?

The NHS staff survey results published in March 2012 show that the Trust improved its score for staff engagement. We achieved 3.81 out of a maximum 5 points, meaning that we remain in the top 20% of acute trusts nationally. The Trust not only improved its score for good communication between senior managers and staff but also came top out of all acute trusts nationally.

We wanted to increase the appraisal rate from 75% to 84% of staff, the percentage that are well-structured from 39% to 41%, and the percentage of staff appraised with a personal development plan from 68% to 72% which would place us in the top 20% of acute trusts nationally.

- The proportion of staff appraised rose to 80%
- The proportion of staff who reported having a well-structured appraisal rose to 46% which is the highest figure achieved by any London acute trust and keeps us in the top 20% nationally
- The proportion of staff appraised with a personal development plan rose from 68% to 72% which was higher than average but not in the top 20%

Priority 4 (Clinical Effectiveness):
To reduce the wait for emergency surgery by 10% and the time spent 'nil by mouth' and to give patients and relatives better information

In 2010/11 we reclassified our emergency surgery targets, to reduce the time patients wait for their operation:

- **Immediate**—within 60 minutes of booking (eg life-threatening bleeding, blockage of the airway)
- **Urgent**— within 24 hours of booking (eg stable non-complex appendicitis, simple abscess)
- **Expedited**—within four working days of booking (eg small lacerations, fractures where swelling needs to settle before surgery)

In 2011/12 we wanted to reduce waiting times further and to improve other aspects of the patient experience in emergency surgery.

What we said we would do in 2011/12

- Increase the availability of emergency operating theatres at the weekend with an extra emergency surgery session on Saturday afternoons
- Reduce the wait for adult emergency surgery by moving children's emergency surgery during normal working hours to the new Chelsea Children's Hospital operating theatre suite
- Tell patients what to expect and let them and their relatives know when there are delays
- Cut the length of time patients have to spend without eating or drinking before their surgery (nil by mouth)
- Make sure that a relevant consultant approves the scheduling of emergency surgery for every patient who needs it to improve quality and safety

What we actually did

- We introduced a second emergency surgery list on Saturday afternoon
- The opening of the new children's operating theatre suite reduced the wait for adult emergency surgery and enabled us to operate on children more quickly, four further emergency surgery lists will be added in the children's suite from April 2012
- We designed a leaflet about emergency surgery and anaesthesia for patients and their relatives
- We redesigned our administration systems to include 'nil by mouth' prompts so that we review patients regularly and make sure they don't have to go without food or drink before surgery for any longer than is necessary, however we need to measure whether this has been effective in cutting the length of time patients are 'nil by mouth'
- Since June 2011 the responsible consultant surgeon/consultant anaesthetist must approve the decision to operate/agree the anaesthesia to be used before the patient is booked for surgery/anaesthetised—an audit showed that this was happening in around half of cases and we are re-enforcing the importance of this practice and will re-audit in September 2012
- We did better on how we collected and analysed our data to make it easier to spot any delays by making some of the data collection more automatic

How did we perform in 2011/12?

The following table shows the proportions of patients operated on within the time frames required for cases categorised as immediate (within 60 minutes), urgent (within 24 hours), and expedited (within four days).

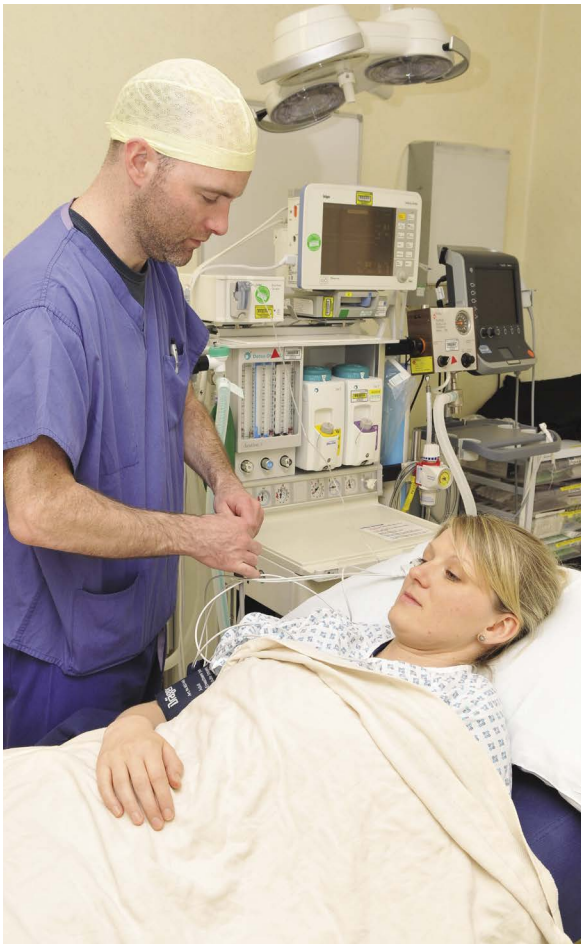
	Q1 (Apr–Jun 2011)	Q2 (Jul–Sep 2011)	Q3 (Oct–Nov 2011)	Q4 (Jan–Mar 2012)
Immediate (within 60 minutes)				
Cases within our standard	2	4	7	4
Total Immediate cases	3	4	9	4
% within our standard	66%	100%	78%	100%
Urgent (within 24 hours)				
Cases within our standard	699	693	695	717
Total Urgent cases	723	738	749	749
% within our standard	97%	94%	93%	96%
Expedited (within 4 days)				
Cases within our standard	295	319	317	297
Total Expedited Cases	304	322	319	299
% within our standard	97%	99%	99%	99%

This shows that we achieved our target within the range that we had set for urgent and expedited categories which were the majority of cases.

We first started improving the quality of care for emergency surgery patients in 2009. Our first audit in 2010 showed that we had already achieved our standards for more than 90% of patients.

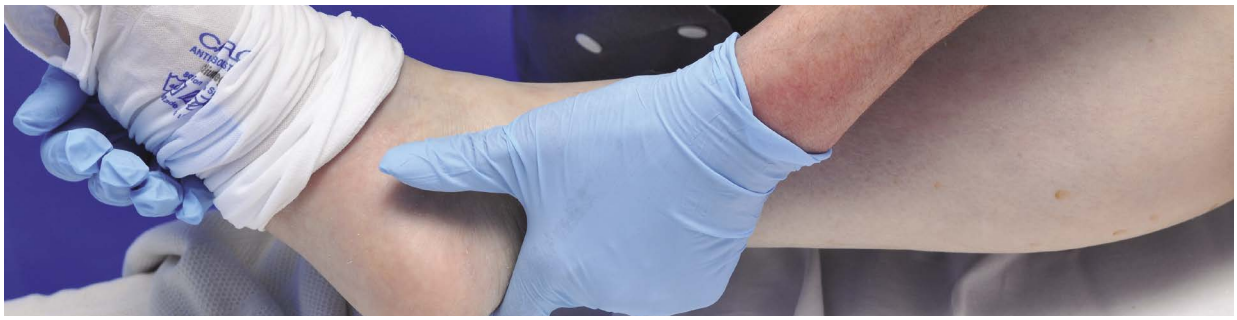
Since then, we have continued to perform at this level or better, so in 2010/11 we planned a 10% reduction in the average waiting time instead. The drawback is that patients do not queue in a 24-hour system—only the most critical, life-saving surgery is carried out between midnight and 8am. Although appropriate for patient safety, this skews the average waiting time figure, which is not affected by shortening the wait at other times of the day. We therefore did not find this measure useful.

Given the significant progress made already, our stakeholders have agreed this will no longer be a priority for 2012/13, but we will continue to monitor our progress on surgery waiting time, information to patients and 'nil by mouth' waiting times, and report to the Trust Executive Quality Committee and Assurance Committee.



Part 2: Our priorities for quality improvement 2012/13

Priority 1 (Patient Safety):
To have no hospital associated preventable venous thromboembolism (VTE)



Why is this important?

Around half of all cases of venous thromboembolism (VTE) occur in patients who have recently been admitted to hospital. VTE is one of the most common preventable causes of hospital deaths, accounting for more than 25,000 deaths in England every year.

We can help prevent VTE occurring by providing preventive treatment, including the use of compression stockings and appropriate medicines.

We have kept this priority from last year because, although we have made good progress, we have not yet achieved our target.

What will we do in 2012/13?

- We will continue to ensure that we meet our target of 90% of all patients admitted having a risk assessment for VTE
- We will continue to offer our patient information leaflet—'Are you at risk of blood clots?'—to all patients admitted to hospital, all pregnant women, and all patients attending A&E requiring a plaster cast
- We will continue to check which patients with preventable VTE associated with their hospital stay or occurring within three months of admission did not receive appropriate preventive treatment
- We will continue to undertake root cause analysis (RCA) in these cases and pinpoint what action we need to take to make sure that patients receive appropriate preventive treatment in future
- We will continue to monitor how many patients on each ward receive appropriate preventive treatment and ensure that we focus on those areas that are falling short
- We will create an online training module on VTE prevention and treatment for all doctors working in the Trust to complement the training modules we already have for nurses, to ensure that all frontline staff are aware of the preventive treatments we use in this hospital and help us standardise training

How will we track progress?

We will track progress by continuing to review the number of adults who are assessed for their risk of VTE when they are admitted to hospital, those patients who acquire a VTE that could have been prevented, and check every month how many were given appropriate preventive treatment.

Our target is to reduce the number of preventable VTEs to nil and we will monitor the numbers every month. We will achieve this target through education and training, ensuring risk assessments are undertaken and that every patient identified to be at risk of VTE is offered appropriate preventive treatment (compression stockings and/or medicines). We will also monitor the uptake of training, risk assessments being undertaken, patient information leaflets being given out, and preventive treatment being used.

How will progress be reported?

Progress will be reported at the Thrombosis and Thromboprophylaxis Committee and at the Trust Executive Quality Committee and the Assurance Committee.

Priority 2 (Patient Experience):
Continue to focus on communication, discharge planning, and the care of older people

Why is this important?

We have made improvements in all three areas over the past year but our national inpatient survey results show that there is still room for improvement in these areas.

What will we do in 2012/13?

We will communicate the agreed Trust values of respectful, kind, safe and excellent, and the related behaviours to staff, patients and their families as well as our other stakeholders.

This will tell everyone what is expected and help drive improvement in all our key areas below. We will ensure these values are part of everything we do as described in our next priority.

Communication

- Improve the content, presentation and timeliness of appointment letters
- Produce information on ward routines for all adult inpatients which will be laminated and attached to each bedside locker

Discharge planning

We are setting up a discharge project and will agree with stakeholders how to measure success. We will however:

- Aim to improve the co-ordination of discharge with primary and community care teams, and so reduce the length of stay and readmissions for patients with complex needs
- Continue to look at setting up consultations with a senior member of staff immediately before discharge, and following up the next day by phone

Care of the older person

- The evidence suggest that the 'wellbeing' rounds are linked to a fall in complaints and a decrease in the number of falls and so we will roll out 'wellbeing' ward rounds to all adult inpatient areas
- We will continue to monitor our performance against the essential standards of quality and safety relating to privacy and dignity through the senior nursing and midwifery clinical rounds
- We will continue monthly audits of nutritional screening and continue to develop other measures to ensure our patients are well fed eg volunteer mealtime support
- We will continue to provide training in dementia for nurses, therapists and doctors—this objective is linked to a CQUIN £ payment

How will we track progress?

We will continue to monitor complaints within each division against these three themes as part of our patient experience strategy. We will initiate quarterly patient experience surveys based on a number of key questions.

For each of the objectives above we have agreed how we will measure progress and how often.

How will progress be reported?

Progress will be reported through the Trust Executive Quality Committee and Assurance Committee.

Priority 3 (Patient Experience):

To be in the top 20% of acute trusts nationally for staff engagement and staff appraisals as measured by the NHS staff survey and to ensure our agreed Trust values inform everything that we do

Why is this important?

Research shows that there is a clear link between satisfied staff and the quality of patient care they deliver. Motivated and engaged staff feel more able to come up with innovative ideas to improve quality and efficiency at work. And they are more likely to want to stay working for us and to provide high quality care.

We have developed a set of four core values—respectful, kind, safe and excellent—which have been agreed with staff and patients, to underpin everything we do at the Trust. We are in the process of describing the behaviours that reflect these values in everyday practice so that our approach is consistent across the Trust and patients know what to expect.

What will we do?

- Hold the first Chelsea and Westminster Star Awards in May 2012 to recognise staff achievements
- Increase appraisal rates to at least 87% and the percentage of staff appraised with a personal development plan (PDP) to 75% which will put us in the top 20% of acute trusts
- Increase the percentage of staff reporting a well-structured appraisal to at least 50%
- Every member of staff will receive written confirmation of our Trust values by the end of June 2012
- We will review all aspects of staffing policy, including recruitment, appraisal, and training in light of these values and take action to amend practice

How will we track progress?

We will measure the staff engagement score in the NHS staff survey, including whether staff would recommend the Trust as a place to work and be treated, and the areas relating to communication. We will look for improvements in the 16 questions in the national inpatient survey where we scored below the national average, in light of our four key values.

We will monitor appraisal rates every month and undertake regular checks on the quality of appraisal documentation.

How will progress be reported?

Internal appraisal rates, the staff survey action plan and progress on translating the Trust's values into everyday behaviours will be reported through the Trust Executive Quality Committee and the Assurance Committee.

Priority 4 (Clinical Effectiveness):

At least 75% of emergency general medical and surgical patients to be seen by a consultant within 12 hours of the decision to admit to hospital or within 14 hours of their arrival at the hospital

Why is this important?

Last year we were the only hospital in England with low mortality rates across all four mortality indicators in the Dr Foster Hospital Guide. However, we recognise that there is more we can do to improve all aspects of patient care and safety.

Guidance from professional bodies shows that consultant-led care for emergency patients is critical to rapid decision-making of appropriate treatment, maintaining standards and improving the patient's care and journey through hospital. This is why we are committed to ensuring that emergency patients at our hospital are seen by a consultant within 12 hours of admission.

Feedback and analysis of complaints data show that involving consultants earlier in a patient's care can improve their satisfaction with, and confidence in, the care they receive. And our own figures show that we tend to discharge fewer patients at weekends which means we are not making the most efficient use of our staff and bed space.

What will we do?

- For our emergency medical and general surgical patients we will ensure that there are consultant-led ward rounds occurring twice a day, in the morning and in the evening, including weekends
- This will allow us to ensure that all emergency medical and general surgical patients are seen within 12 hours of their admission at all times

How will we track progress?

Our Electronic Patient Record (EPR) system (known as Lastword) has the potential to capture when a patient is reviewed, and by whom. We will investigate how we can use this system to monitor how well we meet our target and plan to use it from Summer 2012 onwards.

We think this will help improve patients' care and experience while also shortening hospital stays.

How will this be reported?

Progress will be reported to the Trust Executive Quality Committee and the Assurance Committee.

Part 3: Review of quality performance

How the Trust identifies local improvement priorities

The Trust is committed to understanding and responding to what patients tell us about their experiences of care at the Trust, and there are several ways in which we actively solicit the views of our stakeholders to determine our priorities for quality improvement.

As a Foundation Trust we have the benefit of a well-established and active Council of Governors. The Council represents the views of patients, public and staff, to ensure that their views and experiences are heard.

Governors hold frequent 'Meet a Governor' sessions for this very reason. And they regularly take part in senior nurse and midwife clinical rounds to find out for themselves how care is delivered to patients.

When things are not right, they make a note of them, and check to see what progress has been made to rectify them at subsequent visits. In their role as a 'critical friend' the Governors are consulted on many aspects of the hospital's activities and may participate in the work of teams set up to carry forward particular projects. The perspective they bring is invaluable.

The Council of Governors Quality Sub-Committee is an important source of views and feedback and has a specific remit to help identify priorities for quality and advise us on the content and focus of the Quality Report and plans for quality improvement.

Members include patients, a representative from the Kensington & Chelsea Local Involvement Network and our main commissioning group. They not only feed back the experiences of those they represent but their own, where relevant.

This group has had a key role in agreeing the Trust's patient experience strategy, in particular the focus on discharge planning. They have also agreed the 2012/13 priorities and what local performance indicators we will measure.

We seek clinicians' views via the Trust Executive Quality Committee. And we take an inclusive approach to business planning, ensuring that all staff have the opportunity to be involved in the process.

The feedback from open meetings with staff and Governors during business planning has informed the content of the Quality Report. For example, several staff mentioned the importance of measuring how well we look after the nutritional needs of our patients, prompting our dietitians to include a range of measures.

We also have several mechanisms for more focused discussions on specific areas. For example, we involved more than 800 patients, staff and Governors in developing our values during our 'Who do you think WE are?' consultation campaign in February 2012.

The various patient forums in the Trust influence how we design and deliver our services with an emphasis on quality.

They represent specific areas and include the Patient Environment Action Team, Maternity Services Liaison Committee, HIV Patient Forum, Paediatric Forum and the Learning Disabilities Steering Group.

Equality and Diversity

Our Single Equality Scheme sets out the Trust's approach to equality and diversity, both as a provider of quality healthcare services and as an employer.

Examples of the scheme in action in 2011/12 include:

- Appointments Office letters provided in different languages
- Telephone translation services for patients whose first language is not English
- Information on outpatient clinic TV screens in the six most commonly spoken languages among local residents served by the Trust
- Meeting the Trust target on staff equality and diversity training

The Trust has also been working on a new set of equality objectives, which replace the Single Equality Scheme from April 2012, following the passage into law of the Equality Act 2010.

We have considered the various sources of feedback and have continually tested our proposals for the priorities, local indicators, and other content of the quality report, with our staff and stakeholders to get agreement.

The key issues raised have been addressed in our Quality Report and in our plans for 2012/13.

Patient Forums in action

The Learning Disabilities Forum works with carers and others who understand the needs of these patients.

Ways in which patients have been helped include a communication booklet for staff working with Learning Disabilities patients to help them talk to patients with learning needs, and the group has bought two recliner chairs so that carers can stay next to patients at night and have a good sleep.

Your role

We welcome your views too. The Trust's website now has an interactive dedicated section on quality and safety at www.chelwest.nhs.uk/transparency. You can also give your feedback in this section.

Quality matters to us

Our three clinical divisions have been working hard to drive up the quality of services they deliver for patients over the past year, focusing on patient safety, the patient experience, and clinical effectiveness.

The examples on the following pages show how those themes make a difference in practice.

Patient Story

"Tess was admitted to Chelsea and Westminster Hospital with uncontrolled seizures at the end of March. We were automatically given a cubicle which turned out to be crucial in terms of managing Tess' admission and I was given a bed which enabled me to care for Tess. Our visit was an example of true partnership work, I was able to stay with her, and hospital staff learned from us how to work with Tess.

"I am Tess' mother, I am realistic! I realise that I cannot expect hospital staff to know my daughter in the way I or the staff who work with her on a daily basis do. But what happened during Tess' two week stay was that we were able to share our expertise of how to enable, comfort, care for, love and ultimately have fun with Tess with all of the staff on the ward, this includes people who clean, who deliver meals, who take bloods, as well as nurses and doctors.

"I have come to the conclusion that it is simply by osmosis and leading example that people with learning disabilities including those with complex health needs like Tess will access good healthcare. It's up to the people who know them well and medical staff to honestly work together, to leave their egos, budgets, departments etc outside the door and put people like Tess at the centre of everything we do.

"I have seen a wonderful team of people working in a very stressful environment with huge responsibility for all people in their care, in what seemed to me at times like being on the frontline of a war zone (I don't mean this in a bad way)—simply they never knew what type of case was coming through their door.

"The staff team on the Acute Assessment Unit, and by 'team' I mean, cleaners, meal time hostesses, care assistants, phlebotomists, nurses and doctors do their very best for people, but I feel that we must also support them by sharing our expertise and being 'true' partners in care... it's a two-way street!

"Tess' last two days in hospital were spent writing lists of what she was going to do when she 'got out' and giving staff she considered 'special' stickers, stars and hearts for their name badges... it got quite competitive!

"And since we have left she has met a few people on the street who now know her... this is osmosis at work!"

Pharmacy Department (Patient Safety/ Patient Experience)

The 2010 national inpatient survey found that almost half of our patients said they were not being given enough information about the side-effects of the medicines they were given when they were discharged.

Although our rate was above the national average, it had not changed in several years. What's more, the 2009 national outpatient survey showed that just over half of our patients said they had not been fully involved in decisions about their medicines.

A patient focus group was set up to discuss with Pharmacy staff how best to address these issues. Its first meeting was in July 2011 and since then several changes have been made:

- Pharmacy 'counselling' encourages patients to ask questions about their medicines when they collect them
- Patients are given the medicines information 'calling card' which shows them how to access help over the phone or online 24 hours a day (in conjunction with NHS Direct)
- A leaflet explaining general side-effects is automatically included with all take-home medicines
- *Trust News* ran a feature to remind all staff that specialist pharmacists are available to answer any queries they or patients may have, especially about medicines prescribed for long-term conditions.

The national outpatient survey published in February 2012 showed a 14% fall in the proportion of patients who said they had not been fully involved in decisions about their medicines.

A&E (Clinical Effectiveness/Patient Experience)

Adults and children with minor injuries or a condition that requires urgent attention, but which is not critical or life threatening, can now use the Urgent Care Centre (UCC), a new walk-in service that is part of A&E.

The UCC, which is open 24 hours a day, is run by a team of highly skilled GPs and nurse specialists, all of whom are experienced in the diagnosis and treatment of minor injuries and ailments.

A&E now assesses patients more quickly by 'streaming' them into either A&E services or those provided by the Urgent Care Centre, depending on the severity of their condition.

This helps to ensure that all patients receive the right care in the right place at the right time, which results in patients being treated more quickly.

More than 60% of patients who come to A&E are now directed to the new service.

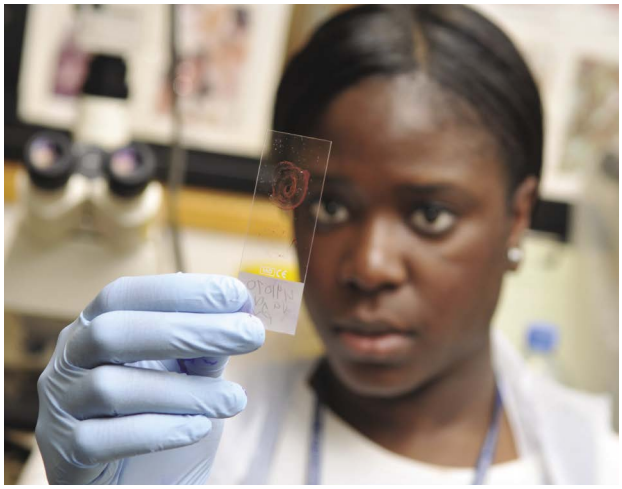
HIV/Sexual Health Services (Patient Safety/ Patient Experience/Clinical Effectiveness)

The SWISH (Sex Workers in Sexual Health) team, which includes senior nurses and sexual health advisers, set up a weekly outreach clinic which is now run in conjunction with a drugs service provided by HIV charity the Terence Higgins Trust.

There were no specific health services for sex workers and those dependent on drugs or alcohol in the area served by the Trust.

This is despite the fact that rates of sex work and drug/alcohol dependency are relatively high.

Sex workers are at increased risk of HIV and other sexually transmitted infections, but do not always access mainstream sexual health or primary care services.



Healthcare Assistant Linda Ofosuah examines a slide as part of the process of testing for sexually transmitted infections

The nature of their work means that they are often victims of violence, added to which they often have other psychological and social issues associated with a chaotic lifestyle, including alcohol/drug dependency.

The outreach clinic provides a safe, non-judgemental fast-track service, staffed by health professionals who respect sex workers' right to work safely and understand their lifestyle.

The clinic offers a full range of services including HIV testing, hepatitis B jabs, partner notification, legal advice, counselling, and screening. It was used by 228 people in its first year.

Maternity Unit (Patient Safety/Patient Experience)

In 2011 an independent survey of women's experiences of maternity services showed that 96% of women cared for at Chelsea and Westminster Hospital rated their care as 'Excellent', 'Very Good', or 'Good'.

In 2011/12 almost 6,000 women chose to give birth at Chelsea and Westminster Hospital, which is one of the safest hospitals to have a baby according to the latest National Confidential Enquiry into Maternal and Child Health.

The installation of a baby tagging system on the Maternity Unit and the Neonatal Intensive Care Unit made it even safer and gives parents extra assurance. An electronic tag is attached to the ankle of every newborn baby, which sounds an alarm if any unauthorised attempt is made to take the baby from either of the units.

The tag stores essential information about mother and baby for quick referencing and identification, in the form of a barcode, which can simply be scanned.

Patient quote

"I came to defend my birthplan for natural birth without medical intervention and the last thing I expected, to be honest, was that you and your team would be so understanding, caring and supportive. Nothing personal, just I've heard in the UK 25% of births end up with Caesarean section so I was afraid you would say my plan is not very realistic... the birthplan you wrote is perfect."

Diagnostics (Patient Experience/Clinical Effectiveness)

Some simple measures adopted by the Phlebotomy service, where patients go for their blood tests, have cut waiting times to an average of 10–15 minutes:

- Staggering the start times for staff shifts to cover periods of heavy demand
- Changing ward services and rotations, including implementing early starts, to make sure that the needs of both outpatients and inpatients are met
- Introducing uniforms for staff to boost professionalism
- Regularly checking the numbers of patients in the waiting area to adjust the service accordingly

Patient quote

"Went in for a blood test today. Normally it would have taken 30 minutes to 1 hour to get this done. Seen straight away! New system in place apparently and appears to be working very well indeed."

Care Quality Commission visit (Patient Safety/Patient Experience/Clinical Effectiveness)

The Care Quality Commission (CQC) undertook a planned unannounced visit of the Trust in February 2012 as is a normal procedure for every NHS trust, to ensure that it meets the essential standards of quality and safety.

The CQC inspectors visited 10 wards and departments in the Trust, speaking to staff, visitors and patients about the care being provided.

During the visits patients told CQC inspectors that they felt well looked after and that staff were attentive and caring.

Patients also provided positive feedback about staff providing reassurance and maintaining their privacy and dignity, as well as the cleanliness of ward areas and infection control.

Feedback was received from patients that the food was good. In the Emergency Department the inspectors had heard that patients had been seen quickly and that current waiting times were acceptable.

The CQC assessment of the hospital was very positive and that the Trust is meeting all of the essential standards of quality and safety.

The CQC has published its final report of their findings following the unannounced inspection—this can be located on their website www.cqc.org.uk.

Local performance indicators

Our performance on local quality indicators 2011/12

The data below is collected locally and according to national definitions unless indicated otherwise.

