Homerton University Hospital NHS
NHS Foundation Trust

# annual report and accounts 2008/09

# Contents

# Annual Report and Accounts 2008/09

## Homerton University Hospital NHS Foundation Trust

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

# Chairman's statement

With economic gales blowing all around us and political forces ever present, Homerton Hospital continues to thrive, delivering vital health services to its population.

Challenges abound, both in the way healthcare is delivered and in relation to the financial context in which foundation trusts operate. We have achieved a good performance in balancing the books and are able to carry forward a small surplus to devote to developing services in the future. Our success in countering the risk of hospital infections has been an object lesson to others and a major effort has been made to meet challenging hygiene standards during the year.

We continue to recruit and retain doctors of impressive standing and experience, supported by dedicated staff who often perform beyond our expectations. Power cuts, snow storms, flu scares, whatever the challenge, the team here always coped impressively and I thank you all for it.

We all know that the national context is going to get tougher as budgets get squeezed. We hope and expect that standards of care in the NHS will be maintained and some improvements in services at Homerton are already under way. This report sets out the detail of the past year and I hope you find it informative and inspiring. The Board, working closely with our Council of Governors, is confident about our direction of travel and look to your continued interest and support in the years to come.

**Michael Cassidy CBE, Chairman**

# Directors' report

In this section we profile the principal activities of the Trust throughout the course of this year and highlight the progress we have made in developing the range and scope of services we provide. Our business review is covered in detail in the operating and financial review section. The final section of the report includes the annual accounts.

Homerton University Hospital was in the first cohort of 10 hospitals in the country to be authorised as a foundation trust in 2004 and we therefore marked our fifth anniversary this year – a significant milestone in our history. Foundation trust status has been a driver for service development and improvement.

During these five years the hospital has grown in stature and size. We have always been a high performing trust but we have grown from being the hospital 'for' Hackney to the hospital 'in' Hackney as we now serve not just the needs the local population, but have also developed a range of specialist services for patients from further afield.

The main hospital is based on one site, with a nursing home, Mary Seacole Nursing Home, situated in Shoreditch. We have three clinical divisions – General and Emergency Medicine, Children, Women and Sexual Health; Diagnostics, Surgery and Outpatients; each led by a Divisional Director who is a clinician. The divisions are supported by a full range of corporate services, which underpin the business of service delivery. Our catering and cleaning services are contracted out to a specialist company.

Clinical Board (our operational management board) has overall responsibility for the operational management and leadership of the hospital and is accountable to the Board of Directors.

The disease profile for Hackney is at variance from the national picture. For example, our population is much more likely to experience major complications of pregnancy than the norm. Conditions such as sickle cell disease, HIV and tuberculosis are routine for us, as are instances of 'tropical' infections. Economic hardship contributes to morbidity and there are high levels of alcohol and drug related problems.

Hackney has the highest levels of childhood obesity in the country. We have therefore developed services, and research programmes, that reflect the prevailing local conditions.

Homerton is not easily compartmentalised, in part because the profile of diseases we see is so unusual, but also because we have a much larger specialist base than is the norm for a hospital primarily serving a local area. The national contribution to service development through our innovation and research programmes also exceeds what one might expect for such a hospital. These are the factors that make Homerton such an exciting and challenging place to work.

## Looking back

In the Directors' report and throughout this document we highlight many of our successes as they relate to our 2008/09 corporate objectives highlighted below.

We were awarded an **excellent rating** for both service quality and use of resources by the Healthcare Commission.

We finished the year having **achieved key targets** for MRSA and Clostridium difficile rates. We also met challenging waiting time targets for emergency, cancer and planned care, and were rewarded with a visit from Ben Bradshaw, Minister for Health who commended us on the latter achievement. We have continued to benefit from sound financial management.

Service quality for stroke care was demonstrated by our achievement of good scores in the London review of stroke services. Our fertility centre pregnancy rates for women under 35 years are amongst the highest in the country.

**Service investment and development** continued, with the formal opening of a new fertility centre by the Lady Mayoress of London. We also opened two new single sex wards and a dedicated stroke unit. We have embarked on the construction of an £8 million centre for newborn and maternity care. Our bariatric (obesity) service received preferred provider status and performed approximately 10 per cent of the country's surgical procedures for obesity.

We went **beyond acute care** in furthering our contribution to the Hackney community. On behalf of the Hackney local strategic partnership we led the 'Reducing Infant Mortality Programme' which received the Health Service Journal

national award for addressing health inequalities. We were successful in our bid to run the community pulmonary disease service. A joint collaboration between Homerton and Hackney police led to the opening of one of the few police stations on a hospital site. It is a source of pride to the local people that Homerton is the hospital for the 2012 Olympic and Paralympic Games.

**Innovation** by the Trust, particularly in the area of the European Working Time Directive, has achieved wide recognition this year, with national bodies looking to see how Homerton achieved August 2009 compliance targets for trainee doctors two years ahead of the deadline.
This year we have continued to develop our Electronic Patient record and improve our data quality. Good clinical coding not only determines payment to the Trust through accurately coded activity, it is also fundamental to good patient care as it allows us to analyse and highlight areas of clinical variation.

We had a major **focus on measuring and improving** the experience of patients using the hospital. The Secretary of State for Health, Alan Johnson, visited the hospital in October 2008 to see for himself the Patient Experience Tracker (PET) work. We commissioned Ipsos MORI to carry out confidential interviews with patients to obtain a more detailed understanding of how they view our services so that we can better address their needs. Alongside this we continued to measure and monitor statistics which indicate levels of safety in the hospital, such as the hospital standardised mortality ratio, which at 99 provides confidence that the hospital is a safe place to be treated.

We continue to strive to develop improvements in **dignity for patients**. In the autumn we worked with the Older People's Reference Group, City & Hackney PCT, the Mental Health Foundation Trust and the London Borough of Hackney to draw up an older People's Dignity Code. At the time of writing the initiative has won the partnership category in the London regional finals of the Health & Social Care Awards and is now being put forward for the national award.

**Teaching and research** continue to be strong. We have actively participated in the Central London Clinical Local Research Network. Homerton is a member of the proposed North East London Health Innovation and Education (HIEC), a partnership of local universities and NHS trusts working collaboratively to promote excellence and innovation in the planning and delivery of education and healthcare.

## Challenges and disappointments

These are just some of our successes. There is more that we could add, and of course, there have been disappointments and issues that we have had to address during the year.

In December 2008 we received a Hygiene Code Compliance Improvement Notice from the Healthcare Commission (HCC). This was major concern for us. Whilst we have always achieved our targets for hospital acquired infection rates, we did not have evidence of policies, procedures, audits and training programmes that the HCC required – we do now, and we should have done then. This was a failing on our part. On a positive note the improvement notice was lifted within three months and we received unconditional HCAI registration.

Homerton along with other London hospitals worked with the HCC this year to try and better understand why responses to the postal questionnaire that the HCC use to measure patient satisfaction across the country tend to reap low response rates and poorer results for London. The response rates for Homerton patients are almost the lowest rates in the country. As stated above we have compensated for this by using tools such as the PET and interview surveys to gain a more detailed understanding of patients' views.

## Looking forward

In the year ahead we will focus on three areas; productivity gains; quality measurements and improvement; and strategic positioning. Our 2009/10 corporate objectives are as follows:

**Productivity and efficiency:** to deliver a level of efficiency and productivity sufficient to sustain the organisation

**Quality and risk:** to achieve strong performance against selected quality metrics, national targets and regulatory requirements

**Strategic direction:** to develop a vision and plan for the future that is realistic, achievable and allows for the future success of the Homerton.

In shaping and agreeing these areas for focus with stakeholders there has been little dissent. The changing economic climate is recognised by all and strong and definite action needs to be taken now in preparation. However, if quality is to be maintained and enhanced, as it must be, it is only through measure to improve productivity and efficiency that this can be achieved. It is also why it is more important than ever to be able to measure and have evidence of quality, hence our focus. Healthcare is never a static business. Change can be evolutionary and emergent or it may be planned and structured. Review of health services in London is bringing a more structured approach to strategic change in the capital and Homerton will actively, purposely and constructively respond and participate in these programmes of change.

We remain deeply indebted to our staff for all they do. It is encouraging that so many of them responded to the national staff survey, and reported positively about their work. We absolutely could and should do more for the people that work here, and the decision made this year to establish a dedicated Workforce Director post reflects this.

Our Council of Governors has as ever steered us ably through the year, acting as the ears and eyes of the people we serve and never letting us forget why we exist, or for whom.

Against a range of measures, 2008/9 has been a good and productive year for us. There is no doubt that foundation trust status has played a major part in our success and we are grateful for the opportunities afforded to us over the last five years through it.

## Board of Directors

The Board of Directors has wide ranging experience and provides strategic direction and leadership of the hospital. Details are included in the Governance section of the report. In 2008/09, its membership consisted of the following executive directors:

## Executive Directors

Chief Executive, Nancy Hallett; Medical Director, John Coakley; Director of Corporate Development (until December 08), Chief Nurse and Director of Governance (from December 08), Pauline Brown; Finance Director, Anna Anderson; Chief Operating Officer, Tracy Fletcher (until November 08); Director of Nursing, Guy Young (until October 08); Chief Operating Officer, Simon Weldon, (from February 09); Director of Human Resources and Environment, Andrew Panniker.

## Non-Executive Directors

Chairman, Michael Cassidy; Deputy Chairman, Ian Luder (until November 08); Deputy Chairman, Eric Sorensen (from November 08); Stephen Hay, Michael Keith, Imelda Redmond (from April 08), Christopher Griffiths (from April 08) and David Stewart (from November 2008) - see the Good Governance section for further information.

**Nancy Hallett OBE, Chief Executive**

# Operating and financial review

This section of the report covers our financial, operational and clinical performance during 2008/09. We look back on our development and performance and highlight the principal risks going forward.

## Our financial performance

The Trust had a very successful year financially, achieving a year-end surplus of £3.7m which was £1.7m better than the planned surplus of £2.0m. Liquidity was also better than expected with a year-end cash balance of £18.3m. The final Monitor financial risk rating was 4, which represents the second best risk rating possible.

Overall patient activity income was above plan. The Trust over-performed on elective and outpatient activity, particularly in surgical specialties, both for City and Hackney PCT, our main commissioner, and other PCTs. Non elective activity and income were below planned levels, but similar to actual activity in 2007/08. Non patient activity income was also above plan for education and training, services provided to other Trusts and interest earned on cash balances. In planning for 2009/10, the Trust has worked with City and Hackney PCT to model expected activity and to ensure that planned activity levels have been set at realistic levels.

On expenditure, there were activity-related overspends against surgical and diagnostic budgets, as well as increases in some other non pay costs including energy. The contingency budget allocated at the start of the year was largely unused and there was some slippage on funding earmarked for specific developments. For 2009/10, expenditure budgets have been reviewed and capacity plans have been developed and translated into budgets to bring these into line with contract activity.

A comparison of planned and actual financial performance in 2008/09 is shown below

| £m | 2008-09 Plan | 2008-09 Actual | 2008-09 variance |
|---|---|---|---|
| **Income** | | | |
| - clinical | 145.9 | 152.5 | 6.6 |
| - non-clinical | 12.1 | 13.6 | 1.5 |
| Total income | 158.0 | 166.1 | 8.1 |
| | | | |
| **Expenses** | | | |
| - pay | -101.3 | -101.9 | -0.6 |
| - non pay | -45.1 | -51.7 | -6.6 |
| Total Expenses | -146.4 | -153.6 | -7.2 |
| | | | |
| **EBITDA** | 11.6 | 12.5 | 0.9 |
| | | | |
| - Depreciation | -6.4 | -6.3 | 0.1 |
| - PDC Dividend | -3.5 | -3.5 | 0.0 |
| - Interest receivable | 0.6 | 1.3 | 0.7 |
| - Interest payable on loans | -0.2 | -0.2 | 0.0 |
| - Loss on asset disposals | -0.1 | -0.1 | 0 |
| | | | |
| **Net surplus** | 2.0 | 3.7 | 1.7 |

The Trust achieved its cost improvement target for the year of £3.8m. For 2009/10, the Trust aims to achieve £5.7m of cost improvements/contribution from activity growth and £4.7m of this has already been identified. A productivity and efficiency programme (PEP) has been established to identify and deliver the balance of £1m. The financial plan for the new year contains £0.5m funding agreed with City & Hackney PCT on a non-recurrent basis, to support 'invest to save' type schemes and to help deliver the PEP.

Liquidity has remained strong for two main reasons: a higher surplus than planned, and slippage on the capital programme. The capital expenditure slippage was mainly due to a delay in commencement of the perinatal development following a change in building contractor. As a result of the strong liquidity position, the Trust earned £1.3m interest on funds held on deposit, although falling interest rates in the latter part of the financial year mean that this level of investment income will not be repeated in 2009/10, and the plan for investment income has been reduced to £0.2m.

Capital expenditure in 2008/09 totalled £9m and the two biggest single projects were the perinatal scheme, £2m, and new facilities for the fertility department, £1.3m. The Trust also invested in introducing single sex wards for surgical patients, medical equipment, IT and the upkeep of buildings.

The Trust complied with the cap on private patient income and will continue to do so in 2009/10. Looking ahead to 2009/10 and beyond the Trust needs to prepare for the impact of the economic downturn and the reduction in resources for the NHS. The Productivity and Efficiency Programme will be key to this and we are looking at the areas where there is scope to improve efficiency as well as areas where clinical practice can change.

## The main financial challenges next year and beyond are:

- understanding referral patterns and ensuring that all activity is coded accurately so that all income due is recovered
- identifying and achieving cost improvements and efficiency gains
- the potential impact of the North East London Provider Landscape Review and the possible reconfiguration of services and organisations that might emerge from that.

Having assessed the risks ahead, and in the light of strong financial performance in recent years, the directors of the Trust have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason the directors continue to adopt the going concern basis in preparing the accounts. The accounts included in this document have been prepared under a direction issued by Monitor. Accounting policies for pensions and other retirement benefits are set out in the accounts and details of senior employees' remuneration can be found in the remuneration report.

## The development and performance of the Trust during the financial year

**Table 1 Activity 2008/09**

| Patient Activity Figures | 2008/09 |
|---|---|
| Elective spells | 14,049 |
| Non-Elective spells * | 23,456 |
| Outpatient attendances | 192,119 |
| A&E Attendances ** | 109,032 |
| Other *** | 834,690 |

* Includes 4,747 babies born
** Includes c. 34,000 PUCC attendances
*** comprised of non-PbR services including:
- Intensive Care Bed Days (Adult and Neonates)
- Stroke and Specialist Rehabilitation
- Diagnostic Imaging

Homerton over-performed on elective and outpatient activity, particularly in surgical specialties, while non-elective activity and income were below planned levels but similar to the previous year's out-turn. This year the number of elective surgical procedures that the Trust provided rose by seven per cent and in the year ahead, this growth is expected to continue, particularly in specialist services.

Outpatient activity also increased, particularly in the medical specialties of Cardiology, Dermatology, Neurology, Respiratory and Rheumatology. The cumulative growth in referrals across all specialties during 2008/09 was 28 per cent. Ongoing growth is expected for 2009/10 particularly in specialties where active joint-working is occurring with GPs through Practice Based Commissioning (PBC) initiatives. This will consequently necessitate an increased focused on capacity management in order to deliver the twin goals of increased activity levels and maintenance of low waiting times.

There were 4,747 babies born which equates to a decrease of 190 on the previous year. We suspect there are two reasons for this; a decrease in the local birth rate; and publicity about new facilities in adjoining areas. We are developing a plan to promote the new delivery suite and neonatal unit due to open in early 2010. In the coming year, we anticipate in the region of 5,000 births with a further increase after that.

## Our operational performance

Homerton strives to deliver clinical and operational excellence for all patients and improve our performance. We have made significant progress in reducing our waiting times for patients whilst providing quality care in a safe environment. We do not know at the time of writing whether this breach coupled with the one breach we had of the 28 day cancellation target (relating to the adverse weather conditions) will affect our excellent rating for service quality but we do know that all other key target were confidently achieved with particular praise gained for short wait times for elective patients. We had some diagnostic breaches and we await final confirmation of the cancer targets following the introduction of new standards in cancer care.

