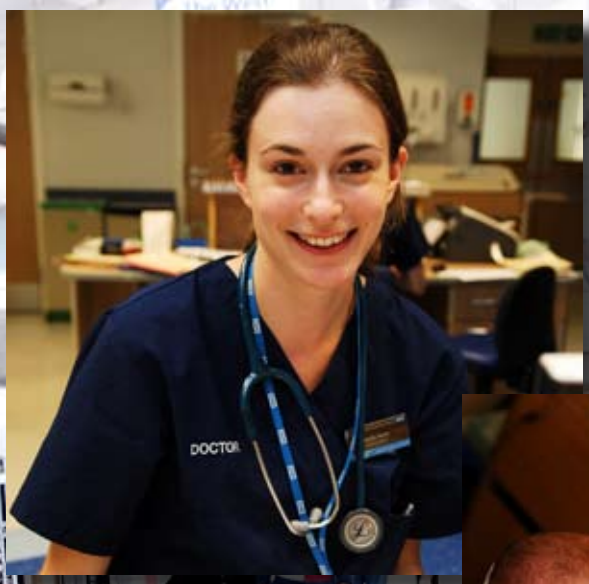
2010/11 Annual Report

West Middlesex University Hospital NHS Trust



Welcome

Welcome to our annual report, covering the year from 1 April 2010 to 31 March 2011. This report should be read in conjunction with our Quality Report 2010/11, to give the reader a broader view of the Trust. You can download a copy from our website: www.west-middlesex-hospital.nhs.uk or collect one from the main reception desk.

Who we are

We are a busy acute hospital in Isleworth, West London. We serve a local population of around 400,000 people, covering the London Boroughs of Hounslow and Richmond upon Thames. Our main commissioners of acute services are Hounslow and Richmond & Twickenham Primary Care Trusts. West Middlesex is the only acute trust in the Hounslow Borough. Neighbouring boroughs comprising acute trusts include Ealing, Kingston and Hillingdon. Additionally there are minor injury units in both the boroughs of Hounslow, and Richmond upon Thames.

What we do

We provide a broad range of services including:

- 24 hour accident and emergency
- Urgent care and critical care including emergency medical and surgical care
- Stroke rehabilitation care
- Chronic disease management
- Common cancer care
- Maternity care
- Children's care
- Sexual health
- A wide range of planned day and inpatient surgery including gynaecology, general, breast, urology, colorectal, oral, orthopaedics and ear, nose and throat surgery
- Outpatient and diagnostics, including MRI, CT, ultrasound and endoscopy
- Community services including outreach outpatient, dermatology and sexual health

Our vision

Our vision is to be a first class hospital for our community

Our guiding principles are:

- Timely patient care that meets individual needs
- Services planned around the patient, in partnership with other organisations
- Well-being, recognition and career development for staff
- Continuous improvement of services and the environment

Our core values are:

- Respect and dignity for all
- Involvement of patients in all we do
- Openness, honesty and responsiveness
- Pride in what we do

Facts and figures 2010/11

As our latest figures clearly show, we have had another extremely busy year with increases in activity across most of our services.

Outpatient attendances:
243,278 (238,472) + 2.0%

A&E attendances:
105,614 (102,725) + 2.8%

Inpatient admissions:
45,598 (47,317) – 3.6%

Babies delivered:
4,760 (4,389) + 7.79%

Patients operated on in our theatres:
10,190 (9,846) + 3.5%

X-rays, scans and procedures carried out by clinical imaging:
170,911 (176,748) – 3.3%

Number of staff, including our partners EcovertFM:
2,265 (2,250) + 0.7%

(2009/10 figures in brackets)

How we performed against our plans for 2010/11

Each year the Trust sets goals for the coming year to ensure that we deliver high quality and safe healthcare to our patients.

We made significant progress during 2010/11 with some excellent results and achievements. Below are some highlights, but if you would like more information about the quality of care at this hospital you can find it in our Quality Report 2010/11 or by visiting our website: www.west-middlesex-hospital.nhs.uk

To improve the quality of care, patient outcomes and assure patient safety

- Improving patient safety and minimising avoidable incidents continues to be one of our highest priorities and has been the focus of staff led initiatives throughout the year. We introduced a new system which improves communication and appropriate responses to manage patients whose condition is deteriorating. A new multidisciplinary Patient Safety Forum was introduced in May 2010 to proactively highlight patient safety concerns
- Our infection rates continue to fall. *Clostridium difficile* infections reduced by 25% from the previous year with 27 cases (against an upper limit of 36 cases). The number of MRSA infections found in the blood stream was one case above our upper limit of 4 cases
- Our hospital mortality rate, the measurement of avoidable deaths in hospital, has remained well below the expected level at a ratio of 81.3 (Hospital Standardised Mortality Ratio) compared to the national benchmark ratio of 100
- We now routinely assess admitted patients to identify risk factors associated with thromboembolism (blood-clots). This year over 77% of these patients were assessed. Over the coming year we will be working hard to increase this rate even further
- We received external assurance from the NHS Litigation Authority that we have robust policies, procedures and practices in place to safeguard patient safety. Following a rigorous assessment by the NHSLA in October 2010 we achieved the maximum score of 100% against each of the standards for patient safety at level 2 in all specialties. We did even better in maternity - earlier in the year we were one of the first hospitals in the country to be assessed against new standards for maternity care, achieving level 3, which was a significant achievement and demonstrates a high quality of service

To improve the patient experience and pathways of care through the hospital

- We have been listening to feedback from our patients and actively engaging with them, enlisting their help to find out what we are doing well and where we can make further improvements. We have made improvements to the way we deal with and learn from complaints
- We made further improvements to ensure that we meet the requirement to provide single sex sleeping accommodation throughout the hospital, except where the patient requires

specialist care, e.g. ITU and HDU. In total 99.26% of adult inpatients stayed in single sex accommodation during the year

- Our aim is that patients spend as little time as possible in hospital, which has been shown to aid recovery and minimise the risk of acquiring infections. We have carried out a great deal of work over the past year to improve this. We have increased the number of operations carried out as day surgery to over 82%. We are also carrying out more procedures in outpatient clinics. This means that the vast majority of patients having planned, non-emergency, operations are able to go home on the day of their surgery. We have also brought in the latest technology to help us plan our inpatient discharges as efficiently and effectively as possible. As a result, our average length of stay has fallen again this year. This means we have been able to reduce the number of hospital beds in regular use, whilst maintaining the flexibility to increase bed numbers if we encounter unpredictably busy periods

Ensure we have a highly skilled, motivated, diverse and productive workforce

- The results of the 2010 staff attitude survey showed that our employees continue to experience good levels of job satisfaction. We have improved in 10 of the 38 indicators compared to 2009. The number of indicators that place us in the average or above average category has risen from 45% to 60.5% and we have not deteriorated against any of the indicators. We are in the best 20% of trusts in the country in relation to: the support staff receive from their immediate managers; the percentage of staff suffering work-related stress; and the percentage of staff witnessing potentially harmful errors, near misses of incidents. We are also above average in 12 indicators including the percentage of staff who feel satisfied with the quality of work and patient care they are able to deliver, work-life balance, and motivation at work

- We have been able to further reduce sickness absence rates from 3.13% last year, to 2.74%
- All our junior doctors work a maximum of 48 hours per week, in line with the European Working Time Directive
- We have continued to see improvements in the numbers of staff receiving mandatory and statutory training
- 80% of staff had appraisals last year, an increase from the previous year

To deliver improved service performance, meeting all national and local performance targets

- More than 98% of patients who attended our Accident & Emergency Department were seen, treated and discharged or admitted to a hospital bed within 4 hours of arrival
- We have again exceeded our targets for patients being seen and treated within 18 weeks of being referred by their GP
- The number of patients with suspected cancer seen within two weeks from their referral has increased further to over 95%
- Following our accreditation as a Stroke Unit and provider of Transient Ischaemic Attack (TIA) services in January 2010, we have passed a number of rigorous assessments that demonstrate the unit is improving the quality of care we provide to local patients

To develop an agile and flexible organisation that can respond to change with a clear strategy for the future of the West Middlesex

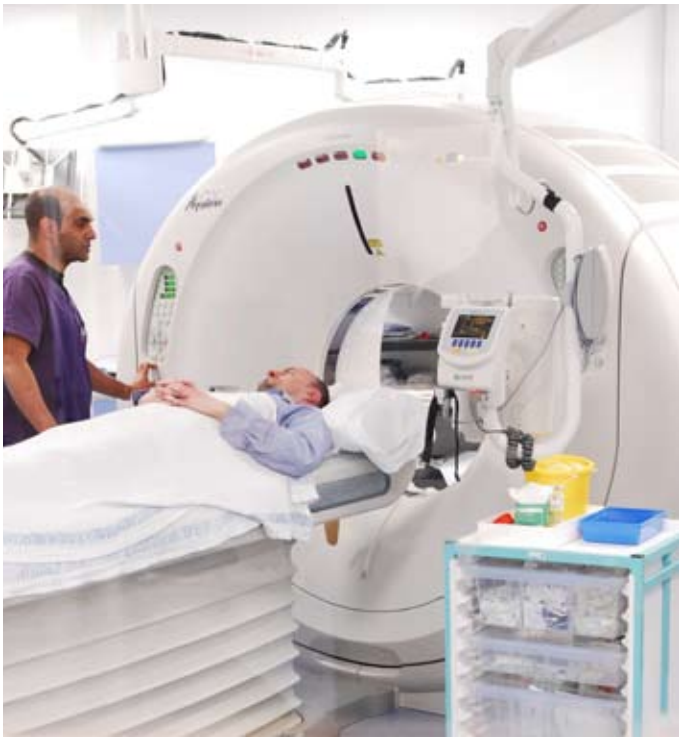
- Following the change in government in 2010, we have responded proactively to the plans outlined in the White Paper, Equality and excellence: Liberating the NHS. This has included engaging with our staff and stakeholders to ensure we continue to provide the highest quality services that meet the needs of our community, whilst delivering value for money in everything we do
- In February 2011 we launched a new Community Dermatology Service. The new service was designed and agreed by local GPs working with NHS Hounslow to give local residents faster access to care, closer to their home. It means that most patients will no longer need to travel to hospital, and will be assessed and treated in a health centre at the same appointment. This is one of a number of improvements we have made to the delivery of services for our patients
- We have invested significantly in our estate and in the latest technology, including a brand new MRI (magnetic resonance imaging) and CT (computer-ised tomography) scanners as well as refurbishing the physical environments that house them

To use our resources efficiently and effectively and deliver a minimum of break even and the cost improvement programme in full

- For the first time in three years we have achieved all our in year statutory financial responsibilities. These include not only breaking even, but achieving a surplus of £0.1 million in addition to achieving our cost improvement programme in full. More information about this and our future plans to improve our financial standing can be found in our Finance Review on page 36

To ensure that governance arrangements support operational excellence

- We have maintained our registration with the Care Quality Commission without conditions, which demonstrates we meet all essential standards of quality and safety
- We have revised and developed our plans for responding to Major Incidents, as well as participating in a number of exercises to test these
- We have ensured that we protect the data we collect from patients. At the end of the year we submitted our assessment to the Department of Health giving assurance that we are compliant in the way we handle information. We had no instances of Serious Incidents about confidentiality breaches or data loss



Performance indicators

The financial year for 2010/11 ended on 31 March 2011 and it is the point at which we are measured against most of our national and local targets. Doing well against these standards means that we are providing our patients with the best possible care. Below is our performance for 2010/11.