Subject	2008/09	2009/10	2010/11	Target 2011/12	Performance 2011/12	Target 2012/13	Comment
Patient safety							
MRSA bacteraemia cases	5	10	6	6	2	2	These targets are those set by the Department of Health
C.difficile cases	41	32	73	31	17	31	As above
Hand hygiene audit completion rates	57.7%	71%	89%	100%	93.6%	100%	Although we did not meet the target we have improved steadily throughout the year
Hand hygiene compliance rates	77%	80%	85%	90%	94.2%	95%	
Inpatient falls per occupied 1,000 bed days	-	-	-	-	3.19 (cumulative rate reported at the end of 2011/12)	3	Last year we said we would focus on all inpatient falls and measure falls per 1,000 occupied bed days. We have replaced 'patient falls resulting in moderate or major harm' with this indicator. This is because the new indicator allows for changes in activity and there is a national benchmark. Also there is limited control over whether a fall causes harm or not and the best way to reduce harm is to reduce falls overall.
Incident reporting rate	6.6%	7.1%	7.09%	8%	6.6%	8%	We plan to introduce online reporting this year to increase the number and quality of incident reports. Data is from Apr—Sep 2011 from the NPSA National Reporting and Learning System (NRLS)
Never Events	0	0	0	0	5	0	The number of incidents classed as 'never events' was increased this year. We have thoroughly reviewed all incidents and the systems in place to prevent reoccurrence. Data from local incident reporting system.
% of adult inpatient (excluding maternity) observation charts scored accurately (CEWSS)	56.3%	68%	81%	85%	89%	85%	The indicator description has been revised to more accurately reflect what is being measured which is whether patients' vital signs are being recorded correctly. There is no national definition for this indicator.
Resuscitation calls (cardiac arrest) due to failure to escalate	-	-	-	-	7	5	This was a new target in 2011/12. This measures whether doctors are being called appropriately when patients begin to deteriorate resulting in a cardiac arrest call. The numbers are low and therefore a % reduction was not considered appropriate. There is no national definition for this indicator.
% patients with International Normalised Ratio (INR) less than 5	No data	97.7 (Aug–Dec 2010)	97.45%	96%	96.8%	96%	INR is a measure of the ability of the blood to clot
Hospital acquired preventable cases of venous thromboembolism (VTE)	-	-	-	0	10 (7 months data)	13	Numbers relate to cases judged to have been preventable after a root cause analysis for the period Jul 2011 to Jan 2012. Our ultimate target will remain as zero and we plan to reduce by at least 25% in 2012/13 as part of our aim to reduce to zero. The 25% reduction is based on an estimate from the data for this year

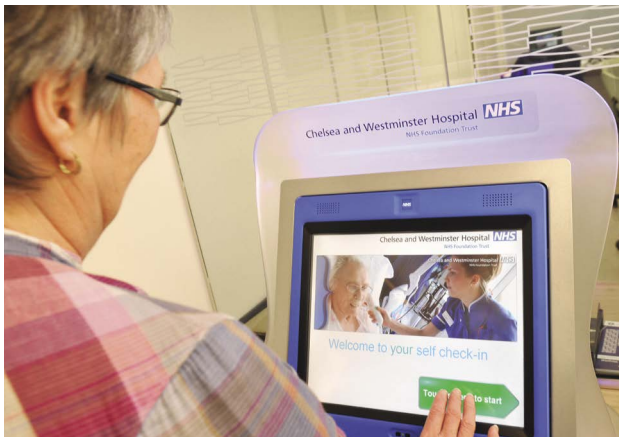
Subject	2008/09	2009/10	2010/11	Target 2011/12	Performance 2011/12	Target 2012/13	Comment
Clinical effectiveness							
Mortality (Hospital Standardised Mortality Indicator—HSMR)	86.2%	80.8%	75.80% (taken from Dr Foster Apr 2010–Jan 2011)—this was 85% for the whole year	None	71.39% (taken from Dr Foster Apr 2011–Jan 2012)	71%	We had anticipated that a new indicator the Summary Hospital-Level Mortality Indicator (SHMI) would replace the HSMR and did not set a target for HSMR last year. However both are being used. The results show that we are one of the safest hospitals in the country. The target is to remain in the 10% of hospitals with the lowest HSMR. Data source Dr Foster.
Mortality (Summary Hospital-level Mortality Indicator—SHMI)	Q2 to Q4 2008/09 was 79.37%	85.1%	78.1%	n/a	Only Q1 and Q2 data available—73.83%	77%	SHMI is a new indicator for mortality. The target is to remain in the 10% of hospitals with the lowest SHMI. Data source Dr Foster.
% of patients with a urinary catheter	28%	17%	13.8%	12.5%	16.75%	-	This indicator will no longer be collected as it was not felt to be a useful measure as the need for urinary catheters depends on the patient mix. How well they are cared for is measured by the indicator below.
Urinary catheters continuing care—compliance with Care bundles	-	-	-	90%	92%	90%	This was a new indicator in 2011/12
% urgent surgery cases operated on within 24 hours of booking	-	93.5% (avg of Dec 2009 and Mar 2009 data)	99% (avg of Nov 2010 to March 2011 data)	100%	95% (while we will always work towards a target of 100% we have set ourselves a tolerance limit of greater than or equal to 90%)	100%	In May we changed our emergency theatre monitoring to include the Paediatric operating theatres. This has increased the numbers of patients' operations we are monitoring. As a result it is not possible to directly compare results from 2011/12 with 2010/11. There is no national definition for this indicator.
% expedited surgery cases operated on within 4 days of booking	-	93.5% (avg of Dec 2009 and Mar 2009 data)	95% (avg of Nov 2010 to March 2011 data	100%	99% (while we will always work towards a target of 100% we have set ourselves a tolerance limit of greater than or equal to 90%)	100%	In May we changed our emergency theatre monitoring to include the Paediatric operating theatres. This has increased the numbers of patients' operations we are monitoring. As a result it is not possible to directly compare results from 2011/12 with 2010/11. There is no national definition for this indicator.
Central line continuing care—compliance with Care bundles	-	-	-	90%	90%	90%	We set ourselves a trajectory target ie we would aim to be 90% compliant by Mar 2012. We will now aim to maintain this consistently.
Peripheral line continuing care—compliance with Care bundles	-	-	-	90%	86%	90%	We set ourselves a trajectory target ie we would aim to be 90% compliant by Mar 2012. We plan to achieve and maintain this in 2012/13. There needs to be more focus on labelling lines.
Numbers of hospital pressure ulcers—grade 2	-	-	120	60	47	-	We are introducing an electronic way to record pressure ulcers in 2012/13 to improve the accuracy and ease of recording and will be setting our target based on these figures.
Numbers of hospital pressure ulcers—grades 3 and 4	-	-	58	44	31	-	As above

Subject	2008/09	2009/10	2010/11	Target 2011/12	Performance 2011/12	Target 2012/13	Comment
% patients nutritionally screened on admission	40%	60%	80%	90%	95%	90%	Initial nutritional screening has been embedded within nursing admission. New indicator. There is no national definition for this indicator.
% patients in longer than a week who are nutritionally rescreened	0%	10%	30%	40%	60%	90%	Rescreening is improving and we are aiming for 90% for 2012/13. New indicator. There is no national definition for this indicator.
Patient experience							
% of patients 'fit' for discharge waiting only for medicines	-	-	-	≤10%	-	-	This indicator proved difficult and resource intensive to measure and a more valid measure will be developed as part of the discharge project
% complaints reopened	-	10%	9%	8%	4%	5%	The % reopened could change if we receive notification at a later date that a complainant is unhappy. There is no national definition for this indicator.
Complaints upheld by the Ombudsman (PHSO)	-	-	-	-	0	0	During the year 2011/12 the PHSO considered 11 complaints. For one, the Trust was asked to undertake a local resolution meeting, in seven no further action is being taken and three are outstanding. There are none upheld to date. There is no national definition for this indicator.
Complaints responded to within target time (formal complaints responded to in 25 working days)	92%	83%	82.5%	90%	80.43%	90%	End March 2012 figures
Complaints (type 1 and type 2)—communication	-	-	260	n/a	198	178	No target was set as this was the first year that we said that we would specifically look at this category. However, this demonstrates a reduction of 24%. We wish to reduce by a further 10% next year. There is no national definition for this indicator.
Complaints (type 1 and type 2)—discharge	-	-	108	n/a	49	50	No target was set as this was first year that we said that we would specifically look at this category. However, this demonstrates a reduction of 55% and we want to maintain this reduction. There is no national definition for this indicator.
Complaints (type 1 and type 2)—older people	-	-	-	n/a	110	20% reduction (max 88)	This was not a specific category for complaints and concerns in 2010/11. Complaints in this category may also appear in other categories. There is no national definition for this indicator.
PEAT scores	E for food and environment. G for privacy and dignity.	E for all	E for all	E for all	E for all	E for all	E = Excellent G = Good

Update on indicators

Apart from those mentioned above, some other indicators have changed.

- We made a decision last year to change our ways of getting patient feedback. Our Matrons are currently performing ward rounds to talk with patients and their feedback is displayed, with actions taken, on the ward areas. Within the Trust as a whole we will be introducing quarterly surveys based on the questions that we think most matter to patients.
- Complaints and concerns for admissions and appointments have been removed as an indicator. It has not been useful to consider them together as admissions refers to inpatients and appointments to outpatients and they have different arrangements within the Trust.
- We have also discovered that the data quality needs to be improved, as the appropriate classification is not always being used. There have been many developments in outpatients and we want to measure the patient experience of the new service. Complaints and concerns around appointments for the last three months of 2011/12 have been checked (total 37) and measurement will continue throughout 2012/13. Complaints and concerns around admissions are also being reviewed to check accuracy of data and will be monitored in 2012/13.
- We have included a new indicator on nutrition. Patients do better and feel better if they are well fed. Improving nutrition can reduce the length of time patients stay in hospital, help patients to maintain their independence and improve quality of life. We are going to see how we can measure weight on admission and discharge for a small group of patients and test if this is a helpful measure of how well we are feeding our patients.



Using complaints to drive improvements

The three main types of complaints (Type 2)* in 2011/12 concerned:

- Aspects of clinical care or treatment (47%)
- Attitude or behaviour of staff (21%)
- Communication (9.5%)

* Percentage of Type 2 complaints received in 2011/12, where the category listed is the primary cause of the complaint

We take patient complaints very seriously and have responded to them in various ways to improve the quality of care we provide, as the following examples show.

More support for new mothers

Concerns from new mothers were highlighted around understanding what happened when they needed complex care. This prompted the creation of a new post—Birth Afterthoughts Lead Midwife.

This midwife takes the lead on listening to women's experiences of giving birth at the Trust and in resolving any concerns they may have. She also arranges for additional support or monitoring as required.

Attentive nursing

An initiative developed on David Erskine Ward looks set to be adopted by other wards. The 'wellbeing round' involves nurses checking all patients every two hours to find out if they are comfortable, pain-free, and if they have any other needs.

The same ward team has also developed a patient passport, similar to the Trust's learning disability passport, for those patients who have dementia. It is used as a tool to communicate the patient's normal routines and preferences to the care team.

Meeting patients' nutritional needs

Several initiatives have been developed to ensure that vulnerable patients are receiving the right nutritional care. These include 'protected mealtimes' when hospital volunteers and ward staff released from clinical duties can assist patients who require help to eat their meals.

A mealtime co-ordinator on every ward makes sure that patients are properly prepared for mealtimes, such as sitting up to eat, for example. They can also assist with feeding, if needed. All newly admitted patients are given a nutritional screen, and nursing staff work closely with the dietetic team to make sure patients get the nutrition they need.

Helpful and responsive staff

Feedback from complaints about staff attitude and/or behaviour has resulted in specific action plans, including training which involves role play around the issues and challenges highlighted in complaints to give staff some insight into their own behaviour and the impact it has on those around them.

All reception staff in outpatient areas will also be taking a Customer Service Apprenticeship.

Keeping relatives informed

Communication is one of the three core strands of the Trust's patient experience strategy, and an example of action taken to keep relatives better informed is the relaunch of an updated Liverpool Care Pathway.

This pathway outlines the care a dying patient can expect in the final days and hours of life. Instead of a single tick box to confirm that relatives have been involved in discussions about this, there are now specific prompts asking what was discussed, when, and with whom. The 'Breaking Bad News' guidelines for staff have also been reviewed and updated.

Outpatients

The Outpatients Department was restructured in April 2011 to improve the quality of our service provision, and there is now a state-of-the-art facility on the Lower Ground Floor.

New facilities for plastics and dermatology services are due to be completed in July 2012, and in early 2013 the Lower Ground Floor will be extended further to accommodate medical outpatients.

Patient Story

Colposcopy

JT came to the Colposcopy Unit for her gynaecological care and said that the support of the nursing and reception staff put her at ease.

This helped make a difficult experience easier because her procedure was explained to her thoroughly. JT said she felt she had "received the best service".

Patient Story

Orthopaedic Surgery and Physiotherapy

As an active person and a keen walker ML had been in severe pain with her knee and was fairly immobile. She was only able to venture outside her flat for short distances by taxi. Coming into hospital for her first ever operation ML was very anxious, but being in pain made her realise surgery was the only option for her.

ML found the "professional, down to earth advice and direct and friendly approach" of her surgeon gave her "confidence and hope". After surgery ML said the physiotherapists used a combination of gentle understanding, sympathy and firm determination to encourage her to do the physiotherapy exercises. ML said this made her want to do her exercises to reach her rehabilitation goals. ML was anxious to let her crutches go, but she did so with the help from her physiotherapists. ML is now pain-free, walking normally and says she "faces an active future".

After her surgery ML became a member of the Volunteer Patient Support Team in January 2012 and stated "I wanted to express my appreciation and give back something to the hospital".

The new structure has streamlined and standardised administrative processes which benefits both staff and patients. It has also improved the consistency of staff training and the way in which we collate and manage patient data, including 'referral to treatment' times.

Part of the upgrade includes a facility for patients to book any diagnostic scans they need when they come to clinic, rather than having to go to different departments to do this. The plan is to include other diagnostic tests in the very near future.

Our performance on key national priorities 2011/12

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

Indicator	Target	2011/12 Performance
Incidence of *Clostridium difficile*	100	Achieved
Incidence of MRSA bacteraemia	6	Achieved
All cancers: 31-day wait from diagnosis to first treatment	96%	Achieved
All cancers: 31-day wait for second or subsequent treatment: surgery	94%	Achieved
All cancers: 31-day wait for second or subsequent treatment: anti cancer drug treatments	98%	Achieved
All cancers: 62-day (urgent GP referral to treatment) wait for first treatment	85%	Achieved
All cancers: 62-day wait for first treatment from consultant screening service referral	90%	Achieved
Cancer: two week wait from referral to date first seen comprising all cancers	93%	Achieved
Referral to treatment waiting times—admitted	<23 weeks	Achieved
Referral to treatment waiting times—non-admitted	<18.3 weeks	Achieved
A&E: Total time in A&E	≤4hrs	Achieved
A&E: Time to initial assessment	≤15 minutes	Achieved
A&E: Time to treatment decision	≤60 minutes	Achieved
A&E: Unplanned re-attendance rate	≤5%	Achieved
A&E: Left without being seen	≤5%	Achieved
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliant	Achieved

Valuing our workforce

The four staff pledges in the NHS Constitution will help create and maintain a highly skilled and motivated workforce capable 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

The 2011 national NHS staff survey results showed that 80% of staff had an appraisal and 72% had a personal development plan based on their objectives in the previous 12 months. The quality of appraisals is regularly checked and monthly figures drawn up on those planned and completed.

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 training courses and has a well-established leadership course for line managers, which includes a strand on managing quality. All new staff attend the Trust's corporate induction, which includes a session led by the Chief Executive explaining the Trust's objectives and core values, our approach to quality, and what role staff can play in this.

We improved our score in the NHS staff survey relating to staff receiving job relevant training, learning or development from 80% to 83% in 2011 and are above average for acute trusts. We do, however, recognise that we need to do more on mandatory training, despite significant progress this year.

Our organisational restructure has increased clinical leadership, accountability, and shared responsibility with managers for delivery of services, and we have embarked on a comprehensive ward manager development programme and a clinical leaders' programme in partnership with the NHS Institute for Innovation and Improvement.

Evaluations of all nursing and professions allied to medicine student placements are carried out by qualified trainers and results are fed back to the Trust by the various universities at the end of each academic year. This feedback guides further change, as appropriate, as well as ideas for further development.

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

We run regular health and wellbeing events for staff which include mini health MOTs and weekly subsidised yoga classes. We have also improved facilities for staff who cycle to work.

Additionally, we provide access to:

- fast-track musculoskeletal physiotherapy services
- specialist counselling and advisory services
- stress management courses in areas where levels of stress are highest

The Trust was the only NHS employer named in the Top Employers for Working Families Awards in 2010 and 2011

Sickness absence levels remain low at under 3.5% and levels of staff engagement, as reported in the NHS staff survey remain in the top 20% of all acute trusts nationally.

The Trust was the only NHS employer named in the Top Employers for Working Families Awards in 2010 and 2011.

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

We have well-established methods of involving staff, including joint consultative frameworks and strong lines of communication. The NHS staff survey results show that the Trust's performance in both communication and staff engagement has improved every year for the past three years.

Putting staff in the driving seat

The Trust recognises that our staff are a valuable resource and have a key role in contributing to helping the NHS make the required substantial savings, while still maintaining and improving the quality of services. But for that to happen, staff need to be fully involved. We have therefore taken a strategic approach to this, and used a range of approaches. These include:

- Open staff forums about key challenges facing the Trust
- Giving staff opportunities to come up with ideas to improve quality or efficiency, such as the Directors' Den initiative
- Monthly team briefings, the *Trust News* staff magazine (monthly), Daily Noticeboard email bulletin, and weekly e-newsletters for specific initiatives to promote an open and transparent culture
- Consultations with staff on key strategic developments that will have a major impact on the Trust. The 'Who do you think WE are?' consultation on the Trust's values in February 2012 included six staff focus groups and an opportunity to vote for the top four values: more than 800 staff and patients did so
- Celebrating the achievements of staff—the Council of Governors Quality Awards recognise the contributions that individuals or teams make to improving the quality of patient care, and the Chelsea and Westminster Star Awards, launched in February 2012, recognise the work of both clinical and non-clinical staff

The Trust was shortlisted in the Internal Communications category of the HR Excellence Awards 2011.

The Trust was also rated the best acute trust nationally for good communication between senior managers and staff in the 2011 NHS staff survey.

Patient Story

Paediatric Diabetes

ML was admitted to the adolescent unit (Jupiter Ward) for review of his insulin pump therapy. Insulin pump therapy is a sophisticated system of insulin delivery that ML had commenced last year to help him control his diabetes.

ML had recently been finding it difficult to manage his diabetes and clearly required some support in better managing his diabetes control. Admission to the adolescent unit allowed ML the opportunity to manage his diabetes with the help and support of the adolescent ward staff in conjunction with the Paediatric Diabetes team.

His pump is designed to control his diabetes by constant delivery of a background 'basal' quantity of insulin which controls his blood glucose level throughout the 24 hour period.

ML then uses a blood glucose monitor to check his blood glucose levels. This unique 'handset' is a sophisticated calculator and specially designed to communicate with the insulin pump, using Bluetooth technology to give ML the required dose of insulin at mealtimes.

The diabetes nurse had recommended ML to come into hospital and together address the issues and problems he was experiencing.

ML's mother said the diabetes specialist nurse helped ML to embrace his experience positively and to reach full independence with his diabetes management.

ML has now been able to achieve optimum blood glucose control since discharge from the unit.

While ML was in hospital the Chelsea Children's Hospital School worked closely with his own school to help him with schoolwork and to ensure his studies were not affected during his important GCSE year.

His mother said she thought he enjoyed the work and worked harder in the Hospital School than he normally did at his own school!

Our physical environment

Chelsea and Westminster is a modern, well-designed hospital, but the physical environment needs to be able to respond to changes in service provision, so the Trust has a multi-million pound investment programme to maintain and improve its facilities.

Patient quote

"The new site is lovely, clean and comfortable."

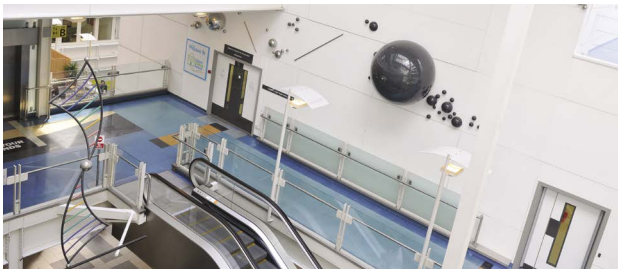
—MA (Diabetic Unit)

Recent developments include:

- A new Outpatients Department on the Lower Ground Floor which opened in January 2011, with a new escalator from the Ground Floor to improve access
- An extension to the hospital completed in January 2012 including four new children's theatres, an integrated children's High Dependency Unit, and a new 19-bed ward for patients living with HIV or cancer
- A £9.8m upgrade to the hospital's energy infrastructure to make it more energy efficient and better value for money
- Refurbishment of the Antenatal Department in 2011
- A maintenance programme to reduce the risks of Legionella infection

Further developments include:

- We are now redeveloping the 1st Floor of the hospital to house all children's inpatient facilities
- A streamlined and upgraded Diagnostic Centre, bringing together endoscopy, cardiology, and associated services, will be developed this year
- All this change means that the hospital signage is now out-of-date and so the Trust has launched its wayfinding project to address this, with work due to begin later this year to make the required changes, which will incorporate the experience of other trusts and the latest technology
- A three-year programme to replace flooring and redecorate public areas continues, as do small-scale energy efficiency schemes and health and safety modifications



Part 4: Statements relating to quality of NHS services provided

Statements of assurance from the Trust Board

During 2011/12 Chelsea and Westminster Hospital NHS Foundation Trust provided and/or subcontracted 70 NHS services. The Trust has reviewed all the available data on the quality of care for all of these services. The income generated by the NHS services reviewed in 2011/12 represents the total income generated from this source by the Trust for 2011/12.

How the Trust reviews its services for quality

The Trust has systems and processes in place to ensure that data on quality and quality improvement are regularly reviewed at divisional level, and across the Trust as a whole. These reviews enable us to pick up on issues that warrant further attention, help us track the progress of any investigations we might need to carry out as a result, and follow up on any changes needed to improve processes/services.

Specific quality reports for each of the Trust's three clinical divisions are issued quarterly so that they can be included in overall performance reviews. These reports include information on:

- Complaints and concerns
- Patient safety incidents
- Legal claims
- New cases of hospital associated infections (MRSA and *Clostridium difficile*)
- Monthly hand hygiene audits
- Clinical guideline updates
- Mandatory training
- Participation in clinical audits
- Research activity
- Actions taken on operational/clinical risks (risk register)

The results of audits carried out across the Trust in areas such as recordkeeping and consent are also fed back to each of the three divisions.

Patient experience is a priority for the Trust, and each division has a clear action plan for this, with activity in this area reported to a dedicated patient experience committee. Periodic in-depth reviews of services are carried out to see if further improvements can be made. In 2011/12, services for newborns (neonates), chronic heart failure, and trauma were all reviewed.

Other checks and balances are provided by:

- The Trust Executive Quality Committee, the most senior management level committee within the Trust which has a specific remit to look at quality
- The Assurance Committee, a sub-committee of the Trust Board

Taking part in clinical audits

Clinical audits collect information on the treatment patients receive and its consequences in important areas of medicine. Participation in them enables healthcare professionals to evaluate their clinical practice against national standards and guidelines, so that they can continuously improve the quality of treatment and care they provide.

National confidential enquiries perform a similar role, but additionally include critical assessment by senior doctors of what actually happened to patients, with a view to driving up standards and enhancing patient safety.

During 2011/12, 41 national clinical audits and four national confidential enquiries covered NHS services provided by the Trust. The Trust took part in 93% of national clinical audits and all the national confidential enquiries for which it was eligible (see table). For an explanation of the acronyms and other terms used here, please refer to the Glossary in Annex 5.

We take your complaints seriously

Complaints are discussed in each division every week, and the responses to them reviewed by the Executive Team—the Chief Executive, the Deputy Chief Executive and/or Chief Nurse. Agreed courses of actions are then regularly reviewed to make sure they have been carried out and corresponding improvements to services made. Senior managers tackle issues arising from complaints, and if warranted, these are subsequently referred to the Executive Team.

National clinical audits in which the Trust was eligible to participate

Subject	Participated	Cases indicated or required	Cases submitted	% Cases submitted	Comment
Around and after birth (perinatal and neonatal)					
MBRRACE-UK: Perinatal mortality	Y	20	20	100%	
NNAP Neonatal intensive and special care	Y	638	638	100%	Data collection is for calendar year 2011, not financial year 2011/12
Children					
BTS: Paediatric pneumonia	Y	21	21	100%	
BTS: Paediatric asthma	Y	32	32	100%	
College of Emergency Medicine: Pain management	Y	50	36	72%	Insufficient number of admissions to meet CEM requirement—cases submitted reflect the total number of eligible cases in relation to the attendance date range specified for this audit
RCPH: Childhood epilepsy	Y	29	29	100%	
RCPCH: Diabetes audit	N	n/a	n/a	n/a	Technical difficulties meant the hospital could not take part—we will participate in 2012/13
Acute Care					
BTS: Emergency use of oxygen	Y	16	16	100%	
BTS: Adult community acquired pneumonia	Y	20	20	100%	Data submitted ahead of May 2012 deadline
BTS: Non-invasive ventilation—adults	Y	20			Closing date for data submission is 31 May 2012 and date will entered by that date
BTS: Pleural Procedures	Y	20	21	105%	
National Cardiac Arrest Audit	Y	All eligible cases	45	100%	
College of Emergency Medicine: Severe sepsis & septic shock	Y	30	30	100%	
ICNARC: Case Mix Programme Database—Adult critical care	N	n/a	n/a	n/a	Data interpretation not useful for individual organisations and very expensive to take part
NHS Blood & Transplant: Potential donor audit	Y	All eligible cases	2	100%	
National Audit of Seizure Management	Y	30	30	100%	
Long term conditions					
National Adult Diabetes Audit	N	n/a	n/a	n/a	Work is underway to support participation in 2012/13
RCOG National Audit of Heavy Menstrual Bleeding	Y	87	19	22%	Data submission subject to patients' approval and 68 patients (78%) did not consent
National Pain Audit: Chronic pain	Y	6	6	100%	
National IBD Audit: Ulcerative colitis & Crohn's disease	Y	40	23	58%	
National Parkinson's Audit: Parkinson's disease	Y	20	20	100%	
BTS: Adult Asthma	Y	20	23	115%	
BTS: Bronchiectasis	N	n/a	n/a	n/a	Too few patients to make participation worthwhile

Subject	Participated	Cases indicated or required	Cases submitted	% Cases submitted	Comment
Elective (planned) procedures					
National Joint Registry: Hip, knee, and ankle replacements	Y	248	248	100%	
National PROMS Programme: Hernia	Y	Average expected monthly return is 21	Average monthly return of 23	Annual average return rate 109%	Standard for participation set by the DH is 80% return rates for 2011/12
National PROMs Programme: Hip replacement	Y	Average expected monthly return is 13	Average monthly return of 9	Annual average return rate 68%	Standard for participation set by the DH is 80% return rates for 2011/12
National PROMs Programme: Knee replacement	Y	Average expected monthly return is 14	Average monthly return of 8	Annual average return rate 66%	Standard for participation set by the DH is 80% return rates for 2011/12
National PROMs Programme: Varicose veins	Y	Average expected monthly return is 33	Average monthly return of 29	Annual average return rate 87%	Standard for participation set by the DH is 80% return rates for 2011/12
Heart disease and stroke					
Acute Myocardial Infarction & other acute coronary syndrome (MINAP)	Y	All eligible cases	54	study ongoing	Figure relates to all eligible cases entered from Apr–Dec 2011—deadline for submission 30 Jun 2012
Heart Failure Audit	Y	Max of 20 per month—total number for period Apr–Sep 2011 is 56	56	100%	
SINAP: Acute stroke	Y	20	7	35%	Audit closes on 30 Sep 2012
Cardiac Rhythm Management Audit	Y	55	55	100%	Continuous submission—figures for 2011/12
Cancer					
National Lung Cancer Audit	Y	Prospective data collection, so numbers unknown	Data entry to 30 June 2012		
National Bowel Cancer Audit Programme	Y	67	67	100%	Continuous audit. Data includes patients diagnosed between 1 Feb 2011 and 31 Jan 2012
National Oesophagogastric Cancer Audit	Y	28	28	100%	Continuous audit. Data includes patients diagnosed between 1 Apr 2011 and 1 Apr 2012—first annual report due in Jun 2012
Trauma					
National Hip Fracture Database	Y	149	149	100%	
TARN: Severe trauma	Y	159	113	71%	Expected number of cases in 2011 is a target figure. TARN reports based on calendar rather than financial year.
Blood transfusion					
National Comparative Audit of Blood Transfusion: Bedside transfusion	Y	50	29	58%	Retrospective audit—sample collection ended at 29 cases with agreement of NHSBT
National Comparative Audit of Blood Transfusion: Medical use of blood	Y	46	46	100%	Part 1 of the audit completed—Part 2 in progress
Health promotion					
National Health Promotion in Hospitals Audit: Risk factors	n/a	n/a	n/a	n/a	Audit has not yet commenced
End of life care					
NCDAH: Care of dying in hospital	Y	30	30	100%	

National Confidential Enquiry participation

Topic	Participated	Cases indicated or required	Cases submitted	% Cases submitted	Comment
NCEPOD: Bariatric surgery	Y	8	7	88%	NCEPOD: Bariatric surgery
NCEPOD: Cardiac arrest procedures	Y	45	45	100%	NCEPOD: Cardiac arrest procedures
NCEPOD: Perioperative care	Y	32	32	100%	NCEPOD: Perioperative care
NCEPOD: Surgery in children	Y	17	12	71%	NCEPOD: Surgery in children
CEMACE: Maternal and perinatal surveillance	Y	20	20	100%	CEMACE: Maternal and perinatal surveillance

National clinical audit review

The reports of seven national clinical audits were reviewed by the Trust in 2011/12 and we intend to take the following actions to improve the quality of healthcare provided.

Audit	Department leading review	Actions to be taken
Major Complications of Airway Management	Emergency Care	Standards are being met. However a sedation/airway proforma is being developed to ensure necessary preparation steps are carried out before non-emergency airway interventions. Audit of management of the airway to be undertaken by end August 2012.
National Sentinel Stroke Audit	Stroke Team—General Medicine	The total score was 94%, which means the Trust is in the top 25% of the 200 participating hospitals. All auditable standards are being met.
TARN	Emergency Care	Standards are being met.
National audit of Heart failure	General Medicine	Standards are being met.
UK Inflammatory Bowel Disease (IBD) Audit	General Medicine	This audit relates to facilities for patients with IBD. In general the service is mostly compliant; however we need additional toilet facilities. This will be taken into account with the new hospital diagnostic centre, which is due to be completed in December 2012. In addition to this, additional sideroom/ensuite facilities are part of the Estates and Facilities organisational building plans.
National Falls and Bone Health Audit	General Medicine	Standards are being met, however improvement is required in order to improve feedback from GPs relating to patients who have been discharged following inpatient treatment for falls, unless these patients return to the outpatient department.
National Neonatal Audit	Neonatal Team	The actions are due to be considered and agreed in May 2012.