Performance against key patient targets
The Trust performed strongly in 2008/09 and hit all access targets and standards. The following table sets out performance against our main targets:

| Key Performance Indicator | 2008/09 | Target Performance |
|---|---|---|
| A&E patients seen < 4hrs | >98% | 98.5% |
| Cancer Waiting List 2008/09 Q1-Q3 YTD | | |
| 2 Week Wait | >98% | 99.0% |
| 31 Day Target | >98% | 100.0% |
| 62 Day Target | >95% | 96.0% |
| Cancer Waiting List 2008/09 confirmation of Q4 awaited | | |
| Inpatient Waiting List < 26weeks | 100% | 100.0% |
| Outpatient Waiting List < 13 weeks | 100% | 100.0% |
| 18 Week Referral to Treatment (RTT) Indicator | | |
| Admitted | >90% | 95.2% |
| Non Admitted | >95% | 98.8% |
| Rapid Access Chest pain (RACP 2 Week Wait) (Q4 2008/09) | >98% | 99.0% |
| Infection Control | | |
| MRSA | <12 | 11 |
| C-Diff | <58 | 50 |

## Reducing your wait: 18 week milestone achieved

The Trust continued to work to reduce the wait for patients and achieved eight months early, the milestone for 18 weeks from referral to operation. This achievement was recognised by the Department of Health when Minister of State Ben Bradshaw visited the hospital and met with staff to congratulate them on their achievement.

- Our average waiting time for a first outpatient appointment is 3 weeks
- Our average waiting time for a surgical operation is less than 5 weeks
- We met the 18 week target 8 months early
- Our average waiting time for MRI, CT scan or Ultrasound is 3.5 weeks

Some of the innovative 18 week service developments that staff have delivered include:

- service improvement sessions with specialty clinical teams to map pathways and identify and reduce delays
- introduction of electronic recording of patient outcomes using our EPR system
- jointly agreed pathways between primary care and the hospital to reduce follow up appointments and increase the number of investigations carried out prior to referral
- speeding up the way in which we review and deal with results by using a variety of different methods such as telephone or paper review clinics
- introducing flexible outpatient and theatre sessions in order to meet patient demand
- introduction of one stop pre-admission clinics
- improved processes for booking surgical admissions

## Infection prevention and control

This has been and continues to be the highest priority for us. This year we failed to ensure full compliance with the HCC Hygiene Code and were issued with an Improvement Notice. We did not have all of the processes and procedures in place that the Code requires. We do now and should have done then. This was a failing but one that we rectified promptly and our period of non-compliance was of limited duration.

During the year we made significant investment in cleaning, training and audit revising our infection control procedures and processes and have retained our position as the hospital with one of the lowest rates of healthcare acquired infections. We are compliant with the new requirements to screen patients for MRSA.

We understand that patients are concerned about hospital acquired infections such as MRSA and Clostrdium difficile (C.diff) when they are admitted to hospital. Here at Homerton we are working hard to reduce the spread of infection. We have a proactive approach to preventing the micro-organisms that cause infections becoming established in the hospital and minimising their spread. Good hand hygiene is the single most important procedure in preventing cross infection. Good practice is a pre-requisite of all hospital staff - all Homerton staff undergo regular training and assessment in hand hygiene techniques.

## We are helping reduce rates by:

- making sure staff and visitors wash their hands and use alcohol gel
- prescribing antibiotics correctly as over prescribing can reduce resistance to MRSA and C. diff
- ensure that wards and equipment are cleaned thoroughly and checked regularly
- giving staff clear guidance on how to deal with infections
- monitoring rates of infection and taking action in poor performing areas
- isolating patients with infections.

## Principal risks and uncertainties

NHS London's Healthcare for London (HCL) and the North East London NHS Sector Review is in progress and has the potential to impact on all hospitals, including Homerton. The HCL review has led to the designation process for stroke and trauma services, which we have participated in. Completion of this process in North East London has been deferred pending the outcome of the North East London (NEL) Review. It is not yet clear what level of service reconfiguration will be proposed or whether changes to organisational configuration are to be considered. These reviews pose potentially significant opportunities and risks for Homerton. Across London mergers are taking place and the case for change in North East London may be considered.

The NEL review was initiated primarily to address issues relating to performance and quality within the context of HCL plans. Since that time the scale of the economic outlook has become starker and affordability has become a greater consideration. Our response to this is to make ourselves as effective and efficient as possible as measured by our cost improvement and productivity and efficiency programme outcomes. The Trust is well placed to meet these challenges, having delivered very strong service quality and financial performance over a number of years.

## Monitoring our performance

As a foundation trust, we are subject to a detailed regulatory framework led by Monitor (the independent regulator). Our internal compliance and performance management framework supports the operational business and ensures we manage all our activities and risks very closely. Monthly performance reports to the Board use a scorecard to report on indicators reflecting a range of standards, targets and risks to identify where improvement is needed and allows us to track improvement over time. Our performance framework allows us to identify concerns and secure action to improve performance in a timely and effective way. In the year ahead the Trust will respond to the new standards on cancer care and 18 weeks which will further improve the level of access that all patients can expect. The framework for assessing our performance will continue to become more sophisticated with an increasing focus on patient safety, the experience of patients and the outcome of clinical activities.

## Progress and innovation in our services

A commitment to improving the quality of patient care drives innovation and performance at Homerton. Strong clinical leadership is of fundamental importance and many of our service developments referred to here have come about because of strong clinical leaders.

# Key service developments

## New Perinatal Centre

In August 2008 work started on a purpose built, completely modernised facility that at a total cost of £12million it will provide state of the art facilities for pregnant women, new born babies and their parents. In January 2009 the first phase of the development completed with the opening of a newly refurbished 42 bed maternity ward.

In May 2009 we will complete 3 new en suite parenting rooms and kitchen. The new refurbished and extended delivery suite will open in early 2010. The number of beds in the delivery suite will increase from nine to sixteen. Four of the beds will be in a dedicated midwifery led care unit which will include two rooms with birthing pools. The new unit will also have a five bed obstetric assessment unit and designated high risk beds. The new unit will ensure that women will have the full range of support and facilities for the birth of their choice. Women and their babies at high risk of complications or poor outcomes will have access to expert services and specialist support, supported by neonatal services. Women at low risk of complications will have a range of options for care including full midwifery led care, a home birth service and other low risk midwifery care options for birth.

The newly refurbished and extended level 3 neonatal intensive care unit will also be complete in early 2010 and will have a total of 40 cots. The additional capacity has been created in recognition of the need within the North East London sector and the increasing demand we have experienced over the last 12 months. In addition to the additional cots the neonatal unit will increase in size making it 70 per cent bigger than the current unit. This additional space will provide the unit with significantly enhanced facilities for parents and families including residential facilities for parents, children's play area and counselling rooms; additional space for medical staff including expanded training facilities; a dedicated eye treatment facility and extensive environmental improvements to support the development of the babies.

## Service improvements in maternity

We have made some important improvements to our maternity services this year including:

- more community midwives providing more continuity in the antenatal and postnatal period along with the ability to offer more support postnatally
- funding to provide maternity support workers for the community
- 7 new midwives for the Delivery Suite to support 1:1 care in labour
- increase in ward establishment to allow 5 midwives per shift along with additional support staff
- increased funding for mandatory training of midwives
- more trainee supervisors of midwives
- improved environment for low risk birthing rooms and pool room including new lighting, mats, chairs and birthing balls
- refurbishment of our maternity ward.

## Fertility Centre

Our brand new Fertility Centre opened in September. The cost of the conversion work was £1.3million and involved the centre moving into the main hospital building. The new unit includes a state of the art laboratory and significantly improved patient waiting area counselling rooms and clinic rooms. Earlier in the year we also recruited a new consultant and a laboratory director, which coincided with the introduction of new techniques. As a result of these improvements the fertility unit is now consistently achieving an average pregnancy rate across all ages of around 40 per cent.

## Surgical services developments

This year we have seen an increase in day case and non elective activity for the surgical specialities during 08/09. Our Bariatric (obesity) service performed approximately 10 per cent of the country's surgical procedures in obesity. A new Surgical Centre was opened November 2008 to manage surgical admissions on the day of surgery more effectively and improve facilities for patients. The centre provides a one stop pre-assessment service where all patients are assessed prior to surgery and screened for MRSA.

## Stroke care

Service quality for stroke care was demonstrated by our achievement of good scores in the London review of stroke services. This year we bid to become a Stroke Unit and TIA service provider and we await the outcome of the provider review in North East London before our status is finalised. It is vital that we are designated as providing these kinds of services in order to preserve our status as a comprehensive provider of major rehabilitation services. We have already refurbished and provided the Stoke Unit with new equipment as part of this plan.

## New Chronic Obstructive Pulmonary Disease Service (COPD)

This year we won the contract to provide a community-based COPD service to the residents of City & Hackney. Focusing on avoiding hospital admissions and ensuring patients are discharged back to their homes as quickly as possible when an admission has to occur. The service brings together acute and community COPD care in an imaginative new service model.

## Community Diabetes Service

This year we introduced another community-based model in Diabetes whereby a new team of nurses and dieticians offer a combination of direct consultations, advice, training and support which improves the patients management. We are working hard to streamline patient pathways so that patients are seen by the right professional at a time and place of their choosing.

## Acute Care Team

2008/09 saw further refinements to the Acute Care Team (ACT) model first introduced in August 2007. This model of care enables us to provide greater continuity of care to acutely ill patients on the Acute Care Unit with a lead doctor providing support and guidance in the day to day running of the team on this exceptionally busy unit. The model has been instrumental in us exceeding European Working Time Directive (EWTD) targets for doctors ahead of the August 2009 deadline. Homerton is one of the few hospitals in the country to have achieved compliance with EWTD which limits the hours of a trainee doctor to 48 hours a week.

## Laboratory services

Our laboratory services have sustained year on year increases in activity this year. The department has invested in new technology to increase the range of in house tests and improve treatment times. Preliminary work has begun to modernise facilities and we expect to complete the design stages next year.

## Joint Clinical Leadership Programme

A successful joint clinical leadership programme has been firmly established this year. This has involved joint working between hospital consultants and practice based commissioners across a range of specialties to lead, implement and audit a programme of pathway development and review. Patient pathways are documented using Map of Medicine, an electronic tool which allows the agreed pathway to be shared amongst hospital and primary care clinicians. The programme has also developed different models of urgent care advice so that GP's have access where appropriate to a specialist hospital opinion without formal referral to hospital. This programme is continuing to go from strength to strength and reflects the good relationships that have been established between Practice Based Commissioners and the Homerton.

## Retinal Screening

This year an additional 3,500 diabetic patients were screened, representing a 25 per cent increase in activity. 2008/09 also saw a quality assurance visit from the National Screening Committee who praised the programme for its high clinical standards and an exceptional uptake rate. We are working closely with PCT colleagues as well as our main ophthalmology providers – Moorfields and Whipps Cross Hospitals to enhance the quality of care provided to diabetic patients in City & Hackney, and Redbridge. 2009/10 is expected to bring a further increase in activity in the region of 10 per cent as the diabetic population increases.

## Sexual Health Services

This year a great opportunity to strengthen our position as the dedicated Olympic Hospital arose when we were asked to provide sexual health care for workers on the Olympic site. We provided sexual health screens including HIV tests for the workers during their breaks. Following an evaluation of the initial pilot, the service has been mainstreamed and we now have fortnightly visits on the Olympic site. Patients receive the same quality of service that would be provided at Homerton and they are registered on to our electronic systems through use of remote computer technology. The Homerton Team are now seen as part of the Olympic Park Health Service.

## Services for children

Our Starlight Paediatric Unit celebrated its 10th birthday during 2008 and our paediatric ambulatory model of care continues to be a great success. Homerton has recently been recognised as a centre of excellence for this model of caring for children. The NHS Institute for Innovation and Improvement have highlighted the paediatric model of care at Homerton as a "beacon of excellence'" This has brought parties of clinicians and commissioners from around the country to visit and learn about the success of this model of paediatric care at Homerton.

## Information technology innovation & EPR

Our electronic patient record (EPR) completed a successful code upgrade in the autumn. The upgrade provides additional functionality allowing us to develop the system further over the next few years. We are also a pilot site for phase 2 of Connecting for Health's "Clinical Dashboard" programme. A dashboard is already established in the Emergency Department and shows waiting times and A&E performance for patients and staff to see. Phase 2 of the pilot will establish clinical dashboards in theatres and on two acute wards. During 2008/09 The Homerton continued to receive regular visits from other hospitals both from the UK and abroad to hear about the success of our EPR system and to learn from our implementation.

## Mixed sex accommodation

We understand how important single sex accommodation is to our patients and this year we have worked hard to increase our single sex accommodation. Following a ward refurbishment programme we have been able to create a 28 bed male surgical ward and a 24 bedded female surgical ward. We were unsuccessful in securing national funding to improve our facilities but we remain committed to creating additional single sex wards in the coming year despite our environmental challenges and constraints.

## Research and development

We have a significant Research and Development (R&D) base at Homerton. We encourage and support research studies in areas of local relevance for example HIV, respiratory disease, neurorehabilitation and neonatal care. We continue to work with other local providers to capitalise on the funding opportunities available and secure future research and academic development at Homerton. This year we have started work on a new Research and Development Strategy and we hosted an excellent research event which showcased a range of innovative projects and developments. In 2008/09 we had 95 research projects underway and 63 published research reports. The studies highlighted below have led to improvements in the quality of care for our patients.

- Crack cocaine as a risk factor for Tuberculosis (TB)
- Vitamin D deficiency in patients with TB
- Immunospot screening for TB infection in HIV positive individuals
- quality of life of women using our Pelvic Floor Dysfunction service (PFD)
- PFD service redesign and a new streamlined care pathway for women using the service

## Education and training

As a teaching hospital, Homerton continues to enjoy an excellent relationship with our partner academic institutions; Queen Mary College University of London, University College London and City University. The link between the hospital and the universities creates an environment where good clinical practice, teaching and research flourish. We continue to receive good feedback from our trainees and from the London Deanery on the quality and provision of our post graduate training. This year we have secured funding for some exciting education developments which will help us to provide clinical and technical skills training through use of simulation as a learning method.

# Working for our patients

## Listening and learning

**Healthcare Commission national patient surveys**
Homerton takes patient feedback very seriously and has a number of systems in place to measure this. This summer we introduced a number of significant additional measures to encourage more patients to complete and return the 2008 National Inpatient Survey. Despite this we received just 293 returns; at 36% amongst the lowest in the country and way below the national average of 60%. Conventional postal questionnaires present us with a particular challenge and may be of limited value in surveying satisfaction levels in young, inner City, ethnically diverse communities.

This year we have undertaken more detailed surveys of patients to provide information on the performance of specific areas within the Trust. The results of the 2008/09 survey showed a small improvement over the previous year, although there were still areas for improvement and we are addressing these. On a positive note we have improved our performance against many of the measures and the written comments from patients reflect this.

***"Whenever I needed assistance from the nursing staff I was always treated with the utmost respect and that nothing was too much trouble for them."***

***"I was treated with kindness and respect by all staff and I had confidence in their professionalism."***

***"The explanations about my treatment were clear and not condescending. When I didn't understand they even drew diagrams for me."***

## Patient Experience Tracker

Homerton is a national leader and award winner in the use of an electronic, real time survey device called the Patient Experience Tracker or PET. The results from PET tell us:

- 92% of patients said their privacy and dignity was respected
- 91% said they felt included in discussions about their care
- 90% said that staff were friendly, approachable and sensitive to their needs.

Whilst these figures are good we accept that there is still much to do and that for some patients their experience could be much improved. We will continue our focus on delivering demonstrable year on year improvement for our patients.

## A few key facts about PET:

- we received 28,000 responses since we started using PET; averaging around 1,200 per month with over 5,000 responses for the period covered by the national postal survey
- we received 14,628 hits in the 2008/09 financial year
- we are seen as national leaders hosting a national conferences and workshops.
- we report the findings to clinical teams, the Governors and the Board.

## Complaints handling

This year the Trust received 217 complaints compared to 145 formal complaints received last year. Whilst a higher number than last year, it is much lower than in comparator groups nationally. 134 of the 217 were answered within 25 working days. We take complaints very seriously and actively try to resolve issues quickly and locally.

Our Patient Advice and Liaison Service (PALS) received 941 enquiries this year including suggestion cards. The top three issues highlighted were; information, staff attitude and communication. During the year the Trust continued to review services in light of complaints and made several service improvements in response to comments received including:

- a new queuing system in the radiology department
- gluten free products made available in restaurant and Café for the public
- revised wording on blood sample forms explaining opening times
- new bereavement service pilot.

## Getting involved

Foundation Trust Members continue to play an important role in planning and developing services by being directly invited to take part in a number of activities. There is a wide spectrum of membership involvement from information giving to more formal consultation. Some examples are given below:

## Privacy & dignity curtains

A new prototype curtain was presented at a Members Matters lecture with over 20 members providing feedback and comments. These were piloted and tested on Templar maternity ward before being rolled out to other wards.

## Jewish community forum

This very active forum has been key in providing feedback from our local orthodox Jewish community members about their experiences of using the hospital. An important development has been the provision of a flat for community members needing overnight accommodation.

**Service users** have worked with us to provide feedback on specialist services throughout the year for example

- Regional Neuro Rehabilitation Unit famliy and friends support group
- ENT service pathway user survey
- patient satisfaction surveys for Orthopaedic outpatients, Urology, Colorectal and Gynaecological services.