Performance Indicators	Target 2010/11	Our performance 2010/11	Target 2009/10	Our performance 2009/10
A&E waiting times	>98%	98.22%	>98%	98.74%
18 week referral to treatment times: Admitted patients Non-admitted patients	 >=90% >=95%	 93.41% 96.47%	 >=90% >=95%	 93.07% 96.86%
Patients with breast cancer symptoms waiting less than two weeks from referral	>=93%	96.3%		86.50%
Cancer 2 week wait	>=93%	95.4%	>=93%	93.8%
31 day diagnosis to treatment for cancer: 31 day 1st treatment – tumour 31 day subsequent treatment – treatment group	 >=96% >=94%	 99.8% 100%	 97% 97%	 99.7% 100%
62 days urgent referral to treatment for cancer: 62 day standard – tumour	 >=85%	 94.5%	 85%	 94.4%
62 day screening standard – tumour[1]	>=90%	86.2%[1]	90%	96%
62 day consultant upgrade	>=85%	88%	85%	95.3%
Cancelled operations: Operations cancelled, by the hospital, for non-clinical reasons, at last minute	<0.406%	0.28%	0.8%	0.495%
MRSA Bacteraemias[2]	Upper limit 4 cases	5 cases[2]	Upper limit 17 cases	16 cases
***Clostridium difficile* infections**	Upper limit 36 cases	27 cases	Upper limit 128 cases	36 cases
Access to genito-urinary medicine clinics[3]	100%	99.99%[3]	100%	98.87%[3]

Notes

1. Due to the low volume of screening patients treated means the Trust is exposed to high variation in performance resulting from single breaches where they occur
2. In 2009/10 we were required to report all cases of MRSA Bacteraemias. For 2010/11 this only includes hospital apportioned cases. Of the 16 cases reported in 2009/10, 7 of these were hospital apportioned. Therefore, between 2009/10 and 2010/11 we have reduced the number of hospital apportioned cases from 7 to 5. However this is one case above our upper limit
3. This is within the allowable threshold (greater than 98%)

Chief Executive's statement

2010/11 has been an especially strong year for us in terms of our performance, with much to be proud of. This is particularly rewarding when set in the context of a very challenging period, not only for ourselves but the whole of the NHS, and the wider public sector.

This annual report aims to demonstrate what we have achieved during 2010/11, against the context of the Government White Paper – Equity and excellence: Liberating the NHS, which sets out the Government's long-term vision for the future of the NHS. The vision builds on the core values and principles of the NHS - a comprehensive service, available to all, free at the point of use, based on need, not ability to pay. It sets out how we:

- put patients at the heart of everything the NHS does
- focus on continuously improving those things that really matter to patients - the outcome of their healthcare; and
- empower and liberate clinicians to innovate, with the freedom to focus on improving healthcare services

Here are just some of our successes:

- A&E performance is now one of the best in London
- We have reduced waiting times for cancer diagnosis and treatment; and all patients with non-urgent conditions are seen and treated within 18 weeks of referral by their GP
- There were fewer than ever reported cases of hospital acquired infections
- We are fully compliant with single sex accommodation provision
- Our stroke service has passed further assessments, which safeguards its future development as a designated Stroke Unit
- Our length of stay has further reduced and is continuing to decrease
- We have increased our day surgery rate, meaning more of our patients are benefiting from getting on with their lives without delay because they do not need an inpatient stay in hospital following surgery
- Staff engagement has improved significantly, borne out by the many Celebrating Success achievements where staff ideas for improving the way we work have been recognised and put into practice
- We have achieved financial balance for the first time in three years, which is a huge achievement for us and helps secure our long-term future
- As a university hospital we are well regarded by our education partners, demonstrated by recognition in a number of extremely positive assessments
- We have been recognised for our Research and Development projects
- Whilst we are fortunate to have a very modern hospital we have continued to upgrade our facilities, investing over £4 million on improvements including a new CT scanner and other medical equipment, refurbishments to our maternity unit and wards, and the latest information technology
- Many individual staff have achieved external recognition for their outstanding contributions to patient care

None of these achievements would have been possible without the ongoing commitment and loyalty of our staff and volunteers. On behalf of the Board, I would like to thank everyone who has made a contribution over the last year.

2010/11 saw a change in government and we embarked on some fundamental changes, which will ensure we provide the best possible clinical care whilst securing our long term future.

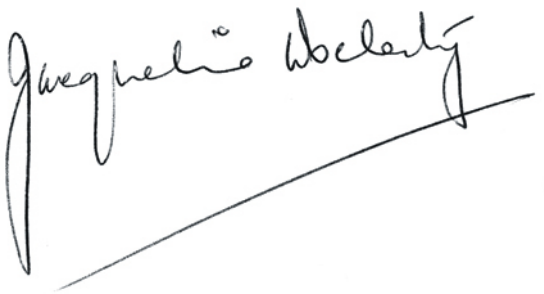
The main purpose of our ambitious cost improvement programme is to ensure the services we provide to the local community are more coordinated and efficient. This is not about cutting back on healthcare that people need. This is about reducing duplication, cutting out waste and improving the way we care for patients.

As part of this programme we have been encouraging all our staff to innovate and make changes that improve patient care. Frontline staff are ideally placed to identify where barriers to improvement exist and to be part of making positive changes.

The Trust will achieve challenging financial savings by ensuring we have the right people to deliver high standards of care to our patients. We will prioritise clinical frontline services over non-clinical support where appropriate and ensure the delivery of high quality services.

Alongside other NHS Trusts, we face a demanding financial environment over the next few years. In line with the National QIPP (Quality, Innovation, Productivity and Prevention) programme we are concentrating upon initiatives which will both improve the patient experience and reduce cost. There is now a greater emphasis on follow-up care in the community so patients can recover and return to their normal lives quicker. As care improves, the length of time patients stay in hospital reduces, and as a consequence results in a decrease in both hospital bed numbers and in the number of staff working in hospitals. Our plan at West Middlesex is to reduce the number of beds by about 30 in the summer of 2011. As changes continue we anticipate reducing our reliance on bank and agency staff significantly and will critically review the need for posts, where vacancies arise, as a consequence of natural wastage.

Our overall goal is to provide excellent quality local health care whilst delivering new standards for efficiency and productivity. This will only be achieved by all of us applying ourselves to the task in hand. Encouragingly, West Middlesex is already rising to the challenge.



Jacqueline Docherty DBE
Chief Executive

Chairman's statement

In the relatively short period that I have been the Chairman of the Trust I have been greatly impressed by the dedication, expertise, care and commitment of all the staff as well as the help and loyalty of our volunteers and support groups.

There is something quite special about West Middlesex. It has been as warm and welcoming to me as the new chairman as it is to our patients and visitors. It has a long and proud history but it has never shied away from change. This is one of its greatest strengths and will stand it in good stead for its long-term future.

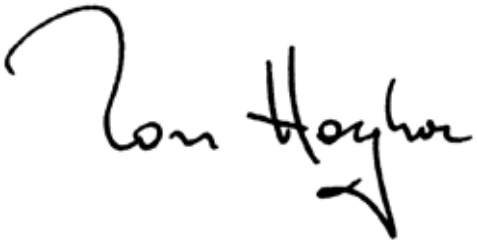
Over the past year the Trust's staff have yet again performed exceptionally well in the face of increasing numbers of patients, severe winter pressures and changes to the way we work. We have met key performance targets, improved our quality, reduced infection levels and developed new facilities and services.

Looking ahead, in common with the rest of the health service, we face a challenging future. Our patients' requirements are changing and their needs are increasing. There is a political and economic imperative for us to improve the quality of our services whilst always delivering value for money.

The Trust is familiar with these challenges and has made significant progress in the past year. We have yet again delivered initiatives to improve quality while reducing costs. Increasingly we are working with community partners to develop urgent care and rehabilitation services. We are also working in partnership with Chelsea & Westminster and Imperial Hospitals to provide care for their patients on this site.

The priority for 2011/12 is to improve the patient experience. We know from patient complaints and other feedback that our administrative processes are not as good as they should be, with appointments being rearranged and delays in letters sent to GPs. One of our biggest projects this year involves improving our processes to ensure we get things right first time, all of the time. The continued support and cooperation of staff and patients is appreciated as we get closer to our ultimate goal of being a first class hospital for our community – delivering excellence in everything we do.

Finally, I would like to take this opportunity to formally thank my predecessor, Sue Ellen, who retired in August 2010 at the end of her second four year term in office. Sue's hard work and commitment to the Trust over the past eight years have seen a remarkable improvement in its facilities and in its patient care. I hope to build on these successes as we enter a new phase in the Trust's history.



Tom Hayhoe
Chairman

Review of the year

Army thanks West Mid for medical support in Afghanistan

We unveil our new state-of-the art MRI scanner at an opening ceremony

Maternity service celebrates first birthday of its caseloading service

We win 'Best Patient Engagement Project of 2010'

BSkyB volunteers brighten up our children's ward with some special artwork

The Mayor of London commends hospital for cycling initiatives

Successful bid for £104,000 of funding to develop diabetic foot project

Harlequins rugby players drop into our Starlight children's ward

Infection prevention and control nurse, Janice Scott, collects a national award for her work

Midwife Natalie Carter (far right) is awarded Johnson's Baby Mums' Midwife of the Year 2011

Putting patients and the public first

In recent times there has been a noticeable shift towards empowering patients to be involved with decisions about their treatment. This starts from choices in where and when they are treated, through to involvement in their treatment plan. We are grateful for all the feedback we receive, and actively engage patients and the public to help improve our services to best meet their needs.

Listening

We have carried out a number of reviews during the year to help us find out what we are doing well and where we can make further improvements. These have covered a range of subjects related to patient experience, improved safety and efficiency.

Compassionate care

'The outcomes we experience reflect the quality of our interaction with the professionals that serve us.' – Equity and excellence: Liberating the NHS

Caring with compassion – treating patients as people rather than just medical cases or conditions – is recognised to be a vital aspect of good nursing care and can make a real difference to your experience of a hospital stay.

Over the summer, Richmond LINk conducted a review of compassionate care for us which focused on our care of the elderly. The review found many areas of good practice. 90% of patients described the personal manner of staff caring for them as excellent, very good, or good. Nursing staff were also rated highly in their efforts to relieve patients' distress. Furthermore, 86% of all patients interviewed said that they "had confidence" in the nursing staff looking after them. The vast majority of patients were also satisfied with the personal dignity they received. Whilst half of the patients interviewed cited their religious belief as a concern or issue during admission, an encouraging 79% of these patients felt that their beliefs had been "always respected" by hospital staff.

The review identified areas for improvement and Richmond LINk has helped us to draw up an action plan to ensure we address these in a timely manner. Some of the areas may seem relatively minor, but often the little details make a real difference, for example ensuring all staff identify themselves before undertaking any care. Other areas are clearly major issues, such as improving the discharge process - informing patients as early as possible when they are likely to go home and what arrangements will be in place for their ongoing support.

We will continue to work with Richmond LINk to ensure that we fulfil all the recommendations.

Learning from complaints

'All sources of feedback, of which complaints are an important part, should be a central mechanism for providers to assess the quality of their services.' – Equity and excellence: Liberating the NHS

In common with every NHS Trust, we receive complaints from dissatisfied patients, their families and their carers. This year we received 303 formal complaints. This is an increase of 28 over the previous year, but when put into the perspective of over half a million patient contacts per year it represents a very small percentage of our patients. The increase may reflect the work we have done to make it easier for people to make a complaint, such as improving access via our website. 2010/11 has also seen a number of significant changes, mentioned elsewhere in this report, which can inevitably be unsettling for patients and staff. We devote considerable resources to investigating and learning from each complaint, and see them as a real opportunity to improve.

This year we started to offer complainants the opportunity to be filmed talking about their experiences, which are shown to the teams of staff who actually cared for the patient. It is a very powerful way of encouraging openness, improving understanding of the emotional impact on patients, and promotes positive learning when staff see the consequences of their actions.

We also use compassionate care training films, which we produced ourselves using members of staff rather than actors. These films feature a number of different scenarios, each with a positive and negative experience, based on the actions of staff in the way they communicate with patients. Simple things such as greeting a patient by name, and introducing ourselves and explaining what our role is can make a significant difference.

Our ultimate aim is to resolve concerns or issues before they escalate. We call this local resolution. We encourage patients, their carers, or members of their family to let us know immediately if they are unhappy or concerned about any aspect of care. They should feel comfortable speaking to a doctor, ward sister, matron, or clinic manager. If they feel they have not got a satisfactory response, or feel unable to speak to this person, then our PALS (Patient Advice and Liaison Service) should be the next point of contact before escalating to a formal complaint. The Trust's complaints procedure is based upon the principles set out in the Parliamentary and Health Service Ombudsman's report, published in May 2010.