Local clinical audit review

The reports of 298 local clinical audits were reviewed by the Trust in 2011/12 and we intend to take action to improve the quality of healthcare provided.

Further details are available on request from Dr Mike Anderson (Medical Director) by emailing mike.anderson@chelwest.nhs.uk.

Participation in clinical research

Excellence in research is a priority for the Trust and is the main focus of its research strategy for 2010–2013, *Improving patients' lives through research and innovation*.

Taking part in research not only helps speed up the development of new treatments and services across the NHS, but also gives our patients the chance to receive cutting edge treatment that would not normally be available.

In 2011/12 the number of patients recruited to take part in research that had been approved by a research ethics committee was 5,193—a 12% increase on the previous year's figures.

In 2011/12 the Trust was actively involved in 245 clinical research studies, 90 of which were part of the National Institute of Health Research (NIHR) portfolio. This is a collection of high quality national studies covering a broad range of clinical areas, such as cancer, stroke and paediatrics.

The Trust collaborates with various research partners to ensure its research is responsive to national and local priorities. They include NIHR research networks, and local charities such as Westminster Medical School Research Trust and Chelsea and Westminster Health Charity.

We also host the NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Northwest London, which aims to apply new treatments and approaches to clinical care in the NHS.

CLAHRC has completed four projects at Chelsea and Westminster:

- Development of evidence-based care for patients with chronic obstructive pulmonary disease (COPD)
- Improving how we tell patients about medicines and their side-effects and how we explain changes in patients' discharge medicines to GPs (see box below)
- HIV testing outside hospital and clinics
- Integrated care for people with alcohol problems

The Trust is working increasingly closely with Imperial College and Imperial College Healthcare NHS Trust across a number of research areas including those sponsored by NIHR CLAHRC for North West London. Specific research areas include allergy, COPD and medicines management. Increasing links are being developed with Imperial College Biomedical Research Centre and the Biomedical Research Units at the Royal Brompton Hospital.

Ongoing projects include improving the care of patients with heart failure or community-acquired pneumonia, and the prevention of stroke.

Other successful research which is ongoing in the Trust includes the Medicine for Neonates (MFN) programme. This work aims to improve health outcomes for babies admitted to neonatal units, and facilitate research into neonatal medicines and therapies.

Our researchers have highlighted the importance of maternal health in influencing newborn health outcome. This work has shown that maternal overweight and obesity often results in babies with excess fat and has been reported in many national newspapers.

Secondly, in the last 10 years it has also been found that the proportion of premature babies born in specialised hospitals has risen from 18–49%, which means that over half will require transfer after they are born. Such research can help to improve the organisation of health services in the future.

The Trust is also involved in the delivery of a high profile national research study investigating the management of patients presenting with septic shock. This trial is called the ProMISe trial and is based on collaboration between a number of clinical teams in A&E, Acute Medicine and the Intensive Care Unit (ICU). This work will help to improve both the quality of care and clinical outcomes for these patients.

In 2011/12 the Trust was shortlisted for the *Health Service Journal* Research Culture Award.

Towards a better understanding of medicines' side effects

In collaboration with CLAHRC the Pharmacy Department has produced 'prompt' cards, which describe the side-effects of commonly prescribed medicines. These are intended to remind nurses and pharmacy technicians to mention side-effects to patients, but they have now been adapted for patients when they are discharged, and the plan is to include this information in the electronic discharge summary and outpatient prescriptions.

Goals agreed with commissioners (CQUINs)

A proportion of Chelsea and Westminster Hospital NHS Foundation Trust's income in 2011/12 was conditional upon 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 2011/12 and for the following 12-month period are available online.

CQUIN in a nutshell

The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of the Trust's income to the achievement of local quality improvement goals.

In 2011/12, income equal to 1.5% of the value of our main acute contract, which covers most of our NHS services, was conditional on achieving CQUIN goals agreed with our host commissioner, North West London Commissioning Partnership.

In addition we also agreed CQUIN payments linked to our work in HIV and Neonatal Intensive Care, which is commissioned by the London Specialised Commissioning Group as well as CQUINs worth a much smaller proportion of our income for our community services in Paediatrics (Children's Services), Dermatology (skin) and Gynaecology (women's reproductive health services).

We achieved 90% of our Regional and National CQUIN-related goals in 2011/12 for which we received a payment of £2,923,000* out of a maximum of £3,039,193 and we achieved 85% of our Specialist Commissioning CQUIN-related goals in 2011/12 for which we received a payment of £895,000* out of a maximum of £1,086,891.

Overall, we achieved 89% of our CQUIN-related goals in 2011/12 for which we received a payment of £3,818,000* out of a maximum of £4,126,085.

* All data above is subject to Q4 sign off which will be confirmed in June 2012.

Statement regarding the Care Quality Commission

The Care Quality Commission (CQC) is the regulatory watchdog for health and adult social care services in England. All NHS Trusts are required to register with the CQC in order to be able to provide their services.

The CQC monitors the quality of services the NHS provides and takes action where these fall short of 'essential' standards.

The CQC uses a wide range of regularly updated sources of external information as well as its own observations during spot checks to assess the quality of care a Trust provides.

If it has cause for concern, it may undertake special reviews/investigations and impose certain conditions.

Chelsea and Westminster Hospital NHS Foundation Trust is required to register with the CQC and its current registration status is registration without conditions.

No enforcement action was taken against the Trust during 2011/12. The Trust has not participated in any special CQC reviews or investigations by the Care Quality Commission during the reporting period.

More information on the CQC and its regulatory powers is available at www.cqc.org.uk.

Information on the quality of data

Coding

Every hospital in England has to send details of all the care it provides to the Secondary Uses System (SUS). This anonymised database is used, among other things, to inform national policy and provide a rich source of material for research. The completeness of the coding determines the validity of the information and the Trust's income.

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

- 92.6% for admitted patient care (inpatients)
- 84.0% for outpatient care
- 76.3% for Accident and Emergency (A&E) care

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

- 98.4% for admitted patient care (inpatients)
- 72.1% for outpatient care*
- 98.9% for Accident and Emergency (A&E) care

* When data is submitted to SUS the GP Practice Code is not included for sexual health outpatient attendances for reasons of confidentiality. Sexual health comprises around 20% of our outpatient activity and therefore our reported figures appear low.

Information Governance Assessment Report

Information governance concerns the way in which organisations process information, both about patients and staff, and the running of the organisation.

The Information Governance Toolkit is an online system that enables NHS organisations and their partnering bodies to measure how well they are complying with Department of Health standards on the correct and secure handling of data, and how well they are protecting data from unauthorised access, loss, and damage.

Chelsea and Westminster Hospital NHS Foundation Trust's Information Governance Assessment Report overall score for 2011/12 was 95% and was graded green.

Improving data quality

Clinicians and managers rely on accurate and complete data to enable them to deliver high quality and cost effective care, so we continually strive to improve the reliability of this information as part of quality improvement.

Accurately recorded clinical activity helps us:

- Compare our standards of care with those of other hospitals
- Reduce delays
- Track value for money
- Cut wastage

Monthly checks ensure that reported activity levels are accurate, and we regularly review the way in which all this activity is coded.

Managers and frontline staff review and correct data reports every day to make sure they accurately reflect both the care that has been provided and what is about to be provided.

In our quest to improve our data, we will:

- Focus the role of the Trust's Data Quality Group on highlighting areas for improvement and ensuring that the right information is available to the right people/committees at the right time
- Make sure that data quality issues are highlighted in performance reports so that managers can brief their teams on any deficiencies in their area—managers are held to account for data quality at monthly divisional board and finance/ performance meetings
- Implement a new 'Referral to Treatment' module on our main admin system to improve data quality on patients' waiting times to avoid unnecessary delays and the build-up of lengthy backlogs
- Continue work on our local performance indicators to ensure that data is correct and meaningful

Clinical coding error rate

Diagnoses and treatment need to be coded properly to reflect what actually happens to patients, so it's important to get it right.

Chelsea and Westminster Hospital NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rate reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) was 8.3%.

The results should not be extrapolated further than the actual sample audited. The sample included 100 Finished Consultant Episodes (FCEs) from Gynaecology and 100 FCEs across all activity covered by a mandatory Payment by Results tariff.

Tell us what you think

We welcome any comments you may have on this report as well as your suggestions for inclusion in future reports.

Please contact Catherine Mooney (Director of Governance and Corporate Affairs) by emailing cathy.mooney@chelwest.nhs.uk.

Annex 1: Statement of Directors' responsibilities in respect of the Quality Report

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

Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011/12:

- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period Apr 2011—May 2012
    - Papers relating to quality reported to the Board over the period Apr 2011—May 2012
    - Feedback from the commissioners—28 May 2012
    - Feedback from Governors—17 May 2012
    - Feedback from Kensington and Chelsea Local Involvement Network (LINk)—11 May 2012
    - The Trust's complaints report 2010/11 published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, Jun 2011
    - The national inpatient survey 2011
    - The national staff survey 2011
    - The Head of Internal Audit's annual opinion over the Trust's control environment—22 Mar 2012
    - CQC quality and risk profile—Mar 2012
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) published at www.monitor-nhsft.gov.uk/annualreportingmanual as well as the standards to support data quality for the preparation of the Quality Report published at www.monitor-nhsft.gov.uk/annualreportingmanual.

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

By order of the Board.

Professor Sir Christopher Edwards
Chairman
28 May 2012

Heather Lawrence OBE
Chief Executive
28 May 2012

Annex 2: Independent Auditor's Assurance Report

Independent Auditor's Assurance Report to the Council of Governors of Chelsea and Westminster Hospital NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Chelsea and Westminster Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Chelsea and Westminster Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2012 (the "Quality Report") and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of Chelsea and Westminster Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting Chelsea and Westminster Hospital NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2012, to enable the Council of Governors to demonstrate that is has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Chelsea and Westminster Hospital NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- *C.Difficile*
- Maximum 62 day wait from urgent GP referral to treatment

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual
- The Quality Report is not consistent in all material respects with the sources specified in section 2.1 of the Detailed Guidance for External Assurance
- The indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports

We read the Quality Report and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and considered the implications for our report if we became aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the documents specified within the detailed guidance. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised)—"Assurance Engagements other than Audits or Reviews of Historical Financial Information" issued by the International Auditing and Assurance Standards Board ("ISAE 3000"). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- Making enquiries of management
- Testing key management controls
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report
- Reading the documents

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The nature, form and content required of Quality Reports are determined by DH/Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts. In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Chelsea and Westminster Hospital NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2012:

- The Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual
- The Quality Report is not consistent in all material respects with the sources specified in the detailed guidance
- The indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports

Deloitte LLP

Deloitte LLP
Chartered Accountants
St Albans
29 May 2012

Annex 3: Statements from key stakeholders

Council of Governors response to Chelsea and Westminster Hospital NHS Foundation Trust Quality Report 2011/12

17 May 2012

The Council of Governors has a Quality Sub-committee, which provides key stakeholder input to the development and implementation of the Trust's quality programme. It keeps under review the whole quality field, including safety, effectiveness and patient experience.

Members of the Sub-committee perform the Governors' role of 'critical friend' in Trust committees and working groups and are consulted on plans for improvement and kept informed of progress on implementation.

The Sub-committee may propose initiatives itself, such as the very successful Council of Governors Quality Awards. The Sub-committee reports to the quarterly meetings of the Council of Governors.

The Sub-committee has warmly encouraged the improvement in layout and style of this year's Quality Report.

The aim is to make it more attractive and readable, at the same time publishing the key points of quality performance in a new Transparency section of the Trust website.

The staff who have been involved in this work have also been responsible for collating the mass of material which makes up the Quality Report, and deserve congratulations for the excellent outcome.

The Governors will be paying close attention to feedback about the Report in preparation for next year's reporting exercise.

The content of the Quality Report shows that the Trust continues to perform at a high level. Some areas of previous concern have shown improvement in the year under report. Others which remain of concern are being given attention which should result in further improvement. This is a satisfactory picture overall.

An area which deserves particular note is the patient-focused values which should underlie everything the Trust does.

The Quality Report mentions the major consultation exercise involving staff, patients and the public which resulted in a set of these core values. In the coming year further work will embed these values into internal training courses and the way in which everyone in the hospital carries out their work.

Many of the Trust's staff already practise these values and the process of defining them has encouraged these staff, some of whom have reached a standard of excellence that has been recognised by the Council of Governors Quality Awards and the recently introduced Star Awards.

The Governors would like to see the appraisal system used to help implement the full adoption of the values by all staff, with specialised training given to those who are found to need it, and to ensure that a robust reappraisal stage following training is introduced.

The Quality Report mentions that an objective is to increase appraisal rates to at least 87%. This would be a welcome improvement, but it needs to be nearer 100% if there is to be assurance of staff commitment and application of the values. The Governors will be watching closely how this develops in the coming year.

Kensington and Chelsea Local Involvement Network (K&C LINk) response to Chelsea and Westminster Hospital NHS Foundation Trust Quality Report 2011/12

11 May 2012

Kensington and Chelsea Local Involvement Network (K&C LINk) welcomes the opportunity to comment on the Chelsea and Westminster Hospital NHS Foundation Trust Quality Report 2011/12.

K&C LINk is pleased to have developed a strong working relationship with the Trust over the last couple of years and would like to commend the hospital on their integrated approach to engagement on Quality Reports locally. We are also delighted to note that considerable work has been carried out to improve nutrition, dignity and medicine management in the Trust and will continue to work in partnership going forward.

The introduction of patient 'diaries' and leaflets should help greatly with 'Patient Experience'. The LINk would appreciate further detail on how the information is distributed and impact measured. It would also be helpful to include regular reporting on concerns and complaints as a standing item on the Quality Sub-committee agenda.

The focus on pre-discharge consultations in 2012/13 is to be commended and aligns with the priorities of K&C LINk. Further to our work on the 'Next Steps' and 're-ablement' pilots with the Foundation Trust, we would be very happy to partake as a stakeholder on the discharge project group and would gratefully receive more detail on the improved co-ordination of discharge. It would be helpful to include a target in the Quality Report for consultations with senior staff prior to discharge.

The K&C LINk notes the national inpatient survey levels of satisfaction and would welcome further information on the sample size to help place the results in context.

The LINk values the importance of staff support for the patient experience. We suggest conducting structured appraisals with all staff where feasible. A breakdown of the appraisal rate by department would be helpful. If staff understanding of the term 'personal development plan' is low, is it possible to localise the terminology used in the NHS staff survey for a more meaningful assessment and to set a more challenging target?

In terms of clinical effectiveness, the LINk is concerned that the responsible consultant is only approving half of the decisions to operate/agree the anaesthesia to be used before the patient is booked for surgery/anaesthetised. We look forward to the results of the re-audit in September 2012. The LINk would appreciate information on the pressure ulcer target once it has been established.

The K&C LINk is delighted to be able to assist with the recent project 'Improving Medication Reconciliation at Discharge—Closing the Loop'. We welcome the significant improvements made in Pharmacy in the last year and look forward to further joint working in 2012/13. The LINk would welcome consideration of arranging delivery of prescription medicine for 'vulnerable' patients who find it difficult to wait or return for a prescription. Further, we would be pleased to work with the Trust on how the care plans assist with medicine management in the Integrated Care Pilot (ICP).

In the coming year, the K&C LINk Dignity Champions will be pleased to 'spot check' for dignity on adult wards including same sex bathing and sleeping and in the 'Accident and Emergency' department.

We also look forward to working with the Foundation Trust on the maternity patient experience in the coming months.

Overall, the LINk believes the 2011/12 Quality Report is a lot more usable and accessible. We are very pleased to note the glossary, the boxed descriptions and the patient stories. We commend the Trust on their progress and we look forward to continuing to strengthen our partnership working over the year ahead.

Thank you

K&C LINk

Note: For further information on this statement please contact Paula Murphy, Community Engagement Manager, Kensington and Chelsea Local Involvement Network by emailing paula.murphy@hestia.org or calling 020 8968 6771.

Local borough responses to Chelsea and Westminster Hospital NHS Foundation Trust Quality Report 2011/12

Introduction

We welcome the opportunity to comment on Chelsea and Westminster Hospital NHS Foundation Trust's[1] Quality Report 2011/12.

Our respective Councils each have a good working relationship with Chelsea and Westminster Hospital NHS Foundation Trust.

Our analysis is limited to the information given by the Quality Report. More benchmarked data would have helped us to see how Chelsea and Westminster Hospital NHS Foundation Trust's performance compared to comparable trusts.

Performance

Chelsea and Westminster Hospital NHS Foundation Trust is a high performing organisation.

We are pleased to note:

- Nationally, the Trust consistently ranks as one of the best providers of high quality clinical care. Chelsea and Westminster Hospital NHS Foundation Trust was the only hospital in England with low death rates across all four indicators listed in the latest Dr Foster Hospital Guide.
- Monitor gave the Trust the best rating for governance and the lowest rating of financial risk.
- The Trust provides services that have met Care Quality Commission essential standards (latest report published 18 April 2012)[2]. However, we note the CQC found a few issues to be resolved on staffing and dealing with/reporting incidents.
- The Trust received 'excellent' ratings for three categories of the PEAT assessment.
- Patient satisfaction scores are high.
- The Trust met its MRSA and *C.difficile* targets.
- The Trust is to keep as priority targets for 2012/13: (1) No hospital associated preventable venous thromboembolism; (2) Communication and discharge planning.
- The Stroke Assessment undertaken by the Cardiac and Stroke Network in October 2011 identified the Trust's nutritional support policy as an example of best practice—this could have also been included in your Quality Report document.
- Some of your staff and patient representatives were winners in the Royal Borough of Kensington and Chelsea's Dignity in Care[3] award—this could have also been included in your Quality Report document.

We are disappointed to note:

- The Trust did not meet the target of no hospital associated preventable venous thromboembolism (VTE). You identified 10 venous thromboembolisms that you may have been able to prevent between July 2011 and January 2012.
- An audit showed that the responsible consultant surgeon/consultant anaesthetist was only approving the decision to operate/agree the anaesthesia to be used before the patient is booked for surgery/ anaesthetised in around half of cases. We are pleased the Trust is re-enforcing the importance of this practice and will re-audit in September 2012.
- The Trust scored poorly for "Waiting in the hospital" in the Care Quality Commission's "Outpatient department survey" (February 2012)[4].

1 Chelsea and Westminster Hospital NHS Foundation trust is an acute trust that became a Foundation Trust on 1 October 2006. The Trust has one main site on the Fulham Road and 522 beds. The services it provides include the full range of inpatient, day care and outpatient services as well as outpatient clinics on a number of other sites.

2 CQC: Chelsea and Westminster Hospital NHS Foundation Trust http://www.cqc.org.uk/directory/rqm00

3 Dignity in care rewarded to Chelsea and Westminster Hospital staff—Kensington Chelsea Today http://www.kensingtonandchelseatoday.co.uk/news/local-news/t6d8brxdc5.html

4 Care Quality Commission: Outpatient department survey (February 12)—Chelsea and Westminster Hospital NHS Foundation Trust scored "about the same" as comparable trusts on all the headline measures except "Waiting in the hospital" where they scored "worse" http://www.cqc.org.uk/survey/outpatient/RQM

Long-term plans

The financial outlook for NHS provider trusts in North West London is considered to be a matter of concern. The cash pressure could lead to cuts to patient care. The Trust is to be supported in its efforts to make efficiency savings without loss of service. The position remains unclear as to Chelsea and Westminster Hospital NHS Foundation Trust's long-term plans and their impact on local services.

We would like to know more about the Trust's long-term plans. There is a need for clarity around:

- From the work to reorganise the NHS in North West London, Chelsea and Westminster Hospital NHS Foundation Trust could be designated a Major Hospital with A&E and associated services. There would need to be an expansion of emergency services, beds etc.
- Last year, Chelsea and Westminster Hospital NHS Foundation Trust was looking at the possibilities for merger or acquisition[5].
- The Trust has indicated that it would expand private work[6] (eg bariatrics, plastics and paediatric surgery) if the private patient cap is lifted.
- We would like to know how Chelsea and Westminster Hospital NHS Foundation Trust's long-term plans fit with Imperial College Healthcare NHS Trust and the Royal Brompton & Harefield NHS Foundation Trust.

Public health

We encourage Chelsea and Westminster Hospital NHS Foundation Trust to be fully involved in local health promoting strategies. More could be said in the Quality Report on how the proposed actions of the Trust align with other major public health campaigns.

Quality Reports process

The Audit Commission report "NHS quality accounts 2010/11"[7] called for all trusts to address the "need to embed producing Quality Reports in trusts' wider quality improvement agenda, rather than treating them as a stand-alone exercise". We encourage the Trust in these endeavours.

We would be pleased if the local overview and scrutiny committees were invited to future stakeholder Quality Report events. Input from overview and scrutiny committees should be sought as early as possible. Our overview and scrutiny committees look forward to being informed of how the priorities outlined in the Quality Report are implemented over the course of 2012/13.

Conclusion

Overall, the progress that the Trust has made over the last year is to be welcomed, and we look forward to being informed of how the priorities outlined in the Quality Report are implemented over the course of 2012/13.

Councillor Mary Weale
Chairman, Health, Environmental Health and Adult Social Care Scrutiny Committee
Royal Borough of Kensington and Chelsea

Councillor Lucy Ivimy
Chairman, Housing, Health and Adult Social Care Select Committee
London Borough of Hammersmith and Fulham

Councillor Sarah Richardson
Chairman, Adult Services and Health Policy Scrutiny Committee
Westminster City Council

5 From page 9 of Chelsea and Westminster Hospital NHS Foundation Trust's "Forward Plan Strategy Document for y/e 31 Mar 2012 (and 2013, 2014)" available at: http://www.monitor-nhsft.gov.uk/home/about-nhs-foundation-trusts/nhs-foundation-trust-directory/chelsea-and-westminster-hospital-nhs

6 HSJ (1 Sept 11): FT plans 20 per cent growth in private patient income http://m.hsj.co.uk/5034288.article

7 Audit Commission: NHS quality accounts 2010/11 http://www.audit-commission.gov.uk/nationalstudies/health/financialmanagement/Pages/nhsqualityaccounts1011.aspx

NHS North West London Cluster statement in response to Chelsea and Westminster Hospital NHS Foundation Trust Quality Report 2011/12

NHS North West London (the Cluster), a cluster of 8 PCTs, has reviewed Chelsea and Westminster Hospital NHS Foundation Trust's Quality Report (QR) for the year 2011/12. The Trust presented its draft QR for formal comments on 30 April 2012 and a further draft on 4 May 2012.

These have been reviewed by the relevant contract manager, the quality team, the performance team, the Clinical Quality Group (CQG) chair and the cluster Quality & Clinical Risk Committee.

This statement has been signed off by the Non-Executive Chair of the cluster's Quality & Clinical Risk Committee on behalf of the Cluster Board. In our view, the QR in general complies with guidance as set out by both Monitor and the Department of Health (DoH).

Review of quality priorities for 2011/12

The Trust has made progress in establishing systems and processes for identifying, recording, reviewing and monitoring Venous Thromboembolism (VTE).

Audits were carried out to identify if patients received appropriate preventive treatment for VTE, however, there is no information on how issues identified from these audits were addressed. For example, of the 10 preventable VTEs identified, the Trust reported that most of the patients missed out on one or two days of medications.

There is no reference to how the Trust will ensure patients do not miss their medications to prevent VTE or how this might link in with what the Trust may be doing about missed medications in general. Specific plan to improve performance on the number of completed stockings monitoring form was also not documented.

Overall, the Trust did not achieve its target for this priority and we welcome the decision to keep this as a priority for 2012/13.

The Trust reported progress under the Patient Experience category, Priority 2, focussing on communication, discharge planning and care of older people. The standards under discharge planning of focusing on pre-discharge consultations and reducing readmission rates were not met.

While the former has been included as a priority for 2012/13, there is no information on what the Trust intends to do about reducing readmission rates.

For Patient Experience Priority 3, we acknowledge progress made in this area and support the Trust's decision to improve performance further and keep this as a priority for 2012/13.

The Trust reported its decision to 'retire' the clinical effectiveness Priority 4. Part of this priority, measuring whether changes made have been effective in cutting the length of time patients are 'nil by mouth', was not achieved and we would suggest the Trust reports on progress in 2012/13.

Overall, we commend the Trust for progress made around patient and staff satisfaction.

Priorities for improvement 2012/13 and Review of Quality Performance

The Trust presented four priorities for improvement for 2012/13 and described its review of quality performance and its services during 2011/12. In our view, there is no evidence that the identification of priorities for 2012/13 was consistently linked to the Trust's review of all its services during 2011/12. However, we do support the Trusts priorities for improvement.

For these priorities, we noted that information on how they will be improved and the targets to be achieved were not consistently provided. For example in Patient Safety Priority 1, providing information on current uptake of training and planned increase, improvement trajectory for risk assessments and specific actions to ensure patients receive preventive treatment would have been helpful.

For Patient Experience Priority 2—Care of the older person; the inclusion of information on issues identified from the monthly nutritional screening audits and specificity about planned improvements would have provided clear targets. We consider the Trust should set a more challenging target for nutritional screening in 2012/13. Under the review of quality performance—local performance indicators, the target for % of patients nutritionally screened on admission for 2012/13 is the same as that for 2011/12, even though this was exceeded in 2011/12.

Information on how the Trust will improve the % of patients in longer than a week that are nutritionally rescreened was also not provided. Where targets presented under local quality performance indicators in 2012/13 are the same as that set in 2011/12 or indeed below 2011/12 performance, an explanation for this apparent lack of challenge would be helpful.

The Trust reported six 'never events' in the QR. These were not properly reported to commissioners during the year as mandatorily required. Learning from these events has also not been shared anywhere in the QR, nor has it been given any weight in the report.

As commissioners, we are committed to ensuring that the services provided for our population are of the highest quality and where things have gone wrong, we expect assurance that lessons have been learned and changes implemented to prevent reoccurrence. We would value a commitment from the Trust to report these events to commissioners in a timely manner and promptly share reports and learning in the spirit of openness and transparency.

Data on the Trust's performance on all national priorities was not available at the time of review. For the priorities where data is available, actual figures, rather than achieved and presenting year on year data would have provided a better baseline for comparison and showcase improvements where these have been made.

For data routinely measured as part of the contract, and presented in the draft received for comments, we can confirm that these are consistent with what is reported on performance scorecards and reviewed at contract meetings.

The Trust reported participation in national clinical audits but has not consistently explained where participation rates are low and its plan for improvement. For example, the National IBD Audit at 58% and the National PROMs programme for Hip replacement and Knee replacement with return rates of 68% and 66% respectively.

Concluding Statement

The Cluster will continue to support the Trust in further developing and monitoring the quality of service it provides for patients.

Whilst we recognise improvements made in 2011/12, we hope the Trust finds these comments helpful and we look forward to continuous improvements in 2012/13.

Annex 4: Trust response to statements from key stakeholders

The Trust is grateful for the considered responses from all our stakeholders. These have been helpful and will be considered where appropriate with the relevant stakeholders in 2012/13.

The Trust notes the comments on never events from the NHS North West London Cluster statement and would like to take the opportunity to confirm that never events were routinely reported to the commissioners through monthly performance reports, which were shared at the Clinical Quality Group meetings. Root cause analyses were undertaken by the Trust and changes implemented accordingly.

We have agreed a further reporting mechanism to ensure the commissioners are made aware in a more timely manner, and which will provide additional information on actions taken. We have also taken this opportunity to confirm that there were five never events, not six, as one was, after investigation, found not to be a never event.