## Working with partners / stakeholder relations

In planning and developing services to meet the healthcare needs of local people, Homerton has developed strong relationships with its partner organisations in health, social care and education. Particular recognition must be given to our host PCT - City and Hackney, our local authority - London Borough of Hackney, Corporation of London, neighbouring specialist and mental health trusts and the Metropolitan Police.

We have built on a culture of involvement and collaboration, with staff and stakeholders helping us to deliver a responsive service. Our elected Council of Governors, who provide the link between the local community and the Board, have helped us to shape our future making sure we serve our membership of patients, public and staff

The Trust is used to working with a range of partners across health and social care in order to improve patient care and deliver improved outcomes. We have a strong history of partnership working particularly in services for older people, vulnerable adults and children's services. This year we have continued to work within established clinical networks for maternity, cancer, TB and cardiac, providing a uniform approach to treatment supported by shared clinical guidelines.

## Health scrutiny

This year, along with other health providers, we have worked with Hackney's Health Overview and Scrutiny Commission and have participated in their reviews. Over the coming year we hope to further develop our relationship with the Hackney Local Improvement Network (LINk).

## Working together for healthy babies in Hackney

This year we have progressed the infant reducing mortality programme commissioned by Team Hackney, the local strategic partnership. This is helping to reach and support some of our most vulnerable pregnant women and their infants. Our innovative Reducing Infant Mortality Programme received national recognition in December when it won a Health Service Journal Award for reducing health inequalities. The service provides targeted maternity services to high risk groups and those that have traditionally not accessed maternity care, with the aim of reducing infant mortality. Interim findings from the research element of the project found that the programme has led to more breast feeding, earlier booking, better attendance at antenatal care and fewer emergency admissions for new babies. The success of the programme has been pivotal in our maternity services receiving significant additional funding from City & Hackney NHS to achieve the 'Maternity Matters' Standards.

Key elements of the scheme include:

- setting up the Hackney Maternity Helpline, which has taken more than 4,685 calls since it was set up in September 2007
- training Labour ward volunteers (known as birth buddies) and peer educators (known as bump buddies) have been trained to help local mums through pregnancy and delivery
- using bilingual maternity support workers to work alongside community midwives
- running a midwifery group practice in Shoreditch.

***"This programme is significant not only because its overall aim is of such fundamental importance to the population we serve, but also because it represents an innovative and hugely successful partnership. A partnership that works across team Hackney, the local NHS Trusts, the voluntary sector and City University and one that we believe will act as a template for the future when we are faced with similar complex problems."***

***Kate Costeloe, Professor of Paediatrics Queen Mary University of London, Consultant Neonatologist, Homerton University Hospital.***

## Working with staff

Homerton has over 2,200 directly employed staff. They are the Trust's most valuable asset and it is their skill, experience and commitment that underpins our ability perform. Our staff survey for 2008/09 which had over a 50 per cent response delivered clear indicators that staff really understand how their role contributes and makes a difference to patient care. Our staff feel supported by their managers and have a high level of job satisfaction.

## Learning and development

We offer comprehensive learning opportunities for all staff. We have a wide range of NVQ courses for administration, portering and patient care and staff can also access diploma, degree and masters programmes through our education contracts with City University. The Trust supports clinical placements for nursing, midwifery, allied health professionals and doctors in training. This year we have invested in externally supported leadership development programmes for our Clinical Directors with the aim of improving skills and developing succession planning. We are also reviewing our Nurse Leadership Programmes with specific programmes to be developed for matrons and ward managers. We have had problems this year monitoring compliance with mandatory training and put a comprehensive plan in place to put this right.

## Environmental matters

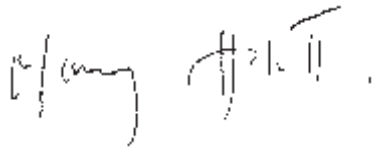
Validated PEAT inspections for 2008/09 have returned good scores for food, environment and privacy and dignity. Work commenced on the maternity and perinatal development in August 2008 and is due to complete in May 2010. Our fertility unit was relocated into refurbished premises at the front of the hospital and the new fertility centre opened its doors to patients in September 2008. Over the summer five wards were refurbished in conjunction with our drive to improve mixed sex accommodation. In addition the on-site Metropolitan Police Office officially build opened in September 2008 providing accommodation for up to 24 'neighbourhood' officers.

# Quality report 2008/09

## Quality narrative

This year we are introducing a quality report as part of the 2008/09 Annual Report and Accounts. This will enable the Board and the Governors to begin to understand what is required for the Quality Account in 2010. We will be reporting on the three quality domains of safety, clinical effectiveness and patient experience with a select number of indicators highlighted in each domain. These indicators are in addition to a core set of information defined by our reporting framework and required by our regulators and commissioners which we already measure and monitor. The Quality Account we publish in 2010 will be based on the measures we identify this year and will include: Care Quality Indicators, Commissioning for Quality and Innovation (CQUIN) targets, local targets and stakeholder priorities.

We welcome the drive for continuous improvement in the quality of care. We will continue to evolve our quality plans in response to benchmarking and direct feedback from stakeholders to ensure we deliver an ever improving service.



**Nancy Hallett OBE**
**Chief Executive**

## Quality objectives 2008/09

This year we have measured our quality performance against selected indicators. Emphasis has been given to reducing harm, developing programmes to ensure effective treatment with good outcomes and improving the patient experience.

## Safety measures

- number of serious untoward incidents resulting in harm
- number and rate of falls per 1,000 bed days
- number of medication errors
- further reduce our MRSA and C.difficile infection rates

## Clinical outcome measures

- Hospital Standardised Mortality Rate (HSMR) less than 100

## Patient experience measures

- reported response to overall do you feel you were treated with dignity and respect (PET, Patient Survey)

## Quality overview 2008/09

For this first report we have chosen to measure our performance against a small number of metrics in order to compare performance over time. Our priority has been to continue to reduce the number of MRSA and C.difficile infections which we were successful in achieving. Tighter policies, increased infection prevention and control monitoring and a focus on restricted antibiotic prescribing helped us to achieve excellent results and low numbers of infections.

Another major achievement has been the achievement of the 98% 4 hour Accident and Emergency target and excellent results from the National Emergency Department Survey. Patients using Homerton A&E expressed a high level of satisfaction with our services. Achieving this target represents a safe and effective pathway and a good patient experience.

We are publishing our Hospital Standardised Mortality Rate (HSMR) for the first time in this quality report. We routinely collect this data and recognise that this information is important to patients. This year we also report on the number of falls and medication errors

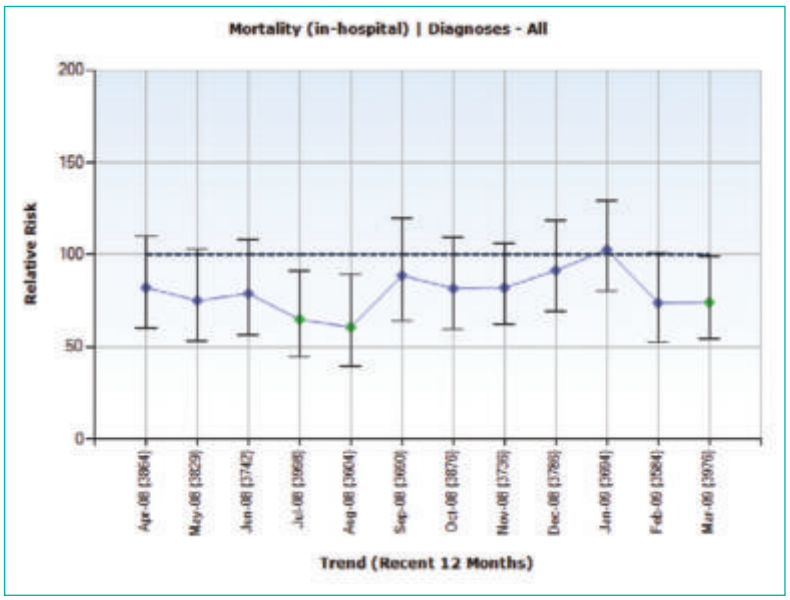
## Patient survey results

Our response rates to the Healthcare Commission National Patient Survey remain low as indicated below.

| | |
|---|---|
| 2008 | 293 (36%) |
| 2007 | 331 (39%) |

It was disappointing not to have seen an increase from 2007 as we had written to every patient discharged during July and September encouraging them to respond should they receive a survey. We had also undertaken additional work to increase response rate by offering online access. This meant that an additional 500 patients were contacted. Whilst we have not improved on last year's performance nationally, we have improved on our 2007/08 position. Work has already started on an action plan to address the issues identified.

| Homerton Quality Metrics | 2008/09 | 2007/08 |
|---|---|---|
| **Safety measures** | | |
| Medication errors | 299 | 281 |
| Number of falls | 593 | 612 |
| Serious untoward incidents resulting in harm | 7 | 13 |
| **Clinical outcome measures** | | |
| Hospital Standardised Mortality Rate (HSMR) less than 100 (see chart below) | 80.3 | 97.7 |
| **Patient experience measures** | | |
| Overall do you feel you were treated with dignity and respect (Patient Survey scores) | 93% | 92% |




**Note: this demonstrates actual outcomes measured against predicted. If all patients who were expected to die did so, the relative risk would be 100.**

| National targets and regulatory requirements | 2008/09 | 2007/08 | 2008/09 Target |
|---|---|---|---|
| **Compliance with 24 HCC core standards.** | 22 out of 24 | 24 | |
| A&E patients seen < 4hrs | 98.5% | 98.2% | 98% |
| Cancer Waiting List 2008/09 Q1-Q3 YTD | | | |
| 2 Week Wait | 99.0% | 100.0% | 98% |
| 31 Day Target | 100.0% | 100.0% | 98% |
| 62 Day Target | 96.0% | 97.0% | 95% |
| Cancer Waiting List 2008/09 confirmation of Q4 awaited | | | |
| Inpatient Waiting List < 26weeks | 100.0% | 100.0% | 100% |
| Outpatient Waiting List < 13 weeks | 100.0% | 100.0% | 100% |
| 18 Week RTT Indicator | | | |
| Admitted | 95.2% | 95.3% | 90% |
| Non Admitted | 98.8% | 97.8% | 95% |
| RACP 2 Week Wait (Q4 2008/09) | 99.0% | 98.9% | 98% |
| **Infection Control** | | | |
| Clostridium Difficile year on year reduction | 50 | 89 | 58 |
| MRSA – maintaining the annual number of MRSA bloodstream | | | |
| infections at less than half the 2003/04 level | 11 | 11 | 12 |

# Externally raised challenges

## Hygiene Code Action Plan

Homerton declared compliance against 22 of the 24 core Standards for Better Health in the Healthcare Commission's annual health check declaration for 2008/09. We breached the Hygiene Code and declared non-compliance in year against core standards C4c in relation to decontamination facilities and C4a in relation to standards of hygiene and cleanliness. We were served with an improvement notice for failing to observe the Hygiene Code in respect of four duties. An action plan was developed in response which focused on:

- sources of assurance to the Board
- audit of Trust Infection Control policies
- decontamination of equipment and cleaning of frequently touched items
- compliance with mandatory infection control training.

We were re-inspected in February 2009 and the Improvement Notice was lifted and we received unconditional HCAI registration.

## Quality Plans 2009/10

The quality measures identified for 2009/10 are derived from a range of sources. They have been developed from externally raised challenges and in response to what matters for patients. For example, mortality is widely accepted indicator of quality of care. Healthcare acquired infection and hygiene are important concerns for our commissioners, governors and patients. The development last year of infection prevention and control metrics and reporting these to the Board was a major contributor to improving compliance with the Hygiene Code. We have done considerable work this year to introduce a new falls pathway and we want to further develop clinical outcome measures this year. Other indicators reflect public concern, information gathered from reported incidents and stakeholder feedback. We hope to make considerable progress to improve quality during 2010/11.

One of our key objectives for 2009/10 in relation to quality and risk is to achieve strong performance against selected quality metrics, national targets and regulatory requirements and to achieve continuous quality improvement. To achieve this we have outlined our primary goals and deliverables in relation to safety, effectiveness and patient experience.

## Safety

**Primary goal:** Safety of patients, staff and visitors.
**Key deliverables:**

- target reductions in healthcare associated infections
- maintain NHSLA CNST level 2 for acute care and maternity standards
- CQC registration and compliance with the Hygiene Code
- reduction in number of falls as measured by Falls Care Pathway (commissioner CQUIN stretch target)
- National Patient Safety (NPSA) Peri Operative Care initiative

## Clinical effectiveness

**Primary goal:** Effective treatment with good outcomes.
**Key deliverables:**

- stroke care (commissioner CQUIN stretch targets)
- systems in place to collate and audit data.
- national audit compliance
- Hospital Standardised Mortality Rate (HSMR) less than 100

## Patient experience

**Primary goal:** A good experience for patients and staff
**Key deliverables:**

- a good experience for patients and staff with improved patient and staff satisfaction as measured by a range of patient feedback mechanisms
- review and redesign outpatients to maximise efficiency and improve the patient experience
- maternity services (commissioner CQUIN stretch targets)
- deliver action plan on patient and staff survey results
- develop "Ward to Board" key quality improvement metrics to include:
  falls assessment
  pressure sore incidence
  privacy and dignity
  infection prevention and control
  medicines administration
  food and nutrition
  patient observations
  pain management
- introduction of Patient Reported Outcome Measures (PROMS)

# Good governance

The following sections of the report illustrate how the Trust applies the main and supporting principles of the NHS Foundation Trust Code of Governance.

The Trust is compliant with the principles and provisions of the Code in all but two areas;

**Balance and independence of the Board of Directors:** At least half the Board comprises independent Non-Executive Directors including the Chairman. The balance of skills and experience is appropriate for the requirements of the business and is kept under review.

**Chief Executive terms of appointment:**
The Chief Executive has a permanent NHS contract and is not subject to re-appointment every five years.

**The Council of Governors**
Our Council of Governors was established on 1 April 2004. The Governors act as a link between the Board of Directors and the membership.

The opinion of the Council of Governors is sought by the Board of Directors on key strategic issues. The Council of Governors discusses issues in detail at its meetings and advise the Chairman of their views. The Chairman ensures that these views are considered at the Board of Directors meeting as part of the decision-making process. The Council of Governors and the Board of Directors meet jointly twice a year. The agendas developed for those meetings reflect the issues both parties need to discuss. In particular the joint meeting enables board members to hear directly the views of Governors and members. In addition the Governors held three meetings in public, three seminars and hosted the Annual Members Meeting.

Should a dispute between the Council of Governors and Board of Directors occur, the Chairman in the first instance will endeavour to resolve it. Should this fail, the Senior Non-Executive Director and the Vice Chairman of the Council of Governors will together attempt to resolve the issue. Should the Senior Independent Director and the Vice Chairman of the Council of Governors fail to resolve the conflict, the Board of Directors, pursuant to section15(2) of schedule 7 of the Act, will decide the disputed matter.

We are committed to embedding transparency and accountability throughout the Trust, and believe that our engagement policy should resolve any matters whereby the Council of Governors would need to inform Monitor of any potential breach of the Terms of Authorisation. However, as the Board of Directors are required to report to Monitor on matters of any potential breach of their Terms of Authorisation at the earliest practicable opportunity, we do not foresee the circumstances whereby it would be necessary for the Governors to have to inform Monitor of any possible breaches.

Public and staff Governors are elected by the membership. Elections are held in accordance with the election rules, as stated in the constitution, using a single transferable vote system. Elections for one staff governor, three governors to the Hackney public constituency and one governor to the Outer constituency were held in 2008/09, to replace those governors who had completed their term of office in accordance with the transition schedule. The election was administered on behalf of the Trust by the Electoral Reform Services Limited.