Research and development

Over this past year we have been involved in a number of exciting projects, with the aim of improving care and treatment not only for our patients, but for all patients, wherever they are. We work closely with the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) at Imperial College, as well as other healthcare colleagues.

Projects looked at a variety of areas including COPD (chronic obstructive pulmonary disease), medicines management and chronic heart failure.

We successfully bid for over £100,000 of funding from CLAHRC for a project on diabetic foot care. This will allow us to progress the project over the next year, with the aim of enhancing the effective management of patients with diabetic foot conditions, as well as focusing on the education of both patients and carers in the community.

Our paediatric department also participated in four exciting research projects, which will lead to improvements in care for premature babies in the future.

"I was very pleased to be invited to join the hospital team taking forward the CLAHRC medicine reconciliation project. As a patient and carer, a past career in the NHS with a continuing involvement with patient safety matters I understand the importance of this project which aims to improve medication management from admission to discharge from acute medical care out into the community. From personal experience I know how important it is that patients and/or their carers have an appropriate level of understanding about the medication they are prescribed, the importance of taking 'the pills' and where to seek advice and support when they have concerns and require repeat medication; also an awareness of their own responsibilities. I hope my contribution on the research team has helped to provide a practical day to day view of problems people have in managing their medicines, particularly at the time of discharge and when they return home. It has been very encouraging that this project is being led by an enthusiastic and committed multidisciplinary team across acute and community care with a prominent role for pharmacists." Margaret Dangoor.
(pictured right)

Best for engagement

In July we were awarded 'Best Patient Engagement Project of 2010', selected by CLAHRC. The aim of the project was to improve care provided to patients with Community Acquired Pneumonia (CAP), an infection of the lungs and the fourth largest cause of death in the UK. Key to the project's success was the way it actively encouraged patient and public involvement.

The project team beat off stiff competition from other hospitals and their unique video presentation, which had a topical World Cup theme, was well liked by the judging panel.

We also won the 'Best Patient Engagement Project of 2011' for the Chronic Heart Failure Integrated Pathway project - a joint project

between ourselves and Chelsea & Westminster Hospital.

Working with patients with learning disabilities

This year we have been working closely with a local group of women with learning disabilities. Speak Out Hounslow women's group has been given a venue at the hospital to meet and listen to speakers discuss a range of topics chosen by them. The first session at the hospital in September was to raise awareness of our Patient Passport which was developed with the London Borough of Hounslow. The passport is filled in by patients with learning disabilities prior to a visit to hospital, giving staff key information about the patient, including their likes and dislikes. Many of the group's members were keen to fill in their own passports, and were given support to do so. Other subjects included heart health, infection prevention and control, and sexual health.

End of life care

'No decision about me without me' – Equity and excellence: Liberating the NHS

For terminally ill patients, we aim to provide the best quality care that meets the wishes of the patient, their family and carers wherever possible.

'How people die remains in the memory of those who live on' - Dame Cicely Saunders, founder of the Modern Hospice Movement.

In October we hosted an End of Life Care Event, with Baroness Finlay, who is a professor of palliative medicine, as the key note speaker. Baroness Finlay, who early in her career was a junior doctor at West Middlesex, chairs the All Party Parliamentary Group on Dying Well, which promotes palliative care. In her thought provoking speech, Baroness Finlay talked about empowering patients to have an active role in decisions about how they are treated when their lives are coming to an end.

We have a well established End of Life Care Group, which includes representatives from clinical and non-clinical staff, voluntary groups, community and hospice staff and our chaplaincy. This year we appointed a dedicated Clinical Nurse Specialist to help develop our palliative care service. This has included establishing a palliative care multi-disciplinary team (MDT), which meets each week to review patients and plan their ongoing care. The MDT is linked with other teams within the hospital to provide seamless care for patients. A number of educational sessions for staff have taken place, and links are being built with external organisations including hospices and community groups to ensure continuity of care for those patients who want, and are able, to leave hospital.

Same sex accommodation

Ensuring the privacy and dignity of our patients is one of our key objectives. This includes making sure that same sex accommodation is available to our patients. This helps to safeguard their privacy and dignity when they are often at their most vulnerable. We are pleased to confirm that we comply with the Government's requirement to eliminate mixed sex accommodation where this is clinically appropriate.

This year we treated 45,598 inpatients. In all our general adult wards patients were cared for in single sex accommodation 99.26% of the time.

Safety

Safety of patients is a Trust priority. We have signed up to the National Patient Safety First Campaign, which aims to build a culture of 'no avoidable death, no avoidable harm'. We are committed to raising awareness of patient safety issues among all staff.

In May 2010 the Patient Safety Forum held its inaugural meeting, with a clear objective of improving patient safety across the Trust by building on recommendations from the

National Patient Safety Agency (NPSA).

We have also been working to simplify the process for staff to report patient safety incidents, which is crucial for us to be able to investigate and learn from.

Following a rigorous assessment by the NHS Litigation Authority (NHSLA), West Middlesex achieved the maximum score possible for patient safety. The NHSLA reviewed our policies and procedures, and most importantly checked that we follow these. We received 100% in all fifty assessment categories, an exceptional achievement. This meant we achieved the level 2 standard, having achieved level 1 in 2009.

All the NHSLA Standards are divided into three levels: one, two and three. NHS organisations which achieve success at level one in the relevant standards receive a 10% discount on their insurance contributions, with discounts of 20% and 30% available to those passing the higher levels.

Although there is no requirement to be reassessed for another three years, we have committed to achieving level 3, the highest standard, in 2012.

Infection prevention and control

Our Infection Prevention and Control Team have used many innovative methods over the past few years to help reduce rates of infection. This year Janice Scott, Specialist Infection Prevention and Control Nurse, won a national award for excellence and innovation in infection prevention and control and was first runner-up at the Healthcare Hero Awards.

Preventing patients from acquiring healthcare associated infections whilst they are in hospital is one of our top priorities for keeping patients safe from harm. The two most common types of potentially serious infections are MRSA (meticillin resistant staphylococcus aureus) in the blood stream and *Clostridium difficile* (*C. difficile*). We are required to record all cases of these infections found in patients.

For 2010/11 the upper limit of cases, set by NHS Hounslow, was no more than 36 cases of *Clostridium difficile*, and we met this ending the year with just 27 cases – 25% below our upper limit.

For MRSA bacteraemias in the blood stream, the upper limit set by the Department of Health for West Middlesex was for no more than 4 hospital apportioned cases. Unfortunately, we just exceeded this target with 5 cases. However, this still shows a continued improvement from the previous year, when there were 7 hospital apportioned cases, and we have seen the number of cases fall each year.

Reducing hospital acquired infections continues to be a priority for us.

Safeguarding children and vulnerable adults

We take our responsibilities for the safety and welfare of children, young people and vulnerable adults extremely seriously. There have been a number of very sad and distressing cases in the media recently, and we are continually reviewing our safeguarding measures to ensure that we protect all our vulnerable patients.

In December, we participated in a peer review, comprising a two day visit by NHS London's Safeguarding Improvement Team – hosted by NHS Hounslow. This was an in-depth review of our systems and practices, and included interviews and visits to key wards and departments.

The visiting team, which included safeguarding professionals from other NHS London organisations, found that we and the wider Hounslow health economy had sound arrangements in place, with some excellent practices. This included the priority given to safeguarding, our strong training ethos, managerial and clinical leadership including advice on safeguarding and good relationships with children's social services.

Whilst we recognise that children are particularly vulnerable to abuse, the same is true of many adults particularly those with a mental or other disability who cannot protect themselves from harm or exploitation.

As part of our adult safeguarding responsibilities, in June 2010 we established a safeguarding adults steering group, chaired by the Director of Quality Improvement, to lead and co-ordinate the Trust's work. The group has identified a named consultant and nurse/manager to be the professional leads for safeguarding adults who are supported by the Nurse Specialist for Older People. Throughout the year we have been reviewing our adult safeguarding policies and auditing compliance, revising and strengthening the provision of training, further developed a database for safeguarding adult referrals and the monitoring of outcomes.

We will continue to work closely with partner agencies to ensure that we maintain the highest levels of safeguarding practices for children and vulnerable adults.

Improving healthcare outcomes

We are constantly striving to improve health outcomes for our patients. This is assisted by technological advances, as well as new pharmaceutical possibilities. In tandem with this more externally driven progress, West Middlesex has also continued to improve the quality of care and encourage research so that patients get better and can go home sooner.

21st century facilities and technology

Over the past year West Middlesex has seen a range of benefits come from new equipment,

as well as improvements to our facilities, which add to the patient experience and health outcomes.

In January 2011, following the unveiling of a state of the art MRI (magnetic resonance imaging) scanner, we started using another brand new hi-tech scanner. The CT (computerised tomography) scanner produces higher quality images, is faster and uses lower amounts of radiation than older generation scanners.

We also launched a new bladder scanner, the result of an application to the Department of Health for a Continence Management project to support the implementation of the National Stroke Strategy. Urinary incontinence is common after stroke and can affect patients' quality of life, as well as increasing time spent in hospital. This non-invasive machine helps determine whether patients need to be put on a continence management programme. A further part of this project has been to develop more training for nurses about continence treatment and its management.

Another piece of new technology, a scalp cooling machine used for preventing hair loss during chemotherapy, has been bought with money generously donated by the Hounslow Rotary Club.

Getting the best quality care

We have realised our aim to provide more consultant-delivered care in a number of areas over the last year. Having more consultants available to assess patients soon after admission means patients will be seen swiftly and at the right time, which is also better for their overall experience in hospital. This also reduces the length of hospital stay, the chances of acquiring an infection and the likelihood of being re-admitted.

An example of this is in our Maternity unit, where more consultants have been employed to enable additional cover for the Labour Ward, including night time. This will helps us reduce the waiting lists for gynaecology cancer surgery, already less than 2 weeks, down to 1 week over the next year.

As a University teaching hospital, it is important that doctors in training are fully involved in patient care and their work with our patients and consultants is a vital part of their learning. This is all part of our drive to further improve the quality of care.

Delivering the highest standards for our patients

As a provider of healthcare for the community, it is important we regularly compare our services against national criteria and the performance of other hospitals.

One recent example of this was in June 2010 when our Stroke Unit, one of London's designated Stroke Units, was the first in North West London to pass a rigorous A2 assessment (in a rolling programme defined by Healthcare

for London).

Stroke is the second highest cause of death and the most common cause of adult disability in London. More than 11,000 people are admitted to London hospitals each year (around one person every hour) and approximately one in six people dies. Clinical evidence shows that patients are 25% more likely to survive if treated in a specialist centre. Specialist centres also speed recovery and reduce levels of disability for many people who suffer a stroke.

The assessors commended the team on their team working, where doctors, nurses, therapists and social workers all work closely together with management and administrative support, to deliver the highest standard of care.

"This assessment is reassuring that we are able to demonstrate high standards of care. It proves our worth and shows we can provide care within national Stroke care guidelines as well as being compared across the board with other London Trusts. This helps us to maintain and strive for gold standards. It drives us as a team to work for further improvements."
Ahlam Wynne,
Stroke Specialist Nurse

Enhanced recovery

West Middlesex began its enhanced recovery programme in 2004 for colorectal patients, when the average length of stay for patients having operations was 16 days. Over the last 5 years the median length of stay has improved to just 5 days.

Over the last twelve months, the length of stay has reduced even more significantly for patients completing the Enhanced Recovery programme. This has been achieved through more laparoscopic (key-hole) surgery - a minimally invasive technique in which operations in the abdomen are performed through small incisions.

There are a number of advantages to the patient with laparoscopic surgery versus an open procedure. These include reduced pain and shorter recovery time.

For the hospital and patient, the benefits of enhanced recovery are reflected in the re-admission rates which have shown a reduction to 6.7%, from an expected rate of 10% without this system in place.

Joanna's story

Joanna Williams (pictured above) was a patient in October 2010. She was treated in the Colorectal Department by Consultant Mr Jason Smith and Colorectal Specialist Nurse, Petra Raffin. She was really pleased with her experience and with the outcome of her successful operation.