Annex 5: Glossary

Abbreviation	Meaning / Definition
A&E	Accident and Emergency Department
Benchmarking	Benchmarking is the process of comparing business processes and performance measurements industry bests and/or best practices from other industries. Issues typically measured are quality, time, and cost.
Bronchietectasis	Inflammation and damage of the bronchi in the lungs
BTS	British Thoracic Society
Care bundle	A care bundle is the end result of an extensive review of literature which identifies the key elements/aspects/intervention of care. If all interventions are performed, the relevant risk of infection is minimised. If not all interventions are performed the risk of infection increases.
Care bundle—ventilator associated pneumonia	As described above, a care bundle is a way of ensuring that recommended evidence based clinical care for patients is actually delivered. The ventilator care bundle is made up of 4 elements, to nurse the patient at 30° head up to prevent gastro-oesophageal reflux, to give preventative treatment for stomach ulcers, to give preventative treatment for clots and to stop sedatives for a period of time daily which reduces the length of stay in the Intensive Care Unit.
Care Quality Commission	This regulatory organisation checks whether hospitals, care homes and care services are meeting government standards
C.difficile (*Clostridium difficile* or *C.diff*)	A specific kind of bacterial infection that causes mild to very severe forms of diarrhoea and colitis.
CEMACE	Centre for Maternal & Child Enquiries
Central line	A tube called a catheter placed into a large vein used to administer medication or fluids, obtain blood tests and obtain cardiovascular (pertaining to, or affecting the heart and blood vessels) measurements
CEWSS	Chelsea Early Warning Score System.
CLAHRC	Collaboration for Leadership in Applied Health Research and Care
Clinical Coding	Clinical Coding is the translation of medical terminology as written by the clinician to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format.
Colposcopy	An investigative diagnostic procedure in which a gynaecologist uses an instrument to look at the cervix and the entrance to the neck of the womb and sometimes to take a small sample or biopsy
Commissioners	A body that identifies the health needs of the local population. Commissioners also evaluate and purchase health services for patients (such provided in hospitals).
Commissioners—North West London Commissioning Partnership (NWLCP)	The eight Primary Care Trusts in NW London have formed a sector-wide North West London Commissioning Partnership (NWLCP) which is developing the capacity of the NHS to commission and manage the performance of acute (hospital based) services from the seven main acute providers in NW London
Commissioners—The London Specialised Commissioning Group	The London Specialised Commissioning Group works on behalf of London's Primary Care Trusts (PCTs) to ensure the people of London have access to the most specialised healthcare when they need it, and to improve the quality and value for money of specialised care. Source: the website of the London Specialised Commissioning Group http://www.londonspecialisedcommissioning.nhs.uk/about_us
Compression stockings	These stockings help maintain circulation in the leg veins and reduce leg swelling. They can help reduce the risk of blood clots forming in the veins of the legs (DVT).
COPD	Chronic Obstructive Pulmonary Disease

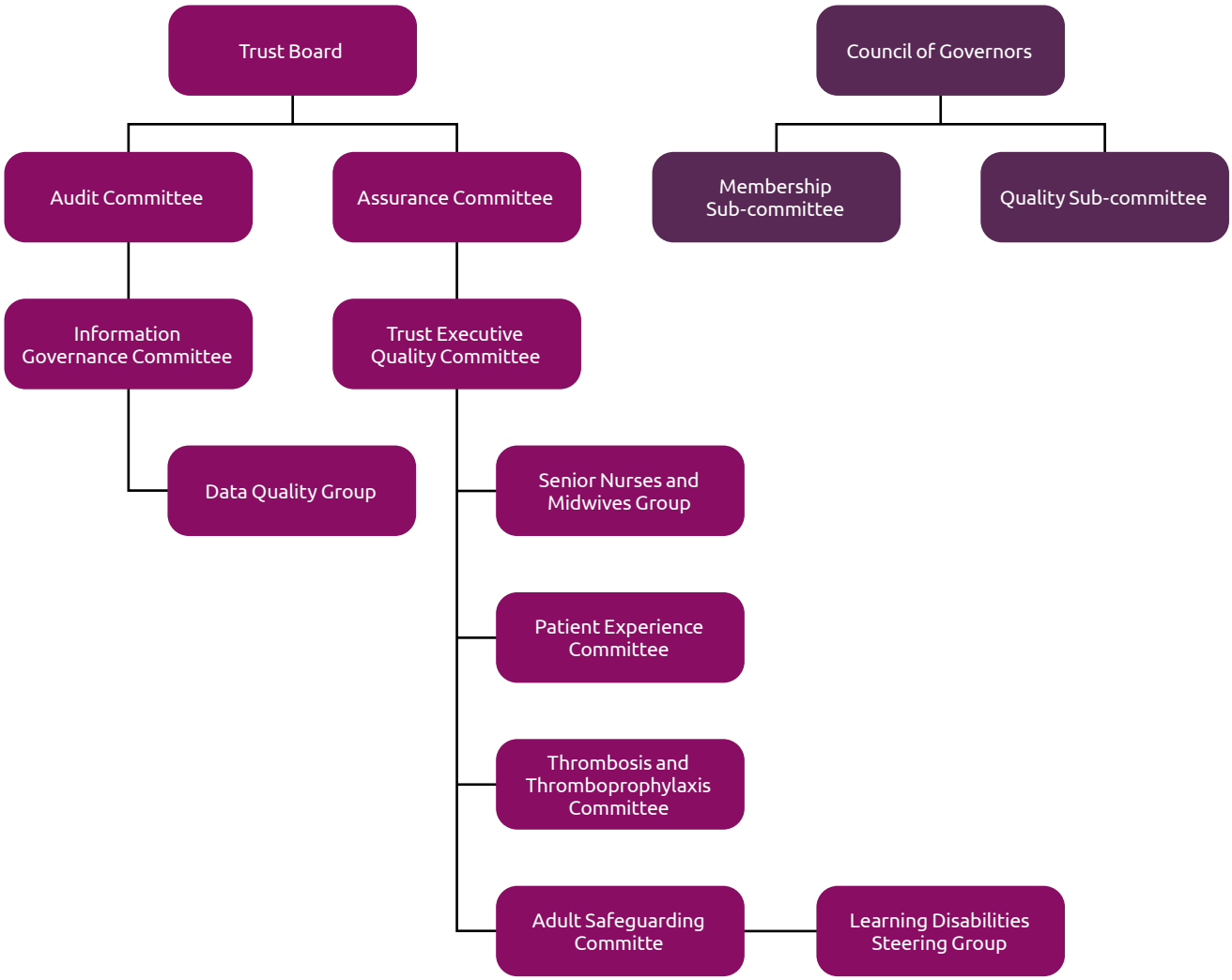
Abbreviation	Meaning / Definition
COPD discharge care bundle	This care bundle is a group of evidence based items that should be delivered to all patients being discharged from the hospital following an Acute Exacerbation of Chronic Obstructive Pulmonary Disease.
CQUIN	Commissioning for Quality and Innovation (A payment framework that enables commissioners to reward excellence by linking a proportion of providers' income to the achievement of local quality improvement goals.)
Dementia	A set of symptoms which include loss of memory, mood changes, and problems with communication and reasoning. These symptoms occur when the brain is damaged by certain diseases
Dementia CQUIN	Four staff members will complete NHS London training and will then ensure further training is provided to Trust staff working in specific areas—25% of all nurses, 40% of allied health professionals (includes therapists), 40% of junior doctors, 65% of consultants and speciality registrars. The CQUIN also includes an incentive to reduce inappropriate prescribing of anti-psychotics.
DoH/DH	Department of Health
DVT	Deep Vein Thrombosis
Engagement (as defined in the staff survey)	The CQC has provided an overall 'Staff Engagement Score' for the last three years. This includes staff's perceived ability to contribute to improvements at work, their willingness to recommend the Trust as a place to work/receive treatment, and the extent to which staff feel motivated and engaged with their work. The Trust's engagement score was 3.81 (on a Likert scale of 5, where 5 is best) placing us in the top 20% of acute trusts nationally for the third year running.
FCE	Finished Consultant Episode—an episode of care from a Consultant to a patient that has concluded
Gastro-oesophageal reflux	A condition in which the acidic contents from the stomach regurgitate or reflux (wash back) into the oesophagus (the gullet).
Hand hygiene compliance rates/ completion rates	Staff compliance with the World Health Organisation '5 moments of hand hygiene'. These are: cleaning hands before and after patient contact, before aseptic tasks, after contact with body fluids and after contact with the patient's environment (within 6ft radius of the patient's bed). Completion rates denote the completion rates of the audits undertaken to monitor hand hygiene.
HIV	Human immunodeficiency virus
HSMR	Hospital Standardised Mortality Ratio (An indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than expected).
IBD	Inflammatory bowel disease
ICNARC CMPD	Intensive Care National Audit and Research Centre Case Mix Programme Database
ICU	Intensive Care Unit
LINk	Kensington and Chelsea Local Involvement Network
Liverpool Care Pathway (LCP)	The LCP is an integrated care pathway that is used at the bedside of a dying patient to promote quality of care in the last hours and days of life.
The London Specialised Commissioning Group	The London Specialised Commissioning Group works on behalf of London's Primary Care Trusts (PCTs) to ensure the people of London have access to the most specialised healthcare when they need it, and to improve the quality and value for money of specialised care.
MBRACCE perinatal mortality	Relevant to mothers and babies: reducing risk through audits and confidential enquiries across the UK. It is the interim arrangement for reporting maternal and perinatal deaths.

Abbreviation	Meaning / Definition
MINAP	Myocardial Ischaemia National Audit Project established in response to the national service framework (NSF) for coronary heart disease, to examine the quality of management of heart attacks in hospitals in England and Wales.
MRSA bacteraemia	The presence of Methicillin-resistant Staphylococcus aureus bacteria in the blood
NHS Institute for Innovation and Improvement	This organisation aims to support the NHS transform healthcare for patients and the public through the development and dissemination of innovative approaches and methodologies
NCDAH	National Care of the Dying Audit
NCEPOD	National Confidential Enquiries into Patient Outcome and Death
National Reporting and Learning System (NRLS)	The system enables patient safety incident reports to be submitted to a national database. Data is analysed to identify hazards, risks and opportunities to improve the safety of patient care.
Never Events	Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented
NIHR	National Institute of Health Research
Nil by mouth	To withhold oral food and fluids from a patient
NNAP (neonatal and special care)	National Neonatal Audit Programme
NWLCP	North West London Commissioning Partnership (NWLCP). The eight Primary Care Trusts in NW London have formed a sector-wide North West. London Commissioning Partnership (NWLCP) which is developing the capacity of the NHS to commission and manage the performance of acute (hospital based) services from the seven main acute providers in NW London.
Occupied per 1000 bed days	Occupied bed days are derived from the ward listing total beds occupied, which should be recorded each day as part of the daily ward listing. This daily count should then be totalled across the period for which the data is required.
Pressure ulcers	Open wounds that form whenever prolonged pressure is applied to skin covering bony areas of the body. Pressure ulcers are commonly known as bedsores.
Pressure ulcers grades 3 & 4	As determined by the European Pressure Ulcer Advisory Panel grading system and adapted for this glossary: • Grade 4: Full thickness skin loss involving muscle, bone or supporting structures • Grade 3: Full thickness skin loss involving damage to subcutaneous tissue (the deepest layer of skin) that may extend to but not through the underlying fascia (strong connective tissue)
ProMISe trial	Protocolised Management In Sepsis (ProMISe): a multicentre, randomised controlled trial of the clinical and cost-effectiveness of early goal-directed protocolised resuscitation for emerging septic shock.
PROMS (Patient Reported Outcome Measures)	PROMs measure quality from the patient perspective for four procedures, hip replacements, knee replacements hernia and varicose veins. They are short, self-completed questionnaires, which measure the patients' health status or health related quality of life at a single point in time. The indicated cases is a figure based on the previous years numbers so conclusions have been drawn on how many procedure we will be performing in one year based on how many we performed the year before so is only an estimate. Cases submitted are an average monthly return rate as the data is collected monthly.

Abbreviation	Meaning / Definition
PEAT	Patient Environment Action Team. PEAT is an annual self-assessment, established in 2000, of inpatient healthcare sites in England with more than 10 beds. Scores range from 1 (unacceptable) to 5 (excellent) for a range of key areas including: food and food service; cleanliness; access and external areas; infection control; privacy and dignity; and patient environment (including toilets and bathrooms, lighting, floors, patient areas, etc).
Peripheral line	A short, thin, plastic tube that goes through the skin and into a vein. This can be connected to and infusion to deliver fluids and medication or a syringe.
PHSO	Parliamentary Health Services Ombudsman
Q1 or Quarter 1	The period April to June 2011
Q2 or Quarter 2	The period July to September 2011
Q3 or Quarter 3	The period October to December 2011
Q4 or Quarter 4	The period January to March 2012
RCA	Root Cause Analysis
RCOG	Royal College of Obstetricians and Gynaecologists
RCPCH	Royal College of Paediatrics and Child Health
RCP	Royal College of Physicians
Referral to Treatment	90% of admitted and 95% of non-admitted patients should start consultant-led treatment within 18 weeks of referral from a GP
SHMI	Summary Hospital-Level Mortality Indicator—a new indicator for mortality. The indicator is for non-specialist acute trusts, and covers all deaths of patients admitted to hospital and those that occur up to 30 days after discharge from hospital.
SINAP	Stroke Improvement National Audit Programme
SUS	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
TARN	Trauma Audit & Research Network
Tertiary	Tertiary Services are specialised health services that are provided in hospitals on a regional basis
Thromboprophylaxis	Prevention of Venous thrombosis (blood clots) forming in veins within the body
VTE	Venous thromboembolism—the collective term for deep vein thrombosis (DVT) and pulmonary embolism (PE)
VTE target 2012/13	We had 10 preventable cases of VTE in 7 months. If we extrapolate this to 12 months this is 17. A 25% reduction is therefore 13
Wayfinding project	This is a project which will involve staff, patients and visitors on how to make it easy for everyone to find their way about.
Wellbeing rounds	A regular routine check made by nurses to find out if patients are comfortable, pain free, and if they have any other needs.

Annex 6: Trust Committee structure and Clinical Divisional structure

Trust Committee Structure (includes committees referred to in the text only)



Clinical Divisional Structure

Division of Medicine and Surgery

- Accident and Emergency (A&E)
- Discharge team
- Medicine
- Surgery including plastic surgery
- Burns
- Pain
- Cancer
- Diabetes

Division of Women, Children and Sexual Health

- Midwifery
- Obstetrics
- Paediatrics
- NICU
- Gynaecology
- HIV
- Sexual Health
- Dermatology

This Division includes:

- Maternity Services Liaison Committee
- HIV Patient Forum
- Paediatrics Forum

Division of Clinical Support

- Pharmacy
- Critical Care
- Therapies
- Diagnostics
- Theatres
- Anaesthetics
- Radiology
- ICU

Directors' Report

Key facts

There was increased demand for Trust services in 2011/12:

Number of patients treated

	2011/12	2010/11	2009/10	2008/09
Inpatients	46,824	46,863	38,751	37,644
Outpatients*	186,035	176,303	160,327	148,941
Day cases	23,103	21,974	17,790	16,821
A&E + UCC**	107,419	108,010	100,905	97,640
Total	**363,381**	**353,150**	**317,773**	**301,046**

* Number of individual patients treated as outpatients not number of attendances in Outpatients (eg if an individual patient attended Outpatients on eight separate occasions, this is counted as one patient and not eight attendances)

** The Urgent Care Centre (UCC) is a 'walk-in' service, developed with GPs, for patients who come to A&E with minor illnesses and injuries that require attention but are not critical or life-threatening

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

- 10% increase in demand for sexual health services in 2011/12 compared with 2010/11 at our three main centres—John Hunter Clinic for Sexual Health at Chelsea and Westminster Hospital, West London Centre for Sexual Health at Charing Cross Hospital, and 56 Dean Street in Soho
- 7,053 people living with HIV on our caseload in 2011/12, compared with 6,623 in 2010/11, 6,005 in 2009/10 and 5,481 in 2008/09
- 5,915 deliveries in Maternity in 2011/12, compared with 5,738 in 2010/11, 5,497 in 2009/10 and 5,311 in 2008/09—these figures include both NHS and Private Maternity Unit deliveries
- 80,299 children treated in 2011/12 as inpatients, outpatients, in Paediatric A&E or as day case patients, compared with 74,876 in 2010/11, 70,357 in 2009/10 and 65,668 in 2008/09

There were high levels of patient satisfaction with Trust services in 2011/12:

- 89% of patients rated their care at Chelsea and Westminster as 'Excellent', 'Very good' or 'Good' in the annual NHS inpatient survey—96% would recommend Chelsea and Westminster Hospital to friends and family
- 89% of patients rated their care at Chelsea and Westminster as 'Excellent', 'Very good' or 'Good' in the annual NHS outpatient survey—93% would recommend Chelsea and Westminster Hospital to their friends and family
- 96% of women rated their care during pregnancy at Chelsea and Westminster as 'Excellent', 'Very good' or 'Good' in the Care Quality Commission's national survey of women's experiences of maternity services
- 94% of women rated their care during labour and birth at Chelsea and Westminster as 'Excellent', 'Very good' or 'Good' in the Care Quality Commission's national survey of women's experiences of maternity services
- 93% of parents of children aged 0–7 and 89% of children and young people aged 8–17 rated their care at Chelsea and Westminster as 'Excellent', 'Very good' or 'Good' in the Care Quality Commission's national survey of paediatric inpatients
- 96% of parents of children aged 0–7 and 97% of children and young people aged 8–17 rated their care at Chelsea and Westminster as 'Excellent', 'Very good' or 'Good' in the Care Quality Commission's national survey of paediatric outpatients

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, general hospital services to the local population, and an increasing number of services in community settings closer to where patients live.

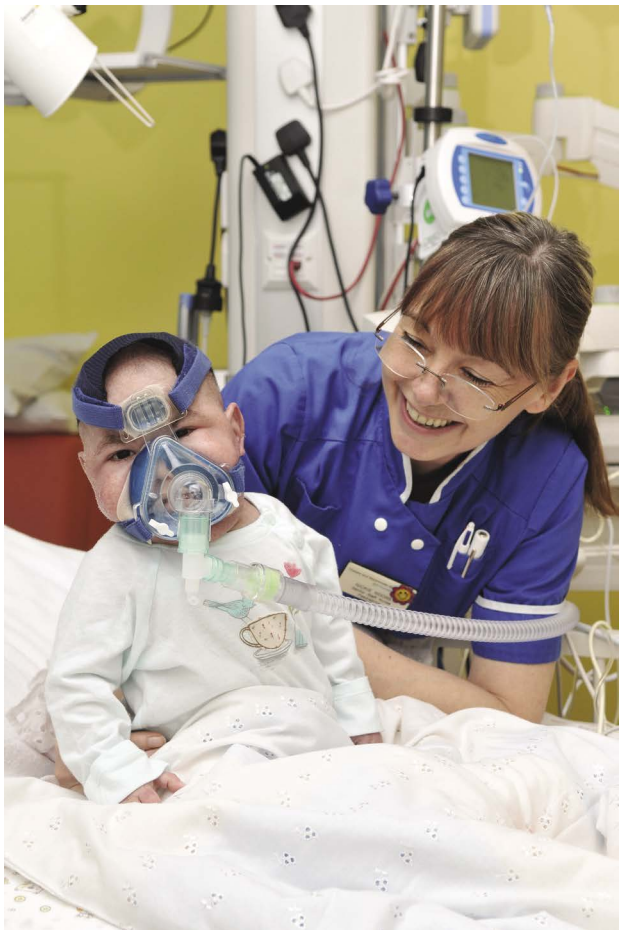
Chelsea and Westminster is a campus of Imperial College London Faculty of Medicine.

Most services are provided at Chelsea and Westminster Hospital but HIV and sexual health services are provided in the John Hunter Clinic for Sexual Health and the Kobler Clinic located in the St Stephen's Centre next to the main hospital building, 56 Dean Street in Soho, the West London Centre for Sexual Health at Charing Cross Hospital, and in a range of community settings.

Community-based services include gynaecology and dermatology clinics in Westminster, Kensington and Chelsea, and Richmond. A mobile community health clinic ('The Bus') also provides services in community settings including Shepherd's Bush Market.

Clinical services are divided into three divisions, each led by a Divisional Medical Director and a Divisional Director of Operations.

Facilities services are contracted out to ISS Facility Services Healthcare—a joint contract with our partners in the Fulham Road Collaborative—and Norland Managed Services.



Review of financial performance

The Trust has maintained its strategic approach to delivering a significant Cost Improvement Programme (CIP) to ensure financial stability. The Trust achieved a CIP of £19.7 million (9% of controllable costs) in 2011/12 following a CIP of £22.6 million (10% of controllable costs) in 2010/11.

A key component has been open, honest and consistent communication with staff by the Executive team about the financial challenges facing the Trust.

Two ongoing internal communications campaigns continued to ensure that staff were well informed—*Fit for the Future* about the need to maintain and improve the quality of patient care while delivering cost savings and *Putting Patients First* about investment in a major redevelopment of the hospital to improve services.

In 2011/12 the Trust's financial performance was given a financial risk rating of 5 out of 5 by Monitor, where 5 is 'low risk', and delivered a surplus of £13.6 million which was £5.2 million ahead of plan.

The Trust's annual income and expenditure performance is set out below.

Summary 2011/12 Income and Expenditure Outturn vs Plan (£m)

	Plan 2011/12	Actual 2011/12	Variance 2011/12
Income			
Clinical income	294.2	301.6	7.9
Non-clinical income	38.9	41.2	1.8
Total income	**333.1**	**342.8**	**9.7**
Expenses			
Pay costs	171.2	171.4	0.2
Non-pay costs	131.9	137.4	5.5
Total expenses	**303.1**	**308.8**	**5.7**
EBITDA	**30.0**	**34.0**	**4.0**
Depreciation	11.0	10.2	0.8
Dividend on PDC	10.1	9.7	0.4
Interest	0.5	0.5	0
Loss on disposal of asset	-	0	0
Net surplus	**8.4**	**13.6**	**5.2**
Cost Improvement Programme (CIP)	**19.7**	**20.9**	**1.2**

Key variances from plan in 2011/12

1. Clinical income was £7.9 million above plan due to increased levels of clinical activity across several clinical specialties and a lower than planned impact of commissioner-led demand management schemes.

2. Non-clinical income was £1.8 million higher than plan due to increased income relating to R&D activity as well as a change in accounting rules relating to donated income for capital assets.

3. Pay costs were broadly in line with plan. This performance was due to continued controls of the use of temporary staffing which is only used in line with activity requirements.

4. Non-pay costs were £5.5 million higher than plan due to increased costs of clinical supplies relating to clinical over-performance. Another factor relating to this overspend was that the Trust increased its level of provisions relating to contractual disputes.

5. Depreciation was £0.8 million lower than plan due to slippage in the delivery of the Trust's capital plan.

6. Dividend on PDC was £0.4 million lower than budget due to higher than planned cash balances than originally planned.

Review of non-financial performance

The Trust performed well in all areas of non-financial performance and achieved the required performance level on all Monitor's indicators.

The Care Quality Commission (CQC) carried out an unannounced inspection of Chelsea and Westminster Hospital in February 2012 to assess our compliance with essential standards of quality and safety.

Inspectors visited 10 wards and departments and spoke to patients and staff. They observed how patients were being cared for and assessed our performance against a number of standards including:

- Respecting and involving people who use services
- Care and welfare of people who use services
- Safeguarding people who use services from abuse
- Cleanliness and infection control
- Supporting staff
- Assessing and monitoring the quality of service provision

The CQC's report published in April 2012 concluded that Chelsea and Westminster Hospital is meeting all the essential standards of quality and safety.

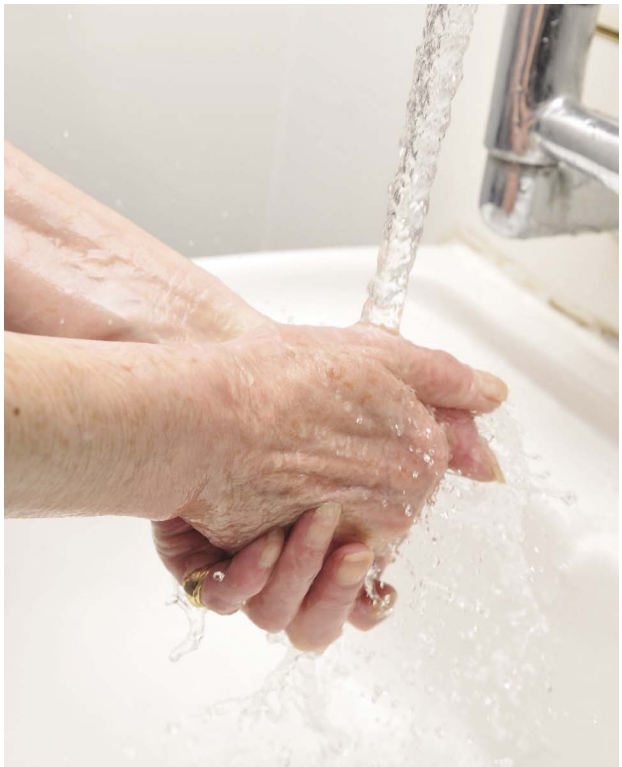
During the visits, patients told CQC inspectors that they felt well looked after and that staff were attentive and caring.

Patients also provided positive feedback about staff providing reassurance and maintaining the privacy and dignity of patients, and the cleanliness of ward areas and infection control.

The inspectors did raise some minor concerns, as follows.

They found that overall the Trust has suitable arrangements in place to ensure that staff are competent and that their welfare and developmental needs are met. However, they found that some staff did not have regular performance review sessions with their line manager and that mentorship training was due for some staff. Improvements are needed as not all staff are supported and receive appropriate training or professional development.

The inspectors also found that the Trust has systems in place to monitor the quality of care delivered but improvements are needed because local management of less serious incidents which had been reported appeared inconsistent and actions were not followed up locally in a timely manner. Not all staff were aware of the progress, feedback and action related to incidents reported.



Developments since the end of 2011/12 financial year

New Chief Executive appointed

Tony Bell was appointed as the new Chief Executive of Chelsea and Westminster Hospital NHS Foundation Trust in May 2012—he is due to take up his post in September 2012. He will succeed Heather Lawrence who leaves Chelsea and Westminster at the end of June 2012.

Tony Bell's appointment was approved at a meeting of the Council of Governors on 3 May 2012. He said: "I am looking forward to working with so many talented and dedicated staff who have helped make Chelsea and Westminster one of the most highly regarded NHS trusts in the country. I aim to lead the Trust forward to continued success, building on the strong foundations provided by the hard work of all staff under the leadership of Heather Lawrence to provide the best possible care for patients."

National recognition for prevention of blood clots

The Trust was named as an Exemplar Centre for VTE prevention in April 2012 for its work in preventing blood clots.

Dr Roopen Arya, national lead for the NHS VTE Exemplar Centre Network, said: "Following my visit to the Trust, I could see the commitment to VTE prevention as well as the quality of VTE services which was highly impressive."

Chelsea and Westminster has introduced an electronic risk assessment tool to identify patients at risk of blood clots when they are admitted to the hospital so they can be offered appropriate preventive treatment. The 'No more clots' campaign has raised awareness of the issue among patients and staff.

CHKS patient safety award

In May 2012, the Trust was shortlisted for the CHKS patient safety award for the second consecutive year. CHKS is an independent provider of healthcare intelligence and quality improvement services to the NHS and the private healthcare sector.

This is a national award for providing a safe hospital environment for patients which is based on criteria including infection and mortality rates and, unlike other awards, is not judged by a panel.

Although the Trust did not win the award, being shortlisted was a major accolade.

Trust wins contract for community MSK services

The Trust and its independent sector partner Connect Physical Health have been awarded the contract to provide community musculoskeletal (MSK) services in Kensington and Chelsea.

The Kensington and Chelsea Community Musculoskeletal Service will be the first fully integrated community MSK service provided by an independent sector provider and an NHS trust. It is due to start providing services to patients in September 2012.

The new service was commissioned by NHS Kensington and Chelsea following a competitive bidding process.

Local GP Dr Naomi Katz said: "As GP MSK Clinical lead I am absolutely delighted that Chelsea and Westminster and Connect Physical Health have won the contract to provide our community musculoskeletal service."

Open Day

More than 2,000 people attended the hospital's popular annual Open Day on 12 May 2012. It included a careers event for young people interested in a career in healthcare and the public launch of the Trust's values.

Chelsea and Westminster physiotherapist James Close treats an MSK patient

Future developments

Shaping a healthier future public consultation

NHS North West London is due to launch its public consultation on major service changes in late June 2012—proposals including reducing the number of full A&E services in North West London from eight to five will have a major impact on the Trust.

Electronic Document Management (EDM)

The Board of Directors has approved the implementation of an Electronic Document Management (EDM) system to improve patient care by making medical records available to clinicians electronically.

This will mean an end to the problems associated with paper records, in particular difficulties with tracking the physical location of records in the Trust, records being lost, and delays caused by cancelled operations when records cannot be located.

EDM is due to go live in October 2012 with early adopters including the specialties of Urology, General Surgery and Dermatology.

Putting Patients First— redevelopment of Chelsea and Westminster Hospital: Next steps

The redevelopment of the hospital will continue in 2012/13.

The Trust's Wayfinding Strategy is expected to be approved by the Board of Directors in June 2012 following the 'Show us the way' consultation with patients and staff about how to make it easier for patients and visitors to find their way around the hospital.

Improvements will be made to signage, maps, and appointment letters.

Construction of a Diagnostic Centre to create a better environment for patients who require diagnostic tests is due to start in Summer 2012. It will bring together diagnostic services that are currently spread throughout the hospital.

The Kensington and Chelsea Community Musculoskeletal Service team

Principal risks and uncertainties facing the Trust

The Trust has mechanisms in place that seek 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.

There are two major areas of uncertainty and risk—continued financial pressures and the potential impact of proposed NHS reforms, both nationally and locally.

In 2012/13, the Trust has a challenging Cost Improvement Programme target of £16.2 million (8% of controllable costs) due to:

- Expected losses in income due to tariff changes
- The anticipated impact of commissioner-led initiatives to reduce the demand for our services in response to the need to save £1 billion in the NHS in North West London in the next three years
- The impact of a 4% efficiency requirement embedded in tariffs for 2012/13
- Funding for the Trust's capital development programme of c. £100 million over three years

A risk is that, if the CIP is not delivered, the Trust will have to underspend in other areas to compensate.