The Council comprised of 26 Governors under the leadership of Chairman Michael Cassidy. The Governors are listed below:

| **Governors** | **Constituency** | **Remaining term of office (years)** | **Attendance at CoG meetings held in public** Number of meetings attended out of 5 (unless otherwise stated): |
|---|---|---|---|
| Michael Cassidy | Chairman (Chair) | Appointed | 5 |
| Angus Mulready-Jones | Public: Hackney (from Sep 07) | 2 | 0 |
| Anna Tatton | Public: Hackney (from Sep 07) | 2 | 2 |
| Eli Kernkraut | Public: Hackney | 2 | 3 |
| Florence Osaigbovo | Public: Hackney | 1 | 5 |
| Doug Hiza | Public: Hackney | 3 | 2 |
| Sue Goodship | Public: Outer | 3 | 1 of 1 |
| Helen Scher | Public: Hackney | 1 | 3 |
| Joe Lobenstein MBE | Public: Hackney | 2 | 3 |
| Katie Lloyd-Thomas | Public: Hackney | Sep 08 | 1 of 2 |
| Patricia Bennett | Public: Hackney | 1 | 3 |
| Sarah Weiss | Public: Hackney | 3 | 5 |
| Suri Friedman | Public: Hackney (from Sep 07) | 2 | 5 |
| James Torr | Public: City | 1 | 4 |
| Geoffrey Rivett | Public: City | 2 | 4 |
| Ezendu Ariwa | Public: Outer | 1 | 0 |
| Jonathan Sibley | Public: Outer | Sep 08 | 0 of 2 |
| Dr Mary Britton | Staff: Clinical | Sep 08 | 1 of 2 |
| Dr Paul Cannon | Staff: Clinical | 1 | 4 |
| Andrew Williams | Staff: Clinical | 1 | 3 |
| David Griffith | Staff: Non-clinical (from Jan 08) | 2 | 3 |
| Jamie McFetters | Staff: Non-clinical (from Jan 08) | 2 | 2 |
| Dr. Helen Cugnoni | Staff Clinical | 3 | 2 |
| Dr Swee Fang | Staff: Clinical (from Jan 08) | 2 | 4 |
| Councillor Nargis Khan | Partner: Hackney Council | 2 | 0 |
| Professor Chris Fowler | Partner: Medical School | 2 | 1 |
| John Bennett | Partner: Corporation of London | Until March 09 | 4 |
| Marian Goodrich | Partner: PCT | 2 | 0 |
| Dr Lesley Mountford | Partner: PCT | 2 | 2 |
| Mary Watts | Partner: City University (from Aug 07) | Until March 09 | 0 |

A register of interests is maintained in relation to the Governors. This is available for viewing in the Foundation Trust Office.

## The Board of Directors

In accordance with the Constitution of Homerton University Hospital NHS Foundation Trust, the Board of Directors has seven Executive and seven Non-Executive directors including the chairman. The Board of Directors is accountable to the membership via the Council of Governors. The Board provides leadership to the hospital and sets the strategic direction of the organisation. The Board decides upon matters of operational performance, risk, assurance and governance. The composition of the Board is in accordance with the Trust's Constitution which is reviewed on an annual basis. Board members are invited to attend Council of Governor meetings and joint Board meetings are held twice a year to discuss strategic plans.

The term of office for Non-Executive directors is three years. Following this term and subject to satisfactory appraisal a non-executive director is eligible for consideration by the Council of Governors for a further uncontested incumbency of three years. The Chairman and Non-Executive Directors can also be removed by the Council of Governors. The appointment process is outlined in section 13 of the constitution. The removal of a Non-Executive Director requires the approval of three-quarters of members of the Council of Governors. Details of disqualification from holding office of a director can be found in the Constitution.

The Executive Directors hold permanent NHS contracts subject to NHS terms and conditions and are appointed by a Nominations Committee. Non-Executive Directors are appointed by the Council of Governors, following a rigorous process undertaken on behalf of the Council of Governors by the Nominations Committee.

The Board collectively considers that it is appropriately composed in order to fulfil its function and remain within Monitor's terms of authorisation. Brief details of each Director, their declared interests and their record of attendance at Board meetings are shown below. Non-Executive Directors meet the independence criteria laid down within the Code of Governance. The performance of Executive Directors is evaluated by the Chief Executive and Board members, and that of the Chief Executive and Non-Executives by the Chairman. The Governors appraise the Chairman on an annual basis. Board performance is also evaluated.

During the year the Board conducted a review of its committees and confirmed that each committee is fit for purpose and functions effectively.

## Members of the Board of Directors

The Board of Directors has seven Non-Executive Directors (including the Chairman) and seven Executive Directors (including the Chief Executive).

## Michael Cassidy, Chairman

Mr Cassidy has held the post of Chairman since December 2006. He was appointed by the Council of Governors to serve for a three year term. Mr Cassidy has been a City lawyer for 35 years. In addition, he has served on the Board of quoted property companies and UBS limited. Mr. Cassidy is also the Chair of the Museum of London. Mr Cassidy chairs the Remuneration and Nominations Committees. He is a member of the Risk Committee and also sits on the Trust's Charitable Funds Committee.

## Non-Executive Directors:

**Ian Luder** (until November 08) was appointed in June 2002. He is a chartered accountant and chartered tax adviser and was president of the Chartered Institute of Taxation in 1994/5. Ian Luder is now Lord Mayor of London. Mr Luder was the Senior Independent Non-Executive Director and Deputy Chairman. He sat on the Finance Committee and chaired the Risk Committee.

**Eric Sorensen** was appointed in September 2005. He is the Director of Central London Forward a sub-regional Local Authority partnership. He has worked on regeneration programmes and projects for many years. Mr Sorensen chairs the Finance Committee and was appointed as Senior Independent Director and Deputy Chairman following Ian Luder's departure. Mr. Sorensen is also a member of the Audit Committee.

**Stephen Hay** was appointed in August 2006. He is a self employed consultant. Prior to this he was a Managing Director at Goldman Sachs. Mr Hay chairs the Audit Committee.

**Michael Keith** was appointed role in February 2007. He is Professor of Anthropology at Merton College Oxford having previously been Professor and Director for the Centre for Urban and Community Research at Goldsmiths University of London. He was previously leader of the London Borough of Tower Hamlets. Professor Keith is a member of the Audit and Risk Committees.

**Imelda Redmond** was appointed in April 2008. She is the Chief Executive of Carers UK. Imelda is a member of the Audit Committee.

**Chris Griffiths** was appointed in April 2008. He is a Professor of General Practice at Queen Mary College, University of London. Professor Griffiths is also a Hackney GP. Chris is a member of the Infection Prevention and Control Committee.

**David Stewart** was appointed in October 2008. He is a fellow of the Institute of Chartered Accounts and a fellow of the Institute of Directors. Mr. Stewart was previously Head of Tax Practice at Deloitte. Mr. Stewart is a member of the Finance Committee and Chairs the Risk Committee.

## Executive Directors:

**Nancy Hallett, Chief Executive**, Ms Hallett has been Chief Executive since 1999. She joined the Trust in 1993. She was awarded an OBE in 2004 for services to health in Hackney. Ms Hallett sits on the Charitable Funds Committee.

**Dr John Coakley, Medical Director, Joint-Deputy Chief Executive**, Dr Coakley has been an intensive care consultant at Homerton since 1992. He became Medical Director of Homerton in 1998 having previously been Director of Postgraduate Medical Education. Dr. Coakley is currently joint Clinical Director to the North East London Provider Landscape Review. Dr Coakley sits on the Charitable Funds Committee.

**Pauline Brown, Chief Nurse and Director of Governance**, Joint-Deputy Chief Executive. Mrs Brown joined the Trust in 2000 as Director of Nursing and Quality and has a background in senior management and education. She was Director of Corporate Development until December 08.

**Anna Anderson, Director of Finance**, Ms Anderson has held this post since January 2008 having held finance director roles in a number of NHS organisations. After a period as Chief Executive of the Peace Hospice in Watford Ms Anderson returned to the NHS and undertook two interim finance director roles before joining the Trust.

**Andrew Panniker, Director of Human Resources and the Environment**, Mr Panniker has held this post since 2002, coming into the NHS from a private consultancy practice where he was the director responsible for surveying and architecture. Mr Panniker is a chartered surveyor by profession.

**Guy Young, Director of Nursing and Quality** (until October 08).

**Tracey Fletcher, Chief Operating Officer** (until November 08) Ms Fletcher is now working at East Kent University Hospitals as Chief Operating Officer.

## Register of Directors' interests

The following interests have been declared as currently relevant by members of the Board. The register is available for inspection by members of the public. Anyone who wishes to see the Register of Directors' interest should make enquiries to the Foundation Trust Secretary on 0208 510 7321. There has not been any material relationships that have influenced the individual Director's roles.

## Register of Directors' interests

| Name | Title | Interest declared |
|---|---|---|
| Pauline Brown | Chief Nurse and Director of Governance from Dec 08 | Trustee (unremunerated), Inspire, Dalston Lane Hackney: Education Business Partnership (Registered Charity) |
| Nancy Hallett | Chief Executive | Trustee (unremunerated) Paintings in Hospital (Registered Charity) |
| Imelda Redmond | NED | Vice Chair Contact a Family (Registered Charity) |
| Ian Luder | NED(until November 2008) | Partner, Grant Thornton Chartered Accountants |
| Stephen Hay | NED | Shareholder: Circle Health |

## Attendance at Board of Directors' meetings

| Name | Role | Attendance at BoD meetings Number of meetings attended out of a maximum of 11 (unless otherwise stated): |
|---|---|---|
| Michael Cassidy | Chairman | 11 |
| Ian Luder | NED (until November 08) | 5 of 5 |
| Michael Keith | NED | 7 |
| Stephen Hay | NED | 10 |
| Chris Griffiths | NED | 9 |
| Eric Sorensen | NED | 10 |
| Imelda Redmond | NED | 8 |
| David Stewart | NED (from November 2008 ) | 1 of 4 |
| Nancy Hallett | Chief Executive | 11 |
| Pauline Brown | Chief Nurse & Director of Governance (from Dec 08) | 10 |
| Guy Young | Director of Nursing (until October 08) | 3 of 7 |
| Tracey Fletcher | Chief Operating Officer (until November 08) | 6 of 6 |
| John Coakley | Medical Director | 11 |
| Andrew Panniker | Director of HR and the Environment | 11 |
| Anna Anderson | Director of Finance | 10 |

## Audit Committee

The Audit Committee's primary purpose is to conclude upon the adequacy and effective operation of the Trust's overall control system. It is directly accountable to the Board. Membership of this committee is four Non-Executive Directors, three of whom are independent Non-Executive directors with recent relevant financial and business expertise.

## Attendance at Audit Committee meetings

Number of meetings attended out of a maximum of 4 (unless otherwise stated):

| Title | Attendance at meetings |
|---|---|
| Stephen Hay NED (Chair) | 4 |
| Imelda Redmond NED | 3 |
| Eric Sorensen | 4 |
| Michael Keith NED | 2 |

## Auditors

The external auditors for Homerton are the Audit Commission, appointed by the Council of Governors in October 2007. The cost of work performed by them in 2008/09 was £53,000.

Audit Commission's accompanying report on our financial statements is based on its examination conducted in accordance with UK Generally Accepted Accounting Practices and the Financial Reporting Manual issued by the independent regulator Monitor. Their work includes a review of our internal control structure for the purposes of designing their audit procedures.

Non-audit work may be performed by the Trust's external auditors where the work is clearly audit related and the external auditors are best placed to do that work. For such assignments the Audit Committee approved protocol in followed which ensures all such work is properly considered. The processes in place ensure auditor objectivity and independence is safeguarded.

As far as the Directors are aware, there is no relevant audit information of which the auditors are unaware and that the directors have taken all of the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information to establish that the auditors are aware of that information.

## Nominations Committees

The Nominations Committee of the Council of Governors comprises public, staff and partner governors and is chaired by the Trust Chairman. Its purpose is to select the Chairman and Non-Executive Directors. In the case of recruiting a new Chairman, the Senior Independent Director replaces the current Chairman for interview purposes. The committee selects a candidate whose is appointed by the Council of Governors. The Nominations Committee of the Board of Directors comprises members of the Board of Directors and is chaired by the Chairman. This committee appoints the Chief Executive and Executive Directors of the Trust. Both committees work to common principles and share similar procedures.

## Nominations Committee of the Council of Governors

The Nominations Committee of the Council of Governors met in April 2008 to select two Non-Executive Directors and again in October 2008 to select a finance Non-Executive Director and to confirm Eric Sorensen as the new Senior Independent Non-Executive Director following the departure of Ian Luder.

Number of meetings attended out of a maximum of 2

| | | |
|---|---|---|
| Michael Cassidy | Chairman | 2 |
| Geoffrey Rivett | Vice Chair and Public Governor | 2 |
| Suri Freedman | Public Governor | 2 |
| David Griffith | Staff Governor | 1 |
| Patricia Bennett | Public Governor | 2 |
| John Bennett | Partner Governor | 1 |
| Andrew Williams | Staff Governor | 1 |

## Nominations Committee of the Board of Directors

The Nominations Committee of the Board of Directors met in November to appoint a Chief Operating Officer and in February 2009 to appoint a Workforce Director. Both appointments were supported by external recruitment agencies.

Number of meetings attended out of a maximum of 2unless otherwise stated

| | | |
|---|---|---|
| Michael Cassidy | Chairman | 2 |
| Eric Sorensen | Deputy Chairman, Senior Independent Director | 2 |
| Stephen Hay | Non-executive director | 2 |
| Nancy Hallett | Chief Executive | 2 |
| Pauline Brown | Chief Nurse | 2 |
| Simon Weldon | Chief Operating Officer | 1 of 1 |
| John Coakley | Medical Director | 1 of 1 |

# Membership

## Membership report

The Trust embraces the concept of a wide membership base, with no limit on the number of people who can register as members within the eligibility criteria increasing and involving the membership is led by the Membership Development Committee, through the Membership Development Strategy. Overall membership has increased over the past year.

| Membership | **At year start (April 1)** | **At year end (March 31)** | **Increase** |
|---|---|---|---|
| Public (Hackney and City) | 4214 | 4318 | 104 |
| Staff | 1449 | 1788 | 339 |
| Total | 5663 | 6106 | 443 |

The public constituencies – Hackney, City and Outer – are broadly representative of the areas from which the majority of patients come to Homerton.

Membership is open to any member of the public over the age of 16 who lives in the London Borough of Hackney, the City of London or the Outer area. The Outer constituency includes Tower Hamlets, Waltham Forest, Newham, Redbridge, Barking, Havering, Camden, Islington, Haringey, Enfield, Lambeth, Southwark, Westminster and Epping Forest District. There is no separate patient constituency.

Active membership is highest within Hackney. The staff constituency is divided into clinical and other staff categories. Any staff on permanent employment contracts or those who have worked at the Trust for at least 12 months, including contractual staff or those holding honorary contracts, are eligible to join.

## A representative membership

Our membership strategy for 2007-2010 sets out our vision for a representative and engaged membership. Five key objectives are set out:

- to increase the number of active, informed members who are representative of our patients and local community (a larger membership)
- to strive for the composition of membership to reflect the diversity of the local community (a diverse membership)
- to engage the local community through community visits to a wide range of groups and stakeholders (an inclusive membership)
- to ensure members receive appropriate communications to improve their understanding about the affairs of Homerton and its relationship with the local community (an inclusive membership)
- to ensure that Homerton is accountable for its performance to the members (an informed membership).

The public membership continues to be largely representative of the local population in terms of ethnicity and gender.

The Trust is able to closely monitor its membership through the membership database and the information supplied by the members on the application form. Ongoing analysis and review of membership enables the Trust to undertake detailed demographic analysis of the membership, and identify where gaps exist in recruitment.

The membership is broadly reflective of the ethnicity of the local population. Hackney and City 2001 Census data is used for comparison of the local population, as the majority of Homerton's patients live in the borough with the majority of public members in the Hackney constituency.

Members receive information about the hospital throughout the year.

## Get in touch

If a member of the public wishes to contact a governor they can do this through members@homerton.nhs.uk or by phoning the Trust Office on 020 8510 5221. A member of the team will then put the query through to a governor.

# Public interest disclosures

## Action to inform, involve and consult staff

We are committed to keeping staff fully informed about the organisation, its activities and policies. We know that for staff to be motivated and provide an excellent service we need to provide them with information, consult with them on key decisions and listen to their concerns. We have well established formal mechanisms to ensure the involvement of staff and staff side organisations on a wide range of issues, including service developments, new policies and updates on key matters relating to Trust business. We have kept staff and their representatives up to date with monthly chief executive "team briefs", staff bulletins, information sessions on specific issues and the newly revamped staff magazine Homerton Life. All briefings are available on the Intranet. The Intranet also plays a key role in keeping staff informed about developments within the organisation. The team briefing sessions which are disseminated throughout the Trust include summary information on quality, financial and economic factors affecting our performance. All our human resources initiatives are undertaken in partnership with our staff side colleagues. The Joint Staff Consultative Committee (JSCC) and the Local Negotiating Committee for doctors meet regularly to ensure the views of employees are taken into account when making decisions.

## Health and safety performance

The Trust has a proactive approach to Health and Safety. At ward and department level, designated risk officers implement Trust policy and ensure health and safety is applied locally. Training is provided for all staff. This year the Health and Safety Executive undertook a two day visit of the Trust in December to review Dermatitis issues in the Trust. We have an action plan in place to minimise the use of latex gloves and to improve health surveillance and treatment of dermatitis.

## Policies in relation to disabled employees and equal opportunities

We have an equal opportunities policy to ensure that there is no direct or indirect discrimination and to build a workforce whose diversity reflects the community we serve. We have published our Disability Equalities Scheme (DES) and action plan as part of a single equalities framework, which outlines how we will work towards equality for staff and service users. We will continue to review the scheme to ensure it reflects the views and involvement of those it affects.