"When I initially felt unwell I went to see my GP who thought I may have kidney stones. He told me if it became too painful to attend my local A&E, which I did shortly afterwards. When I came to West Mid's A&E they were brilliant. They gave me a CT scan and discovered it was not kidney stones.

"I thought after that it was going to take 6 weeks to get an appointment, so I was pleasantly surprised when I was scheduled an appointment with the colonoscopy team within five days, and within seven days I was given my results. I didn't know what it was, but I was told by Mr Smith and Petra Raffin I had bowel cancer.

"From my arrival in A&E every bit of care was excellent; it was amazing. They told me I had cancer on the 11th October 2010, and I had my operation on the 21st; within 10 days of finding out. Before I had the operation I also saw Dr Ahmed in oncology who took time to explain to me what would happen after the operation. You would think it would be a long process in hospital, but I was in hospital for a day and a half, then had my operation and was able to go home within 46 hours following my operation. I recovered at home for 4 weeks and was able to go back to work!"

Successful recovery rates

Patients want to be treated with the latest methods and by the best qualified clinicians. Of equal importance is knowing their chances of a healthy recovery after any illness are positive. Over the past two years our mortality rate has been significantly lower than the national average. We constantly try to improve this through investment in new technology and through testing and implementing practices which will improve health outcomes.

Smoking cessation for the local community

Smoking remains the single biggest cause of preventable death in the UK, killing over 80,000 people per year in England alone. Smokers are more likely to experience post-operative

complications and slower wound healing. This can result in the need for further surgery, a longer hospital stay and increased costs to the health service. These patients need support to quit prior to surgery and are four times more likely to quit with NHS help. We have an onsite Stop Smoking Service for patients, staff and visitors to the hospital. We have also signed up to the Department of Health Stop Smoking Interventions in Secondary Care project.

There were 716 referrals to the in-house Stop Smoking Service in 2010/2011. Patients who were not yet ready to quit were also given a brief intervention about their smoking and given information about the Stop Smoking Service available to them. It is hoped that they will use these services at a later date. A total of 210 patients set a quit date and 114 of these patients successfully quit at 4 weeks. The average quit rate for the year so far has been 55%.

A number of staff have been given Brief Intervention Training this year, which is one of the most cost-effective and clinically proven preventative actions a healthcare professional can make. Illness brings people into contact with hospital health professionals who are in a prime position to deliver the stop smoking message. This year has also seen the Stop Smoking Service give training at every induction for new members of staff and an E-Learning package has been piloted with A&E staff.

Cutting bureaucracy and improving efficiency

'…liberate professionals...from top-down control…is the only way to secure the quality, innovation and productivity needed to improve outcomes.'

'Staff who are empowered, engaged, and well supported provide better patient care'

– Equity and excellence: Liberating the NHS.

Innovation

We encourage all our staff to innovate, and make positive changes to improve patient care. Staff are ideally placed to know where barriers to improvement exist and to highlight how these could be overcome.

Using process improvement techniques, originally developed in private industry, we have been looking at ways to improve quality and efficiency to give a better service to our patients.

With around a quarter of a million attendances a year, the Outpatient Department is where most patients experience the hospital services. As the majority of these attendances are planned in advance, this gives the biggest opportunity to make improvements.

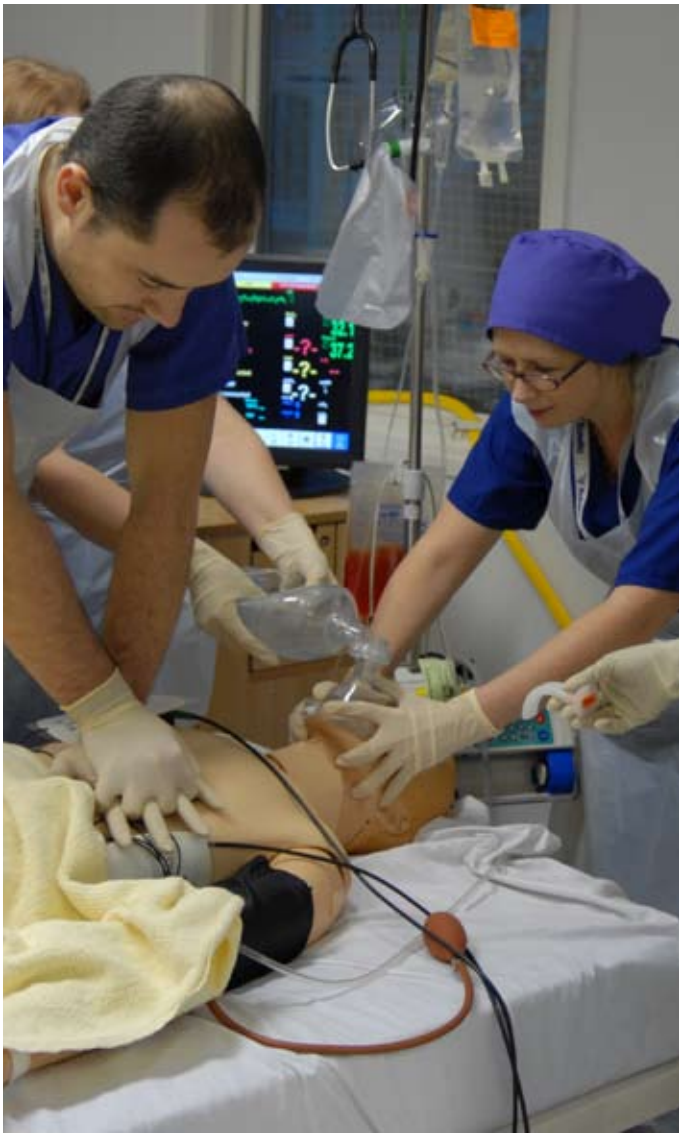
We have been piloting a number of innovations including an outpatient appointment reminder service. Early results indicate this has been a great success in reducing missed appointments in a number of specialties where it has been trialled.

Ensuring patients are discharged as soon as is safely possible is a key issue for every hospital. Most patients would like to know in advance

when they are going to be discharged, and do not want to stay any longer than they need to. Evidence shows that the longer a patient remains in hospital the more likely they are to need continuing additional support when they leave. They are also more at risk of acquiring an infection, and frailer patients of losing their independence.

This year we implemented a new computer-based system, RealTime, which gives staff up-to-date information about inpatients and their treatment plan at their fingertips, improving discharge planning so that the patients can leave hospital without unnecessary delay.

The system has now gone live on all adult acute wards in the hospital, and early signs are that it is already making a difference in reducing the length of stay in some areas. Feedback from staff has also been positive; as they find the system helps them very visibly see what is going on in their area as well as giving an overall picture of what is happening across the hospital to aid the allocation of beds.



University hospital

We are extremely proud to be a university hospital and of our excellent reputation for teaching doctors, nurses and other health professionals. Learning and development is embedded in our culture. We aim to nurture all staff so that they can make the most of their career opportunities and deliver the highest quality service to our patients. Each year we celebrate staff achievements at our Staff Training And Recognition (STAR) awards.

Educational inspection visits

During the year we received a number of external inspection visits to ensure we are providing training of the highest standard. These included visits by the London Deanery, Nursing & Midwifery Council, Imperial College, and Thames Valley University. The feedback from these visits has been very positive. The London Deanery said that 'The Trust was noted to be committed to and supportive of the training of junior doctors', 'The specific successes with reference to the Darzi Fellowship and Simulation Centre were acknowledged', and 'The Education Centre facilities and staff support to trainees was reported as being good, as were the Library Services at the Trust.' The North West Thames Foundation School Visit highlighted a number of areas for commendation including that 'almost all Foundation Doctors would recommend their posts at West Middlesex' and that the training provided for Foundation Doctors 'is of the highest standards currently undertaken in the North West Thames trusts'. They further added that the West Middlesex 'should be commended for its excellent education facilities and committed staff providing a positive training environment.'

A number of our staff were recognised for their excellence in clinical teaching they have given to Imperial College London medical students over the academic year.

We also received some excellent feedback from our medical students, who we train to become the next generation of doctors. The students from Imperial College London rated their training here during 2010/11, giving an overwhelmingly positive response and highlighting a number of areas as outstanding.

Darzi Fellows and clinical leadership

Darzi Fellowships were created in 2009 in response to a health review by NHS London and the London Deanery. Their role is to lead on a variety of priority service change projects and develop leadership skills to aid them in future roles as consultants and clinical leaders.

Our first Darzi Fellow completed her time at West Middlesex last year and we welcomed our second Darzi Fellow in 2010.

The Fellow has been involved in a number of new projects including developing a clinical handover module in our new RealTime IT system. This will help ensure that doctors have all the key information about the patients whose care they are taking responsibility for during their shifts. He has also developed and piloted a training package for the SBAR (Situation, Background, Assessment, Recommendation) communication tool. SBAR is designed to help structure conversations when a patient may need an urgent review. It encourages everyone to prepare what they are going to say and to have the necessary details at their fingertips, so that a safe decision can be made quickly about the need for further action or assessment.

The Darzi Fellow has been working in partnership with the Learning and Development team overseeing the second cohort of doctors on the Clinical Leadership Programme, made up of eight senior doctors, who each focused on a specific service improvement project. These ranged across a variety of areas including improving the discharge pathway following day case surgery to improving the weekend handovers in medicine.

"The aim of the Clinical Leadership Programme is to give doctors the skills and empowerment to bring about change. It's great to see their ideas for improvement turning into action that can really make things better for patients."
- David Stanton, Darzi Fellow

From April 2011 the Clinical Leadership Programme will be expanded to include multi-disciplinary staff, such as nurses and physiotherapists.

Recognising diversity and equality

The Trust recognises the diversity of our patients and staff in line with the Equality Act 2010, which includes the protected characteristics: Age, Disability, Gender reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Sex, Race, Sexual Orientation and Religion and Belief.

Our Single Equality Scheme (SES), enables us to fulfil and go beyond our statutory obligations. In recognition of the growing importance of equality and diversity within our local community we have changed our governance arrangements to create a new Equalities Committee to lead the development, implementation and monitoring of compliance with the SES.

The workforce report in September 2010 highlighted that we have a workforce that is broadly representative of the local population from a race perspective. In relation to gender issues, the proportion of female Board members is higher than the NHS average and is more reflective of the workforce than other NHS organisations.

We supported the launch of our local black and minority ethnic (BME) network, and launched our BME leadership programme to encourage a more representative workforce at every

level within the organisation. To date at least 27% (6 out of 22 staff) have progressed in their careers as a result of the programme.

We have arrangements in place with the London Borough of Hounslow for face to face interpretation for British Sign Language users as well as telephone translation for other languages.

Improved choice for patients

We are continually looking for ideas to improve the way we deliver care to our patients. This includes care closer to home, as well as greater choice and involvement.

Local residents benefit from local skin service

Hounslow residents with skin problems are benefiting from a new Community Dermatology Service, launched in February 2011. The service was designed and agreed by local GPs working with NHS Hounslow, following a public consultation, to give local residents faster access to care, closer to their home. It means most patients will no longer need to travel to hospital, and will be assessed and treated at the same appointment. West Middlesex was selected to run the service after a competitive tender.

West Middlesex consultant dermatologists manage the service, supported by a range of other staff including specialist nurses. Clinics are held at The Heart of Hounslow, Brentford Health Centre and Feltham Centre for Health.

West Middlesex's dermatologists are offering Hounslow GPs specialist training to allow them to provide enhanced diagnosis and treatment for patients with routine cases. For complex cases, including patients with conditions that overlap specialties, there are new combined hospital based clinics with other specialists to ensure a joined-up approach to their treatment.

Greatest choice for mums-to-be

Our award winning maternity service continues to grow, delivering 4,760 babies this year – an increase of nearly 400 babies over the previous year.

The service provides a range of birth options including home birth and a purpose-built natural birth centre – which offers a midwife-led home-from-home experience with the reassurance of specialist support availability from our adjoining maternity unit.

In February we held a birthday party to mark the first anniversary of our caseloading midwifery service, which comprises a team of six midwives who provide one-to-one care for local women throughout pregnancy, labour and after birth.