There are uncertainties with regard to the potential impact of the implementation of the Health and Social Care Act, in particular the transfer of responsibility for commissioning services to GPs, relaxation of the private patient income cap, more choice for patients, and increased competition.

The overall Trust strategy has taken these issues into account and plans are in place to mitigate the risks and/or benefit from these changes.

The potential outcome of *Shaping a healthier future*, NHS North West London's public consultation on major service reconfiguration which is due to start in late June 2012, is a major risk for the Trust.

If a full A&E service is retained at Chelsea and Westminster instead of Charing Cross, our future as a 'major hospital' is safeguarded, we will see increased A&E activity, more emergency admissions, and increased inpatient and theatres activity.

However, the Trust is embracing the need to focus on the move to more care being provided out of hospital, top decile performance, and a transformation programme to improve medical and surgical services.

If A&E is retained at Charing Cross instead of Chelsea and Westminster, the future of the Trust is threatened because Chelsea and Westminster will be downgraded to a 'local hospital', we will lose income from more than 100,000 A&E attendances a year, and we will also lose an estimated 60% of current adult inpatient activity.

The Trust is embarking on further scenario planning and sensitivity analysis to address this significant risk. However, it is important to note that no changes to services are planned to take place before 2015/16.

Finally, there is some uncertainty about the reconfiguration of specialised services within North West London and London as a whole including tertiary Paediatrics, HIV and Burns.

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

National factors

The Health and Social Care Bill received Royal Assent to become the Health and Social Care Act on 27 March 2012. It is expected that policy reforms introduced by the Act will begin to alter the local health economy in 2012/13.

This will include changes to commissioning structures by putting greater decision-making in the hands of GPs through Clinical Commissioning Groups and potentially placing sexual health services under the control of local authorities.

The Act will also encourage greater contestability and competition between providers through the interpretation of 'any qualified provider'.

In addition, the increase to the private patient cap may expose the Trust to greater competition for private patient activity although it will also provide the Trust with an opportunity to increase its private patient income.

The Act emphasises the need to promote increased patient choice. The Trust will continue to improve the quality of information provided to patients, not least through our website which now includes a Transparency section.

Regional and local factors

The Health and Social Care Act's devolution of commissioning to GPs in Clinical Commissioning Groups will have an impact on how our services are commissioned in future and on our key relationships. See the 'Stakeholder relations' section for details of how we have been strengthening relationships with GPs in preparation for changes in the commissioning landscape.

The NHS in North West London must save £1 billion over the next three years and so in the contracting round for 2012/13 there have been challenging negotiations with the current commissioners in North West London.

Our income plans for 2012/13 reflect the commissioner's drive to move activity from hospitals into community settings—we anticipate £3 million of work will be moved from Chelsea and Westminster in this financial year.

Strict ratios for new-to-follow-up outpatient appointments and consultant-to-consultant referrals may reduce the extent to which we are paid for the activity we carry out.

Secretary of State for Health Andrew Lansley speaks with David Radbourne (Chief Operating Officer), Odette Ferrao (Head of Peri-operative Services), Ria Lane (Service Support Manager, Paediatrics) and Zoë Penn (Divisional Medical Director) during a visit to the Chelsea Children's Hospital at Chelsea and Westminster

Research and Development

The Trust's Research Strategy, *Improving Patients' Lives through Research and Innovation*, is now being implemented by the Research Strategy Board which is chaired by the Trust Chairman, Professor Sir Christopher Edwards.

Chelsea and Westminster was shortlisted in the Research Culture category of the *Health Service Journal* Awards 2011.

In 2011/12, the Trust hosted 245 active research projects, recruited 5,193 patients into research studies, and generated £5.35 million of income from research and development activities.

Chelsea and Westminster hosts the National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Northwest London.

The CLAHRC aims to embed research findings into clinical practice as quickly as possible, with a focus on funding projects to improve quality.

It is the biggest research programme at Chelsea and Westminster and currently supports 18 major research projects across North West London.

CLAHRC-funded projects at Chelsea and Westminster have included medicines management, a shared alcohol care pathway, and a 'care bundle' for Chronic Obstructive Pulmonary Disease (COPD) patients—see case study below for details.

The CLAHRC has developed and implemented an evaluation framework for patient and public involvement in quality improvement projects and run knowledge delivery events for more than 1,000 staff and academics.

Key Fact

More patients are taking part in research at Chelsea and Westminster—in 2011/12, the Trust recruited 5,193 patients into research studies, a 12% increase from 2010/11

Staff based at Chelsea and Westminster are involved in a number of other significant research programmes:

- Professor Neena Modi leads the Medicine for Neonates programme funded by the NIHR to improve health outcomes for babies admitted to neonatal units and facilitate research into neonatal medicines and therapies
- The Trust is involved in the ProMISe trial, a national research study investigating the management of patients presenting with septic shock
- The St Stephen's AIDS Trust (SSAT) Clinical Trials Unit in the St Stephen's Centre next to Chelsea and Westminster Hospital conducted 67 clinical trials in 2011/12 involving 2,023 patients
- Internationally renowned researchers based at Chelsea and Westminster include Professor Frances Gotch (Immunology), Professor Mark Johnson (Obstetrics & Gynaecology) and Professor Mark Bower (Oncology/HIV)

Chelsea and Westminster is a key partner in the new Academic Health Science Partnership (AHSP) for North West London which aims to develop innovative solutions and translate research into practice to improve quality of health outcomes for patients.

It brings together providers of primary, secondary, tertiary, community and mental healthcare in North West London to work with Imperial College London.

The Trust hosts the North West London Health Innovation and Education Cluster (HIEC) which supports the quick uptake of innovative technologies and services, focusing on the three workstreams of cancer, cardiac care and education.

A training course to help A&E staff manage acute oncological (cancer) emergencies has been completed by 245 staff in 43 NHS organisations.

The HIEC is supporting the development of the North West London Local Education and Training Board (LETB) whose purpose is to commission and deliver education and training in new ways to improve multi-professional working and care pathways.

Case Study

New approach to COPD care attracts international attention

Professor Derek Bell, the Trust's Director of Research & Development and also Director of the NIHR CLAHRC for Northwest London, hosted a visit to the hospital in February 2012 by the World Health Organisation.

Doctors from countries including Saudi Arabia, Turkey, Cuba and Sudan came to Chelsea and Westminster to hear about the implementation of an innovative 'care bundle' approach to the treatment of COPD.

This was developed and piloted at Chelsea and Westminster by a multi-disciplinary team, funded by the CLAHRC, and it has now been rolled out to five other hospitals in North West London.

Published research has shown that, following implementation of the care bundle, fewer patients were readmitted to hospital within 30 days of a stay in hospital—11% of 94 patients on the care bundle compared with 16.4% of 365 patients not on the bundle.

Hospital admissions and readmissions caused by COPD cost the NHS an estimated £600 million per year which is why the COPD care bundle approach to reducing patient readmissions to hospital is so important.

Consultant Physician Dr Dilys Lai (left) welcomes World Health Organisation delegates to Chelsea and Westminster Hospital

Our staff

More than 3,000 people work at Chelsea and Westminster including staff employed directly by the Trust, facilities staff employed by contractors, and hospital volunteers.

The Trust is committed to celebrating the achievements of staff. We launched a new annual staff awards scheme, the Star Awards, in March 2012. We also have an annual Christmas Cheer Awards scheme, a monthly Team/Employee of the Month Award and regular Council of Governors Quality Awards.

See the 'Staff Survey' section for NHS staff survey results.

Winners of the Council of Governors Quality Awards in January 2012—Ms Beryl De Souza, Ms Aanchal Jain and Ms Shivali Patel from the Plastic Surgery team (top), Phlebotomy Department (bottom left) and the Musculoskeletal Physiotherapy team (bottom right)

Quality

The Trust has reviewed the four areas of the quality governance framework—strategy, capabilities and culture, processes and structures, and measurement.

In each area, Trust practice has been outlined and consideration has been given to developments to strengthen quality governance further.

The Trust considers that there are robust structures and processes in place to ensure required standards are met, action is taken to address sub-standard performance, there are plans to drive continuous improvement which is based on best practice, and risks to quality of care are identified and managed.

The exception is that we did not meet the NHS Connecting for Health percentage accuracy scores for clinical coding following a data quality/clinical coding audit. An action plan is in place to address this.

Other areas for development include the implementation of an online risk management system which will facilitate a more thorough and flexible approach to identification and management of risks.

The Trust will continue to focus on data quality with a view to publication of progress on local indicators on the Trust website as part of the drive for transparency.

Further information is in the Quality Report and the Annual Governance Statement.

Physiotherapist Kate McCann treats a patient

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.

Another key benefit of Foundation Trust status is financial flexibility and access to the Foundation Trust Finance Facility to invest in improvements to patient care.

The new Lower Ground Floor Outpatients Department was made possible by a combination of these two benefits.

The development cost £2.4 million which was funded by a combination of surpluses and a loan from the Foundation Trust Financing Facility.

Secretary of State for Health Andrew Lansley said: "This new development encapsulates the spirit of the modern NHS. It has been designed with patients and their views at its heart.

"Chelsea and Westminster was able to unveil this fantastic new facility for patients within months. Foundation Trusts are free to make decisions more quickly than other NHS trusts which means patients get innovative new services more quickly."

Engagement with patients, members of the public and staff who are Foundation Trust members is another key benefit—as demonstrated by the attendance of members at the Annual Members' Meeting, Open Day and 'Medicine for members' seminars.

Performance against key patient targets

The Trust met all key national targets in 2011/12. We treated 95% of outpatients and 90% of inpatients within 18 weeks of GP referral. We also saw and treated 98% of A&E patients within four hours.

The Trust met challenging targets set by the Foundation Trust regulator Monitor to reduce infection rates.

There were two cases of MRSA bacteraemia in 2011/12 (against a target maximum of three cases) and 17 cases of *C.difficile* (against a target maximum of 31 cases).

Targets agreed with local commissioners

A proportion of our income is conditional on performance in relation to goals relating to quality agreed through the Commissioning for Quality and Innovation (CQUIN) payment framework.

In 2011/12, income equal to 1.5% of the value of our main acute contract (which covers most of our NHS services) was conditional on achieving CQUIN goals agreed with our host commissioner, North West London Commissioning Partnership.

We also agreed CQUIN payments linked to our work in HIV and Neonatal Intensive Care, commissioned by the London Specialised Commissioning Group, as well as CQUINs for community services in Paediatrics, Dermatology and Gynaecology.

We achieved 90% of our regional and national CQUIN goals in 2011/12—payments totalling £2.92 million.

We achieved 85% of our specialist commissioning CQUIN goals in 2011/12—payments totalling £895,000.

Overall we achieved 89% of our CQUIN goals in 2011/12—payments totalling £3.82 million.

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

A waiting area on the new HIV and Cancer Unit

New or significantly revised services

A number of new services opened in 2011/12.

New HIV & Cancer Unit

We opened a new unit for patients living with HIV and cancer in February 2012 including an inpatient ward—Ron Johnson Ward—with 19 beds, all in single ensuite rooms, as well as day care and outpatient facilities.

The HIV & Cancer Unit is located on the 2nd Floor of the hospital and incorporates oncology (cancer) and haematology (blood cancer) services previously provided in the Medical Day Unit on the Ground Floor.

Chelsea and Westminster Hospital is a national referral centre for HIV-related cancers which is why HIV and cancer treatment facilities are now co-located. All chemotherapy and other anti-cancer therapies for outpatients are now provided in the new HIV & Cancer Unit.

Chelsea Children's Hospital

We are developing a fully integrated children's hospital on the 1st Floor of Chelsea and Westminster Hospital to achieve our vision of providing world class children's services.

This major investment in our children's services follows our designation as the lead centre for specialist children's and neonatal surgery in North West London.

In September 2011 we opened two new, state-of-the-art children's operating theatres as well as surgical admissions and pre-assessment areas.

In February 2012 we opened two more new children's operating theatres (bringing the total to four) as well as an extended paediatric High Dependency Unit, a new day surgery ward, and an expanded surgical recovery area.

Birthing Unit

Our Birthing Unit for women who want a homebirth experience, but in a hospital setting, was officially opened in July 2011.

It is for women who have had an uncomplicated pregnancy and want to give birth naturally without the use of an epidural.

Birthing Unit rooms have access to a birthing pool, birthing balls and stools to help women find a comfortable position during labour and delivery.

Shereen Jones, Labour Ward Matron, says: "The Birthing Unit is perfect for women who like the idea of a homebirth but want the security of having extra medical support nearby if it's needed.

"We aim to make labour and birth as normal and special for women as possible, so the new facility allows us to provide a sanctuary within a busy hospital environment."

A room on the new Birthing Unit

Responding to complaints

The Trust takes complaints very seriously. All new serious complaints and incidents are reviewed by the Executive team at their weekly meeting.

All complaints are logged and reported to directorates through quarterly clinical governance reports. Trustwide quarterly reports and an annual report are prepared for the Patient Experience Committee. The reports provide a summary and analysis of complaints raised through the Complaints team and an overview of changes made in response.

The Trust's Membership and Patient Advice & Liaison Service (M-PALS) is available to provide patients with information, support, advice and help in resolving concerns.

In line with national guidance, the Trust places its emphasis on local resolution of concerns raised. Staff are encouraged to do this by acknowledging the problem and where possible resolving the issue or providing an explanation. It is important that the complainant understands what the outcome will be and that this will meet their expectations.

The completion of action plans is monitored and reported in the quarterly reports. The figures for the year show that while there is room for improvement in terms of the divisions returning action plans, 86% of all complainants (Type 2 and Type 3 complaints) were contacted to discuss their complaint and the type of resolution they were seeking. Feedback from patients and staff on this type of resolution has been very positive.

The Trust has set three levels of response depending on the nature, seriousness and complexity of the complaint.

Type 1 (less serious) complaints should be resolved within 10 working days, Type 2 (more serious) complaints should be resolved within 25 working days, while Type 3 (the most serious and often complex) complaints may require a longer timescale which should be discussed and agreed with the complainant.

In 2011/12, 874 Type 1 complaints were received and of these 71% were responded to within the Trust target of 10 working days while 419 Type 2 complaints were received and of these 80% were responded to within the Trust target of 25 working days.

A total of 18 Type 3 complaints were received—eight of the investigations were completed within 50 working days and 10 of the investigations took longer than 50 working days to complete. Therefore 44% of Type 3 complaints were completed within 50 working days.

Service improvements following patients' complaints

Improvements made in response to formal complaints include:

- The introduction of a 'comfort round' on the postnatal ward which involves a member of staff going round the ward every two hours, talking to every patient, and checking that patient needs are being met or escalated as appropriate
- Additional hand therapy clinics have been set up and therefore there has been an increase in the number of sessions and appointments available
- The structure of dermatology clinics has been reviewed to ensure that all patients are seen by a consultant and team

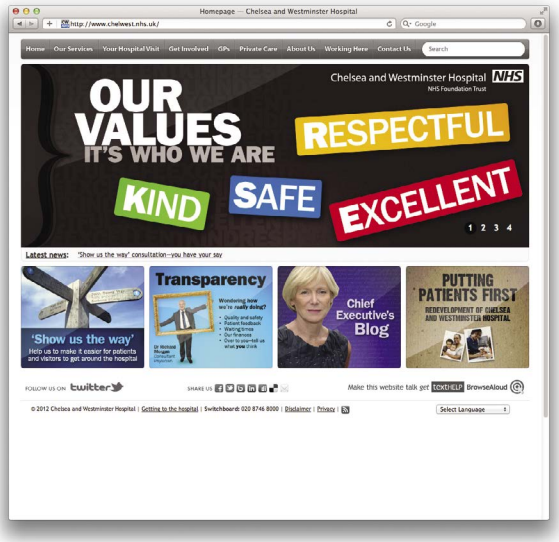
Improvements in patient information

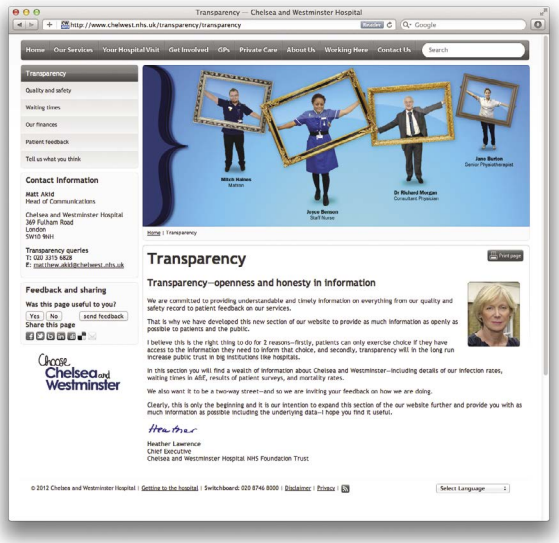
The Trust website was relaunched in Summer 2011 to improve the quality of information available online for patients and carers.

It was redeveloped in partnership with representatives from our Council of Governors and staff from throughout the Trust who are on our Website Development Steering Group.

The website is managed by the Trust's Communications Department with input from 130 'web editors' who are frontline clinical staff responsible for maintaining their sections of the website.

The website now has 70,000 'hits' a month—a 50% increase year-on-year—and was shortlisted for the Chartered Institute of Public Relations (CIPR) Excellence Awards 2012.





Stakeholder relations

The Trust has maintained and strengthened its relationships with a wide range of key stakeholders.

Key stakeholders have nominated representatives on the Council of Governors which also includes elected representatives of patients, members of the public, and staff.

The Trust has strengthened its relationship with Kensington and Chelsea Local Involvement Network (LINk). A LINk representative is on the Quality Sub-committee of the Council of Governors.

In light of the Health and Social Care Act's proposals to devolve accountability for commissioning to GPs, we are developing ever closer links with key local GPs—our GP Relationship Manager facilitates this work.

Chief Executive Heather Lawrence and Medical Director Dr Mike Anderson met with all local Clinical Commissioning Groups (CCGs) in 2011/12.

The Trust is part of the Integrated Care Pilot (ICP) for North West London, working in partnership with GPs and Imperial College Healthcare NHS Trust to improve care for patients with diabetes and patients aged over 75.

It has been championed as an example of how the NHS can work in new ways to improve patient care and won the 'Improving Long Term Conditions' category of the *Health Service Journal* Awards 2011.

This year we worked in partnership with our neighbours on the Fulham Road—Royal Brompton & Harefield NHS Trust and The Royal Marsden NHS Foundation Trust—to explore opportunities for providing 'back office' functions more efficiently. See below for details of our joint contract for Soft Facilities Management (FM) services.

Case Study

Shared services contract delivers efficiency savings

Following a competitive tendering process to identify best value for money and best quality of service, in January 2012 the Trust awarded the contract for its Soft Facilities Management (FM) services (including catering, cleaning, portering, security etc) for the next five years to ISS Facility Services Healthcare.

The contract includes not only Chelsea and Westminster but also Royal Brompton & Harefield NHS Foundation Trust, The Royal Marsden NHS Foundation Trust, and the Institute of Cancer Research, which will result in significant efficiency savings.

This initiative was shortlisted in the 'Procurement Initiative of the Year' category for health and social care organisations in the National Government Opportunities Excellence in Public Procurement Awards 2012.

Our catering and porter services are provided by ISS Facilities Services Healthcare

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 mandatory goods and services.

The Trust's governance arrangements are reviewed yearly against the provisions of Monitor's Code of Governance to ensure 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 2012 Chelsea and Westminster Hospital NHS Foundation Trust complied with all the provisions of the Code of Governance published by Monitor in March 2010 with the exception of the provision relating to the independent external adviser being a member of the Nominations Committee, which is included in the Trust constitution, and the provision relating to an Executive member of the Board leaving the employment of an NHS Foundation Trust without the Board first having completed and approved a full risk assessment, which was found to be impracticable in the circumstances.

The Trust Board

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 'Board of Directors—Who's Who' 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. The Audit Committee and Assurance Committee undertake a yearly review of their effectiveness, which is reported to the Board. Due to having three new Non-Executive Directors in 2011/12, the Board plans to undertake a review of its effectiveness in 2012/13.

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 3315 6716.

Board meetings

The Board meets regularly, on average once a month. Special meetings are organised as and when required. There were 10 ordinary meetings in 2011/12. No special meetings were held.

Directors' attendance at Board meetings 2011/12

Non-Executive Directors	Attendance
Prof Sir Christopher Edwards	10/10
Sir John Baker[1]	10/10
Andrew Havery[2]	5/6
Prof Richard Kitney	9/10
Jeremy Loyd[3]	9/10
Sir Geoffrey Mulcahy[4]	10/10
Karin Norman	9/10
Charles Wilson[5]	6/6

Executive Directors	Attendance
Heather Lawrence	10/10
Amanda Pritchard	10/10
Dr Mike Anderson	10/10
Lorraine Bewes	10/10
Thérèse Davis	9/10
Catherine Mooney[6]	10/10

1 Non-Executive Director Designate until 31 October 2011
2 Term ended 31 October 2011
3 Non-Executive Director Designate until 31 October 2011
4 Non-Executive Director Designate until 31 October 2011
5 Term ended 31 October 2011
6 Attends Board meetings as Company Secretary

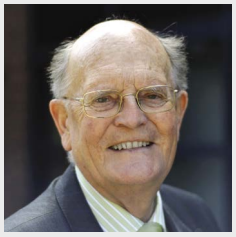
Significant commitments of the Trust Chairman

The Chairman is a Senior Research Fellow at Imperial College London and Chairman of the Council of the British Heart Foundation. He is also Chairman of EasiGeothermal and on the Board of Cluff Geothermal. 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 and reappointed for a further three years in November 2010. 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.



Sir John Baker CBE, Vice Chair: Sir John's appointment as a Non-Executive Director Designate was approved by the Council of Governors in December 2010. He became a full Non-Executive Director in November 2011 for a period of three years. Sir John has had a career in both public and private sectors. He is currently Chairman of Renewable Energy Holdings Plc. He spent 10 years dealing with transport policy as a senior civil servant, followed by 10 years leading an urban regeneration and social housing agency, before becoming Managing Director of the Central Electricity Generating Board in 1979 and leading the management of the UK electricity privatisation and restructuring programme. He was Chief Executive and then Chairman of National Power PLC from 1989 to 1997 and he was Chairman of the World Energy Council from 1995 to 1998. Outside the business arena Sir John is Chairman of the Governing Body of Holland Park School and Chairman of the Board of Trustees of the Mayor of London's Fund for Young Musicians. He is the Vice Chair of the Board of Directors, chairs the Audit Committee, and is the Senior Independent Director.

Andrew Havery: Andrew was reappointed for a term of one year ending on 31 October 2011. He has been a councillor in Westminster since 2002. Andrew is a chartered accountant and worked for KPMG for eight years before becoming a compliance officer to investment banks. He chaired the Audit Committee before his term of office attended.

Professor Richard Kitney OBE: Professor Kitney was reappointed for a term of two years in October 2010. He is Professor of Biomedical Systems Engineering and Dean of the Faculty of Engineering at Imperial College London. A leading authority on the use of IT in healthcare, Professor Kitney is Chairman and Director of Visbion Ltd. He is a member of the Assurance Committee and the Audit Committee.

Jeremy Loyd: Jeremy's appointment as a Non-Executive Director Designate was approved by the Council of Governors in December 2010. He became a full Non-Executive Director in November 2011 for a period of three years. Jeremy is currently a Non-Executive Director of UCL Cancer Institute Research Trust and the Marine Management Organisation. He was formerly Director and General Manager of Carlton Television, Managing Director of Capital Radio and a Non-Executive Director of several other companies in both the UK and USA. Jeremy was also Deputy Chairman of Blackwells, the academic information distributer and retailer. He chairs the Patient Experience Committee and is a member of the Assurance Committee.

Sir Geoffrey Mulcahy: Sir Geoffrey's appointment as a Non-Executive Director Designate was approved by the Council of Governors in December 2010. He became a full Non-Executive Director in November 2011 for a period of three years. Sir Geoffrey is Chairman of Javelin Group (a retail consultancy), a trustee of CCCS (a debt counselling charity) and an operating partner of GLP (an investment adviser). Until 2002 he was Chief Executive of Kingfisher plc, a retail business operating in 14 countries worldwide with brands in the UK including B&Q, Comet, Superdrug, and Woolworths. He retired after demerging Kingfisher into three separately quoted businesses. Previously he worked for British Sugar, Norton Company (a US engineering company) and Esso. He has been a Non-Executive Director of a number of companies including BT and Intercontinental Hotels (previously Bass plc). He is a member of the Finance & Investment Committee and the Audit Committee.

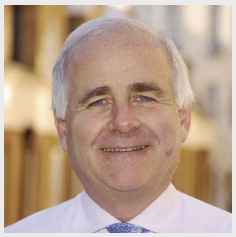
Karin Norman: Karin was reappointed for a term of three years in October 2009. She worked in investment banking in London and New York as a fixed income specialist, advising on investments, risk and capital management, and structured finance. She was a Non-Executive Director of the NHS Pensions Agency and is currently a member of the Audit Committee and the Investment Committee for Parkinson's UK, a Trustee of the Nursing and Midwifery Council, and My Generation, a community and youth charity that she co-founded. She chairs the Assurance Committee and is a member of the Finance & Investment Committee.

Charles Wilson: Charles was reappointed for a term of one year ending on 31 October 2011. He was the Vice Chair of the Board of Directors, chaired the Assurance Committee and was the Senior Independent Director before his term of office ended. 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. Charles is on the board of a number of charities and is Vice-Chairman of Addaction, the leading drugs treatment charity.

Executive Directors

Heather Lawrence OBE, Chief Executive: Heather Lawrence trained and worked as a nurse before moving into health service management. She has more than 24 years' experience at NHS Trust Board level, having served as Chief Executive of both 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. She has also held a number of national positions, for example as NHS Employers' lead negotiator for the three-year pay deal for staff on Agenda for Change and as 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. She is currently taking a key role in transformative change in North West London by leading the North West London Health Innovation and Education Cluster (HIEC) and its successor organisation the North West London Local Education and Training Board (LETB). Heather was awarded the OBE in the New Year's Honours 2009 for services to healthcare. She announced in January 2012 that she would be leaving Chelsea and Westminster in Summer 2012 after 12 years as Chief Executive.

Amanda Pritchard, Deputy Chief Executive (Director of Integrated Service Delivery & Modernisation): Prior to her appointment in September 2006, Amanda worked in the Prime Minister's Delivery Unit. She was previously Acting Director of Strategy & Service Development and General Manager for the Surgery and Anaesthetics & Imaging Directorates at Chelsea and Westminster, and Assistant Director of Critical Care & Ambulatory Services at West Middlesex Hospital. Amanda was an inaugural Health Foundation Leadership Fellow. Both Amanda's children were born at Chelsea and Westminster Hospital, in January 2008 and December 2009. She announced in January 2012 that she would be leaving Chelsea and Westminster in April 2012 to take up a new role as Chief Operating Officer at Guy's and St Thomas' NHS Foundation Trust.



Dr Mike Anderson, Medical Director: Dr Anderson was appointed in Summer 2003. Previously, he was a Consultant Physician and Gastroenterologist at West Middlesex Hospital where he also held the post of Medical Director. He is an Honorary Clinical Senior Lecturer of Imperial College and continues in active clinical practice as a Consultant Gastroenterologist. He is a Medical Director for NHS North West London's *Shaping a healthier future* programme which aims to improve healthcare for a population of 1.9 million people living in North West London.

Lorraine Bewes, Director of Finance: 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 Ltd. Lorraine has led the early implementation of service line reporting in the NHS and is the Senior Information Risk Owner on the Board with the lead on information governance. She is a graduate of Oxford University and is a chartered accountant.

Thérèse Davis, Chief Nurse and Director of Patient Experience and Flow: Thérèse rejoined the Trust as Interim Director of Nursing in June 2010, having been Director of Nursing at the Trust a number of years previously. She was appointed to the substantive post of Chief Nurse and Director of Patient Experience and Flow in February 2011. Thérèse has been a nurse in London for the past 26 years, originally specialising in medical and oncology nursing, and a Director of Nursing for the past 13 years including at the Royal Free Hospital in Hampstead. Her successes include implementing systems and initiatives to improve the experience of patients in hospital. She has also led many initiatives to enhance patient safety and effectiveness, setting goals and targets to achieve positive change. Thérèse has a degree in nursing from Manchester University and an MBA from Henley College, for which she received an NHS bursary.

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

Audit Committee

Membership and attendance

The Audit Committee is chaired by Sir John Baker, a Non-Executive Director, and includes two other Non-Executive Directors, Sir Geoffrey Mulcahy and Professor Richard Kitney.