A key aim of the DES is that disabled people have the same opportunities as other people to gain employment and promotion at Homerton. We have procedures in place, which satisfy all government legislation and best-practice relating to the employment of disabled people; ensuring as far as we possibly can that staff who become disabled continue in employment. Training and career development opportunities apply to disabled employees. The Trust has been accredited with 'two ticks' for being 'positive about disability', which demonstrates our commitment to supporting disabled people seeking employment.

## Occupational health performance

The service provides confidential occupational health services to all staff. A team of staff provide advice on health surveillance programmes, immunisation, investigation of work-related ill health and health assessment prior to and during employment.

The Occupational Health department saw 1,117 staff during the last calendar year. This included face to face contacts with staff, fitness for work assessments and screening for infectious diseases.

The department led on the development of Trust policies for areas including Tuberculosis for Healthcare Workers, Staff MMR, Legionella and a range of staff health policies.

## Counter fraud policies and procedures

The Trust has a Counter Fraud policy for dealing with suspected fraud and corruption, and other illegal acts involving dishonesty or damage to property. Nominated officers who staff can contact confidentially if they suspect a fraudulent act are the director of finance and the local counter fraud specialist. Bentley Jennison is the Trust's counter fraud specialists.

## Involvement and consultation

The Trust has a statutory duty to collaborate with partners in health and social care. Good partnership arrangements are in place. We have representation at the monthly Hackney Health Scrutiny Commission meetings, which are held in public, providing them with regular service and performance updates. Other partnership and public and patient involvement activities are detailed in the Operating and Financial Review section of the report.

# Remuneration report

## Senior managers' remuneration

For the purposes of this report the disclosure of remuneration to senior managers is limited to Executive and Non-Executive Directors of the Trust.

In accordance with the Constitution, the remuneration and allowances of Executive Directors were determined by a committee of the Non-Executive Directors of the Trust. In accordance with the Constitution, remuneration for the Chairman and Non-Executive Directors is determined by the Remuneration Committee of the Council of Governors.

The Council of Governors is responsible for setting the remuneration of the Chairman and Non-Executive Directors (NEDs). The Chairman and NEDs are responsible for setting the remuneration of the Chief Executive and Executive Directors. In accordance with the constitution, the Trust has two remuneration committees for this purpose. The Non-Executive Director Remuneration Committee is drawn from the Council of Governors and the Executive Director Remuneration Committee comprises the Non-Executive Directors and Chairman. Both committees work to common principles and procedures. Remuneration levels are set taking into account the requirements of the role, market rates, the performance of the Trust, internal comparability and afford-ability. No individual is involved in any decision that sets their own pay level. Both committees are supported by the Deputy Director of Human Resources who takes a key advisory role in terms of human resource and labour market issues. Both committees adopt the principles of good governance in setting remuneration, and take into account a wide range of pay guidance across other public sector organisations and relevant independent organisations to inform the process.

The Remuneration Committee advises on any major changes in employee benefit structure in the Trust and ensures that contractual terms on termination and any payments made are fair to the individual and the organisation. Both committees are authorised to obtain external or other professional advice on any matters within its terms of reference, with due regard to probity and cost. Both committees consider board performance and individual performance as part of the remuneration review. The Trust does not award performance bonuses.

Executive Directors are required to give six month's notice to terminate their employment contracts. Non-Executive Directors are required to provide one month's notice. All Directors have permanent contracts. Non-Executive Directors are appointed for a period of three years according to the constitution.

The Trust currently carries a provision of £125k for early retirements relating to ex-members of staff.

## Attendance at Remuneration Committee of the Council of Governors

The Remuneration Committee of the Council of Governors met in May 2008 to consider Non-Executive remuneration. The members of the Remuneration Committee of the Council of Governors for 2007/8 were as follows:

| Name | Role | Number of meetings attended out of a maximum of 1: |
|---|---|---|
| Geoffrey Rivett | Public Governor, Vice chairman, Council of Governors | 1 |
| Patricia Bennett | Public Governor | 1 |
| David Griffiths | Staff Governor | 1 |
| Suri Freidman | Public Governor | 1 |
| John Bennett | Partner Governor | 1 |
| Andrew Williams | Staff Governor | 1 |

## Attendance at Remuneration Committee of the Board of Directors

The Remuneration Committee of the Board of Directors met in April 2008 to consider Executive Director remuneration. The members of the Remuneration Committee of the Board of Directors were as follows:

| Name | Role | Number of meetings attended out of a maximum of one |
|---|---|---|
| Michael Cassidy | Chairman | 1 |
| Michael Keith | Non-executive Director | 1 |
| Eric Sorensen | Non-executive Director | 1 |
| Stephen Hay | Non-executive Director | 1 |
| Imelda Redmond | Non-executive Director | 1 |
| Chris Griffiths | Non-executive Director | 1 |

Salary and pension entitlements of senior managers are available in the accounts.

**Nancy Hallett, Chief Executive**

# Statement of Accounting Officer's Responsibilities

## Statement of the chief executive's responsibilities as the accounting officer of Homerton University Hospital NHS Foundation Trust

The Health and Social Care (Community Health and Standards) Act 2003 states that the chief executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the accounting officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

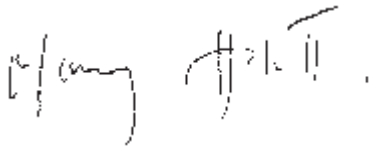
Under the Health and Social Care (Community Health and Standards) Act 2003, Monitor has directed the Homerton University Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Homerton University Hospital NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

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

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

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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



**Nancy Hallett**
**Chief Executive**
**June 3rd 2009**

# Statement of Internal Control

A copy of the Trust's statement of internal control is available in the full set of financial accounts.

# Accounts 2008/09

## Homerton University Hospital NHS Foundation Trust

# Contents

# Foreword to the Accounts

These accounts for the year ended 31 March 2009 have been prepared by the Homerton University Hospital NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 to the NHS Act 2006.

# Statement on Internal Control 2008/09

## 1. Scope of responsibility

The Board is accountable for internal control. As Accounting Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, while safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accountable Officer Memorandum.

As designated Accountable Officer, I am accountable to the Board for the implementation of risk management in the Trust. The Chief Nurse and Director of Governance leads on risk management issues at Board level whilst the Director of Finance has delegated responsibility for managing the strategic development and implementation of Financial Risk Management. Operational responsibility for risk management is assigned to the Risk Department. The Risk Committee, as a Board Sub-Committee, takes overall responsibility for co-ordinating and monitoring all risk issues within the Trust including considering reports from both internal and external sources. A number of sub-committees and working groups report to the Risk Committee on both clinical and organisational risk. Key risks are highlighted to and reviewed by the Trust Board either as part of its regular monitoring of performance (e.g. Board receives minutes of both the Risk and Audit Committee) or in the context of specific issues that arise.

There are extensive arrangements in place for working with stakeholders and partner organisations, including close working with the NHS London SHA, City & Hackney Primary Care Trust, other Primary Care Trusts (PCTs), the Council of Governors and the London Borough of Hackney. These cover both operational and strategic issues such as service planning and commissioning, performance management and clinical governance.

## 2. The purpose of the system of internal control

The system of internal control has been in place in Homerton University Hospital NHS Foundation Trust for the year ended 31 March 2009 and up to the date of approval of the annual report and accounts. The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives; and

- evaluate the likelihood of those risks being realised, and the impact should they be realised, and to manage them efficiently, effectively and economically.

A Board Assurance Framework including the principal risks to the achievement of the Trust's principal objectives was in place for the whole of the financial year and provided the basis for monitoring progress on the effectiveness of the management of the Trust's principal risks. The Assurance Framework has been reviewed regularly and updated through the year with the latest version reflecting the position at 31st March 2009.

Homerton University Hospital NHS Foundation Trust - Annual Accounts 2008/09

## 3. Capacity to handle risk

The Trust has ensured that risk management receives the appropriate leadership through the nomination of an Executive Director (Director of Nursing and Quality) to lead on these matters and a Non-executive Director to oversee its application as Chair of the Risk Committee. An overview of the leadership framework with regard to the risk management process is outlined in Section 1 above. In more detail:

- The Risk Committee, which has been established for a number of years, is chaired by a senior independent Director (NED) and its membership includes the chairman and Trust Executive Directors. The Risk Committee meets on a quarterly basis and reports to the Board of Directors.

- The Risk Committee is kept informed on all aspects of risk management by way of reports and minutes from the Clinical Governance and Modernisation Committee, Audit Committee, Finance Committee and the Risk Management Forum.

- The Heads of Clinical and Non-Clinical Risk report regularly to the Director of Nursing and Quality who has Board level responsibility for risk management issues.

- As required by the Trust's Risk Management Strategy and Policy, each Director is responsible for co-ordinating risk management processes within directorates including completion of regular risk audits and management of the directorate risk register.

The Trust is continuing to develop comprehensive risk registers at both Trust and directorate level. The Clinical Risk Manager is responsible for the maintenance of the registers. The risk registers are reviewed and validated on a monthly basis at the Patient Safety Committee.

Risk management training is delivered to all staff as part of induction; there is mandatory health and safety training for managers, and clinical directorates participate in clinical risk training days and clinical risk workshops. Designated departmental risk facilitators and risk officers are provided with two days of training to assist them in discharging their delegated responsibilities.

The Trust continues to carry out an annual exercise to capture both clinical and non-clinical risk data at directorate and departmental levels through its Local Risk Assessments. In addition, ongoing risk assessments form part of the departmental arrangements with regard to risk management. Best practice is highlighted and shared across directorates through directorate risk leads and both the Clinical Governance Committee and Health and Safety Committee and their respective sub-groups. Directorates report six monthly on clinical governance, including processes to manage risk, to the Clinical Governance Committee.

## 4. The risk and control framework

This section describes:-

- the key elements of the Trust's Risk Management Strategy including the way in which risk (or change in risk) is identified, evaluated, and controlled;

- the key ways in which risk management is embedded into the activities of the organisation;

- the elements of the Trust's Assurance Framework and how this provides the evidence to support the Statement on Internal Control;

- the way in which public stakeholders are involved in managing risks which impact upon them.

The Trust has a comprehensive Risk Management Strategy which is reviewed annually by the Risk Committee and approved by the Trust Board and is available to all staff through the Trust's intranet.

The Strategy and Policy describes the Trust's overall risk management strategy, corporate and directorate responsibilities for risk, the risk management process and the Trust's risk identification, assessment and control system. It includes guidance on the qualitative risk assessment matrix used to evaluate risks to facilitate inclusion on the Trust's risk registers.

## Embedding Risk Management

Risk management is embedded in the activities of the organisation through a number of channels:

- Both corporate and directorate objectives are risk assessed as part of the annual business planning and performance management process.

- Structured process for the completion of local risk assessments to populate the Trust's Risk Register.

- The Trust is compliant with the NHSLA standards for both its General and Maternity Services at Level 2.

- There are structured processes in place for incident reporting, the investigation of Serious Untoward Incidents (SUIs), complaints and litigation cases, and there is a Trust Major Incident Plan in place.

- The Executive Directors regularly review the Assurance Framework to ensure that appropriate action is being taken against key risks.

## Assurance Framework

As noted in Section 2, the Trust has an Assurance Framework which has been approved by the Trust Board. The Assurance Framework was based around the principal objectives set out in the Trust's 2008-09 Annual Plan and identified the principal risks to the achievement of those objectives, the key controls in place to manage those risks and the sources of assurance about the effectiveness of those controls.

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

The principal risks in the Assurance Framework are monitored and reviewed by the Risk Committee at each of its meetings and reports provided to the Trust Board on key issues arising. Many of the principal risks identified are monitored regularly through standing performance reports to the Trust Board.

## Information Governance

The Trust has established a process of information governance led by the Medical Director. Systems and processes have been reviewed, including using the Information Governance Toolkit, and the Trust declared in quarter 3 that these have complied with information governance guidelines and the Data Protection Act 1998. There are no Serious Untoward Incidents involving data loss or confidentiality isues during the year.

## Stakeholder Involvement

Stakeholders are involved in managing risks which impact on them through their involvement in and contributions to many aspects of the work of the Trust, including for example: "

### Patients and the public

The Patient Advice and Liaison Service (PALS).
The Trust's Patient and Public Involvement (PPI) Committee
Ongoing consultation and involvement from the Members of the Trust.
Ongoing consultation with the local community on Foundation Trust status.
The National Patient Survey Programme.
Public and co-opted Governor representation on the Council of Governors.
Hackney Local Improvement Network (LINk)

### Staff

The Annual Staff Survey.
Open meetings for staff with the Chief Executive.
Staff representation on the Council of Governors.
Joint Staff Committee (includes management and staff side representatives).
Local Negotiating Committee

### Health partners

Regular discussion of key issues and performance management arrangements.
Stakeholder membership of various Trust working groups which includes the Council of Governors.

The Health and Social Care Partnership Board, and membership of the Local Strategic Partnership.
Joint strategic planning meetings with healthcare partners.
Hackney Health Scrutiny Commission

## 5. Review of Economy, Efficiency and Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibilty for the development and maintenance of the system of internal control also provide me with assurance. The external auditors also provide comments in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and risk committe and a plan to address weaknesses and ensure continuous improvement of the system is in place. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

In addition, I am informed by the following:

- Reports from both the Internal and External Auditors and the Local Counter Fraud Specialist.
- Patient and staff surveys.
- NHSLA assessments
- The Trust's regular reporting to Monitor providing additional assurance with regard to compliance with our Terms of Authorisation.

The mechanisms outlined above also provide assurance about the economy, efficiency and effectiveness of the use of resources. Internal audit has an important role, as does the Finance Committee, to challenge how resources are used. The Trust also has an internal performance management review process which provides evidence of performance in individual directorates and actions being taken to ensure resources are being used effectively and efficiently. In addition the annual business planning process, including the requirement to identify cost improvements, provides another mechanism to achieve this aim.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Risk Committee, Audit Committee, Clinical Governance Committee and Finance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.
Key roles in reviewing the effectiveness of the system of internal control have been as follows:

- The Board has been actively involved in developing and reviewing the Trust's risk management processes including receiving and reviewing reports and minutes from the Risk, Audit, Finance and Clinical Governance Committees. The Board has also reviewed the Assurance Framework as well as monitoring performance objectives via the balanced scorecard.
- The Risk Committee has overseen the effectiveness of all the Trust's risk management arrangements including review and endorsement of the Strategy and Policy for Risk Management and the development Assurance Framework. The Risk Committee also monitors all key clinical and non-clinical risks highlighted by other committees from whom it receives reports (i.e. Audit, Finance, Clinical Governance and Health and Safety)."

- The Audit Committee has been a directing force in relation to reviewing the framework of internal control particularly with regard to corporate risk, counterfraud and the Assurance Framework.

- Executive Directors have ensured that key risks have been highlighted and monitored within their directorates and the necessary action taken to address them. Executive Directors were also directly involved in producing and reviewing the Assurance Framework.

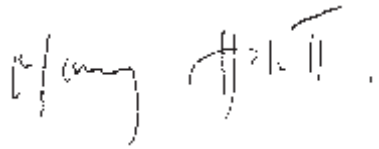
- Internal Audit have provided consistent support and advice with regard to the system of internal control including the development of the Assurance Framework.

- The Finance Committee is responsible for developing performance management and regulation, and of developing the Trust's longer term financial strategy.

- The Clinical Governance Committee is responsible for the governance and management of clinical risk.

Internal Audit's review of the Assurance Framework has reported the assurance framework provides reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the Trust.

As noted above, the Board Assurance Framework identifies gaps in control and gaps in assurance in relation to the Trust's principal risks and the actions being taken to address them.



**Chief Executive**

# Statement of Accounting Officer's Responsibilities

The National Health Service Act 2006 (the Act) designates the Chief Executive of the NHS Foundation Trust as the Accounting Officer. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by the Independent Regulator of NHS Foundation Trusts (""Monitor"").

The Act specifies that the Accounting Officer has the duty to prepare the accounts in accordance with the Act. An Accounting Officer has the personal duty of signing the NHS foundation trust's accounts. By virtue of this duty, the Accounting Officer has the further duty of being a witness before the Committee of Public Accounts (PAC) to deal with questions arising from those accounts or, more commonly, from reports made to Parliament by the Comptroller and Auditor General (C&AG) under the National Audit Act 1983.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS

Foundation Trust Financial Reporting Manual and in particular to:

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

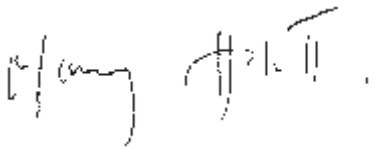
The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as the directors are aware there is no relevant information of which the auditors are unaware, and that the directors have taken all the steps they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

After making enquiries the directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason they continue to operate the going concern basis in preparing the accounts.

The annual accounts have been prepared by the Directors of the NHS Foundation Trust and reviewed by the Audit Committee. The Board of Directors adopts the accounts following recommendations by the Audit Committee and once it is satisfied that the accounts give a true and fair view of the Trust's state of affairs. The Board of Directors also consider going concern and sign the management representation letter.