Celebrating success

In September 2010 a hospital wide 'Turnaround' programme was launched with a series of staff meetings emphasising a key principle underpinning the programme: 'better for patients, better for costs'.

Change could not be achieved without the active involvement of our staff and a key part of this has been the 'Celebrating Success' scheme, encouraging staff to submit their innovative ideas for patient care and savings.

One such success was from Clinical Imaging, who made an impressive saving of around £11,500 a year. £10,000 of this came after completing a review of the contrast media administered to patients for diagnostic imaging. Practice was to administer a standard dose regardless of patient size. However, research has shown that the dose of contrast media should be tailored to the size of the patient. After trials, the team have now introduced contrast media syringes which they fill themselves, rather than using the more expensive prefilled syringes. As well as saving money, this also improves the quality of the imaging process. A second saving of £1,500 came from an idea of giving water to patients to drink before they are scanned, instead of expensive contrast solution mixed with orange juice. It was found there was no difference in the quality of the images.

Another successful initiative came from changing the provider of sterile gloves used in theatres, which will save around £30,000 a year.

Involving patients in cost improvement initiatives

We have involved patients in discussions about improving our efficiency. A Patient Focus Group Event included members from Speak Out Hounslow and Diabetes UK as well as other members of the community who wanted to help us understand their service needs. As service users, they are in the right place to see where we can improve the patient experience and reduce waste. Their input has been invaluable in planning our improvements and we intend to host further similar events in the future.

Improving efficiency for our patients

It can be very frustrating if your operation is cancelled by us and we have been improving our processes to minimise the likelihood of this occuring. Theatres now have a dedicated admissions area for inpatients, rather than waiting on the wards.

A further initiative in theatres has been investment in their own clinical imaging equipment. This reduces dependency on the radiography department, located in a different part of the hospital, allowing surgeons to perform non-complicated imaging processes themselves, reducing delays to patients.

Changes in the way we procure

Our procurement department has been working to source items more efficiently and cost effectively. The work has involved standardisation and rationalisation of the product ranges used. Stationery items have been reduced and changing to re-manufactured printer cartridges, has led to an annual cost reduction of £27,000.

Procurement has been working very closely with clinical units, looking at saving money through contract renewals. A recent contract renewal for the Orthotics Service led to a new provider who agreed a capped annual expenditure, reducing costs by £60,000 per year without compromising patient care.

There has been further good news in terms of efficiency, with a move to a new provider for our e-Rostering service. This system of electronically capturing staff rotas and adjusting them accordingly ensures there is sufficient staff coverage within the clinical units. This is much more efficient than manually inputting such information.

The Trust works closely with the London Procurement Programme (LPP) to increase

buying power and reduce commodity and service costs. An example is in agency costs for Medical Locums and Nursing Agency staff.

A further cost reduction has come from a review of maintenance contracts. The procurement of a second CT scanner has removed the need for extended maintenance for the existing CT scanner, reducing costs by £26,000 per year.

Procurement has been a vital part of our cost improvement programme. The overall use of technology to remove manual processors, working closely with all clinical units to review current practices and exploring the market for opportunities is continuing to drive cost reductions and improve efficiencies.

Working to reduce our impact on the environment

Managing social, ethical and environmental issues in a way that grows value and helps the Trust, our patients and visitors be more sustainable, is very important to us.

Green travel

As part of our transport initiatives we have a well established travel plan through which we have undertaken a wide range of cycle friendly projects, including the provision of substantial numbers of cycle stores, improved security through the provision of CCTV and changing facilities. We have also recently overhauled our staff parking scheme to encourage alternative travel modes.

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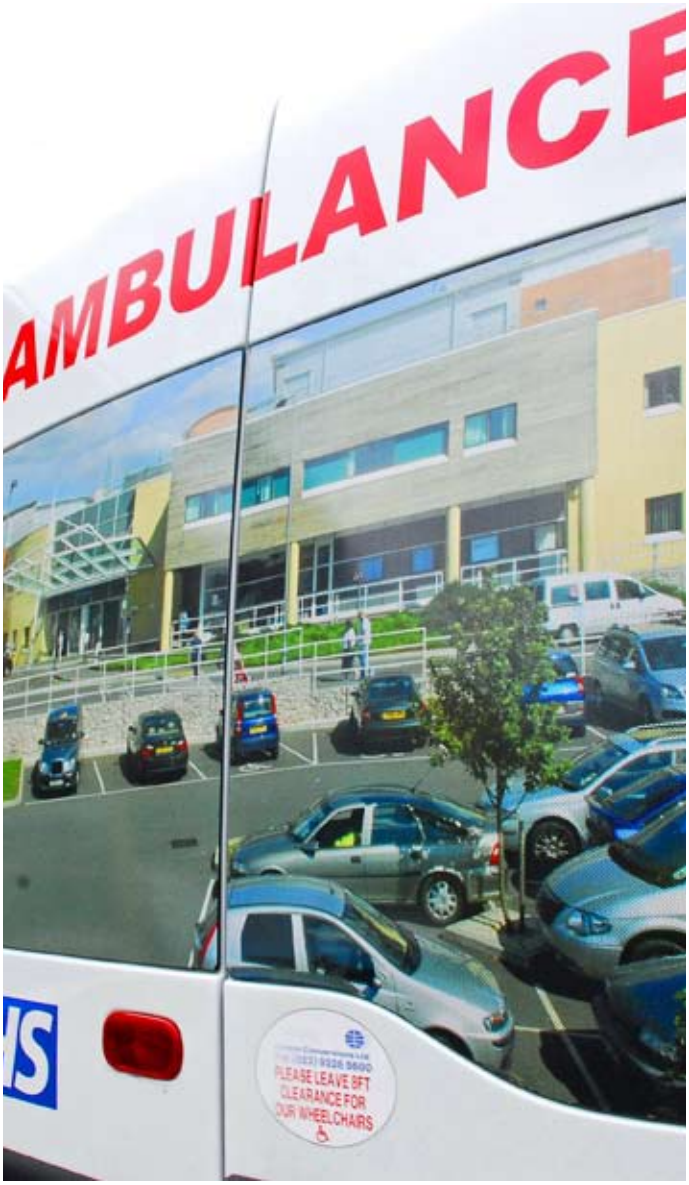
Reducing our energy use

The Trust has an energy strategy which seeks to reduce energy consumption in the medium to long term by training staff in good practice in the use of energy; investing in maintenance and capital schemes to reduce energy usage.



The Trust is one of the largest local consumers of electricity and as our activity increases and the power demand from modern equipment rises we have seen continued pressure on our overall consumption. In response to this, we have signed a green energy contract so that 20% of our power is now provided from renewable sources including wind generation, solar, wave and hydroelectric schemes. We have also continued to convert all of our lighting to low energy LED systems and installed several voltage optimisation devices. Energy consumption is also now considered as part of our equipment selection processes and we continue to review the power usage of our building electrical installations such as our lifts and air conditioning system.

2010/11 saw the first benefits of this strategy with our energy consumption down 6.2% year on year and over 9% for March 2011 as against March 2010. We have set ourselves an ambitious target for a 15% reduction in our energy usage by April 2012.

Increasing our recycling

2010/11 saw increased emphasis placed on improving our recycling rates. Additional recycling streams for all forms of domestic waste have been established. We have set ourselves an ambitious target of 50% of all domestic waste being recycled during 2011/12, increasing to 70% from April 2012.

Procurement

Through our supply chain initiatives, we seek to ensure that the working conditions in our supply chain meet all recognised standards. We also seek to ensure that waste packaging and transportation miles are minimised. Over time we expect to be able to make substantial and cumulative improvements, particularly on our upstream supply chains environmental impact.

Our carbon reduction commitment

The Carbon Reduction Scheme is a mandatory carbon emissions trading scheme to cover all organisations using more than 6,000MWh of electricity per year (equivalent to an annual electricity bill of about £500,000). The Trust is one of the approximately 5,000 UK organisations that are covered by the scheme, along with supermarkets, banks, property management companies, government departments, hotel groups, food retail chains and local authorities. Each year, the scheme will require participating organisations to purchase and submit sufficient allowances to meet their annual emissions covered by the scheme. The CRC is central to the Government's strategy for improving energy efficiency and reducing carbon dioxide (CO2) emissions in order to meet the legally binding targets for reducing greenhouse gas emissions established by the Climate Change Act 2008. During 2010/11 we reduced our energy emissions by over 400 tonnes.

Accountability to the local community

The Trust is committed to being accountable to its local community and the people we serve; the Chief Executive and Executive Directors regularly attend both Hounslow and Richmond Council's Scrutiny Committees to answer the questions of local Councillors. Foundation Trust status in the future will formalise our accountability to the local community, our staff and stakeholders.

Finance review

For the first time in three years the Trust achieved its in year statutory financial responsibilities. These were in relation to the break-even duty for operational financial performance, cash and capital management and return on assets. Year on year we improved from a £5.5m deficit in 2009/10 to a £0.1m surplus in 2010/11. This left the Trust's cumulative deficit at £21.6 million and consequently we have yet to deliver our cumulative breakeven duty. The substantial turnaround in our financial performance can be attributed to an absolute focus on cost control and driving efficiency gains out of our services. Although our income increased by £5.8m, we were able to undertake additional work and absorb all the normal NHS cost pressures with a net increase in our cost base of just £0.3m.

Looking ahead, in line with the rest of the public sector the Trust and the local health economy face a considerable financial challenge over the next spending review period to 2014/15. We expect cost reduction measures of at least £22 million will be required over the next four years with the majority of this required over the next two years. The Trust has been preparing itself for this for some time and has undertaken a comprehensive review of all potential efficiency savings that can be achieved. We have also significantly strengthened our management and governance arrangements to support the delivery of this.

On a positive note, the local health economy has returned to overall financial balance and is in a stronger position to face the challenges ahead compared to recent years where the significant accumulated deficit had to be repaid by the Trust's main commissioner – Hounslow PCT. The strong partnership working that has helped to turnaround our respective positions will be required in even greater strength if the local health system is to succeed over the next three to four years.

Like all London hospital trusts, we will also face increased competition and service change. Some of these changes, like the new model for stroke services, benefit the Trust but others will undoubtedly see work moving away to community settings.

Our long-term financial planning has considered the likely impact of these changes as signalled by our local Commissioners in their service planning intentions. Clearly, this has necessitated the Trust taking a more prudent view of acute activity levels over the next strategic planning period and to plan for tougher downside scenarios should service changes have a greater financial impact than envisaged at present.

Despite these service and financial pressures, the Trust achieved its best overall performance to-date, across the wide range of operational and quality performance measures formally assessed nationally. This demonstrated the money was well spent and delivered more high quality acute health services for the people of Hounslow, Richmond and Twickenham and the surrounding boroughs.

As we develop the Trust's future strategy, we have continued to invest in both equipment and our facilities. During 2010/11, we spent £4.2m on capital schemes including the provision of a new CT scanner and other medical equipment totalling £1.6m, refurbishments to our maternity unit and wards totalling £1.6m and IT investments of £1m. We are planning further capital expenditure of £5.1m in 2011/12, excluding the provision of our new urgent care centre which is being funded by NHS Hounslow. These investments underline our confidence in the future of our services and our commitment to providing the most appropriate environment and equipment for a busy, modern, local acute hospital.

In 2008/09, the Trust received a loan of £17m from the Department of Health

(£15.3m of which remains outstanding as at 31 March 2011). Discussions over the future repayment of this continue with the North West London Challenged Trust Board. Total Trust borrowings including those related to our PFI buildings now stand at £56.6m - a reduction of £0.8m on 2009/10. The interest on servicing this debt cost the Trust £4.7m in 2010/11.

Financial governance

The Trust operates within the regulatory framework determined by the Department of Health. Risk management is monitored through the Trust's Board Assurance Framework, as described in the Statement of Internal Control which is published with our full annual accounts. Directors are members or attendees of the Trust Board and the Chief Executive, as the accountable officer, has put in place systems that provide appropriate information and assurance to the Trust Board.