Sir John Baker took over the Chair in January 2012 from Andrew Havery, whose term of office as a Non-Executive Director ended on 31 October 2011. Also in January 2012, Sir Geoffrey Mulcahy and Professor Richard Kitney became members in place of Charles Wilson, whose term of office as a Non-Executive Director ended on 31 October 2011, and Karin Norman.

The Audit Committee met six times in 2011/12—see below for details of individual Directors' attendance.

Directors' attendance at Audit Committee meetings 2011/12

	Attendance
Sir John Baker	2/2
Andrew Havery	4/4
Prof Richard Kitney	2/2
Sir Geoffrey Mulcahy	2/2
Karin Norman	4/4
Charles Wilson	3/4

How the Committee discharges its responsibilities

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

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

Policy for safeguarding the external auditors' independence

In so far as the Trust has not purchased work from its external auditors outside the audit code in 2011/12, the external auditors' objectivity and independence have been safeguarded.

Responsibility for preparing the annual accounts

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

Nominations Committees

Both the Board of Directors and the 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 standing for appointment, in which case another Non-Executive Director), two elected Governors and one appointed Governor.

There were no meetings of the Nominations Committee of the Council of Governors in 2011/12.

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

The Nominations Committee is a Standing Committee of the Board of Directors which makes recommendations to the Appointments Committee for the Chief Executive post (subject to approval of the Council of Governors), other Executive Directors (Board members) and the Secretary.

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 Committee which consists of the Chairman, Chief Executive (except for his/her own appointment) and other Non-Executive Directors. An external adviser may be invited to give advice to the Appointments Committee.

The Nominations Committee met in January and February 2012 to agree the job description, person specification and process for appointment of the Chief Executive. An extensive search was carried out by an external consultancy firm and an advertisement was placed in *The Sunday Times* and *Health Service Journal*.

The Nominations Committee longlisting meeting took place on 23 March 2012. The Nominations Committee shortlisting meeting took place on 16 April 2012. The Appointments Committee undertook a formal interview with the candidates on 2 May 2012.

The appointment of Tony Bell OBE as Chief Executive was approved by the Council of Governors at its meeting on 3 May 2012.

Mark Gammage, Director of Human Resources, attended meetings of the Nominations Committee and the Appointments Committee to provide advice and secretarial services. Miles Scott, Chief Executive of St George's Healthcare NHS Trust, attended the Appointments Committee as an external adviser.

Attendance at Nominations Committee and Appointments Committee meetings 2011/12

	Attendance
Prof Sir Christopher Edwards	3/3
Sir John Baker	3/3
Prof Richard Kitney	3/3
Jeremy Loyd	3/3
Sir Geoffrey Mulcahy	2/3
Karin Norman	2/3
Mark Gammage	3/3
Miles Scott	1/1

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, members of the 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. There are corporate governance arrangements in place incorporated within the Reservation of Powers to the Board and Delegation of Powers outlining which decisions are to be delegated by the Board to the Executive management.

The types of decisions delegated by the Board to the Executive management include contracts, tendering procedures, security of the Trust's property, monitoring and ensuring compliance with Department of Health directions on fraud and corruption, delegated approval limits, budget submission, annual accounts and reports, banking arrangements, payroll, borrowing and investment, risk management and insurance arrangements.

Key roles of the Council of Governors are to:

- Appoint or remove the Chairman and other Non-Executive Directors and approve the appointment 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 Engagement 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 at least quarterly. There were five meetings in 2011/12. Executive and Non-Executive Directors are invited to attend. Details of their attendance are in the table 'Directors' attendance at Council of Governors meetings 2011/12'. Details of Governors' attendance at meetings are in the table 'Council of 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.

Elections held during 2011/12

An election was held in November 2011 in the Patient, Public and Staff constituencies and the following were elected:

- **Patient**
  Anna Hodson-Pressinger
- **Public: Kensington & Chelsea Area 2**
  Sandra Smith-Gordon
- **Staff: Support, Administrative & Clerical**
  Maddy Than

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, London, SW10 9NH, via email ftsecretary@chelwest.nhs.uk or on 020 3315 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. A joint Board and Council of Governors Away Day was held in November 2011.

The Deputy Chief Executive gave a presentation on strategy and business planning at the Council of Governors meeting in February 2012 to obtain views.

Further business planning meetings were organised in March 2012 to which Governors were invited and contributed.

Council of Governors —Who's Who

Name (Constituency/Organisation)	Date elected or appointed	Attendance at Council Meetings 2011/12*
Prof Sir Christopher Edwards (Chairman)	Nov 2007	5/5
Adams, Eddie (Public-Kensington & Chelsea 1)	Jun 2010	2/5
Ball, Lucy (Staff—Allied Health Professionals, Scientific & Technical)[1]	Nov 2009	2/4
Baverstock, Paul (Patient)	Jun 2010	0/3
Birch, Chris (Patient)	May 2007	5/5
Blewett, Christine (Public—Hammersmith & Fulham 2)	Nov 2009	5/5
Browne, Nicky (The Royal Marsden NHS Foundation Trust)	Dec 2006	3/5
Cadman, Dr Anthony (Patient)	Nov 2010	4/5
Cass, Fergus (NHS Kensington and Chelsea)	Jul 2011	4/4
Cass-Horne, Cass J (Patient)	Nov 2009	3/5
Cleary, Alan (Patient)	Nov 2009	5/5
Coolen, Edward (Patient)	Nov 2009	3/5
Culhane, Samantha (Public—Hammersmith & Fulham 1)	Jun 2010	3/5
Dale, Carol (Staff—Management)	Nov 2009	3/5
Finch, Dr David (NHS Wandsworth)[2]	May 2009	0/3
Gazzard, Prof Brian (Staff—Medical & Dental and Deputy Chairman)[3]	Nov 2009	3/5
Glazebrook, Rosie (NHS Hammersmith and Fulham)	Nov 2009	3/5
Higham, Prof Jenny (Imperial College London)	Feb 2011	3/5
Hodson-Pressinger, Anna (Patient)	Nov 2011	2/2
Jeremiah, Melvyn (Public—Westminster 2)	Nov 2010	5/5
Jesus, Jacinto (Staff—Contracted)	Nov 2009	3/5
Lewis, Martin (Public—Westminster 1)	Nov 2010	5/5
Longworth, Catherine (NHS Westminster)[4]	Oct 2006	1/1
Mackenzie Crooks, Charlotte (Staff-Support, Admin & Clerical)[5]	Jun 2010	3/3
Mangold, Kathryn (Staff—Nursing & Midwifery)	Nov 2010	5/5
Marrash, William (Patient)	Nov 2010	5/5
Maxwell, Susan (Patient)	Nov 2009	5/5
McWatters, Wendie (Patient)	Nov 2009	4/5
Morgan, Harry (Public—Wandsworth 1)	Nov 2010	4/5
Nemeth, Cllr Cyril (Westminster City Council)	Nov 2009	3/5
Smith-Gordon, Sandra (Public—Kensington & Chelsea 2)	Nov 2011	5/5
Taylor, Cllr Frances (Royal Borough of Kensington and Chelsea)	Oct 2006	5/5
Than, Maddy (Staff—Support, Admin and Clerical)	Nov 2011	2/2
While, Alison (King's College London)	Oct 2009	4/5
Youngstein, Taryn (Patient)	Nov 2009	3/5

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

1 Resigned Jan 2012
2 Resigned Oct 2011
3 Prof Brian Gazzard is the Lead Governor
4 Resigned July 2011
5 Resigned Nov 2011

Directors' attendance at Council of Governors meetings 2011/12

Non-Executive Directors	Attendance
Prof Sir Christopher Edwards	5/5
Sir John Baker[1]	3/5
Andrew Havery[2]	1/3
Prof Richard Kitney	3/5
Jeremy Loyd[3]	4/5
Sir Geoff Mulcahy[4]	5/5
Karin Norman	2/5
Charles Wilson[5]	3/3

Executive Directors	Attendance
Heather Lawrence	4/5
Amanda Pritchard	3/5
Dr Mike Anderson	3/5
Lorraine Bewes	3/5
Thérèse Davis	3/5
Catherine Mooney[6]	5/5

1 Non-Executive Director Designate until 31 October 2011
2 Term ended 31 October 2011
3 Non-Executive Director Designate until 31 October 2011
4 Non-Executive Director Designate until 31 October 2011
5 Term ended 31 October 2011
6 Attends Board meetings as Company Secretary

Young visitors enjoy our annual hospital Open Day which is supported by the Council of Governors

Members of the Council of Governors

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 treated at the hospital in the last three years
- **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 2012
Patients	5,685
Public	5,942
Staff	3,231
Total	**14,858**

How are we developing our membership?

The Membership Sub-Committee of the Council of Governors develops and reviews the Membership Development and Engagement Strategy which focuses on the recruitment of new members, development of a representative membership, and engagement with existing members.

Recruitment of new members

The Trust gained 600 new members through hospital-based recruitment drives in May and September 2011 and a further 140 new members through a community roadshow at a shopping centre in Hammersmith in February 2012.

The Membership and Patient Advice & Liaison Service (M-PALS) promotes membership by giving membership application forms to visitors to the M-PALS office in the hospital and sending out membership application leaflets with letters responding to comments received by M-PALS.

Development of a representative membership

Analysis of the membership database by age, gender and ethnicity is undertaken to help the Trust work towards developing a membership that is representative of the communities we serve.

It is recognised that membership recruitment should focus particularly on increasing the number of Black and Minority Ethnic (BME) members. Targeted activities have included the recruitment of 30 new members from a Somali women's group at West London Centre for Sexual Health in March 2012 and the recruitment of new members at regular community mobile health clinic sessions at Shepherd's Bush Market.

Engagement with existing members

Governors hold regular 'Meet a Governor' sessions in the hospital's Information Zone which give members an opportunity to discuss issues of concern with a Governor.

We have also engaged with members through a range of activities including 'Medicine for Members' seminars, the 'Who do you think WE are?' consultation in February 2012 to define the Trust's values, and a new monthly email newsletter.

Key Fact

'Who do you think WE are?'

More than 900 people including many Foundation Trust members took part in the Trust's consultation to define our values in February 2012.

Case Study

medicine for members

‘Medicine for Members’ seminars

A new series of free health seminars for Foundation Trust members, ‘Medicine for Members’, was launched in February 2012—the first two topics were bowel cancer and dementia.

Dr Richard Morgan, Consultant Physician at Chelsea and Westminster Hospital, and Dr Claudia Wald, Consultant Psychiatrist with the Kensington & Chelsea Memory Service, were the keynote speakers for the dementia seminar.

The level of interest shown by Foundation Trust members in the topic of dementia means that we plan to repeat the seminar.

Feedback from members who attended the seminar was positive with the majority saying they found the event useful and would recommend future ‘Medicine for Members’ events to friends and family.

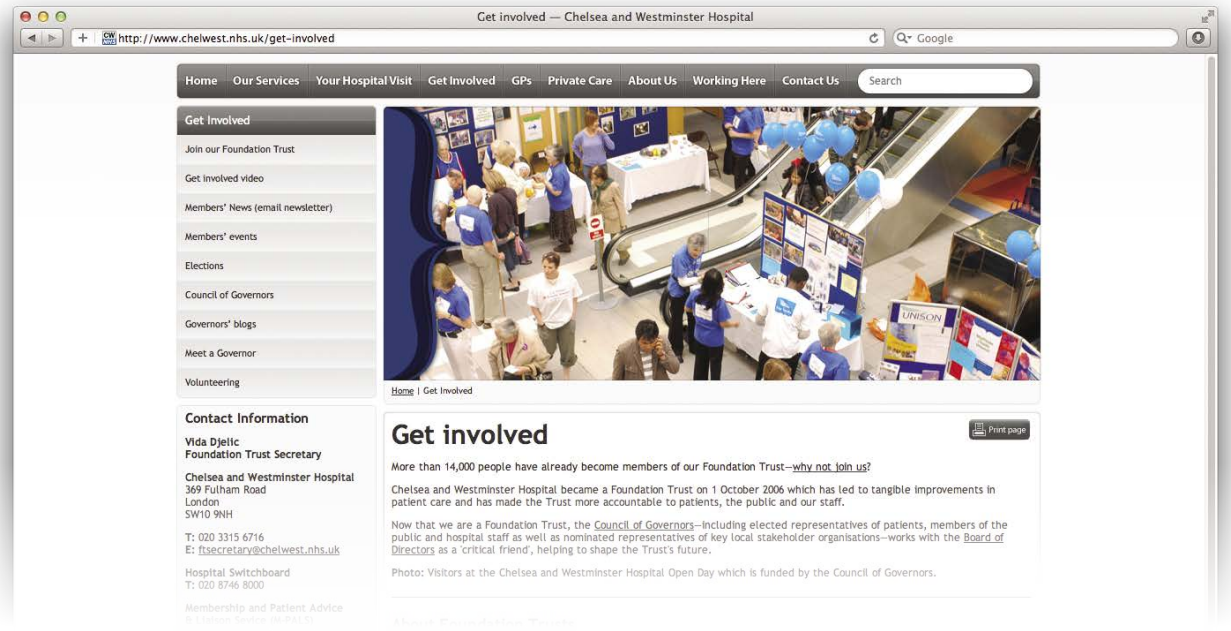
For example, one member said: “The more events like this the better, especially for carers who need support and information.”

Dr Richard Morgan speaks at the dementia seminar

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 3315 6716.

Members can keep up-to-date with all the latest membership news on the Trust website at www.chelwest.nhs.uk/get-involved.



Statutory Information

Directors

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

Non-Executive Directors

The Chairman is Professor Sir Christopher Edwards.

The five other Non-Executive Directors are Sir John Baker CBE, Professor Richard Kitney OBE, Jeremy Loyd, Sir Geoffrey Mulcahy and Karin Norman.

Executive Directors

The five Executive Directors are Heather Lawrence OBE (Chief Executive), Dr Mike Anderson (Medical Director), Lorraine Bewes (Director of Finance), Thérèse Davis (Chief Nurse and Director of Patient Experience and Flow) and David Radbourne (Interim Chief Operating Officer—took up post April 2012)

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 Oct 2006 under the Health and Social Care (Community Health and Standards) Act 2003.

Environmental matters

The Trust pledged to reduce its carbon footprint by joining the Carbon Trust's NHS Carbon Management programme in May 2007.

We have committed to improve our environmental sustainability by exceeding the NHS national target of 10% carbon reduction by 2015.

A £9.8 million project to overhaul the hospital's energy infrastructure was completed in 2011/12. This transformation of the way in which electricity, heating and cooling is supplied to the hospital will reduce the Trust's carbon footprint and make us self-sufficient in terms of the power needed to keep services running smoothly.

All staff are encouraged to help cut carbon emissions and reduce energy bills by taking simple steps to be more energy efficient.

Financial information

Disclosure of audit information

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

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

Electronic publication of the Annual Report & Accounts

The Directors are responsible for the maintenance and integrity of the corporate and financial information included on the Trust's website. Legislation in the United Kingdom governing the preparation and dissemination of financial information differs from legislation in other jurisdictions.

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.

Going concern

The financial performance and position of the Trust, together with the factors likely to affect its future development and the principal risks and uncertainties it faces, are described in the Directors' Report.

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

Remuneration Report

Remuneration Committee

The Remuneration Committee is a 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—Sir John Baker, Professor Richard Kitney, Jeremy Loyd, Sir Geoffrey Mulcahy and Karin Norman.

The Remuneration Committee met on 26 January 2012. All six members of the Committee were present. The meeting was also attended by the Chief Executive, Heather Lawrence, and the 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 that, in the light of the current national 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.

For a breakdown of salary and pension entitlements of senior managers, please see Note 5.6 of the signed accounts.

Hutton Disclosure—audited information

For the first time reporting bodies are required to disclose the relationship between the remuneration of the highest paid Director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid Director in the Trust in the financial year 2011/12 was £200,000–£205,000. This was 5.7 times the median remuneration of the workforce, which was £35,609.

Total remuneration includes salary, non-consolidated performance related pay, benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Heather Lawrence

Heather Lawrence OBE
Chief Executive (on behalf of the Board)
28 May 2012

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.

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, and raise staff awareness of financial and economic factors affecting the Trust's performance:

- Executive Directors meet Staffside representatives at the monthly meeting 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 six elected staff representatives, meets at least quarterly—five times in 2011/12
- Communication with staff includes a staff magazine published nine times a year, a monthly face-to-face Team Briefing with Executive Directors which is disseminated through the line management structure to all staff, the Chief Executive's Blog which is published fortnightly, and the Daily Noticeboard email bulletin
- The Chief Executive holds staff forums to engage with staff on Trust strategy
- Executive Directors are allocated specific areas of the Trust on a monthly basis and are expected to visit these areas, engage with staff, and feed back any issues to other members of the Executive team
- The Trust has staff networks (eg Creating Excellence Together, the Black and Minority Ethnic staff network)

The Trust was ranked among the top 20% of acute trusts in the 2011 NHS staff survey for staff engagement, for the third consecutive year, and achieved the highest rating of any acute trust for staff reporting good communication between senior management and staff.

Summary of performance—results from the staff survey 2011

61% of staff completed the NHS staff survey 2011 (compared with a national average response rate for acute trusts of 52%). This response rate was the second highest among acute trusts in London and in the top 20% 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 were reported under 38 key findings (KFs).

Since 2009 the Care Quality Commission has 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 engagement score was 3.81 (compared to 3.74 in 2010) which put us in the top 20% of acute trusts nationally for the third consecutive year.

The Trust improved or maintained its performance in all but one of the 38 KFs, with 26 better than in 2010. The Trust achieved the highest score of any acute trust in four KFs including Trust commitment to work-life balance, staff having opportunities to develop their potential, and good communication between senior management and staff.

Responses for staff feeling there are good opportunities to develop their potential at work and staff reporting good communication between senior managers and staff were the highest of any Association of UK University Hospitals (AUKUH) Trust.

The Trust was placed in the top 20% of acute trusts nationally for a further five KFs including Trust commitment to work-life balance, staff having a well-structured appraisal in the previous 12 months, fairness of reporting procedures, and staff feeling able to contribute towards improvements at work.

Areas of concern for the Trust were focused around four KFs for which we were placed in the lowest 20% of acute trusts nationally.

These were % of staff working extra hours, % of staff receiving health and safety training in the previous 12 months, % of staff reporting handwashing materials always being available, and % of staff experiencing discrimination at work in the previous 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 2011 and Job Satisfaction KF

	2011/12		2010/11		Trust improvement/ deterioration
	Trust	National Average	Trust	National Average	
Response rate	61%	53%	64%	54%	-3%
KF32: Staff job satisfaction*	3.58	3.47	3.48	3.48	+0.1

* Scored from 1–5 with 1 representing very unsatisfied staff and 5 representing very satisfied staff

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 (bottom)

	2011/12		2010/11		Trust improvement/ deterioration
	Trust	National Average	Trust	National Average	
Top ranking scores					
KF30: % of staff reporting good communication between senior management and staff	42%	26%	37%	26%	+5%
KF7: Trust commitment to work-life balance	3.64	3.36	3.49	3.38	+0.15
KF10: % of staff feeling there are good opportunities to develop their potential at work	51%	40%	51%	41%	No change
KF23: % of staff experiencing physical violence from patients, relatives or the public in last 12 months	4%	8%	7%	8%	-3%
Bottom ranking scores					
KF16. % of staff receiving health & safety training in last 12 months	64%	81%	59%	80%	+5%
KF28. Impact of health and well-being on ability to perform work or daily activities	1.66	1.56	1.62	1.57	+0.04
KF8. % of staff working extra hours	70%	65%	71%	66%	-1%
KF19. % of staff saying hand washing materials are always available	58%	66%	53%	67%	+5%

Future priorities and targets

The Trust plans to engage with staff in accordance with the NHS Constitution. The Trust staff survey action plan will focus on addressing areas of concern from this year's staff survey and building on areas of strength. Each department and directorate will develop its own action plan to address local issues. Progress will be reported through the Trust's established internal communication systems.

The Trust plans to introduce an internal survey for staff during the year to ensure that action plans are being delivered and enable stronger engagement with staff on these plans.

Key Fact

Our staff would recommend the hospital to friends and family

- 80% of staff would recommend Chelsea and Westminster for treatment (national average 63%)
- 70% of staff would recommend Chelsea and Westminster as a place to work (national average 51%)

Case Study

Directors' Den

We launched a new staff engagement initiative Directors' Den in October 2011 to encourage staff to be innovative and suggest ways to improve their own services—the 'carrot' for the winning entries was that they could win funding from the Directors' Den panel to turn their ideas into reality.

There was an excellent response from staff. Almost 50 entries were received and six were shortlisted for presentation to a panel which included Executive Directors, Non-Executive Director Sir Geoffrey Mulcahy, and *Health Service Journal* Editor Alastair McLellan.

The panel allocated funding of more than £200,000 to five projects including:

- **Annabel Bryant** (Midwifery Development Lead) & **Shereen Jones** (Intrapartum Matron)

  Two linked proposals to promote natural birth—'The Nest', an area where low risk women can establish their labour in peace, and training for midwives in complementary therapies

- **Laura Hoare** (Paediatric Inpatient Administrative Co-ordinator) & **Noel Palmer** (Jupiter Ward Manager)

  A new website for Chelsea Children's Hospital patients and parents

- **Carol Dale** (Learning & Organisational Development Manager)

  A mandatory training video for non-clinical staff accessible at work or at home via the Trust website

- **Cherry Brennan** (Interim Maternity Inpatients Matron), **Zoe Macgrath** (Interim Postnatal Ward Lead) & **Lena Karam** (Antenatal Ward Lead)

  A 'campaign for peace' in Maternity to make it easier for women to speak to staff who are responsible for their care by replacing the current call bell system with a new system of communication fobs which women can activate to request assistance

- **Dr Sophie Graeme-Baker** (Specialist Registrar, Radiology)

  Improving the training of staff in ultrasound-guided biopsy skills in Radiology by purchasing ultrasound simulators which allow trainees to practice on dummy patients.

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 terms of authorisation.

The financial indicators used to derive the financial risk rating incorporate five individual ratings which are each rated from 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

Governance risk rating performance

In 2011/12 the Trust was rated green for governance. The plan for 2011/12 was for an amber/green rating.

The Trust performance was better than plan due to the number of MRSA and *Clostridium difficile* cases being less than nationally agreed targets.

Financial risk rating performance

The Trust planned to achieve an overall financial risk rating of 4 in 2011/12 but the Trust's actual performance was a rating of 5, on the cumulative position.

The overall financial risk rating reflects the weighted average of five individual ratings. In 2011/12 the Trust achieved a higher rating than plan in three of these ratings—Return on Capital Employed, Surplus Margin and Liquidity.

The Return on Capital rating assesses the level of return generated from the Trust's net assets. In 2011/12 the Trust achieved a return of 6.9% which provides a rating of 5 compared to a plan of 4.

The Surplus Margin rating assesses the level of surplus generated from the Trust's operating income. In 2011/12 the Trust achieved a margin of 4% which provides a rating of 5 compared to a plan of 4.

The Liquidity rating assesses the level of cash available to the Trust and the number of days it could continue to pay its creditors without receiving income. During each quarter the Trust had an average of 31.5 days of cash which provides a rating of 4 compared to a planned rating of 3.

2011/12	Annual Plan	Q1	Q2	Q3	Q4
Financial risk rating	4	3	4	5	5
Governance risk rating	AMBER/GREEN	GREEN	GREEN	GREEN	GREEN

2010/11	Annual Plan	Q1	Q2	Q3	Q4
Financial risk rating	4	5	5	5	5
Governance risk rating	GREEN	GREEN	AMBER/ GREEN	AMBER/ GREEN	GREEN

Public interest disclosures

Action to inform, involve & consult with staff

See the 'Staff survey' section for details.

Policies in relation to equal opportunities

We have an Equality & Diversity Policy to explain the current equalities legislation and to ensure that staff are aware of their responsibilities as employees of the Trust.

The Trust has a zero tolerance approach to bullying and harassment which is set out in our Harassment & Bullying Policy.

The Trust considers requests for flexible working or reasonable adjustments through the respective policies for flexible working and the recruitment and retention of staff with disabilities.

Policies in relation to disabled staff

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

The Trust has an Equality & Diversity Policy and a Recruitment and Selection Policy and Procedure which supports applications from disabled candidates to receive full and fair consideration. Specific support for Trust staff is provided through mandatory recruitment training for recruiting managers, as well as a policy for the recruitment and retention of staff with disabilities.

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 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 appraisals and any training needs or personal development opportunities should be identified during the employee's appraisal in accordance with the Trust's Appraisal Policy and Study Leave Policy.

Health & Safety performance

The number of incidents reported to the Health & Safety Executive increased from 22 in 2010/11 to 27 in 2011/12.

Occupational Health performance

The Occupational Health service offers advice to staff on all aspects of health, safety and wellbeing at work, to ensure a safe working environment for staff, and provides a comprehensive range of services to maintain and improve the health and wellbeing of the workforce.

In 2011/12 the Occupational Health department introduced services for staff such as osteopathy, reflexology and massage.

Staff have access to an Employee Assistance Programme which is a free and confidential service that provides staff with specialist information and advice on issues that are of concern to them.

The Occupational Health and Physiotherapy departments have also introduced a fast-track referral process to provide staff with quick access to physiotherapy services.

In 2011/12 a total of 712 pre-employment health and medical interviews were undertaken by the Occupational Health department to establish the fitness of staff to work and to ensure staff are appropriately immunised against infectious diseases in accordance with Department of Health guidance.

In addition, 828 management referrals/reviews were undertaken in 2011/12. Line managers continue to be the main source of referrals, requesting Occupational Health assistance with the management of sickness absence, rehabilitation and performance issues.

Occupational Health also provided support and guidance to staff who may be experiencing personal problems or work-related issues and as a result a total of 147 self-referrals were seen.

Case Study

‘I’ve had mine. Have you had yours?’ flu campaign

The Trust ran a successful staff flu vaccination campaign supported by the Occupational Health department.

The aim of the campaign was to encourage staff to protect themselves, their patients and their family by having their flu jab.

Senior clinicians advocated vaccination through a series of eye-catching posters and staff from Occupational Health as well as trained nurses from other clinical teams carried out vaccination on wards as well as in the department.

The success of the campaign was recognised nationally by a Flu Fighter Award from NHS Employers. It has also been shortlisted for the Chartered Institute of Public Relations (CIPR) Excellence Awards 2012.

Key Fact

Staff flu vaccination programme to protect our patients

- 61% of staff had their flu vaccination (best vaccination rate of any hospital in London)

Counter-fraud policies and 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 and the Local Counter-fraud Specialist (LCFS).

Sickness absence data

The annual sickness absence level in the Trust in 2011/12 was 3.87% compared with 3.44% in 2010/11. However, this was still within the Trust’s internal target for the year.

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 NHS Foundation Trust 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; and
- Prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable 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
28 May 2012

Annual Governance Statement

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.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of 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 2012 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

The Trust has a risk management strategy and operational policies approved by the Trust Board. This outlines the strategic direction for the management of risk and the framework for the continued development of risk management processes. The responsibilities of the Trust Board are outlined confirming the role of the Chief Executive as the Accountable Officer. There is currently an Interim Chief Operating Officer and the Chief Executive leaves in June. A new Chief Executive has been appointed. The remaining Executive team are experienced and well established and it is not envisaged that the interim arrangements will affect the Trust's capacity to handle risk.

All Directors working in the Trust take responsibility for risk identification, management and mitigation within their areas of work and practice, in line with the management and accountability arrangements in the Trust. The Divisions are responsible for their areas and this is supported by quarterly Divisional quality reports which contain a wide range of information including information on risks, incidents, complaints, infection control, and training. Risk management is overseen at corporate level through the Trust's Risk Management Committee and in addition other committees as appropriate eg the Health and Safety and Fire Committee, the Capital Programme Board and the Facilities Committee. The Risk Management Committee reports to the Trust Executive Quality Committee and also provides reports to the Assurance Committee, which reports to the Board.

The dissemination of good practice and lessons learned from incidents or near misses is achieved through a variety of mechanisms including Divisional reports, discussion of incidents and risk assessments at relevant committees eg the Risk Management Committee and Trust Executive Quality Committee, and newsletters.

Risk management training is given to staff on induction and regular training opportunities are provided within the hospital to staff at all levels, based on their responsibilities and the Training Needs Analysis. Compliance with training requirements is monitored quarterly at divisional level. In addition regular trust-wide reports are provided to the Trust Executive Quality Committee and Assurance Committee.

The Trust is currently at level 2 of the Clinical Negligence Scheme for Trusts (CNST) maternity standards and retained level 2 in the general NHS Litigation Authority Risk Management Standards following the assessment in December 2011.

The risk and control framework

Risk management strategy and management of risk

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 subsequently identification of action plans to reduce risk. These actions are monitored through the divisions and the Risk Management Committee.

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. Gaps in meeting key

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. Risks graded red are considered serious risks and risks graded orange are considered high risk. These risks are peer reviewed.