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



**Chief Executive**

# Independent Auditor's Report to the Board of Governors of Homerton University Hospital NHS Foundation Trust

I have audited the financial statements of Homerton University Hospital NHS Foundation Trust for the year ended 31 March 2009 under the National Health Service Act 2006. The financial statements comprise the Income and Expenditure Account, the Balance Sheet, the Cash Flow Statement, the Statement of Total Recognised Gains and Losses and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described as having been audited.

This report is made solely to the Board of Governors of Homerton University Hospital NHS Foundation Trust as a body in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. My work was undertaken so that I might state to the Board of Governors those matters I am required to state to it in an auditor's report and for no other purpose. In those circumstances, to the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Foundation Trust as a body, for my audit work, for the audit report or for the opinions I form.

## Respective responsibilities of the Accounting Officer and auditor

The Accounting Officer's responsibilities for preparing the financial statements in accordance with directions made by the Independent Regulator of NHS Foundation Trusts (Monitor) are set out in the Statement of Accounting Officer's Responsibilities.

My responsibility is to audit the financial statements in accordance with statute, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland).

I report to you my opinion as to whether the financial statements give a true and fair view in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts. I report whether the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts. I also report to you whether, in my opinion, the information which comprises the Directors' Report; Operating and Financial Review; and Good Governance section, included in the Annual Report, is consistent with the financial statements.

I review whether the Accounting Officer's statement on internal control reflects compliance with the requirements of Monitor contained in the NHS Foundation Trust Financial Reporting Manual 2008/09. I report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information I are aware of from my audit of the financial statements. I am not required to consider, nor have I considered, whether the Accounting Officer's statement on internal control covers all risks and controls. Neither am I required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.
I read the other information contained in the Annual Report and consider whether it is consistent with the audited financial statements. This other information comprises the Chair's Statement; the Directors' report; Operating and Financial Review; Quality Report; and Good Governance. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

## Basis of audit opinion

I conducted my audit in accordance with the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor, which requires compliance with International Standards on Auditing (United Kingdom and Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements and the part of the Remuneration Report to be audited. It also includes an assessment of the significant estimates and judgments made by the directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that:

- the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error; and
- the financial statements and the part of the Remuneration Report to be audited have been properly prepared.

In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Remuneration Report to be audited.

## Opinion

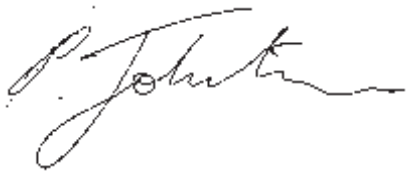
In my opinion:

- the financial statements give a true and fair view of the state of affairs of Homerton University Hospital NHS Foundation Trust as at 31 March 2009 and of its income and expenditure for the year then ended in accordance with the accounting policies adopted by the Trust;
- the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts; and
- information which comprises the Directors' Report;

Operating and Financial Review; and Good Governance section, included in the annual report, is consistent with the financial statements.

## Certificate

I certify that I have completed the audit of the accounts in accordance with the requirements of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.



**Phil Johnstone**
**Officer of the Audit Commission**
**First Floor**
**Millbank Tower**
**Millbank**
**London SW1P 4BR**
**5 June 2009**

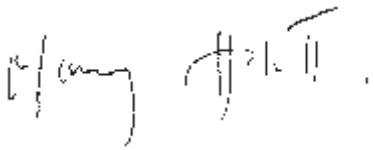
# Income and expenditure account for the year ended 31 March 2009

| | NOTE | 2008/09 £000 | 2007/08 £000 |
|---|---|---|---|
| **Income from activities** Continuing Operations | 3 | **152,568** | 145,764 |
| **Other operating income** Continuing Operations | 4 | **13,617** | 13,001 |
| **Operating expenses** Continuing Operations | 5-7 | **(159,904)** | (148,152) |
| **OPERATING SURPLUS/(DEFICIT)** | | **6,281** | 10,613 |
| Cost of fundamental reorganisation/restructuring | | **0** | 0 |
| Profit (loss) on disposal of fixed assets | 8 | **(91)** | (96) |
| **SURPLUS/(DEFICIT) BEFORE INTEREST** | | **6,190** | 10,517 |
| Net Financing Costs | | **1,027** | 620 |
| **SURPLUS/(DEFICIT) FOR THE FINANCIAL YEAR** | | **7,217** | 11,137 |
| Public Dividend Capital dividends payable | | **(3,505)** | (3,620) |
| **RETAINED SURPLUS FOR THE YEAR** | | **3,712** | 7,517 |

# Balance Sheet as at 31 March 2009

| | NOTE | 2008/09 £000 | 2007/08 £000 |
|---|---|---|---|
| **FIXED ASSETS** | | | |
| Intangible assets | 10 | **91** | 141 |
| Tangible assets | 11 | **120,415** | 124,138 |
| | | **120,506** | 124,279 |
| **CURRENT ASSETS** | | | |
| Stocks and work in progress | 13 | **665** | 765 |
| Debtors | 14 | **8,551** | 7,505 |
| Investments | 15 | **12,001** | 16,009 |
| Cash at Bank and in Hand | 19.3 | **6,348** | 11,255 |
| **Total Current Assets** | | **27,565** | 35,534 |
| **CREDITORS:** Amounts falling due within one year | 16.1 | **(21,572)** | (30,512) |
| **NET CURRENT ASSETS (LIABILITIES)** | | **5,993** | 5,022 |
| **TOTAL ASSETS LESS CURRENT LIABILITIES** | | **126,499** | 129,301 |
| **CREDITORS:** Amounts falling due after more than one year | 16.1 | **(4,564)** | (4,821) |
| **PROVISIONS FOR LIABILITIES AND CHARGES** | 17 | **(509)** | (535) |
| **TOTAL ASSETS EMPLOYED** | | **121,426** | 123,945 |
| **FINANCED BY:** | | | |
| **TAXPAYERS' EQUITY** | | | |
| Public dividend capital | 18.2 | **83,137** | 83,137 |
| Revaluation reserve | 18.3 | **25,733** | 32,002 |
| Donated asset reserve | 18.3 | **1,992** | 1,954 |
| Other reserves | 18.3 | **0** | 0 |
| Income and expenditure reserve | 18.3 | **10,564** | 6,852 |
| **TOTAL TAXPAYERS EQUITY** | 18.1 | **121,426** | 123,945 |

The financial statements on pages 9 to 38 were approved by the Board on and signed on its behalf by



**Chief Executive**

**Director of Finance**

# Statement of Total Recognised Gains and Losses for the year ended 31 March 2009

| | **2008/09 £000** | 2007/08 £000 |
|---|---|---|
| Surplus (deficit) for the financial year before dividend payments | **7,217** | 11,137 |
| Unrealised surplus/(deficit) on fixed assets and current asset investment revaluations | **(6,268)** | 14,344 |
| Increases in the donated asset/government grant reserve due to receipt of donated/government granted assets receipt of donated/government granted assets | **0** | 0 |
| Reductions in the donated asset/government grant reserve due to depreciation, impairment and/or disposal of donated/government granted assets | **(115)** | (67) |
| Additions/(reduction) in "Other reserves" | **0** | 0 |
| **Total gains and losses recognised in the financial year** | **834** | 25,414 |

# Cash Flow Statement for the year ended 31 March 2009

| | NOTE | 2008/09 £000 | 2007/08 £000 |
|---|---|---|---|
| **OPERATING ACTIVITIES** | | | |
| **Net cash inflow/(outflow) from operating activities** | 19.1 | **2,999** | 25,914 |
| **RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:** | | | |
| Interest received | | **1,159** | 676 |
| Interest paid | | **(235)** | (181) |
| Interest element of finance lease rental payments | | **0** | 0 |
| **Net cash inflow/(outflow) from returns on investments and servicing of finance** | | **924** | 495 |
| **CAPITAL EXPENDITURE** | | | |
| (Payments) to acquire tangible fixed assets | | **(9,725)** | (4,600) |
| (Payments) to acquire intangible assets | | **(8)** | (20) |
| **Net cash inflow/(outflow) from capital expenditure** | | **(9,733)** | (4,620) |
| **DIVIDENDS PAID** | | **(3,505)** | (3,620) |
| **Net cash inflow/(outflow) before management of liquid resources and financing** | | **(9,315)** | 18,169 |
| **MANAGEMENT OF LIQUID RESOURCES** | | | |
| (Purchase) of current asset investments | | **0** | (15,318) |
| Sale of current asset investments | | **4,008** | 0 |
| **Net cash inflow/(outflow) from management of liquid resources** | | **4,008** | (15,318) |
| **Net cash inflow/(outflow) before financing** | | **(5,307)** | 2,851 |
| **FINANCING** | | | |
| New public dividend capital received | | **0** | 0 |
| Public dividend capital repaid | | **0** | 0 |
| Loans received from Foundation Trust Financing Facility | | **0** | 3,005 |
| Other Loans received | | **0** | 0 |
| Loans repaid to Foundation Trust Financing Facility | | **(225)** | (89) |
| Other loans repaid | | **(31)** | (31) |
| Other capital receipts | | **656** | 841 |
| Capital element of finance lease rental payments | | **0** | 0 |
| **Net cash inflow/(outflow) from financing** | | **400** | 3,726 |
| **Increase/(decrease) in cash** | | **(4,907)** | 6,577 |

# Notes to the Accounts

## 1 Accounting Policies

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

## 1.1 Accounting convention

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

## 1.2 Acquisitions and discontinued operations

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

a) the sale (this may be at £Nil consideration for activities transferred to another public sector body) or termination is completed either in the period or before the earlier of three months after the commencement of the subsequent period and the date on which the financial statements are approved;

b) if a termination, the former activities have ceased permanently;

c) the sale or termination has a material effect on the nature and focus of the reporting NHS Foundation Trust's operations and represents a material reduction in its operating facilities resulting in either from its withdrawal from the particular activity or from material reduction in income in the Foundation Trust's continuing operations;

d) the assets, liabilities, results of operations and activities are clearly distinguishable, physically, operationally and for financial reporting purposes.

Operations not satisfying all these conditions are classified as 'continuing'.

Activities are considered to be 'acquired' whether or not they are acquired from outside the public sector.
1.3Income recognition

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

Income from partially completed spells is accrued at the year end and accounted for as deferred income.

The Trust's healthcare contract income operates under the system of Payment by Result (PbR). This system results in income for most clinical services being paid at a national tariff for 2008/09. In addition the Trust receives a Market Forces Factor Payment direct from the Department of Health which totalled £23.4m in 2008-09.

## 1.4 Expenditure Recognition

Expenditure is accounted for by applying the accruals convention.

## 1.5 Tangible fixed assets

**Capitalisation**

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

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

**Valuation**

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

All land and buildings are revalued to current value using professional valuations in accordance with FRS 15 every five years. A three yearly interim valuation is also carried out, with the most recent on 31st March 2008.

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The last full asset valuations were undertaken in 2004 as at the prospective valuation date of 1 April 2005. The revaluation undertaken at that date was accounted for on 31 March 2005.

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

Additional alternative open market value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal.

Residual interests in off-balance sheet private finance initiative properties are included in assets under construction within tangible fixed assets at the amount of unitary charge allocated for the acquisition of the residual with an adjustment. The adjustment is the net present value of the change in the fair value of the residual as estimated at the start of the contract and at the balance sheet date.

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

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

**Depreciation, amortisation and impairments**

Tangible fixed assets are depreciated at rates calculated to write them down to estimated residual value on a straight-line basis over their estimated useful lives. No depreciation is provided on freehold land, and assets surplus to requirements.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as assessed by the NHS Foundation Trust's professional valuers. Leaseholds are depreciated over the primary lease term.

Equipment is depreciated on current cost evenly over the estimated life.

The following UEL's apply to each individual Asset class :
These represent standard asset lives adjusted for local use and expected technology changes

* Land - remaining useful life of the asset
* Non Residential Buildings & Dwellings - average remaining useful life of the Building Block as per the DV report
* Transport Equipment - 7 years
* Plant and Machinery & Med equipment - 5 years
* Soft Furnishings, Office & IT Equipment - 5 years
* Mainframe IT type installations - 5 years
* Computer Software licenses - 5 years

Fixed assets impairments resulting from losses of economic benefits are charged to the Income and Expenditure Account. All other impairments are taken to the revaluation reserve and reported in the statement of total recognised gains and losses to the extent that there is a balance on the revaluation reserve in respect of the particular asset. Completed Building Assets brought into use during the year from AUC (Assets under Construction) or in year projects that have a negative revaluation reserve due to initial non-economic changes were revalued during the 3 yearly interim re-valuation (31 March 2008) and would subsequently be cleared as the values of the asset increase.

## 1.6 Intangible Fixed Assets

Intangible assets are capitalised when they are capable of being used in a Trust's activities for more the one year, they can be valued and have a cost of at least £5,000.

Intangible fixed assets held for operational use are valued at historical cost and are amortised over the estimated life of the asset on a straight line basis. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Purchased computer software licences are capitalised as grouped intangible fixed assets where such expenditure of at least £5,000 is incurred and is then amortised over the shorter of the term of the licence and their useful economic lives.

## 1.7 Donated fixed assets

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

## 1.8 Foreign Exchange

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

## 1.9 Government grants

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

## 1.10 Cash, bank and overdrafts

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

## 1.11 Stocks and work-in-progress

Stocks and work-in-progress are valued at the lower of cost and net realisable value. Work-in-progress comprises goods and services in intermediate stages of production.

## 1.12 Research and development

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

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

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

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

## 1.13 Provisions

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

## 1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets but are disclosed in note 22 where an inflow of economic benefits is probable.

Contingent liabilities are provided for where a transfer of economic benefits is probable. Otherwise, they are not recognised, but are disclosed in note 22 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

## 1.15 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 17.

## 1.16 Non-clinical risk pooling

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

## 1.17 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. As a consequence it is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme under FRS 17. The cost of the scheme is equal to the contributions payable to the scheme for the accounting period. The total employer contribution payable in 2008-09 was £8.4m (2007-08 £7.9m).

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the income and expenditure account at the time the trust commits itself to the retirement, regardless of the method of payment.

The Scheme is subject to a full actuarial investigation by the Government Actuary every four years. The main purpose of which is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience) and to recommend the contribution rates to be paid by employers and scheme members. The last such investigation, on the conclusions of which Scheme contribution rates are currently based, had an effective date of 31 March 2004 and covered the period from 1 April 1999 to that date. Between the full actuarial valuations, the Government Actuary provides an annual update of the Scheme liabilities for FRS 17 purposes. The latest assessment of the liabilities of the Scheme is contained in the Scheme Actuary report, which forms part of the NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on Business Service Authority - Pensions Division website at www.nhspa.gov.uk. Copies can also be obtained from The Stationery Office (TSO).

The conclusion of the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. This is after making some allowance for one-off effects of pay modernisation, but before taking into account any of the scheme changes which come into effect on 1 April 2008. Taking into account the changes in the benefit and contribution structure effective from 1 April 2008, employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008, employees paid contributions at the rate of 6% (manual staff 5%) of their pensionable pay. After 1 April 2008, employees have been paying contributions according to a tiered scale from 5% up to 8.5% of their pensionable pay.

NHS bodies are directed by Monitor to charge employers' pension costs contributions to operating expenses as and when they become due. Until 2002-03 HM Treasury paid the Retail Price Indexation costs of the NHS Pension scheme direct but as part of the Spending Review Settlement, these costs have been devolved in full. For 2003-04 the additional funding was retained as a Central Budget by the Department of Health and was paid direct to the NHS Pensions Agency and the employers' contribution remained at 7%. From 2004-05 this funding was devolved in full to NHS Pension Scheme employers' and the employers' contribution rate rose to 14%.

The scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on

retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year pensionable pay for death in service, and up to five times their annual pension for death after retirement, is payable. Additional pension liabilities arising from early retirement are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the income and expenditure account at the time the Trust commits itself to the retirement, regardless of the method of payment.

The Scheme provides the opportunity to members to increase their benefits through money purchase Additional Voluntary Contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee/member can make contributions to their pension benefits. The benefits payable relate directly to the value of the investments made.

## 1.18 Investments

Deposits and other investments that are readily convertible into known amounts of cash at or close to their carrying amounts are treated as liquid resources in the cash flow statement.

## 1.19 Value Added Tax

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

## 1.20 Current Tax

Homerton University Hospital Foundation Trust is a Health Service Body within the means of s 519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for Treasury to disapply the exemption in relation to specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities which are not related to, or ancillary to, the provision of healthcare, and where the profits there from exceed £50,000 pa.

Homerton University Hospital Foundation Trust is generally not in business for VAT purposes and therefore can only recover VAT to the extent that it incurs costs in relation to eligible contracted out service and certain types of taxable business activity under s41 (2) and (3) VATA 1994.