The Statement of Directors' Responsibilities in respect of the accounts is signed by the Chief Executive and Finance Director. The statement was signed by order of the Board and confirms that the Directors have to the best of their knowledge and belief complied with all audit requirements. In particular, that there is no relevant information of which the Trust's auditors are not aware; and that the Directors have taken all steps that ought to have been taken as Directors in order to make themselves aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

The Finance and Performance Committee is responsible for providing assurance to the Trust Board on all aspects of financial performance. The Trust has also engaged Internal Audit to review our core financial systems and undertake various value for money reviews. Their findings and recommendations are reported directly to the Audit Committee.

The Trust has policies and procedures to minimise corruption and fraud. We have engaged a Local Counter Fraud Specialist (LCFS) who assists the Trust in promoting an anti-fraud culture. The LCFS also investigates any suspected cases of corruption or fraud and during the year a number of cases were investigated, some leading to dismissal and prosecution.

Simon Marshall
Chief Financial Officer

Financial performance summary

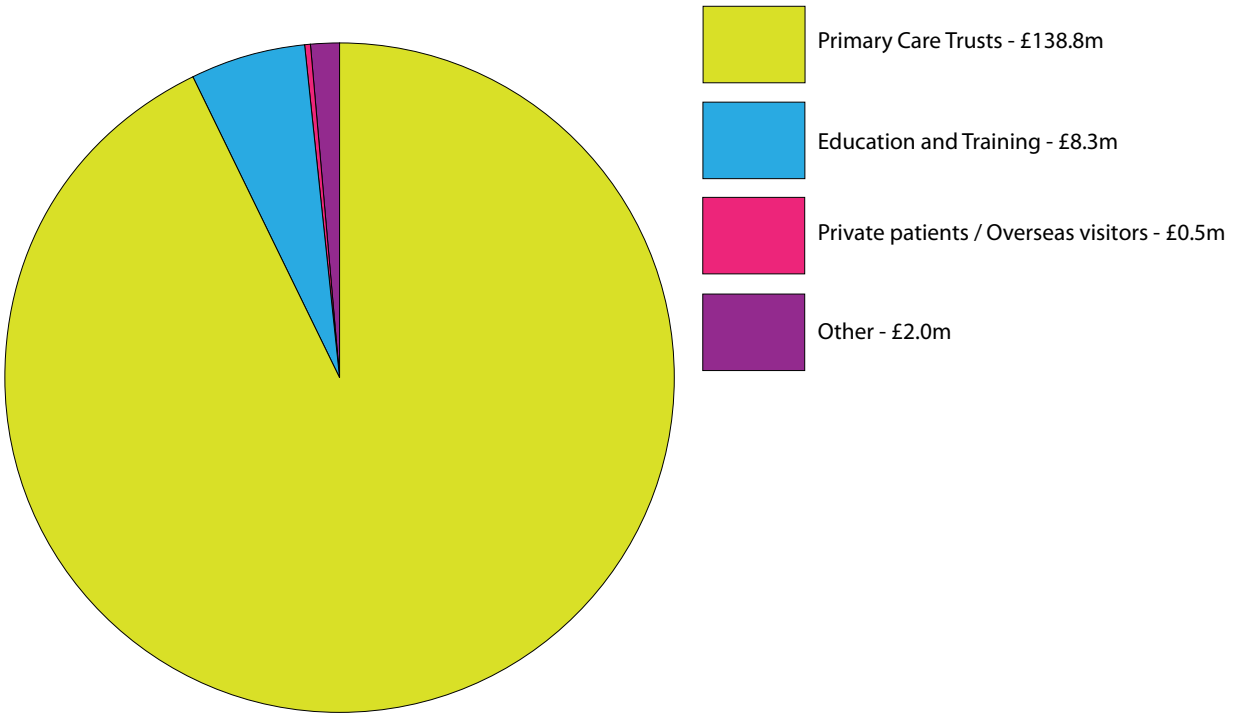
Annual accounts

The information contained in the annual report has been prepared taking into consideration the recommendations outlined in the Accounting Standards Board's (ASB's) Reporting Statement: Operating and Financial Review. However, the following summary financial statements do not contain sufficient information to allow a full, in depth, understanding of the results and state of affairs of the Trust. Where more detailed information is required a copy of the Trust's last full accounts and reports are obtainable free of charge from the Trust's Finance Department and will be made available on our website.

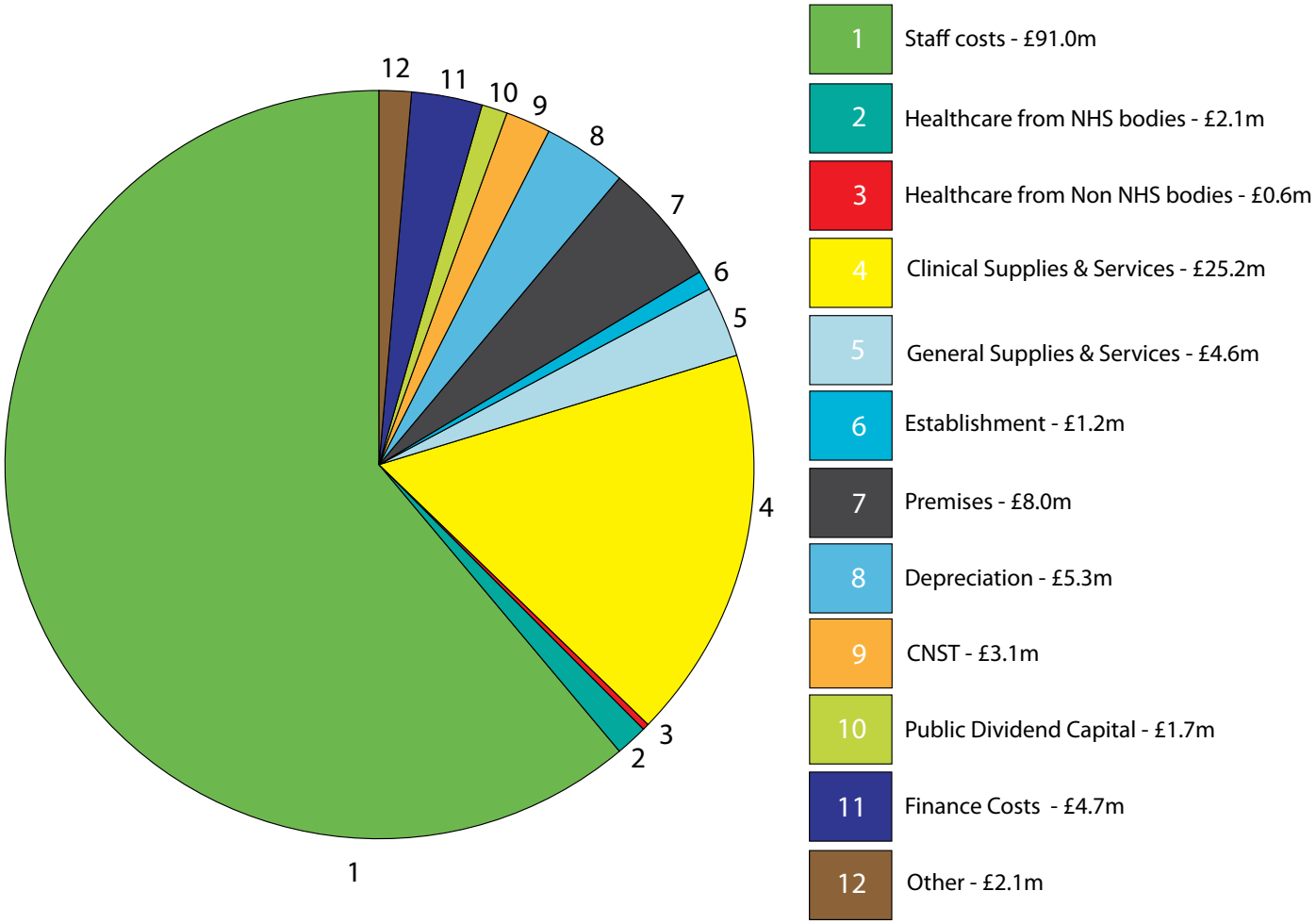
The Statement of Comprehensive Income records the income and the expenditure incurred by the Trust during the year in the course of running its operations. It includes cash expenditure on staff and supplies as well as non-cash expenses such as depreciation (a charge that reflects the consumption of the assets used in delivering healthcare). If income exceeds expenditure, the Trust has a surplus. If expenditure exceeds income, a deficit is incurred. The statement also includes other unrealised gains and losses such as those on the revaluation of our assets or resulting from impairment reviews. The Trust 2010/11 Statement of Comprehensive Income is shown below.

STATEMENT OF COMPREHENSIVE INCOME - Year ended 31st March 2011		
	2010/11 £000	2009/10 £000
REVENUE		
Revenue from patient care activities	137,251	131,443
Other operating revenue	12,387	12,361
Operating expenses	(143,152)	(142,893)
Operating Surplus (deficit)	**6,486**	**911**
Finance costs:		
Investment revenue	12	11
Finance costs	(4,704)	(4,682)
Surplus / (deficit) for the financial year	1,794	(3,760)
Public dividend capital dividents payable	(1,690)	(1,781)
Retained surplus / (deficit) for the year	**104**	**(5,541)**
OTHER COMPREHENSIVE INCOME		
Impairments and reversals	0	(6,875)
Gains on revaluations	342	2,518
Receipt of donated / government granted assets	0	54
Reclassification adjustments:		
- Transfers from donated and government grant assets	(31)	(34)
Total comprehensive income for the year	**415**	**(9,878)**

Income for the year totalled £149.6m million, a real increase of £5.8 million (3.9%) over 2009/10. A breakdown of the sources of this income is shown below.



Total expenditure for the year totalled £149.6 million, an increase of just £0.3 million (0.2%) over 2009/10. A breakdown of this expenditure is shown below.



The Statement of Financial Position provides a snapshot of the Trust's financial condition at the end of the financial year. It lists assets (everything the Trust owns that has monetary value), liabilities (money owed to external parties) and taxpayers' equity (public funds invested in the trust). At any given time, the assets minus the liabilities must equal taxpayers' equity. The Trust's balance sheet as at 31st March 2011 is shown below.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2011		
	31 March 2011 £000	31 March 2010 £000
NON-CURRENT ASSETS		
Property, plant and equipment	107,854	108,940
Intangible assets	410	91
Trade and other receivables	494	510
Total non-current assets	**108,758**	**109,541**
CURRENT ASSETS		
Inventories	1,419	1,524
Trade and other receivables	6,992	8,424
Cash and cash equivalents	708	550
Total current assets	**9,119**	**10,498**
TOTAL ASSETS	**117,877**	**120,039**
CURRENT LIABILITIES		
Trade and other payables	(10,801)	(13,158)
Borrowings	(9,846)	(5,245)
Provisions	(826)	(238)
Net current assets/(liabilities)	**(12,354)**	**(8,143)**
Total assets less current liabilities	**96,404**	**101,398**
NON-CURRENT LIABILITIES		
Borrowings	(46,726)	(52,119)
Provisions	(494)	(510)
Total assets employed	**49,184**	**48,769**
FINANCED BY TAXPAYERS' EQUITY		
Public dividend capital	21,362	21,362
Retained earnings	(17,762)	(18,036)
Revaluation reserve	45,388	45,221
Donated asset reserve	158	175
Government grant reserve	38	47
TOTAL TAXPAYERS' EQUITY	**49,184**	**48,769**

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY						
	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Donated asset reserve	Gov't grant reserve	Total
	£000	£000	£000	£000	£000	£000
Changes in taxpayers' equity for 2009/10						
Balance at 1 April 2009	**16,362**	**(12,495)**	**49,578**	**202**	**0**	**53,647**
Total Comprehensive Income for the year:						
Retained surplus/(deficit) for the year	0	(5,541)	0	0	0	(5,541)
Impairments and reversals	0	0	(6,875)	0	0	(6,875)
Net gain on revaluation of property, plant, equipment	0	0	2,518	0	0	2,518
Receipt of donated/government granted assets	0	0	0	7	47	54
- transfers from donated asset/ government grant reserve	0	0	0	(34)	0	(34)
New PDC received	5,000	0	0	0	0	5,000
Balance at 31 March 2010	**21,362**	**(18,036)**	**45,221**	**175**	**47**	**48,769**

Balance at 1 April 2010	21,362	(18,036)	45,221	175	47	48,769
Total Comprehensive Income for the year:						
Retained surplus/(deficit) for the year	0	104	0	0	0	104
Transfers between reserves	0	170	(170)	0	0	0
Net gain on revaluation of property, plant, equipment	0	0	337	5	0	342
Reclassification adjustments:						
- transfers from donated asset/ government grant reserve	0	0	0	(22)	(9)	(31)
Balance at 31 March 2011	**21,362**	**(17,762)**	**45,388**	**158**	**38**	**49,184**

The Statement of Changes in Taxpayers' Equity provides a summary of all the Trust's gains and losses, whether they have been realised or not.