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 Risk Management Committee and if appropriate by other committees eg those with capital implications are reviewed at the Capital Programme Board. Risks identified through completion of the Assurance Framework are monitored by the Board. Risk assessments and the directorate risk register are part of the quarterly Quality 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 further embedded in the activity of the organisation in a number of other ways. Local risk management processes reflect the overall strategy of the Trust. Directorates and departments are required to identify risks associated with the delivery of 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. An approach to more explicit recognition and management of key risks has been agreed for 2012/13.

Quality Governance

The key elements of the quality governance arrangements are as described in Monitor's Quality Governance Framework; strategy, capabilities and culture, processes and structure and measurement. More detail is provided in the annual report and quality report. The quality of performance information is assessed by the performance managers and by the Divisions' top teams through monthly performance reporting to Divisional Boards and to the monthly Performance and Finance Meetings chaired by the Chief Operating Officer. Performance information is also assessed at the weekly ED meeting and at the fortnightly outpatients meeting.

Care Quality Commission

Compliance with the Care Quality Commission (CQC) registration requirements is assured by the Assurance Committee through review of the CQC standards compliance and by the monitoring of action plans and feedback from patients and staff. The CQC undertook a routine inspection in February 2012 and reported that the Trust was meeting all of the essential standards of quality and safety.

Data Security

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 assured. Based on the Trust's performance over the last two years internal audit do not consider it is necessary to audit every year.

The Information Governance toolkit (Connecting for Health) assessment for 2011/12 which was independently verified by Internal Audit assessed all major requirement areas at Level 3. Overall one requirement, in relation to data quality on coding, which was not audited, is assessed at Level 1 and an action plan has been submitted to Monitor to rectify. The Audit Committee receives a regular update on information governance and assures the Board through the reports to the Board.

The major strategic risk relates to NHS London reconfiguration plans *Shaping a Healthier Future*. Subject to the outcome of the consultation, this will have a significant impact on the Trust as either Accident and Emergency activity will be lost or there will be an increase. The Executive team is actively engaged in the strategy development in relation to clinical strategy, financial assumptions and out of hospital care. The Board has considered the possible outcomes for Chelsea and Westminster Hospital and the impact is being assessed through scenario planning and considering the opportunities arising out of the Health and Social Care Act.

Patients are involved in risks which affect them through representation via the Governors at the Council of Governors and through the Council of Governors Quality Sub-committee. Kensington and Chelsea Local Involvement Network and the

commissioners are also members of the Quality Sub-committee and involved in setting priorities as described in the Quality Report. The lead PCT is also 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, 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 registration requirements of the Care Quality Commission.

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 into 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 in accordance with 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.

Review of economy, efficiency and effectiveness of the use of resources

The development and reporting of patient level costing and service level reporting continues, to ensure that the Board is aware of relative profitability and efficiency. The Trust started a programme of deep dive specialty reviews in 2011/12 to support the delivery of the Cost Improvement Programme.

Monthly finance and performance reports are provided to the Board. 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 and are reported to the service on a monthly basis. The Trust has exceeded the target for generation of net surplus and has delivered its target Cost Improvement Programme.

It is within Internal Audit's remit to make recommendations on the effective use of resources and they have undertaken a review of processes for cost improvement, Quality Innovation Performance and Prevention (QUIPP), financial management and financial reporting.

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) 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 Director of Governance and Corporate Affairs led the process with the support of other Directors, the Head of Quality and Safety and the key stakeholders through the Council of Governors meetings, the Council of Governors Quality Sub-committee and Executive and other meetings within the Trust. The involvement of stakeholders and how our priorities were set is described in more detail in the Quality Report. Reports were regularly reviewed by stakeholders internally and externally in order to ensure that we present a balanced view and the data is accurate. Other assurance was obtained through our own assurance processes and internal and external audit. The quality report outlines our position on data quality in more detail. Quality Report data is reported to the Board monthly, with an update on progress on priorities quarterly.

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, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual Report and other performance information available to me, including

financial reports throughout the year and internal and external assurance through audit. My review is also informed by 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 the Assurance 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 and reporting 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 five 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 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, a safe and clean hospital environment and staff satisfaction and to ensure that there is evidence of robust governance and assurance processes in these areas. The Trust Executive Quality Committee, the Risk Management Committee and the Facilities Committee report into the Assurance Committee.

Internal audit services are outsourced to KPMG. KPMG have provided 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 a 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 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. There is a quarterly report to the Board on progress on objectives, including a review of the risks.

There is a clinical audit strategy, a policy and a yearly plan which takes into account national and local clinical audit requirements. There is a continued focus on clinical audit to drive service improvement and patient safety.

A serious incident in October 2011, which involved the death of a member of staff, identified a lack of control over the safe use of liquid nitrogen in the Trust. A range of measures were put in place to mitigate any future risk. Additional recommendations following a review of the incident are being implemented.

The unexpected death of a patient during routine surgery in August 2011 identified deficiencies in following up on out of range blood results and in handover. A number of actions have been implemented including a more robust process for out of range blood results and a review of handover in surgery. A review of handover across the Trust is in progress.

The list of 'never events' was extended to 25 for 2011/12 and our reporting systems identified five occurring this year. These have been thoroughly investigated and measures put in place to prevent re-occurrence. Prevention of never events will remain a high priority for 2012/13.

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
28 May 2012

Independent Auditor's Report

Independent Auditor's Report to the Board 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 2012 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 38. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor—Independent Regulator of NHS Foundation Trusts.

This report is made solely to the Board 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 auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the accounting officer and auditor

As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code of NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- Give a true and fair view of the state of the Trust's affairs as at 31 March 2012 and of its income and expenditure for the year then ended;
- Have been properly prepared in accordance with the accounting policies directed by Monitor—Independent Regulator of NHS Foundation Trusts; and
- Have been prepared in accordance with the requirements of the National Health Service Act 2006.

Opinion on other matter prescribed by the National Health Service Act 2006

In our opinion:

- The part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006; and

- The information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if, in our opinion:

- The Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls;
- Proper practices have not been observed in the compilation of the financial statements; or
- The NHS Foundation Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Certificate

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

Heather Bygrave FCA BA (Hons)
(Senior Statutory Auditor)
For and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
St Albans United Kingdom
29 May 2012

These accounts for the year ended 31 March 2012 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 OBE
Chief Executive
28 May 2012

Statement of comprehensive income for the year ended 31 March 2012

	Note	2011/12 £000	Restated 2010/11 £000
Operating income			
Operating income from operations	3	**342,805**	331,895
Operating expenses from operations	4	**(319,002)**	(308,701)
Operating surplus		**23,803**	23,194
Finance costs			
Finance income	8.1	**134**	112
Finance expense—financial liabilities	8.2	**(629)**	(462)
Public dividend capital dividend payable		**(9,670)**	(8,951)
Net finance costs		**(10,165)**	(9,301)
Surplus for the year		**13,638**	13,893
Other comprehensive income			
Revaluation (loss)/gain on property, plant and equipment		**(6,234)**	40,278
Total comprehensive income for the year		**7,404**	54,171

The 2010/11 surplus has been restated to reflect the accounting policy change in treatment of donated income and government grants (Note 1). The previously reported operating surplus of £13.8m has increased to £13.9m which is due to the following movements: increases to operating income from activities due to release of £0.03m deferred income from other current liabilities (note 16.1), release of £0.2m deferred income from other non-current liabilities (note 16.2), increase to income of £0.05m for donation to fund capital equipment; and a reduction to operating income from activities of £0.2m to reverse in year transfers from the donated asset reserve for the income equivalent to donated asset depreciation.

The 2010/11 other comprehensive income has also been restated to reflect the impact of the change in treatment of donated assets. The impact was to reduce by £0.05m to nil the receipt of donated assets and to reduce by £0.19m to nil the other reserve movements. Both adjustments are now reflected within operating income from operations.

Statement of financial position as at 31 March 2012

	Note	31 Mar 2012 £000	Restated 31 Mar 2011 £000	Restated 1 Apr 2010 £000
Non-current assets				
Intangible assets	9	**5,603**	4,870	0
Property, plant and equipment	10	**333,973**	318,342	265,939
Total non-current assets		**339,576**	323,212	265,939
Current assets				
Inventories	12	**6,340**	6,081	6,045
Trade and other receivables	13	**13,106**	15,554	18,617
Cash and cash equivalents	21	**40,997**	38,773	19,861
Total current assets		**60,443**	60,408	44,523
Current liabilities				
Trade and other payables	15	**(31,698)**	(40,320)	(27,843)
Borrowings	17.1	**(1,802)**	(169)	(919)
Provisions	20.1	**(6,490)**	(2,386)	(1,896)
Other liabilities	16.1	**(7,058)**	(6,625)	(4,772)
Total current liabilities		**(47,048)**	(49,500)	(35,430)
Total assets less current liabilities		**352,971**	334,120	275,032
Non-current liabilities				
Borrowings	17.2	**(26,286)**	(14,819)	(6,624)
Provisions	20.2	**(461)**	(456)	(459)
Other liabilities	16.2	**(150)**	(175)	(3,450)
Total non-current liabilities		**(26,897)**	(15,450)	(10,533)
Total assets employed		**326,074**	318,670	264,499
Financed by (taxpayers' equity)				
Public dividend capital		**162,549**	162,549	162,549
Revaluation reserve	23	**89,262**	95,880	55,726
Income and expenditure reserve		**74,263**	60,241	46,224
Total taxpayers' equity		**326,074**	318,670	264,499

Heather Lawrence

Heather Lawrence OBE, Chief Executive
28 May 2012

Statement of changes in taxpayers' equity for the year ended 31 March 2012

	Note	Total £000	Public dividend capital £000	Revaluation reserve £000	Donated assets reserve £000	Income and expenditure reserve £000
Taxpayers' Equity at 1 Apr 2011—restated		**318,670**	162,549	95,880	0	60,241
Surplus for the year		**13,638**	0	0	0	13,638
Revaluation loss on property, plant and equipment		**(6,234)**	0	(6,234)	0	0
Asset disposals		**0**	0	(384)	0	384
Taxpayers' Equity at 31 Mar 2012		**326,074**	162,549	89,262	0	74,263
Taxpayers' Equity at 1 Apr 2010 as previously stated		**264,408**	162,549	55,696	4,986	41,177
Prior period adjustment	1	**91**	0	30	(4,986)	5,047
Taxpayers' Equity at 1 Apr 2010—restated		**264,499**	162,549	55,726	0	46,224
Surplus for the year		**13,893**	0	0	0	13,893
Revaluation loss on property, plant and equipment		**40,278**	0	40,278	0	0
Asset disposals		**0**	0	(124)	0	124
Taxpayers' Equity at 31 Mar 2011		**318,670**	162,549	95,880	0	60,241

The impact of the restatement for the accounting policy change in relation to donated income and government grants (Note 1) resulted in a net movement in taxpayers' equity of £0.09m on the restated position at 1 April 2010, affecting the reserves as follows: income and expenditure reserve increased by £5.05m as a result of release of deferred income of £0.09m and transfer from donated asset reserve to income and expenditure reserve of £4.95m; the donated assets reserve reduced to nil as a result of moving £4.95m to income and expenditure reserve and £0.03m to revaluation reserve, this was the only change to the revaluation reserve.

Statement of cash flows for the year ended 31 March 2012

	Note	2011/12 £000	Restated 2010/11 £000
Cash flows from operating activities			
Operating surplus		**23,803**	23,194
Non-cash income and expense			
Depreciation and amortisation	4	**10,231**	8,478
Decrease in trade and other receivables		**2,901**	3,063
(Increase) in inventories		**(259)**	(36)
(Decrease)/increase in trade and other payables		**(4,881)**	7,746
Increase/(decrease) in other liabilities		**408**	(1,416)
Increase in provisions		**4,086**	387
Other movements in operating cash flows		**43**	93
Net cash generated from operations		**36,332**	41,509
Cash flows from investing activities			
Purchase of intangible assets		**(1,935)**	(615)
Purchase of property, plant and equipment		**(34,305)**	(20,565)
Net cash used in investing activities		**(36,240)**	(21,180)
Cash flows from financing activities			
Interest received		**135**	110
Loans received		**13,276**	12,525
Loans repaid		**0**	(4,917)
Capital element of finance lease rental payments		**(173)**	(158)
Interest paid		**(422)**	(234)
Interest element of finance leases		**(116)**	(127)
PDC dividends paid		**(10,568)**	(8,616)
Net cash used in financing activities		**2,132**	(1,417)
Increase in cash and cash equivalents		**2,224**	18,912
Cash and cash equivalents at 1 Apr 2011		**38,773**	19,861
Cash and cash equivalents at 31 Mar 2012		**40,997**	38,773

The impact of the restatement for the accounting policy change in relation to donated income and government grants (Note 1) resulted in an increase in release of deferred income of £0.22m which increased operating surplus from continuous operations to £23.19m and increased the reduction in other liabilities to £1.42m; the transfer from the donated asset reserve was reduced from £0.19m to nil; other movements in operating cashflows reduced by £0.05m for the receipt of donated asset income.

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 following financial statements have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2011/12 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.

Prior Period Adjustment—Monitor has adopted the new accounting requirements for donated, government grant and other grant funded assets as set out in HM Treasury's 2011/12 Financial Reporting Manual. In summary this restricts deferral of grant income relating to an asset to situations where the funder imposes a condition on the asset. It also requires an identical accounting treatment for donated assets as that adopted for government grants. As a result, any future grant funding relating to assets which is not subject to conditions on the grant must be released fully within income in the year in which it is received, and similarly where no conditions are attached to a donated asset a credit will be recognised in income in the year in which the asset is received. Any such income deferred in prior years and held in the donated asset reserve has been transferred to the income and expenditure reserve as a prior period adjustment. The comparative figures in the primary statements and notes to these accounts have been restated to reflect the new policy. Refer to Note 38, Prior Year Adjustment.

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 have not yet been adopted in the Annual Reporting Manual. 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.

- IFRS 7 Financial Instruments: Disclosures—Transfers of Financial Assets
- IFRS 9 Financial Instruments: Financial Assets & Liabilities
- IFRS 10 Consolidated Financial Statements
- IFRS 11 Joint Arrangements
- IFRS 12 Disclosure of Interests in Other Entities
- IFRS 13 Fair Value Measurement
- IAS 1 Presentation of Financial Statements, on other comprehensive income (OCI)
- IAS 12 Income Taxes Amendment
- IAS 27 Separate Financial Statements
- IAS 28 Associates and Joint Ventures

The directors do not expect that the adoption of these standards and interpretations will have a material impact on the financial statements in future periods. All other revised and new standards have not been listed here as they are not considered to have an impact on the Trust.

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 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.

The Scheme is subject to a full actuarial valuation every four years by the Government Actuary (until 2004, based on a five year valuation cycle) and an accounting valuation every year.

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken relates to the period from 1 April 1999 to 31 March 2004, and published in December 2007.

The conclusion from the 2004 valuation was that the Scheme had a national deficit of £3.3 billion, and that the scheme continues to operate on a sound financial basis.

The Scheme actuary reported that employer contributions should continue at the existing rate of 14% of pensionable pay. From 1 April 2008, employees contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

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; or
- 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, have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- 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 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 asset values.

A valuation of land and buildings was carried out by Montagu Evans (Independent Chartered Surveyors, Registration number OC312072). Montagu Evans valued the underlying land as at 31 March 2012, with regard to prevailing land values in the vicinity of the existing site and in a manner consistent with the Trust's occupational requirements and current land ownership. Buildings were valued at depreciated replacement cost on a modern equivalent asset basis as at 31 March 2012. 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. The useful life of the main hospital was assessed as part of the valuation and was revised from 36 to 39 years. As a result of the extensive refurbishment that has taken place on the first and second floors, it has been assessed that the refurbishment has extended the useful economic life of the building.

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:

- Buildings are depreciated on a straight line basis, after accounting for residual value, over the remaining useful economic life of 36 to 39 years;
- Dwellings and leasehold improvements are depreciated over the shorter of the useful economic life or lease term;
- Plant and machinery, furniture and fittings and information technology are 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.
- Transport equipment is depreciated on a straight line basis over 5 years.

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 a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses 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'.

In accordance with the Foundation Trust Annual Reporting Manual, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

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'; and

  (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, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation / grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case the donation / grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met. The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

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 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; and

(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 eg 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 eg 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.

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. Software is amortised over 3-10 years.

1.16 Revenue government and other 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.

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. These balances are readily convertible to a known amount of cash and are subject to an insignificant risk of changes in value. Monies held in the Trust's bank account belonging to patients are excluded from cash and cash equivalents (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 it relates. 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 below.

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'; or
- 'Loans and receivables'; or
- 'Available-for-sale' financial assets.

Financial liabilities are classified as either:

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

1.24 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 date of the Statement of Financial Position, 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.

1.25 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 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. Evidence is gathered via formal communication between the Trust and the counterparties.

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 bad debt provision. The bad debt provision is charged to operating expenses.

1.26 Leases

1.26.1 Finance leases

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

1.26.2 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.

1.26.3 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.

1.27 Provisions

The 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.

1.28 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at note 20.3 to the accounts.

1.29 Non-clinical risk pooling

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

1.30 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; or

(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.

1.31 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 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 Service (GBS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility, 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 of the audit of the annual accounts.

1.32 Value Added Tax

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

1.33 Corporation tax

Corporation tax is not applicable to the Trust.

1.34 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; and
- 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.

1.35 Third party assets

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

2 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, which are described in note 1, the directors are required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from

other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

2.1 Critical judgements in applying the group's accounting policies

The following are the critical judgements, apart from those involving estimations (which are dealt with separately below), that the directors have made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in financial statements.

Revenue recognition

The directors have determined that the recoverability of overseas patient income is critical to the recognition of income in the financial statements. In accordance with the requirements of IAS 18 Revenue, the Trust makes an assessment of the recoverability of overseas debt at the point of delivery of treatment. This is to ensure adherence to the accounting principles set out in IAS 18 that: 'Revenue is recognised only when it is probable that the economic benefits associated with the transaction will flow to the entity'. Overseas patients arise for a number of reasons, and every overseas patient in the Trust is interviewed by an Overseas Officer as soon as is reasonably practical to do so, to assess their NHS entitlement, status and ability to pay.

Disputes with Commissioners

As set out in Note 20.3, Management has made an assessment of the potential liability of the Trust from contractual disputes with commissioners. Provisions for the disputes are £4.4m at 31 March 2012. The disputes relate to challenges on pricing or charging that it has not been possible to settle by reference to the contract, under which the Trust has been entitled to the income. The Trust has recognised the income in relation to the disputes in its Statement of Comprehensive Income and the commissioning bodies have settled the debts. However there is precedent for the Trust agreeing a negotiated settlement with commissioners, on contractual challenges raised during the year on issues that are not sufficiently clear in the contracts. The Trust has determined the level of provision on a basis that reflects settlement of the issue for the financial year in which the issue was raised and any subsequent years but not to retrospectively settle claims.

2.2 Key sources of estimation uncertainty

The key assumptions concerning the future, and other key sources of estimation uncertainty at the statement of position date, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year, are discussed below.

Valuation of land and buildings, including life of main hospital building

The Trust's main hospital building was revalued at 31 March 2012 by external independent valuers who determined that the use of a general hospital build cost index (provided by BCIS) applied to the gross internal area of the hospital was the appropriate index to be used. Management supports the use of this index, which is consistent with the index used in prior years, as opposed to changing to an alternative index. The alternative index would be a detailed list of specialist indices (provided by BCIS) applicable to the gross internal area of each part of the building, for example, wards, theatres or laboratories. The directors are satisfied that the application of a consistently applied general index in the property valuation is more important than refecting minor changes in valuation from change in use of areas of the hospital building through use of a department specific index, particularly when the independent valuers have advised the difference in overall valuation between the two methods would not be significant. The impact of the valuation of buildings is shown in note 10.1.

The Trust's main hospital building was revalued at 31 March 2012 following the successful completion of a £32m extension and refurbishment project (Netherton Grove extension) during the year. The development expanded the specialist paediatric capacity and remodelled adjacent internal areas to provide new paediatric theatres and wards, in the new Chelsea Chidlren's Hospital. The extensive refurbsihment led the independent external valuers to reassess the remaining life of the hospital building from 36 years to 39 years, which increased the value of the hospital at 31 March 2012. The directors support the extension to the hospital's life, which reflects the impact on the life of the extensive remodelling of the interior.

3 Operating income from operations

3.1 Operating income (by classification)

	Note	2011/12 £000	Restated 2010/11 £000
Income from activities			
Elective income		**46,590**	45,169
Non elective income		**70,524**	70,183
Outpatient income		**67,660**	62,209
Accident & Emergency income		**11,061**	10,631
Other NHS clinical income		**92,232**	89,894
Private patient income	3.3	**11,264**	10,788
Other non-protected clinical income		**2,224**	2,274
Total income from activities	3.4	**301,555**	291,148

The 2010/11 figures have been restated as a result of two material reclassifications of income in the current year 2011/12 relating to Neonatal/Paediatric care and HIV. This had a net nil impact on total income from activities in 2010/11 of £291.1m. The two movements were as follows; (a) reclassification of £12.6m from non elective income to other NHS clinical income relating to Neonatal Intensive Care (£8.1m), Special Care Baby Unit (£2.4m) and Paediatric HDU (£2.1m) and (b) reclassification of £3.3m of HIV income from other NHS clinical income to elective (£1.3m) and non elective (£2.0).

3.2 Other operating income

	2011/12 £000	Restated 2010/11 £000
Other operating income		
Research and development	**5,347**	4,153
Education and training	**25,901**	25,286
Charitable and other contributions to expenditure	**89**	22
Non-patient care services to other bodies	**955**	914
Other income	**8,958**	10,372
Total other operating income	**41,250**	40,747
Total operating income from operations	**342,805**	331,895

The 2010/11 figures have been restated as a result of the accounting policy change in treatment of donated income and government grants (Note 1). Total other operating income previously stated in 2010/11 of £40.7m has increased to £40.8m as a result of the following restatements: release of £0.03m deferred income from other current liabilities (note 16.1); release of £0.2m deferred income from other non-current liabilities (note 16.2); increase to income of £0.05m for donation to fund capital equipment; and a reduction to income of £0.2m to reverse in year transfers from the donated asset reserve for the income equivalent to donated asset depreciation.

Other income includes the following significant amounts: Staff recharges £1.9m (2010/11 £3.5m), Estates recharges £1.4m (2010/11 £1.5m), Clinical Excellence Awards £1.1m (2010/11 £1.0m), Car parking £0.9m (2010/11 £0.7m) and donated contributions to capital £0.7m (2010/11 nil).

3.3 Private patient income (PPI)

	Base year restated £000	2011/12 £000	2010/11 £000
Private patient income	5,824	**11,264**	10,788
Total patient related income	157,015	**301,555**	291,148
Proportion (as percentage)	3.7%	**3.7%**	3.7%

3.4 Operating income (by type)

	2011/12 £000	2010/11 £000
Income from activities		
NHS foundation trusts	1,012	1,129
NHS trusts	64	10
Primary Care Trusts	288,066	278,085
Local authorities or other government bodies	171	27
Non NHS: Private patients	10,464	9,843
Non NHS: Overseas patients (non-reciprocal)	800	945
NHS injury scheme	895	887
Non NHS: Other	83	222
Total	301,555	291,148

4 Operating expenses from operations

	2011/12 £000	2010/11 £000
Operating expenses		
Staff costs	170,422	163,832
Executive Directors costs	781	830
Non Executive Directors costs	128	137
Termination benefit	16	96
Early retirements	29	28
Drug costs	52,126	50,634
Supplies and services—clinical (excluding drug costs)	36,422	34,950
Supplies and services—general	5,184	4,897
Transport	1,595	1,440
Research and development	878	943
Establishment	4,896	4,947
Premises	20,914	19,299
Services from NHS trusts and foundation trusts	797	513
Purchase of healthcare from non NHS bodies	1,394	1,273
Legal fees	261	611
Consultancy costs	2,127	1,354
Training, courses and conferences	835	773
Patient travel	131	112
Car parking and security	42	4
Hospitality	71	77
Insurance	201	191
Audit fees:		
Audit services—statutory audit	124	138
Other auditors remuneration—further assurance services	0	12
Clinical negligence	5,623	5,124
(Decrease)/increase in bad debt provision	(2,683)	6,559
Increase in other provisions	4,109	0
Depreciation on property, plant and equipment	9,029	8,453
Amortisation on intangible assets	1,202	25
Loss on disposal of other property, plant and equipment	20	50
Other	2,328	1,399
Total operating expenses from operations	319,002	308,701

4.1 Operating leases

4.1.1 Arrangements containing an operating lease

	2011/12 £000	2010/11 £000
Minimum lease payments	1,936	1,817

4.1.2 Arrangements containing an operating lease

	31 Mar 2012 £000	31 Mar 2011 £000
Future minimum lease payments due:		
• not later than one year	1,592	1,769
• later than one year and not later than five years	3,720	5,209
• later than five years	3,334	3,334
Total	8,646	10,312

5 Employee expenses and numbers

5.1 Employee expenses

	2011/12 £000	Restated 2010/11 £000
Salaries and wages	**130,067**	127,436
Social security costs	**12,083**	11,189
Employers' contributions to NHS Pension Scheme	**14,596**	13,945
Termination benefit	**16**	96
Agency/contract staff	**16,541**	13,941
Costs capitalised as part of assets	**(2,055)**	(1,821)
Total	**171,248**	164,786

The 2010/11 figures have been restated to include capitalised staff costs.

5.2 Average number of persons employed—Whole Time Equivalent (WTE) Basis

	2011/12 WTE	2010/11 WTE
Medical and dental	**560**	539
Administration and estates	**607**	592
Healthcare assistants and other support staff	**273**	248
Nursing, midwifery and health visiting staff	**1,047**	1,057
Scientific, therapeutic and technical staff	**373**	300
Bank and agency staff	**441**	411
Other	**0**	27
Total	**3,301**	3,174
Of which: number of employees engaged on capital projects	**27**	23

5.3 Employee benefits

	2011/12 £000	2010/11 £000
Employee benefits	**23**	100

5.4 Retirements due to ill-health

During 2011/12 there were two early retirements from the Trust agreed on the grounds of ill-health; the estimated additional pension liabilities of ill health retirements for the year ended 31 Mar 2012 were £0.2m. In 2010/11 there were three; the estimated additional pension liabilities of ill-health retirements for the year ended 31 Mar 2011 were £0.2m.

5.5 Exit packages

During 2011/12 there was one compulsory redundancy within banding £10,000–£25,000. In 2010/11 there were three; each within banding £25,001–£50,000.

There were no other departures for staff except for exit packages relating to senior managers disclosed in the Directors' remuneration note, whose details are within note 5.6.

5.6 Salary and pension entitlements of senior managers

	a) Remuneration				
	Salary for the year ended 31 Mar 2012 Bands of £5,000	Salary for the year ended 31 Mar 2011 Bands of £5,000	Performance related pay for the year ended 31 Mar 2012 Bands of £5,000	Performance related pay for the year ended 31 Mar 2011 Bands of £5,000	Other costs for the year ended 31 Mar 2012 Bands of £5,000
Executive Directors					
Heather Lawrence OBE, Chief Executive	**185–190**	175–180	**15**	0	**0**
Dr Mike Anderson, Medical Director	**170–175**	160–165	**0**	0	**0**
Lorraine Bewes, Director of Finance	**130–135**	130–135	**0**	0	**0**
Amanda Pritchard, Deputy Chief Executive (Director of Integrated Service Delivery & Modernisation)	**120–125**	80–85	**0**	0	**0**
Mark Gammage, Interim Deputy Chief Executive[1]	**0**	75–80	**0**	0	**0**
Andrew MacCallum, Director of Nursing[2]	**0**	25–30	**0**	0	**0**
Thérèse Davis, Chief Nurse and Director of Patient Experience and Flow[3]	**110–115**	140–145	**0**	0	**0**
Non-Executive Directors					
Professor Sir Christopher Edwards, Chairman	**35–40**	35–40	**0**	0	**0**
Sir John Baker CBE, Vice Chair[4]	**15–20**	0–5	**0**	0	**0**
Karin Norman, Non-Executive Director	**10–15**	10–15	**0**	0	**0**
Prof. Richard Kitney OBE, Non-Executive Director	**10–15**	10–15	**0**	0	**0**
Jeremy Loyd, Non-Executive Director[4]	**10–15**	0–5	**0**	0	**0**
Sir Geoffrey Mulcahy, Non-Executive Director[4]	**10–15**	0–5	**0**	0	**0**
Andrew Havery, Non-Executive Director[5]	**10–15**	15–20	**0**	0	**0**
Charles Wilson, Non-Executive Director[5]	**10–15**	15–20	**0**	0	**0**
Colin Glass, Non-Executive Director[6]	**0**	5–10	**0**	0	**0**
Directors					
Mark Gammage, Director of Human Resources[1]	**75–80**	60–65	**0**	0	**0**
Catherine Mooney, Director of Governance & Corporate Affairs	**85–90**	85–90	**0**	0	**0**
Axel Heitmueller, Director of Strategy and Service Planning[7]	**80–85**	25–30	**0**	0	**0**
Lucy Hadfield, Director of Strategy and Service Planning[8]	**0**	75–80	**0**	0	**0**
Amit Khutti, Director of Strategy and Service Planning[2]	**0**	10–15	**0**	0	**0**
Bill Gordon, Acting Director of Information Management and Technology	**80–85**	80–85	**0**	0	**0**
Alex Geddes, Director of Information Management & Technology[9]	**0**	0	**0**	0	**0**
Kelda Alleyne, Deputy Director of Finance	**85–90**	85–90	**0**	0	**0**

Notes to senior managers' salary and pension table

1 Covered maternity leave of the Deputy Chief Executive until 31 October 2010—paid via Dearden Consulting Ltd for this period. From 1 November 2011 reverted to Interim Director of HR, paid via Dearden Consulting Ltd until joined Trust payroll in March 2011. Cost reported until 28 February 2011 is therefore full cost to the Trust. Mark Gammage is Managing Director of Dearden Consulting Ltd.