## 1.21 Third Party Assets

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

## 1.22 Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as a tangible fixed asset and a debt is recorded to the lessor of the minimum lease payments discounted by the interest rate implicit in the lease. The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The interest element of the finance lease payment is charged to the Income and Expenditure Account over the period of the lease at a constant rate in relation to the balance outstanding. Other leases are regarded as operating leases and the rentals are charged to the Income and Expenditure Account on a straight-line basis over the term of the lease.

## 1.23 Public Dividend Capital (PDC) and PDC Dividend

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the original NHS Trust.

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

Note 18.2 to the accounts discloses the rate that the dividend represents as a percentage of the actual average carrying amount of assets less liabilities in the year.

## 1.24 Financial Instruments and Financial Liabilities

**(i) Recognition**

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

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

**(ii) De-recognition**

All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

**(iii) Classification and Measurement**

Financial assets are categorised as Fair Value through Income and Expenditure, Loans and receivables or Available for sale financial assets.

Financial liabilites are classified as 'Fair value through Income and Expenditure' or as 'Other Financial liabilities'.

**(iv) Loans and receivables**

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

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

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

Interest on loans and receivables is calculated using the effective interest method and credited to the income and expenditure account.

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

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

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

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

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the assets carrying amount and the present value of the revised future cash flows discounted at the assets carrying amount and the present value of the revised future cash flows discounted at the assets original effective interest rate. The loss is recognised in the income and expenditure account and the carrying value of the asset is reduced directly.

## 1.25 Losses and Special Payments

Losses and Special Payments are charged to the relevant functional headings on a cash basis, including losses which would have been made good through insurance cover had Foundation Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

The total value and number of losses and special payment cases is shown in note 29 in the accounts.

## 2. Segmental Analysis

No business segments are deemed large enough in their own right to be separately distinguishable nor significant enough to warrant separate disclosure.

## 3.1 Income from activities

| | **2008/09** | 2007/08 |
|---|---|---|
| | **£000** | £100 |
| Elective Income | **18,269** | 15,749 |
| Non-elective Income | **42,600** | 44,962 |
| Outpatient Income | **25,871** | 26,242 |
| Other type of activity Income | **45,265** | 38,175 |
| A&E Income | **7,719** | 7,719 |
| PBR Transitional gain | **0** | 0 |
| PBR Clawback | **0** | 0 |
| Private Patient Income | **292** | 293 |
| Other Non-protected Clinical Income | **12,552** | 12,624 |
| **TOTAL** | **152,568** | 145,764 |

## 3.2 Private Patient Income

| | **2008/09** | base year |
|---|---|---|
| | **£000** | £000 |
| Private Patient Income | **292** | 224 |
| Total Patient Related Income | **152,568** | 99,924 |
| Private Patient % CAP | **0.19%** | 0.22% |

Section 44 of the NHS Act 2006 requires that the proportion of private patient income to the total patient related income of NHSFTs should not exceed its proportion whilst the body was an NHS trust in 2002/03 or the base year.

## 3.3 Income by Source

| | **2008/09** | 2007/08 |
|---|---|---|
| | **£000** | £000 |
| NHS Foundation Trusts | **4,259** | 13 |
| NHS Trusts | **430** | 5,073 |
| Strategic Health Authorities | **11,298** | 537 |
| Primary Care Trusts | **110,177** | 114,850 |
| Department of Health | **23,388** | 21,130 |
| NHS Other | **95** | 85 |
| Non NHS: Private Patients | **292** | 293 |
| Non NHS: Overseas Patients | **8** | 121 |
| Non NHS : Other | **2,326** | 3,250 |
| NHS Injury Scheme (was Road Traffic Act) | **295** | 412 |
| **TOTAL** | **152,568** | 145,764 |

NHS Injury Scheme income is subject to a provision for doubtful debts of 7.8% (2007/08 7.7%) to reflect expected rates of collection.

## 4. Other Operating Income

| | 2008/09 £000 | 2007/08 £000 |
|---|---|---|
| Research and development | **685** | 685 |
| Education and training | **10,377** | 10,316 |
| Transfers from donated asset reserve in respect of depreciation, impairment and disposal of donated assets | **115** | 67 |
| Other | **2,440** | 1,933 |
| **TOTAL** | **13,617** | 13,001 |

## 5. Operating Expenses

### 5.1 Operating expenses comprise:

| | 2008/09 £000 | 2007/08 £000 |
|---|---|---|
| Services from other NHS Foundation Trusts | **0** | 0 |
| Services from other NHS Trusts | **0** | 0 |
| Services from other NHS Bodies | **0** | 0 |
| Purchase of healthcare from non-NHS bodies | **0** | 0 |
| Directors' costs | **1,142** | 1,127 |
| Staff costs | **100,803** | 96,403 |
| Drugs costs | **9,312** | 8,591 |
| Supplies and services - clinical (excluding drug costs) | **9,374** | 8,346 |
| Supplies and services - general | **1,300** | 1,135 |
| Establishment | **2,394** | 1,790 |
| Research and development | **685** | 685 |
| Transport | **1,215** | 1,267 |
| Premises | **19,226** | 18,116 |
| Bad debts | **357** | 162 |
| Depreciation and amortisation | **6,302** | 6,080 |
| Audit fees | **51** | 59 |
| Other auditor's remuneration | **2** | 4 |
| Clinical negligence | **3,081** | 2,798 |
| Exceptional costs | **0** | 0 |
| Other | **4,660** | 1,589 |
| **TOTAL** | **159,904** | 148,152 |

### 5.2/1 Operating lease rentals:

| | 2008/09 £000 | 2007/08 £000 |
|---|---|---|
| Hire of plant and machinery | **374** | 277 |
| Other operating lease rentals | **0** | 29 |
| | **374** | 306 |

In addition to leases whose financial values are declared above, the Trust has a lease for Mary Seacole Nursing Home from Newlon Housing Trust ("Newlon") for a building which we have occupied for a number of years at a peppercorn rent.

### 5.2/2 Operating lease commitments:

| | Land and buildings £000 | Other leases £000 | 2008/09 Total £000 | 2007/08 Total £000 |
|---|---|---|---|---|
| Annual commitments on leases expiring: | | | | |
| Within 1 year | 0 | 338 | **338** | 218 |
| Between 1 and 5 years | 0 | 744 | **744** | 706 |
| After 5 years | 0 | 0 | **0** | 125 |
| **TOTAL** | 0 | **1,082** | **1,082** | 1,049 |

## 5.3 Salary and Pension entitlements of senior managers

### A) Remuneration

| Name and Title | 2008/09 Directors salary £000 | 2008/09 Other remuneration £000 | 2008/09 Salary (bands of £5000) £000 | 2007/08 Salary (bands of £5000) £000 |
|---|---|---|---|---|
| Hallett N - Chief Executive | 140-145 | n/a | 140-145 | 130-135 |
| Brown P - Director of Corporate Development | 100-105 | n/a | 100-105 | 95-100 |
| Coakley J - Medical Director | 50-55 | 140-145 | 190-195 | 185-190 |
| Clarke C - Director of Finance (to 25.1.08) | 0 | n/a | 0 | 75-80 |
| Anderson A - Director of Finance | 100-105 | n/a | 100-105 | 25-30 |
| Costeloe K - Non Executive Director | 0 | n/a | 0 | 10-15 |
| Fletcher T - Director of Service Development (to 6.11.08) | 60-65 | n/a | 60-65 | 95-100 |
| Weldon S - Chief Operating Officer (from 2.2.09) | 15-20 | n/a | 15-20 | 0 |
| Young G - Director of Nursing & Quality (to 30.9.08) | 95-100 | n/a | 95-100 | 90-95 |
| Panniker A - Director of Environment | 95-100 | n/a | 95-100 | 90-95 |
| Crowe J - Non Executive Director (to 31.3.08) | 0 | n/a | 0 | 10-15 |
| Luder I - Non Executive Director (to 31.10.08) | 5-10 | n/a | 5-10 | 10-15 |
| Sorensen E - Non Executive Director | 10-15 | n/a | 10-15 | 10-15 |
| Cassidy M - Chairman | 40-45 | n/a | 40-45 | 35-40 |
| Hay S - Non Executive Director | 10-15 | n/a | 10-15 | 10-15 |
| Keith M - Non Executive Director | 10-15 | n/a | 10-15 | 10-15 |
| Stewart D - Non Executive Director (from 3.11.08) | 5-10 | n/a | 5-10 | 0 |
| Redmond I - Non Executive Director | 10-15 | n/a | 10-15 | 0 |
| Griffiths C - Non Executive Director | 10-15 | n/a | 10-15 | 0 |

### B) Pension Benefits

| Name and title | Real increase in pension and related lump sum at age 60 (bands of £2500) £1000 | Total accrued pension & related lump sum at age 60 at 31 March 2009 (bands of £2500) £1000 | Cash Equivalent Transfer Value at 31 March 2009 £1000 | Cash Equivalent Transfer Value at 31 March 2008 £1000 | Real Increase in Cash Equivalent Transfer Value £1000 | Employers Contribution to Stakeholder Pension To nearest £100 |
|---|---|---|---|---|---|---|
| Hallett N - Chief Executive | 10 - 12.5 | 220 - 222.5 | 1,153 | 787 | 366 | 0 |
| Brown P - Director of Corporate Development | 10 - 12.5 | 142.5 - 145 | 682 | 501 | 181 | 0 |
| Coakley J - Medical Director | 35 - 37.5 | 270 - 272.5 | 1,441 | 965 | 476 | 0 |
| Anderson A - Director of Finance | 32.5 - 35 | 157.5 - 160 | 887 | 507 | 380 | 0 |
| Fletcher T - Director of Service Development | 12.5 - 15 | 82.5 - 85 | 279 | 183 | 96 | 0 |
| Young G - Director of Nursing & Quality | 5 - 7.5 | 115 - 117.5 | 543 | 398 | 145 | 0 |
| Panniker A - Director of Environment | 5 - 7.5 | 27.5 - 30 | 120 | 78 | 42 | 0 |
| Weldon S - Chief Operating Officer | 2.5 - 5 | 45 - 47.5 | 177 | 134 | 43 | 0 |

There were no payments in the year in respect of other remuneration, golden hellos, compensation for loss of office or benefits in kind for any of the senior managers. As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

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 the disclosure applies. The CETV figures, and from 2004-05 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 pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

## 6. Staff costs and numbers

### 6.1 Staff costs

| | Permanently Employed | Other | 2008/09 Total | 2007/08 Total |
|---|---|---|---|---|
| | **£000** | **£000** | **£000** | £000 |
| Salaries and wages | 75,729 | 0 | 75,729 | 73,996 |
| Social Security Costs | 7,318 | 0 | 7,318 | 6,926 |
| Employer contributions to NHSPA | 8,398 | 0 | 8,398 | 7,989 |
| Other pension costs | 0 | 0 | 0 | 0 |
| Agency/contract staff | 0 | 10,500 | 10,500 | 8,619 |
| | **91,445** | **10,500** | **101,945** | 97,530 |

### 6.2 Average number of persons employed

| | Permanently Employed | Other | 2008/09 Total | 2007/08 Total |
|---|---|---|---|---|
| | **Number** | **Number** | **Number** | Number |
| Medical and dental | 329 | 0 | **329** | 311 |
| Ambulance staff | 0 | 0 | **0** | 0 |
| Administration and estates | 461 | 0 | **461** | 440 |
| Healthcare assistants and other support staff | 189 | 0 | **189** | 208 |
| Nursing, midwifery and health visiting staff | 715 | 0 | **715** | 724 |
| Nursing, midwifery and health visiting learners | 25 | 0 | **25** | 45 |
| Scientific, therapeutic and technical staff | 311 | 0 | **311** | 290 |
| Bank and agency staff | 0 | 195 | **195** | 155 |
| Other | 39 | 0 | **39** | 26 |
| **TOTAL** | **2,069** | **195** | **2,264** | 2,199 |

This information was extracted from the Human Resources Manpower Planning computer system.

### 6.3 Employee benefits

There are no individual employee benefit costs for 2008-09 (2007-8 £Nil).

### 6.4 Retirements due to ill-health

| | 2008/09 Number | 2008/09 £000 | 2007/08 £000 |
|---|---|---|---|
| Number of early retirements agreed on the grounds of ill-health | 2 | 196 | 83 |
| **TOTAL** | **2** | **196** | 83 |

## 7. The Late Payment of Commercial Debts (Interest) Act 1998

There are no amounts included within other Interest Payable arising from claims made under this legislation.

## 8. Disposal of Fixed Assets:

| | **2008/09** | 2007/08 |
|---|---|---|
| | **£000** | £000 |
| Loss on disposal of land and buildings (protected assets) | **0** | 0 |
| Loss on disposal of other tangible fixed assets (unprotected assets) | **(91)** | (96) |
| **TOTAL** | **(91)** | (96) |

## 9. Interest Payable and similar charges:

| | **2008/09** | 2007/08 |
|---|---|---|
| | **£000** | £000 |
| Loans from the Foundation Trust Financing Facility | **222** | 188 |
| Overdrafts | **0** | 0 |
| Finance leases | **0** | 0 |
| **TOTAL** | **222** | 188 |

## 10. Intangible Fixed Assets

| | **Software Licences** | **2008/09 Total** | 2007/08 Total |
|---|---|---|---|
| | **£000** | **£000** | £000 |
| Gross cost at 1 April 2008 | 309 | 309 | 289 |
| Additions - purchased | 8 | 8 | 20 |
| Disposals | 0 | 0 | 0 |
| **Gross cost at 31 March 2009** | **317** | **317** | 309 |
| Amortisation at 1 April 2008 | 168 | 168 | 115 |
| Provided during the year | 58 | 58 | 53 |
| Impairments | 0 | 0 | 0 |
| Disposals | 0 | 0 | 0 |
| **Amortisation at 31 March 2009** | **226** | **226** | 168 |
| **Net book value at 31 March 2008** | **141** | **141** | **174** |
| **Net book value at 31 March 2009** | **91** | **91** | **141** |

## 11.1 Tangible Fixed Assets

| | Land | Buildings excluding dwellings | Assets under construction and poa | Plant and Machinery | Transport Equipment | Information Technology | Furniture & fittings | 2007/08 Total | 2006/07 Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Cost or valuation at 1 April 2008 | 26,177 | 87,045 | 1,165 | 16,102 | 73 | 9,320 | 1,113 | **140,995** | 131,096 |
| Additions - purchased | 0 | 3,942 | 2,041 | 2,267 | 0 | 708 | 12 | **8,970** | 4,050 |
| Additions - donated | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 0 |
| Additions - government granted | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 0 |
| Other revaluations | (3,167) | (3,242) | 49 | 389 | 2 | 0 | 29 | **(5,940)** | 6,952 |
| Impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 0 |
| Reclassifications | 0 | 186 | (186) | 0 | 0 | 0 | 0 | **0** | 0 |
| Disposals | (17) | (73) | 0 | (830) | 0 | 0 | 0 | **(920)** | (1,103) |
| **Cost or valuation at 31 March 2009** | **22,993** | **87,858** | **3,069** | **17,928** | **75** | **10,028** | **1,154** | **143,105** | **140,995** |
| Depreciation at 1 April 2008 | 0 | 0 | 0 | 11,827 | 54 | 4,337 | 639 | **16,857** | 19,170 |
| Provided during the year | 0 | 3,015 | 0 | 1,602 | 11 | 1,452 | 164 | **6,244** | 6,027 |
| Other in year revaluation | 0 | 0 | 0 | 310 | 2 | 0 | 16 | **328** | (7,392) |
| Disposals | 0 | 0 | 0 | (739) | 0 | 0 | 0 | **(739)** | (948) |
| **Depreciation at 31 March 2009** | **0** | **3,015** | **0** | **13,000** | **67** | **5,789** | **819** | **22,690** | **16,857** |
| Net book value | | | | | | | | | |
| - Purchased at 1 April 2008 | 26,177 | 85,123 | 1,165 | 4,243 | 19 | 4,983 | 474 | **122,184** | 110,469 |
| - Donated at 1 April 2008 | 0 | 1,922 | 0 | 32 | 0 | 0 | 0 | **1,954** | 1,457 |
| **Total at 1 April 2008** | **26,177** | **87,045** | **1,165** | **4,275** | **19** | **4,983** | **474** | **124,138** | **111,926** |
| Net book value | | | | | | | | | |
| - Purchased at 31 March 2009 | 22,993 | 83,010 | 3,069 | 4,769 | 8 | 4,239 | 335 | **118,423** | 122,184 |
| - Donated at 31 March 2009 | 0 | 1,833 | 0 | 159 | 0 | 0 | 0 | **1,992** | 1,954 |
| - Government Granted at 31 March 2009 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 0 |
| **Total at 31 March 2009** | **22,993** | **84,843** | **3,069** | **4,928** | **8** | **4,239** | **335** | **120,415** | **124,138** |

## 11.2 Analysis of tangible fixed assets:

| | Land | Buildings excluding dwellings | Assets under construction and poa | Plant and Machinery | Transport Equipment | Information Technology | Furniture & fittings | 2007/08 Total | 2006/07 Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Net book value | | | | | | | | | |
| - Protected assets at 31 March 2009 | 22,993 | 84,843 | 0 | 0 | 0 | 0 | 0 | **107,836** | 113,222 |
| - Unprotected assets at 31 March 2009 | 0 | 0 | 3,069 | 4,928 | 8 | 4,239 | 335 | **12,579** | 10,916 |
| **Total at 31 March 2009** | **22,993** | **84,843** | **3,069** | **4,928** | **8** | **4,239** | **335** | **120,415** | **124,138** |

## 11.3 Assets held at open market value:

| | Land | Buildings excl dwellings | 2008/09 Total | 2007/08 Total |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| Open market value at 31 March 2009 | 0 | 0 | 0 | 0 |

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

| | Plant and Machinery | 2008/09 Total | 2007/08 Total |
|---|---|---|---|
| | £000 | £000 | £000 |
| Cost or valuation at 31 March 2009 | 0 | 0 | 0 |

**11.4/1 The total amount of depreciation charged to the income and expenditure account in respect of assets held under finance leases and hire purchase contracts:**

| | Plant and Machinery | 2008/09 Total | 2007/08 Total |
|---|---|---|---|
| | £000 | £000 | £000 |
| Depreciation | 0 | 0 | 0 |

**11.5 The net book value of land, buildings and dwellings at 31 March 2009 comprises:**

| | Protected | 2008/09 Total | 2007/08 Total |
|---|---|---|---|
| | £000 | £000 | £000 |
| Freehold | 107,836 | 107,836 | 113,222 |
| Long leasehold | 0 | 0 | 0 |
| Short leasehold | 0 | 0 | 0 |
| **TOTAL** | 107,836 | 107,836 | 113,222 |

## 12. Fixed Asset Investments:

There were no fixed asset investments held at 31 March 2009 (31 March 2008 - £Nil).