The Statement of Cash Flows summarises the cash flows of the Trust during the accounting period. These cash flows include those resulting from operating and investment activities, capital transactions, payment of dividends and financing. Even if an organisation reports a surplus on the Statement of Comprehensive Income it does not mean its cash balance will increase by an equivalent amount. Similarly, a deficit does not necessarily translate into an actual shortage of cash in the short term. For example, while depreciation is included as an expenditure charge, it does not involve an outlay of cash. Similarly, any capital purchase will involve an upfront outlay of the full purchase price, while expenditure only records the depreciation of the asset – spreading the full cost over the lifetime of the asset. The impact of an organisation's operating performance on its cash position can only be gleaned from both the Statement of Cash Flows and the Statement of Financial Position. See note on page 36 for details on our cash-flow issues.

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2011		
	2010/11	2009/10
	£000	£000
Cash flows from operating activities		
Operating surplus/(deficit)	6,486	911
Depreciation and amortisation	5,298	5,075
Impairments and reversals	0	30
Transfer from donated asset reserve	(22)	(34)
Transfer from government grant reserve	(9)	0
Interest paid	(4,704)	(4,682)
Dividends paid	(1,761)	(1,781)
(Increase)/decrease in inventories	105	(126)
(Increase)/decrease in trade and other receivables	1,448	447
Increase/(decrease) in trade and other payables	(2,296)	2,063
Increase/(decrease) in provisions	557	2
Net cash inflow/(outflow) from operating activities	**5,102**	**1,905**
Cash flows from investing activities		
Interest received	12	11
(Payments) for property, plant and equipment	(3,618)	(6,005)
(Payments) for intangible assets	(426)	0
Net cash inflow/(outflow) from investing activities	(4,032)	(5,994)
Net cash inflow/(outflow) before financing	**1,070**	**(4,089)**
Cash flows from financing activities		
Public dividend capital received	0	5,000
Capital element of finance leases and PFI	(912)	(707)
Net cash inflow/(outflow) from financing	**(912)**	**4,293**
Net increase/(decrease) in cash and cash equivalents	158	204
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year	550	346
Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year	**708**	**550**

Salary and pension entitlements of senior managers

Trust Senior Managers salary and pension entitlements are disclosed in the following tables.

Salary entitlements of senior managers						
Name and title	2010-11			2009-10		
	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in kind (Rounded to the nearest £000)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in kind (Rounded to the nearest £000)
	£000	£000	£000	£000	£000	£000
Sue Ellen - Chairman (left August 10)	5 -10	-	-	20-25	-	-
Tom Hayhoe - Chairman (joined September 10)	10 -15	-	-	N/A	-	-
Dame Jacqueline Docherty - Chief Executive	175 - 180	-	-	175-180	-	-
Alison McIntosh - Deputy Chief Executive (left March 11)	90 - 95	-	-	85-90	-	-
Simon Marshall - Chief Financial Officer	95 - 100	-	-	95-100	-	-
Andrew Winning - Medical Director (until August 10)	15 - 20	50 - 55	-	45 - 50	120-125	-
Stella Barnass - Medical Director (started September 10)	45 - 50	40 - 45	-	N/A	-	-
Yvonne Franks - Director of Nursing & Midwifery	85 - 90	-	-	80 - 85	-	-
Nina Singh - Director of Workforce & Development	75 - 80	-	-	75 - 80	-	-
Anne Gibbs - Director of Operations and Strategy	85 - 90	-	-	80 - 85	-	-
Andrew Daws - Non-Executive Director	5 - 10	-	-	5-10	-	-
Stephen Clark - Non-Executive Director	5 - 10	-	-	5-10	-	-
Luke de Lord - Non-Executive Director	5 - 10	-	-	5-10	-	-
Nicholas Gash - Non-Executive Director	5 - 10	-	-	5-10	-	-
Jenny Higham - Non-Executive Director	5 - 10	-	-	5-10	-	-

Pension entitlements of senior managers								
Name and title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2011 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2011 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2011	Cash Equivalent Transfer Value at 31 March 2010	Real increase in Cash Equivalent Transfer Value at March 2011	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Dame Jacqueline Docherty - Chief Executive	Information not available as not directly employed by the Trust							
Alison McIntosh - Deputy Chief Executive (left March 11)	0 - 2.5	0 - 2.5	20 - 25	65 - 70	362	386	(23)	-
Simon Marshall - Chief Financial Officer	0 - 2.5	0 - 2.5	5 -10	25 - 30	111	125	(12)	-
Andrew Winning - Medical Director (left August 10)	-	-	65 - 70	205 - 210	-	-	-	-
Stella Barnass - Medical Director (started September 10)	N/A	N/A	35 - 40	105 - 110	716	N/A	N/A	-
Yvonne Franks - Director of Nursing & Midwifery	0 - 2.5	2.5 - 5	30 - 35	100 - 105	606	614	(17)	-
Nina Singh - Director of Workforce & Development	0 - 2.5	0 - 2.5	10 - 15	40 - 45	215	230	(15)	-
Anne Gibbs - Director of Operations & Strategy	0 - 2.5	2.5 - 5	15 - 20	45 - 50	147	161	(11)	-

Cash equivalent transfer values

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

Real increase in CETV

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

Management costs

The Trust's management costs comprise 4.0% of income. The definition of management costs can be found on www.doh.gov.uk/managementcosts

Management costs		
	2010/11	2009/10
Management costs (£000)	5,973	5,529
Income (£000)	148,422	142,774
Management costs as a percentage of income (%)	4.02	3.87

Financial performance targets

Breakeven performance

Trusts have a statutory duty to achieve breakeven 'taking one year with another' (which means that expenditure must not exceed income over three or, exceptionally, five years). This statutory duty is the key financial duty for NHS trusts. Trusts such as ours that have breached this statutory duty are required to agree a financial recovery plan with their SHA, where performance is monitored on a regular basis until the deficit has been recovered. The following note provides details of the Trust's performance against our breakeven duty. Each year's performance against the breakeven duty is recorded stretching back to the inception of the Trust. A materiality threshold also applies so that a trust is considered to have achieved its breakeven duty providing the cumulative deficit is less than 0.5 per cent of current year turnover. Discussion with our

Strategic Health Authority over the recovery of our accumulated deficit continue.

Breakeven Performance					
The Trust's historical breakeven performance is as follows:					
	2006/07	2007/08	2008/09	2009/10	2010/11
	£000	£000	£000	£000	£000
Turnover	118,854	129,285	132,894	143,804	149,638
Retained surplus/(deficit) for the year	(3,295)	19	(3,534)	(5,541)	104
Adjustment for:					
2006/07 Prior Period Adjustment (relating to 2005/06)	-	-	-	-	-
Adjustments for Impairments	-	-	-	20	-
Consolidated Budgetary Guidance - Adjustment for Dual Accounting under IFRIC12	-	-	-	525	110
Break-even in-year position	(3,295)	19	(3,534)	(4,996)	214
Break-even cumulative position	(13,271)	(13,252)	(16,786)	(21,782)	(21,568)
Materiality test (i.e. is it equal to or less than 0.5%):					
Break-even in-year position as a percentage of turnover	(2.77%)	0.01%	(2.66%)	(3.47%)	0.14%
Break-even cumulative position as a percentage of turnover	(11.17%)	(10.25%)	(12.63%)	(15.15%)	(14.41%)

External financing limit (EFL)

This is a cash limit on net external financing and is one of the controls used by the Department of Health to keep cash expenditure of the NHS as a whole within the level agreed by Parliament in the public expenditure control totals. Trusts must not exceed the EFL target, which effectively determines how much more (or less) cash a Trust can spend over that which it generated from its activities. The Trust was well within its target External Financing Limit for the year having reported an undershoot of £1,070k.

Capital resource limit (CRL)

The Trust underspent its Capital Resource Limit by £911k in 2010/11.

Better payment practice code

The Better Payment Practice Code requires trusts to pay all undisputed NHS and non NHS trade invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is the later. The target in the NHS is for trusts to pay 95 per cent of invoices within 30 days. This note reports on how the Trust performed against this target. As in prior years our continuing cash management difficulties significantly limited our progress towards this target.

Better Payment Practice Code - measure of compliance				
	2010/11		2009/10	
	Number	£000	Number	£000
Total Non-NHS trade invoices paid in the year	31,474	51,877	34,469	41,551
Total Non NHS trade invoices paid within target	26,159	43,670	26,286	38,395
Percentage of Non-NHS trade invoices paid within target	83%	84%	76%	92%
Total NHS trade invoices paid in the year	1,239	13,228	1,231	12,291
Total NHS trade invoices paid within target	582	5,247	467	2,324
Percentage of NHS trade invoices paid within target	47%	40%	38%	19%

Prompt payments code

The Trust has signed up to the Prompt Payments Code.

The Board

The role of the Board is to lead the organisation through:

- Formulating strategy for the Trust
- Holding the organisation to account for delivery of that strategy and ensuring that systems for monitoring and control of performance are robust and effective.
- Shaping a positive culture for the Board and the Trust

The Board's combined objective is to work together towards ensuring that West Middlesex attains its vision of becoming a first class hospital for our community and providing the highest possible standards of care to our patients. This objective guides the Board's development of strategy and underpins key policy decisions for which the Board is responsible on matters such as patient safety, workforce, finances and performance.

The Board, led by a Non-Executive Chair, is made up of a mixture of Executive and Non-Executive Directors. The Executive team consist of the Chief Executive and Directors of the hospital who are responsible for the day-to-day running of the organisation. The Non-Executive Directors bring their independence and specialised expertise to the Board, providing the necessary checks and balances to ensure the effective governance of the organisation.

Board meetings take place eight times a year and are open to the public (details of these meetings can be found on our website). The Trust Board has a number of committees to provide greater scrutiny over the governance arrangements and to oversee the procedural and financial management of the hospital.

Left to right: Luke de Lord, Nina Singh, Anne Gibbs, Tom Hayhoe, Simon Marshall, Dame Jacqueline Docherty, Stella Barnass, Stephen Clark, Nick Gash, Yvonne Franks, Jenny Higham. Not pictured Andrew Daws.

Non-Executive Directors

Tom Hayhoe, Chairman[1]
Committees: Remuneration (Chair), Charitable Funds (Chair), Finance & Performance (member) Clinical Excellence (member).

Nick Gash, Deputy Chairman
Committees: Finance & Performance (Chair), Audit (member), Remuneration (member), Clinical Excellence (member).

Stephen Clark
Committees: Clinical Excellence (Chair), Remuneration (member), Finance & Performance (Member), Audit (member).

Andrew Daws
Committees: Audit (member), Finance & Performance (member), Charitable Funds (member), Remuneration (member), Clinical Excellence (member).

Jenny Higham
Committees: Integrated Governance (Chair), Remuneration (member).

Luke de Lord
Committees: Audit (Chair), Finance & Performance (member), Remuneration (member).

Executive Directors

Dame Jacqueline Docherty – Chief Executive
Anne Gibbs – Director of Operations and Strategy[2]
Stella Barnass – Medical Director[3]
Simon Marshall – Chief Financial Officer
Yvonne Franks – Director of Nursing and Midwifery
Nina Singh – Director of Workforce and Development

Footnotes:

1. Sue Ellen was Chairman of the Trust until 31 August 2010. Tom Hayhoe took up Chairmanship on 1 October 2010
2. Alison McIntosh was Director of Operations until February 2011 when Anne Gibbs took on this role
3. Andrew Winning was Medical Director until September 2010 when Stella Barnass then became Acting Medical Director before being appointed Medical Director in January 2011

None of the directors hold company directorships or other significant interests, which may conflict with their management responsibilities.