2 Director of Nursing and Director of Strategy left the Trust in May 2010.

3 Paid via Delphi Consulting Ltd for period to 31 Mar 2011 as Interim Chief Nurse and Director of Patient Experience and Flow, therefore cost reported for that period is full cost to the Trust. Joined Trust payroll from 1 April 2011 following appointment to the post on 1 April 2011. Thérèse Davis is Managing Director of Delphi Consulting Ltd.

4 Appointed 1 November 2011. During 2011/12 Sir John Baker was also appointed Vice Chair and Chair of the Audit Committee.

			b) Pension				
Other costs for the year ended 31 Mar 2011 Bands of £5,000	Total salaries for the year ended 31 Mar 2012 Bands of £5,000	Total salaries for the year ended 31 Mar 2011 Bands of £5,000	Accrued pension and related lump sum at age 60 as at 31 Mar 2012 Bands of £2,500	Real increase/ (decrease) in pension and related lump sum at age 60 as at 31 Mar 2012 Bands of £2,500	CETV at 31 Mar 2012 £000	CETV at 31 Mar 2011 £000	Real increase/ (decrease) in CETV for the year ended 31 Mar 2012 £000
0	200–205	175–180	0	0	0	0	0
0	170–175	160–165	332.5–335.0	20.0–22.5	0	1,752	(1,817)
0	130–135	130–135	140.0–142.5	7.5–10.0	651	544	87
0	120–125	80–85	85.0–87.5	12.0–12.5	257	160	91
0	0	75–80	0	0	0	0	0
0	0	25–30	0	0	0	529	0
0	110–115	140–145	130.0–132.5	(2.5–0.0)	528	506	3
0	35–40	35–40	0	0	0	0	0
0	15–20	0–5	0	0	0	0	0
0	10–15	10–15	0	0	0	0	0
0	10–15	10–15	0	0	0	0	0
0	10–15	0–5	0	0	0	0	0
0	10–15	0–5	0	0	0	0	0
0	10–15	15–20	0	0	0	0	0
0	10–15	15–20	0	0	0	0	0
0	0	5–10	0	0	0	0	0
0	75–80	60–65	45.0–47.5	(12.5–10.0)	241	192	42
0	85–90	85–90	117.5–120.0	(7.5–5.0)	530	523	(13)
0	80–85	25–30	0–2.5	0–2.5	16	3	13
0	0	75–80	0	0	0	0	0
0	0	10–15	0	0	0	34	0
0	80–85	80–85	0	0	0	0	0
25–30	0	25–30	0	0	0	0	0
0	85–90	85–90	2.5–5.0	0–2.5	44	22	21

5 Left 31 October 2011.

6 Left 31 October 2010.

7 Joined the Trust in December 2010.

8 Interim paid via agency between May and December 2010 therefore cost reported is full cost to the Trust.

9 Left the Trust in November 2009—other costs relate to payments made within a compromise agreement.

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 spouse's contingent 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) regulations. These placed responsibility for the calculation method for CETVs (following actuarial advice) on Scheme Managers or Trustees. Further regulations from the Department for Work and Pensions to determine cash equivalent transfer values (CETV) from Public Sector Pension Schemes came into force on 13 October 2008.

6 Better Payment Practice Code

6.1 Better Payment Practice Code—measure of compliance

	2011/12		2010/11	
	Number	£000	Number	£000
Total bills paid in the year	**70,830**	**183,460**	62,846	161,633
Total bills paid within the target	**65,430**	**176,799**	56,892	142,138
Percentage of bills paid within target	**92.4%**	**96.4%**	90.5%	87.9%

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.

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

There were no amounts included within interest expense (note 8.2) arising from claims made under this legislation (2010/11—nil).

7 Loss on disposal of fixed assets

The loss on disposal of fixed assets was £0.02m(2010/11—£0.05m) arising from the disposal of engineering plant.

8 Finance

8.1 Finance income

	2011/12 £000	2010/11 £000
Interest on loans and receivables	**134**	112

8.2 Finance expense—financial liabilities

	2011/12 £000	2010/11 £000
Loans from the Foundation Trust Financing Facility	**516**	331
Finance leases	**113**	122
Other	**0**	9
Total	**629**	462

9 Intangible assets

9.1 Software licences/Information Technology

	31 Mar 2012 £000	31 Mar 2011 £000
Cost or valuation at 1 April	**6,100**	0
Additions—purchased	**355**	914
Additions—donated	**0**	0
Additions—internally generated	**1,580**	0
Impairments	**0**	0
Reclassifications	**0**	5,186
Revaluation surpluses	**0**	0
Disposals	**0**	0
Cost or valuation at 31 March	**8,035**	6,100
Amortisation at 1 April	**1,230**	0
Provided during the year	**1,202**	25
Reclassifications	**0**	1,205
Revaluation surpluses	**0**	0
Disposal	**0**	0
Amortisation at 31 March	**2,432**	1,230
Opening net book value		
Owned	**5,603**	4,870
Finance lease	**0**	0
Donated	**0**	0
Opening net book value total	**5,603**	4,870
Closing net book value		
Owned	**4,870**	0
Finance lease	**0**	0
Donated	**0**	0
Closing net book value total	**4,870**	0

10 Property, plant and equipment

10.1 Property, plant & equipment at the balance sheet date 31 March 2012

	Land £000	Buildings excluding dwellings £000
Cost or valuation at 1 Apr 2011	50,000	225,896
Additions—purchased	0	0
Additions—donated	0	654
Impairments charged to revaluation reserve	0	0
Reclassifications	0	32,058
Other revaluations	0	(9,247)
Disposals	0	(23)
Cost or valuation at 31 Mar 2012	**50,000**	**249,338**
Accumulated depreciation at 1 Apr 2011	0	241
Provided during the year	0	3,187
Impairment	0	0
Reclassifications	0	0
Revaluation surplus	0	(2,791)
Disposal	0	(3)
Accumulated Depreciation at 31 Mar 2012	**0**	**634**
Net book value		
Owned at 31 Mar 2012	50,000	242,778
Finance lease at 31 Mar 2012	0	0
Donated at 31 Mar 2012	0	5,926
NBV Total at 31 Mar 2012	**50,000**	**248,704**
Protected assets at 31 Mar 2012	50,000	246,147
Unprotected assets at 31 Mar 2012	0	2,557
Total at 31 Mar 2012	**50,000**	**248,704**
Net book value		
Owned at 31 Mar 2011	50,000	220,450
Finance lease at 31 Mar 2011	0	0
Donated at 31 Mar 2011	0	5,205
Total at 31 Mar 2011	**50,000**	**225,655**
Protected assets at 31 Mar 2011	50,000	222,715
Unprotected assets at 31 Mar 2011	0	2,940
Total at 31 Mar 2011	**50,000**	**225,655**

10.2 Property, plant & equipment at the balance sheet date 31 Mar 2011

Cost or valuation at 1 Apr 2010	50,000	180,196
Additions—purchased	0	0
Additions—donated	0	0
Impairments charged to revaluation reserve	0	0
Reclassifications	0	7,641
Other revaluations	0	38,075
Disposals	0	(16)
Cost or valuation at 31 Mar 2011	**50,000**	**225,896**
Accumulated depreciation at 1 Apr 2010	0	0
Provided during the year	0	2,456
Impairment	0	0
Reclassifications	0	0
Revaluation surplus	0	(2,203)
Disposal	0	(12)
Accumulated Depreciation at 31 Mar 2011	**0**	**241**
Net book value		
Owned at 31 Mar 2011	50,000	220,450
Finance lease at 31 Mar 2011	0	0
Donated at 31 Mar 2011	0	5,205
NBV Total at 31 Mar 2011	**50,000**	**225,655**
Protected assets at 31 Mar 2011	50,000	222,715
Unprotected assets at 31 Mar 2011	0	2,940
Total at 31 Mar 2011	**50,000**	**225,655**
Net book value		
Owned at 31 Mar 2010	50,000	176,005
Finance lease at 31 Mar 2010	0	0
Donated at 31 Mar 2010	0	4,191
Total at 31 Mar 2010	**50,000**	**180,196**
Protected assets at 31 Mar 2010	50,000	177,828
Unprotected assets at 31 Mar 2010	0	2,368
Total at 31 Mar 2010	**50,000**	**180,196**

Dwellings £000	Assets under construction and payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
2,001	15,927	39,523	121	11,123	427	345,018
0	27,818	1,716	0	0	662	30,196
0	0	34	0	30	0	718
0	0	0	0	0	0	0
0	(34,806)	1,190	0	1,558	0	0
0	0	0	0	0	0	(9,247)
0	0	(6,413)	0	0	0	(6,436)
2,001	**8,939**	**36,050**	**121**	**12,711**	**1,089**	**360,249**
111	0	21,506	24	4,746	48	26,676
111	0	3,666	24	1,953	88	9,029
0	0	0	0	0	0	0
0	0	0	0	0	0	0
(222)	0	0	0	0	0	(3,013)
0	0	(6,413)	0	0	0	(6,416)
0	**0**	**18,759**	**48**	**6,699**	**136**	**26,276**
0	8,939	16,529	0	5,982	953	325,181
2,001	0	235	0	0	0	2,236
0	0	527	73	30	0	6,556
2,001	**8,939**	**17,291**	**73**	**6,012**	**953**	**333,973**
2,001	0	0	0	0	0	298,148
0	8,939	17,291	73	6,012	953	35,825
2,001	**8,939**	**17,291**	**73**	**6,012**	**953**	**333,973**
0	15,927	17,056	1	6,377	379	310,190
1,890	0	353	0	0	0	2,243
0	0	608	96	0	0	5,909
1,890	**15,927**	**18,017**	**97**	**6,377**	**379**	**318,342**
1,890	0	0	0	0	0	274,605
0	15,927	18,017	97	6,377	379	43,737
1,890	**15,927**	**18,017**	**97**	**6,377**	**379**	**318,342**
2,001	4,394	40,746	186	19,387	697	297,607
0	22,440	1,899	0	149	71	24,559
0	0	50	0	0	0	50
0	0	0	0	0	0	0
0	(10,907)	693	0	(2,742)	129	(5,186)
0	0	0	0	0	0	38,075
0	0	(3,865)	(65)	(5,671)	(470)	(10,087)
2,001	**15,927**	**39,523**	**121**	**11,123**	**427**	**345,018**
0	0	21,967	65	9,154	482	31,668
111	0	3,358	24	2,468	36	8,453
0	0	0	0	0	0	0
0	0	0	0	(1,205)	0	(1,205)
0	0	0	0	0	0	(2,203)
0	0	(3,819)	(65)	(5,671)	(470)	(10,037)
111	**0**	**21,506**	**24**	**4,746**	**48**	**26,676**
0	15,927	17,056	1	6,377	379	310,190
1,890	0	353	0	0	0	2,243
0	0	608	96	0	0	5,909
1,890	**15,927**	**18,017**	**97**	**6,377**	**379**	**318,342**
1,890	0	0	0	0	0	274,605
0	15,927	18,017	97	6,377	379	43,737
1,890	**15,927**	**18,017**	**97**	**6,377**	**379**	**318,342**
0	4,394	17,614	1	10,233	215	258,462
2,001	0	490	0	0	0	2,491
0	0	675	120	0	0	4,986
2,001	**4,394**	**18,779**	**121**	**10,233**	**215**	**265,939**
2,001	0	0	0	0	0	229,829
0	4,394	18,779	121	10,233	215	36,110
2,001	**4,394**	**18,779**	**121**	**10,233**	**215**	**265,939**

11 Net book value of assets held under finance lease contracts at the Statement of Position date

11.1 Finance lease assets

	31 Mar 2012 £000	31 Mar 2011 £000
Dwellings	2,001	1,890
Plant and machinery	235	353

11.2 Total amount of depreciation charged to the Statement of Comprehensive Income in respect of assets held under finance lease

	2011/12 £000	2010/11 £000
Dwellings	111	111
Plant and machinery	118	137

Contingent rents charged to the Statement of Comprehensive Income in the period are not material.

12 Inventory

12.1 Inventories

	31 Mar 2012 £000	31 Mar 2011 £000
Raw materials and consumables	6,340	6,081

12.2 Inventories recognised in expenses

	31 Mar 2012 £000	31 Mar 2011 £000
Inventories recognised in expenses	39,740	45,027
Write-down of inventories as expense	0	0
Total	39,740	45,027

13 Trade receivables and other receivables

13.1 Current receivables

	Note	31 Mar 2012 £000	31 Mar 2011 £000
NHS receivables		7,431	13,950
Provision for impaired receivables	14.1	(4,497)	(7,938)
Prepayments		1,495	1,422
Accrued income		835	337
PDC dividend		454	0
Other receivables		7,388	7,783
Total current trade and other receivables		13,106	15,554

14 Impairment of receivables

14.1 Provision for impairment of receivables

	31 Mar 2012 £000	31 Mar 2011 £000
At 1 April	7,938	2,736
Increase in provision	3,139	9,326
Amounts utilised	(758)	(1,357)
Unused amounts reversed	(5,822)	(2,767)
At 31 March	4,497	7,938

14.2 Analysis of impaired receivables

	31 Mar 2012 £000	31 Mar 2011 £000
Ageing of impaired receivables		
Up to three months	**1,975**	3,919
In three to six months	**105**	139
Over six months	**2,417**	3,880
Total	**4,497**	7,938
Ageing of non-impaired receivables past their due date		
Up to three months	**726**	0
In three to six months	**359**	718
Over six months	**18**	0
Total	**1,103**	718

15 Trade and other payables

15.1 Current payables

	31 Mar 2012 £000	31 Mar 2011 £000
NHS payables	**3,813**	10,406
Trade payables—capital	**1,297**	4,688
Trade payable—other related parties	**2,321**	0
Other trade payables	**5,312**	5,042
Other payables	**7,030**	6,393
Accruals	**11,925**	13,791
Total current payables	**31,698**	40,320

16 Other liabilities

16.1 Current

	31 Mar 2012 £000	Restated 31 Mar 2011 £000	Restated 01 Apr 2010 £000
Deferred income	**5,558**	6,625	4,772
Deferred Government grant	**1,500**	0	0
Total other current liabilities	**7,058**	6,625	4,772

16.2 Non-current

	31 Mar 2012 £000	Restated 31 Mar 2011 £000
Deferred income	**0**	6
Deferred Government grant	**150**	169
Total other non-current liabilities	**150**	175

17 Borrowings

17.1 Current borrowings

	31 Mar 2012 £000	Restated 31 Mar 2011 £000
Loans from Foundation Trust Financing Facility	**1,613**	0
Obligations under finance leases	**189**	169
Total current borrowings	**1,802**	169

17.2 Non-current borrowings

	31 Mar 2012 £000	Restated 31 Mar 2011 £000
Loans from Foundation Trust Financing Facility	**24,188**	12,525
Obligations under finance leases	**2,098**	2,294
Total non-current borrowings	**26,286**	14,819

18 Finance Lease

18.1 Finance Lease Obligations

	31 Mar 2012 £000	31 Mar 2011 £000
Gross Lease Liabilities	**3,025**	3,296
Of which liabilities are due:		
Not later than one year	**275**	271
Later than one year and not later than five years	**727**	848
Later than five years	**2,023**	2,177
	3,025	3,296
Less: Finance charges allocated to future periods	**(738)**	(833)
Net lease liabilities	**2,287**	2,463
Of which liabilities are due:		
Not later than one year	**189**	176
Later than one year and not later than five years	**459**	555
Later than five years	**1,639**	1,732

18.2 Finance lease commitments

	31 Mar 2012 £000	31 Mar 2011 £000
Minimum payments	**3,025**	3,277
Number of years of commitment	**16**	17

19 Prudential Borrowing Limit (PBL)

	31 Mar 2012 £000 Authorised	31 Mar 2012 £000 Actual	31 Mar 2011 £000 Authorised	31 Mar 2011 £000 Actual
Total long term borrowing	**55,300**	**28,088**	42,200	14,988
Working capital facility	**20,000**	**0**	20,000	0
Total	**75,300**	**28,088**	62,200	14,988

Disclosure of the actual working capital facility as at 31 Mar 2012 and 31 Mar 2011 is the amount drawn down.

Financial ratios	Prudential Borrowing Limits	IFRS 31 Mar 2012 Approved PBL ratio	IFRS 31 Mar 2012 Actual PBL ratio	IFRS 31 Mar 2011 Approved PBL ratio	IFRS 31 Mar 2011 Actual PBL ratio
Minimum dividend cover (times)	>1.0x	**2.9x**	**3.5x**	4.1x	3.5x
Minimum interest cover (times)	>3.0x	**43.1x**	**54.3x**	40.7x	70.0x
Minimum debt service cover (times)	>2.0x	**34.7x**	**42.6x**	20.1x	5.7x
Maximum debt service to revenue (%)	<3.0%	**0.3%**	**0.2%**	0.5%	1.7%

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 four ratio tests set out in the Prudential Borrowing Code for NHS foundation trusts. 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, and
- the amount of any working capital facility approved by Monitor.

Further information on the *Prudential Borrowing Code for NHS Foundation Trusts* and *Compliance Framework* can be found on Monitor's website.

20 Provisions for liabilities and charges

20.1 Current provisions

	31 Mar 2012 £000	31 Mar 2011 £000
Pensions relating to other staff	13	3
Other provisions including short term employee benefit	6,477	2,383
Total current provisions	**6,490**	2,386

20.2 Non-current provisions

	31 Mar 2012 £000	31 Mar 2011 £000
Pensions relating to other staff	385	408
Other provisions including short term employee benefit	76	48
Total non-current provisions	**461**	456

20.3 Provisions for liabilities and charges analysis

	Pensions—other staff £000	Others including employee benefit £000	Contractual disputes £000	Total provision £000
At 1 Apr 2011	411	2,431	0	2,842
Arising during the year	0	51	4,420	4,471
Utilised during the year	(13)	(300)	0	(313)
Reversed unused	0	(49)	0	(49)
At 31 Mar 2012	**398**	**2,133**	**4,420**	**6,951**
Expected timing of cash flows:				
Not later than one year	13	2,133	4,420	6,566
Later than one year and not later than five years	52	0	0	52
Later than five years	333	0	0	333
Total	**398**	**2,133**	**4,420**	**6,951**

The contractual disputes provision relates to disputes with NHS North West London on NHS Clinical Contract Income. They relate to challenges on pricing and/or charging disputes relating to 2011/12 activity. The basis for these figures is contractual disputes raised by NHS North West London, extrapolated to associated commissioners in line with contractual guidance.

Clinical Negligence Liabilities

Amount included in provisions of the National Health Service Litigation Authority at 31 Mar 2012 in respect of clinical negligence of the Trust is £58.9m (2010/11—£46.3m).

21 Cash and cash equivalents

	31 Mar 2012 £000	31 Mar 2011 £000
Balance at 1 April	38,773	19,861
Net change in year	2,224	18,912
Balance at 31 March	**40,997**	38,773
Comprising:		
Cash at commercial banks and in hand	59	46
Cash with the Government Banking Service	40,938	38,727
Cash and cash equivalents as in Statement of Cash Flows	**40,997**	38,773

22 Third Party Assets

The Trust held £0.02m cash at bank at 31 Mar 2012 (2010/11—£0.02m) 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.

23 Revaluation Reserve

	31 Mar 2012 £000	Restated 31 Mar 2011 £000
Revaluation reserve at 1 April	**95,880**	55,696
Prior period adjustment	**0**	30
Revaluation reserve at 1 April restated	**95,880**	55,726
Revaluation (losses)/gains and impairment losses on property, plant and equipment	**(6,234)**	40,278
Asset disposals	**(384)**	(124)
Revaluation reserve at 31 March	**89,262**	95,880

The position at 31 Mar 2011 has been restated for the accounting policy change in treatment of donated income funding purchase of donated assets (Note 1). The impact of the restatement on the previously stated revaluation reserve of £55.7m was an increase to the reserve of £0.03m reflecting the net revaluation applied to donated assets, transferred from the donated assets reserve to revaluation reserve.

24 Contractual Capital Commitments

Commitments under capital expenditure contracts at 31 Mar 2012 were £0.9m (2010/11—£6.0m).

25 Events after the reporting period

There have been no events after the reporting period since the Statement of Position date.

26 Contingencies

There were no contingent liabilities at the Statement of Position date.

27 Related Party Transactions

27.1 Related Party Relationships

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. No funds are held in trust by Chelsea and Westminster Hospital NHS Foundation Trust on behalf of the Chelsea and Westminster Health Charity, but are held by the Trustees who prepare the Charity's accounts independently of the Trust. There were related party transactions between the Trust and related companies during the year as follows:

- HR consultancy services were provided by Dearden Consulting Ltd and Dearden Search and Selection Ltd to the Trust during the year. Mark Gammage, Director of Human Resources and Organisational Development, is Managing Director of Dearden Consulting Ltd. Dearden Consulting Ltd holds a minority shareholding in Dearden Search and Selection Ltd. Transactions totalled £24k with Dearden Consulting Ltd and £28k with Dearden Search and Selection Ltd. There were no outstanding balances at 31 March and no debts were written off during the year. There is a commitment for coaching for two members of staff in place for next year.

- Specialist procurement services were provided by Linea Group Ltd during the year. Ian Chambers, Chief Executive of Linea Group Ltd was the Joint Director of Procurement for the Trust and Royal Marsden Hospital from 1 July 2011 to 31 Mar 2012, an arrangement hosted by Chelsea and Westminster Hospital NHS Foundation Trust as part of a procurement collaboration initiative between three organisations. Transactions total £1.0m for services of Ian Chambers, provision of specialist procurement services and management and provision of contract tendering services, of which £0.39m is owed at 31 Mar 2012. The net cost included in the Trust's expenditure is £0.47m and the remainder of the costs totalling £0.55m were recharged to other organisations. Future commitments include the provision of the services of Ian Chambers as Interim Director of Procurement and transitional procurement support.

27.2 Related party transactions

	31 Mar 2012 Income £000	31 Mar 2012 Expenditure £000
Croydon PCT	66,176	124
Kensington and Chelsea PCT	58,981	29
Hammersmith and Fulham PCT	38,188	91
Wandsworth PCT	29,460	291
Westminster PCT	25,547	61
NHS London	23,046	0
Ealing PCT	9,175	54
Hounslow PCT	7,111	0
Brent PCT	4,631	164
Lambeth PCT	4,625	0
Richmond and Twickenham PCT	4,616	0
Imperial College Healthcare NHS Trust	3,295	16,185
Department of Health (Foundation Trust Financing Facility)	0	516
Other Government departments and central bodies:		
HM Revenue & Customs	0	44,390
NHS Pensions Agency	0	22,398
NHS Business Services Authority	0	6,533
NHS Litigation Authority	0	5,757

27.3 Related party balances

	Accounts Receivable £000	Accounts Payable £000
Croydon PCT	822	69
Kensington and Chelsea PCT	528	19
Hammersmith and Fulham PCT	34	139
Wandsworth PCT	906	282
Westminster PCT	474	40
NHS London	225	26
Ealing PCT	282	26
Hounslow PCT	421	3
Brent PCT	235	18
Imperial College Healthcare NHS Trust	205	966
Other Government departments and central bodies:		
HM Revenue & Customs	605	3,763
NHS Pensions Agency	0	1,931
NHS Business Services Authority	0	924
NHS Litigation Authority	0	133

The Trust has related party balances and transactions with the Department of Health for dividend payments for public dividend capital. The transactions are shown in the Statement of Comprehensive Income and the receivables balance is disclosed in note 13.1.

28 PFI Schemes

The Trust is not party to any PFI Schemes.

29 Losses and Special Payments

There were 906 cases of losses and special payments (2010/2011—1,232 cases) totalling £1.0m (2010/2011—£1.6m) for the year ended 31 Mar 2012. The amounts reported as losses and special payments are reported on an accruals basis but excluding provisions for future losses.

30 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.

31 Categories of financial instruments

31.1 Financial assets

	31 Mar 2012 £000	31 Mar 2011 £000
Loans and receivables (including cash)	**52,153**	52,905
Total	**52,153**	52,905

31.2 Financial liabilities

	31 Mar 2012 £000	31 Mar 2011 £000
Other financial liabilities (amortised cost)	**62,869**	53,992
Total	**62,869**	53,992

32 Financial instruments book value to fair values

32.1 Book values of financial assets & liabilities

	Book value 31 Mar 2012 £000	Book value 31 Mar 2011 £000
Financial assets	**0**	0
Financial liabilities		
Finance leases obligation for more than 1 year	**2,098**	2,294
Loans due in more than 1 year	**24,188**	12,525
Total	**26,286**	14,819

32.2 Fair values of financial assets & liabilities

	Fair value 31 Mar 2012 £000	Fair value 31 Mar 2011 £000
Financial assets	**0**	0
Financial liabilities		
Finance leases obligation for more than 1 year	**2,098**	2,294
Loans due in more than 1 year	**24,188**	12,525
Total	**26,286**	14,819

As allowed by IFRS 7, short term trade debtors and payables measured at amortised cost may be excluded from the above disclosure as their book values reasonably approximate their fair values.

33 Liquidity and interest risk tables

33.1 Financial assets

	Weighted average 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		**11,157**	**0**	**0**	**0**	**11,157**
Variable interest rate instrument	**0.45%**	**40,996**	**0**	**0**	**0**	**40,996**
Gross financial assets at 31 Mar 2012		**52,153**	**0**	**0**	**0**	**52,153**
Non-interest bearing		14,132	0	0	0	14,132
Variable interest rate instrument	0.45%	38,773	0	0	0	38,773
Gross financial assets at 31 Mar 2011		52,905	0	0	0	52,905

33.2 Financial liabilities

	Weighted average 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		**27,935**	**0**	**0**	**0**	**27,935**
Finance lease liability	**3.84%**	**286**	**381**	**667**	**953**	**2,287**
Fixed interest rate instrument	**3.06%**	**1,613**	**3,225**	**9,675**	**11,288**	**25,801**
Provisions under contract	**0.33%**	**6,448**	**13**	**39**	**346**	**6,846**
Gross financial assets at 31 Mar 2012		**36,282**	**3,619**	**10,381**	**12,587**	**62,869**
Non-interest bearing		36,239	0	0	0	36,239
Finance lease liability	3.84%	286	286	667	1,853	3,092
Fixed interest rate instrument	3.06%	0	783	4,697	7,045	12,525
Provisions under contract	0.33%	2,366	12	36	352	2,766
Gross financial assets at 31 Mar 2011		38,891	1,081	5,400	9,250	54,622

34 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.

35 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, unutilised at 31 Mar 2012. Details are included in note 19.

36 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 maximum exposure of the Trust to credit risk is equal to the total trade and other receivables within Note 13.

37 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.

38 Prior year adjustment

Statement of comprehensive income

	Restated 31 Mar 2011 £000
Total comprehensive income for the year 2010/11	**53,947**
Operating income	
Increase in operating income from operations	**88**
Other comprehensive income	
Decrease in donated receipts	**(50)**
Increase in other reserves movements	**186**
Restated total comprehensive income for the year 2010/11	**54,171**

Statement of financial position

	Restated 31 Mar 2011 £000	Restated 1 April 2010 £000
Total non-current assets	**323,212**	265,939
Total current assets	**60,408**	44,523
Total current liabilities	**(49,620)**	(35,521)
Release of deferred income	**120**	91
Restated total assets less current liabilities	**334,120**	275,032
Total non-current liabilities	**(15,645)**	(10,533)
Release of deferred income	**195**	0
Restated total assets employed	**318,670**	264,499

Taxpayers' equity

	Restated 31 Mar 2011 £000	Restated 1 April 2010 £000
Taxpayers' equity	**318,355**	264,408
Increase in revaluation reserve	**1,089**	30
Increase in income and expenditure reserve	**4,820**	4,956
Decrease in donated asset reserve	**(5,909)**	(4,986)
Increase in deferred income	**315**	91
Restated total taxpayers' equity	**318,670**	264,499


Open Day

Cover photo: Staff Nurse Rachael Cooper cares for patient Shahiem Lewis in the Chelsea Children's Hospital at Chelsea and Westminster

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