The directors confirm that as far as they are aware there is no relevant audit information of which the NHS body's auditors are unaware and he/she has taken all the steps that he/she ought to have taken as a director in order to make himself aware of any relevant audit information and to establish that the NHS body's auditors are aware of that information.

Remuneration issues

The membership of the Remuneration Committee comprises the Chairman and the non-executive directors of the West Middlesex University Hospital NHS Trust. The Committee uses the following key principles to guide remuneration of directors of the Trust:

- Objective setting should be realistic, and linked to the Trust's business plan. Individual objectives should be measurable, achievable, limited in number, and include the performance of the individual within the appropriate team (and therefore team performance).
- Performance is measured against agreed objectives and achievement is assessed through an annual appraisal. Performance is one of the key principles of the overall remuneration assessment.
- Market comparisons of salaries should be reviewed each year and the effect of divergences considered.

Contracts of employment are permanent unless there are overriding business reasons for other arrangements. Notice periods and termination payments are set out in contracts of employment.

Pay increase for 'agenda for change' (AFC) and medical staff groups followed national guidance. The pay award consisted of an increase of 2.25% to the AFC payscale and 1.0% to the medical payscale, excluding consultants who had a pay freeze.

No performance-related pay or other bonus payments have been approved for any Executive Directors. A total of 24 clinical excellence awards were made during 2010/11. The total value of these payments was £87,000. These awards are part of a national scheme to reward consultants who perform above and beyond the normal expectations of their role.

All Executive Directors were on permanent contracts as at 31st March 11, with the exception of the Chief Executive who is on secondment. These contracts are subject to three months notice periods, with the exception of the Chief Executive, whose notice period is six months.

Termination arrangements are applied in accordance with statutory regulations as modified by national NHS conditions of service agreements (specified in Agenda for Change), and the NHS pension scheme. Specific termination arrangements will vary according to age, length of service and salary levels. The Remuneration Committee will agree any severance arrangements.

Reporting of other compensation schemes - exit packages

Reporting of other compensation schemes - exit packages					
	a	b	c	d	e
1	Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band (total cost)	Number of departures in (b) and (c) where special payments have been made (special payment element totalled)
2	<£20,000	1	12	13 (£138,066)	0
3	£20,001 - £40,000	0	4	4 (£104,794)	0
4	£40,001 - £100,000	0	1	1 (£88,204)	0
5	£100,001 - £150,000	0	0	0	0
6	£150,001 - £200,000	0	0	0	0
7	Total number of exit packages by type (total cost)	1 (£11,258)	17 (£319,806)	0	0
8	Total number (and cost) of exit packages	0	0	18 (£331,064)	0

Glossary of terms

Accruals	An accounting concept. In addition to payments and receipts of cash (and similar), adjustment is made for outstanding payments, debts to be collected, and stock (items bought, paid for but not yet used). This means that the accounts show all the income and expenditure that relates to the financial year.
Amortisation	The process of charging the cost of an asset over its useful life as opposed to recording its cost as a single entry in the income and expenditure records. Amortisation follows the same principle as depreciation (see below) but tends to be used for intangible assets.
Assets	An item that has a value in the future. For example, a debtor (someone who owes money) is an asset, as they will in future pay. A building is an asset, because it houses activity that will provide a future income stream.
Benchmarking	The process of comparing performance within an organisation and against similar organisations with a view to identifying areas of potential improvement.
Break-even (duty)	A financial target. Although the exact definition of the target is relatively complex, in its simplest form the break-even duty requires the NHS organisation to match income and expenditure, i.e. make neither a profit nor a loss.
Capital	In most businesses, capital refers either to shareholder investment funds, or buildings, land and equipment owned by a business that has the potential to earn income in the future. The NHS uses this second option, but adds a further condition – that the cost of the building/equipment must exceed £5,000. Capital is thus an asset (or group of functionally interdependent assets), with a useful life expectancy of greater than one year, whose cost exceeds £5,000.
Capital Resource Limit (CRL)	An expenditure limit determined by the Department of Health for each NHS organisation limiting the amount that may be expended on capital purchases, as assessed on an accruals basis (i.e. after adjusting debtors and creditors).
Clinical Negligence Scheme	A system in which organisations voluntarily contribute 'insurance' premiums to the NHS Litigation Authority to pool the risk of payments in respect of the Scheme for Trusts clinical negligence.
Corporate Governance	Corporate governance is the system by which organisations are directed and Governance controlled. It is concerned with how an organisation is run – how it structures itself and how it is led. Corporate governance should underpin all that an organisation does. In the NHS this means it must encompass clinical, financial and organisational aspects.
Cost Improvement Programme	The identification of schemes to reduce expenditure or increase efficiency within the Organisation.
Current Assets	Debtors, stocks, cash or similar, whose value is, or can be converted into cash within the next twelve months.
Depreciation	The process of charging the cost of an asset over its useful life as opposed to recording its cost as a single entry in the income and expenditure records. Accumulated depreciation is the extent to which depreciation has been charged in successive years' income and expenditure accounts since the acquisition of the asset.
External Financing Limit (EFL)	A cash limit on net external financing set by the Department of Health. The EFL is designed to control the cash expenditure of the NHS as a whole to the level agreed by Parliament in the public expenditure control totals. The EFL determines how much more (or less) cash than is generated from its operations that a Trust can spend in a year.
Fixed / Non-current Assets	Land, buildings, equipment and other long term assets that are expected to have a life of more than one year.
Intangible Asset	Goodwill, brand value or some other right, which although invisible is likely to derive financial benefit (income) for its owner in future, and for which you payment may be made.
Net Book Value	The value of items (assets) as recorded in the Statement of Financial Position (SOFP) of an organisation. The net book value takes into consideration the replacement value.
Care Quality Commission	An independent review body endowed with the power to investigate and comment on the performance of NHS organisations.
Primary Care Trust	Primary care organisations that provide and manage services delivered within the primary and community care sector as well as commission acute and other services.
Public Dividend Capital	At the formation of NHS trusts, the purchase of Trust assets from the Secretary of State was half funded by public dividend. It is similar to company share capital, with a dividend being the payable return on the Secretary of State's investment.
Revenue	On-going or recurring costs or funding for the provision of services.
Tangible (asset)	A sub-classification of fixed assets, to exclude invisible items such as goodwill and brand values. Tangible fixed assets include land, buildings, equipment, and fixtures and fittings.

Independent auditors' statement to the Directors of the Board of West Middlesex University Hospital NHS Trust

We have examined the summary financial statement for the year ended 31 March 2011 which comprises the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, the related notes and the information in the Directors' Remuneration Report that is described as having been audited.

Respective responsibilities of directors and auditors

The directors are responsible for preparing the Annual Report and summary financial statement, in accordance with directions issued by the Secretary of State.

Our responsibility is to report to you our opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statement and the Directors' Remuneration Report and its compliance with the relevant requirements of the directions issued by the Secretary of State.

We also read the other information contained in the Annual Report and consider the implications for our statement if we become aware of any apparent misstatements or material inconsistencies with the summary financial statement. The other information comprises only the Finance Director's Review, Financial Performance Summary, Chief Executive's Statement, Chairman's Statement and the unaudited part of the Remuneration Report.

This statement, including the opinion, has been prepared for, and only for, the Board of West Middlesex University Hospital NHS Trust in accordance with Part II of the Audit Commission Act 1998, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and of Audited Bodies (Local NHS Bodies) published by the Audit Commission in March 2010 and for no other purpose. We do not, in giving this opinion, accept or assume responsibility for any other purpose or to any other person to whom this statement is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

We conducted our work in accordance with Bulletin 2008/3 issued by the Auditing Practices Board. Our report on the statutory financial statements describes the basis of our audit opinion on those financial statements, the Directors' Report and the Directors' Remuneration Report.

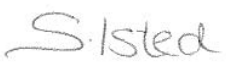
Opinion

In our opinion the summary financial statement is consistent with the statutory financial statements and the Directors' Remuneration Report of the Trust for the year ended 31 March 2011 and complies with the relevant requirements of the directions issued by the Secretary of State.

Our opinion on the statutory financial statements included an emphasis of matter paragraph because of the significant uncertainty relating to the Trust's liquidity.

Emphasis of matter –liquidity

We draw attention to note 21 in the financial statements which shows that the Trust has a £15.3 million loan from the Department of Health outstanding as at 31 March 2011. The Trust negotiated a revised repayment schedule for the loan at the beginning of 2009/10 but has subsequently not made any repayments of the principal element of the loan in either 2009/10 or 2010/11. The Department of Health could require repayment of the overdue payments at any time which indicates the existence of a material uncertainty which may cast significant doubt about the Trust's liquidity. Our opinion is not qualified in respect of this matter.



Sarah Isted Engagement Lead

For and on behalf of PricewaterhouseCoopers LLP
Appointed Auditors
London
30 June 2011


Main Entrance
WHS

Becoming a member

We are looking to recruit people who are interested in their local hospital to join us as members. We want to do this so we can involve more people in decisions about how to improve our services.

By becoming a member of the Trust you will be able to make a real difference to how we deliver and develop our services. You can choose how much you wish to be involved. It could be as easy as receiving regular information about the hospital and its plans and progress, or you could take a more active role.

Membership is completely free of charge and registering is easy. Pick up a membership form from our main reception desk or fill out the form on our website.

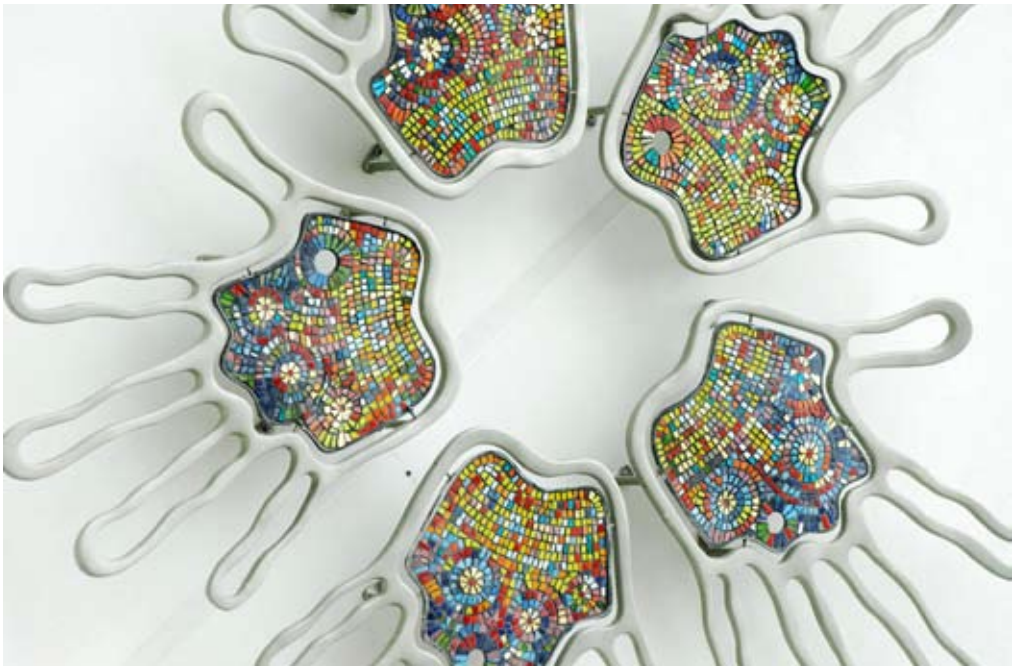
Giving us your feedback

We are always looking to hear your thoughts, experiences and opinions of West Mid and we encourage you to give us your feedback.

There are several ways to get in touch. You can ring our Patient Advice and Liaison Service (PALS) on 020 8321 6261 or email them via: pals.service@wmuh.nhs.uk

You can also pick up comment cards from around the hospital, which can be posted into the special post boxes while you are here.

As well as this, you can leave feed back on the NHS Choices website by visiting www.nhs.uk and typing "West Middlesex Hospital" into the search box and clicking on our page.



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