## 13. Stocks and Work in progress:

| | 2008/09 | 2007/08 |
|---|---|---|
| | £000 | £000 |
| Raw materials and consumables | 665 | 765 |
| **Total Stock and Work in Progress** | 665 | 765 |

## 14. Debtors

| | 2008/09 | 2007/08 |
|---|---|---|
| **Amounts falling due within one year:** | **£000** | £000 |
| NHS debtors | **3,582** | 3,768 |
| Provision for irrecoverable debts (all debts) | **(943)** | (594) |
| Prepayments and accrued income | **1,731** | 1,111 |
| Tax receivable | **0** | 0 |
| Other debtors | **4,181** | 3,220 |
| **Sub Total** | **8,551** | 7,505 |
| **Debtors: due after more than one year:** | **0** | 0 |
| **TOTAL DEBTORS** | **8,551** | 7,505 |

## 15. Current Asset Investments

| | 2008/09 | 2007/08 |
|---|---|---|
| | **£000** | £000 |
| Cost or valuation at 01 April 2008 | **16,009** | 691 |
| Cost or valuation at start of period for new Foundation Trusts | **0** | 0 |
| Additions | **0** | 15,318 |
| Disposals | **(4,008)** | 0 |
| Revaluation | **0** | 0 |
| Cost or valuation at 31 March 2009 | **12,001** | 16,009 |

## 16.1 Creditors

| | 2008/09 | 2007/08 |
|---|---|---|
| **Amounts falling due within one year:** | **£000** | £000 |
| NHS creditors | **3,190** | 2,084 |
| Non - NHS trade creditors - capital | **113** | 868 |
| Other tax and social security costs | **3,417** | 3,186 |
| Obligations under finance leases and hire purchase contracts | **0** | 0 |
| Bank overdrafts / Committed facilities | **0** | 0 |
| Loans | **257** | 257 |
| Interest payable | **0** | 15 |
| Other creditors | **3,070** | 2,364 |
| Payments received on account | **317** | 14,251 |
| Tax payable | **0** | 0 |
| Accruals and deferred income | **11,208** | 7,487 |
| **Sub Total** | **21,572** | 30,512 |
| **Creditors: due after more than one year:** | | |
| Loans | **4,564** | 4,821 |
| **TOTAL CREDITORS** | **26,136** | 35,333 |

| **16.2/1 Loans - payment of principal falling due:** | **2008/09** | 2007/08 |
|---|---|---|
| | **£000** | £000 |
| Within one year | **257** | 257 |
| Within one and two years | **257** | 257 |
| Between two and five years | **771** | 770 |
| After five years | **3,536** | 3,794 |
| **TOTAL** | **4,821** | 5,078 |

| **16.2/2 of which:** | **2008/09** | 2007/08 |
|---|---|---|
| | **£000** | £000 |
| Wholly repayable within 5 years | **1,285** | 1,284 |
| Wholly repayable after 5 years, not by instalments | **0** | 0 |
| Wholly or partially repayable after 5 years by instalments | **3,536** | 3,794 |
| **TOTAL** | **4,821** | 5,078 |

| **16.3 Prudential borrowing limit:** | **Actual 2008/09** | Actual 2007/08 |
|---|---|---|
| | **£000** | £000 |
| Prudential borrowing limit set by Monitor | **35,700** | 35,300 |
| Working Capital Facility | **11,000** | 11,000 |
| Total Prudential borrowing limit | **46,700** | 46,300 |

The Trust has a Prudential borrowing limit of £46.7m in 2008/09 (£46.3m in 07/08). The Trust has actually borrowed £Nil in 2008/09 (£3.01m in 2007/08) and made capital principal repayments of £0.26m (£0.12m in 2007/08). Further information on the NHS Foundation Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

| **Financial ratio** | **Actual ratios 2008/09** | **Approved PBL ratios 2008/09** | **Actual ratios 2007/08** | **Approved PBL ratios 2007/08** |
|---|---|---|---|---|
| Maximum debt / capital ratio | 2.98% | 3.23% | 3.17% | 4.66% |
| Minimum dividend cover | 4.4x | 3.4x | 4.8x | 3.2x |
| Minimum interest cover | 58.5x | 44.5x | 93.6x | 56.1x |
| Minimum debt service cover | 58.5x | 29.7x | 63.5x | 39.4x |
| Maximum debt service to revenue | 0.16% | 0.25% | 0.18% | 0.20% |

* The Trust currently has £11m of approved working capital facility (£11m in 2007/08). The Trust had drawn down £Nil of its working capital facility at 31 March 2009 (£Nil at 31 March 2008).

The Trust is required to comply and remain within its prudential borrowing limit, which is currently £46.7m (£46.3m in 2007/08).

This is made up of two elements :

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

* The amount of any working capital facility approved by Monitor.

| **16.4 Finance lease obligations** | **2008/09** | 2007/08 |
|---|---|---|
| | **£000** | £000 |
| Within one year | **0** | 0 |
| **Sub-total** | **0** | 0 |
| Less finance charges allocated to future periods | **0** | 0 |
| **NET OBLIGATIONS** | **0** | 0 |

## 17. Provisions for liabilities and charges

| | Pensions relating to former directors | Other | **2008/09 Total** | 2007/08 Total |
|---|---|---|---|---|
| | £000 | £000 | **£000** | £000 |
| At 1 April 2008 | 504 | 31 | **535** | 367 |
| Arising during the year | 0 | 54 | **54** | 197 |
| Change in discount rate | 0 | 0 | **0** | 0 |
| Utilised during the year | (78) | (13) | **(91)** | (36) |
| Reversed unused | 0 | 0 | **0** | 0 |
| Unwinding of discount | 11 | 0 | **11** | 7 |
| At 31 March 2009 | **437** | **72** | **509** | 535 |
| Within one year | 42 | 72 | **114** | 72 |
| Between one and five years | 168 | 0 | **168** | 164 |
| After five years | 227 | 0 | **227** | 299 |
| **TOTAL** | **437** | **72** | **509** | 535 |

The provision arising in the year relate to matters handled by the NHSPA (NHS Pensions Agency) and the NHSLA (NHS Litigation Authority). At the year end there is also a contingent liability of £30k (see note 22)

| Clinical Negligence Liability | **2008/09 Total** | 2007/08 Total |
|---|---|---|
| | **£000** | £000 |
| Amount included in provisions of NHSLA at 31 March 2009 in respect of CN liabilities of the NHS Foundation Trust | **22,199** | 11,056 |

## 18.1 Movements in taxpayers' equity:

| | 2008/09 | 2007/08 |
|---|---|---|
| | **£000** | £000 |
| Taxpayers' equity at 1 April 2008 | **123,945** | 102,151 |
| Prior period adjustments | **0** | 0 |
| Surplus/(deficit) for the financial year | **7,217** | 11,137 |
| Public dividend capital dividends | **(3,505)** | (3,620) |
| Surplus/(deficit) from revaluation of purchased fixed assets | **(6,268)** | 14,344 |
| New public dividend capital received | **0** | 0 |
| Transfer from the donated asset reserve | **37** | (67) |
| Additions to/transfer from the government grant reserve | **0** | 0 |
| Additions / Reductions in other reserves | **0** | 0 |
| **Taxpayers' equity at 31 March 2009** | **121,426** | 123,945 |

## 18.2 Movement in Public Dividend Capital

| | 2008/09 | 2007/08 |
|---|---|---|
| | **£000** | £000 |
| Public Dividend Capital as at 1 April 2008 | **83,137** | 83,137 |
| New Public Dividend Capital received (including transfers from dissolved NHS Trusts) | **0** | 0 |
| **Public Dividend Capital as at 31 March 2009** | **83,137** | 83,137 |

The dividend paid for the year was 3.5%

## 18.3 Movements on Reserves

Movements on reserves in the year comprised the following:

| | Revaluation Reserve | Donated Asset Reserve | Other reserves | Income and Expenditure Reserve | **2008/09 Total** | 2007/08 Total |
|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | **£000** | £000 |
| At 1 April 2008 | 32,002 | 1,954 | 0 | 6,852 | **40,808** | 19,014 |
| | 32,002 | 1,954 | 0 | 6,852 | **40,808** | 19,014 |
| Transfer from the income and expenditure account | 0 | 0 | 0 | 3,712 | **3,712** | 7,517 |
| Surplus on other revaluations of fixed assets | (6,269) | 1 | 0 | 0 | **(6,268)** | 14,344 |
| Receipt of donated/government granted assets | 0 | 0 | 0 | 0 | **0** | 0 |
| Transfer of realised profits /(losses) to the income and expenditure reserve | 0 | 152 | 0 | 0 | **152** | 0 |
| Transfers to the Income and Expenditure Account for depreciation, impairment, and disposal of donated/government granted assets | 0 | (115) | 0 | 0 | **(115)** | (67) |
| Other transfers between reserves | 0 | 0 | 0 | 0 | **0** | 0 |
| Movement on other reserves | 0 | 0 | 0 | 0 | **0** | 0 |
| At 31 March 2009 | **25,733** | **1,992** | **0** | **10,564** | **38,289** | 40,808 |

## 19. Notes to the cash flow statement

### 19.1 Reconciliation of operating surplus/(deficit) to net cash inflow/(outflow) from operating activities:

| | **2008/09** | 2007/08 |
|---|---|---|
| | **£000** | £000 |
| Total operating surplus (deficit) | **6,281** | 10,613 |
| Depreciation and amortisation | **6,302** | 6,080 |
| Transfer from donated asset reserve | **(115)** | (67) |
| Other movement | **(100)** | (118) |
| (Increase)/decrease in stocks | **100** | 3 |
| (Increase)/decrease in debtors | **(1,046)** | (1,146) |
| Increase/(decrease) in creditors | **(8,397)** | 10,381 |
| Increase/(decrease) in provisions | **(26)** | 168 |
| **Net cash inflow from operating activities** | **2,999** | 25,914 |

### 19.2 Reconciliation of net cash flow to movement in net debt

| | **2008/09** | 2007/08 |
|---|---|---|
| | **£000** | £000 |
| Increase/(decrease) in cash in the period | **(4,907)** | 6,577 |
| Cash inflow from new debt | **0** | (3,005) |
| Cash outflow from debt repaid and finance lease capital payments | **0** | 0 |
| Cash outflow from increase in liquid resources | **(21,841)** | 15,318 |
| Change in net debt resulting from cash flows | **(26,748)** | 18,890 |
| Non - cash changes in debt | **0** | (800) |
| Net debt at 1 April 2008 | **40,276** | 22,186 |
| **Net debt at 31 March 2009** | **13,528** | 40,276 |

**19.3 Analysis of changes in net debt**

| | At 1 April 2008 | Cash changes in year | Non-cash changes in year | 2008/09 At 31 March 2009 | 2007/08 At 31 March 2008 |
|---|---|---|---|---|---|
| | **£000** | **£000** | **£000** | **£000** | £000 |
| OPG cash at bank | 11,186 | (4,941) | 0 | 6,245 | 11,186 |
| Commercial cash at bank and in hand | 69 | 34 | 0 | 103 | 69 |
| Debt due after one year | (4,821) | 257 | 0 | (4,564) | (4,821) |
| Debt due within one year | (257) | 0 | 0 | (257) | (257) |
| Finance leases | 0 | 0 | 0 | 0 | 0 |
| Bank overdrafts | 0 | 0 | 0 | 0 | 0 |
| Current asset investments | 16,009 | (4,008) | 0 | 12,001 | 16,009 |
| **TOTAL** | **22,186** | **(8,658)** | **0** | **13,528** | 22,186 |

## 20. Contractual Capital Commitments

Commitments under capital expenditure contracts at the balance sheet totalled £6.63m (31 March 2008 £0.7m).

## 21. Post Balance Sheet Events

There are no post balance sheet events having a material effect on the accounts.

## 22. Contingent (liabilities)/assets:

| | 2008/09 | 2007/08 |
|---|---|---|
| | **£000** | £000 |
| LTPS Members contribution | **(30)** | (17) |

## 23. Related Party Transactions

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Homerton University Hospital NHS Foundation Trust.

Government Departments and their agencies are considered by HM Treasury as being related parties. During the year Homerton University Hospital NHS Foundation Trust has had a significant number of material transactions with Government Departments and their agencies. These entities are listed below:

| Name | Relationship | Commissioning Healthcare Income £000 | Other Services Income £000 | Commission Healthcare Expenditure £000 | Other Services Expenditure £000 |
|---|---|---|---|---|---|
| Barts and London NHS Trust | Commissioner | 260 | 0 | 3,132 | 0 |
| City and Hackney Teaching PCT | Commissioner | 90,834 | 0 | 126 | 0 |
| Department of Health | Commissioner | 23,388 | 0 | 0 | 0 |
| East London NHS Foundation Trust | Commissioner | 0 | 4,234 | 0 | 0 |
| Enfield PCT | Commissioner | 1,304 | 0 | 0 | 0 |
| Haringey Teaching PCT | Commissioner | 4,255 | 0 | 0 | 0 |
| Islington PCT | Commissioner | 3,026 | 0 | 0 | 0 |
| London Borough of Hackney | Council tax provider | 0 | 0 | 0 | 965 |
| London SHA | Commissioner | 9,866 | 0 | 5 | 0 |
| NHS Litigation Authority | Insurer | 0 | 0 | 0 | 2,928 |
| NHS PASA | Supplier | 0 | 0 | 0 | 2,135 |
| Newham PCT | Commissioner | 2,234 | 0 | 51 | 0 |
| Redbridge PCT | Commissioner | 1,388 | 0 | 0 | 0 |
| South East Essex PCT | Commissioner | 1,711 | 0 | 0 | 0 |
| Tower Hamlets PCT | Commissioner | 9,041 | 0 | 155 | 0 |
| Waltham Forest PCT | Commissioner | 3,418 | 0 | 0 | 0 |
| Yorkshire and the Humber SHA | Commissioner | 1,387 | 0 | 0 | 0 |

The Trust has also received revenue and capital payments from the Homerton University Hospital NHS Foundation Trust Charitable Fund. The Charity is registered with the Charity Commissioners (Charity Number 1061659) and has its own Trustees drawn from the NHS Trust Board. It produces a set of annual accounts and an annual report (separate to that of the NHS Foundation Trust) and these documents are available on request from the Finance Department.

## 24. Private Finance Transactions

### 24.1 PFI schemes deemed to be off-balance sheet

The Foundation Trust did not enter into any PFI schemes during 2008-09.

### 24.2 For the "Services" element of PFI schemes deemed to be on-balance sheet:

The Foundation Trust did not enter into any PFI schemes during 2008-09.

## 25. Financial Instruments

FRS 25,26 and 29, Derivatives and Other Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the continuing service provider relationship that the Foundation Trust has with local Primary Care Trusts and the way those Primary Care Trusts are financed, the Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which FRS 25, 26 and 29 mainly applies.

As allowed by FRS 25, 26 and 29, debtors and creditors that are due to mature or become payable within 12 months from the balance sheet date have been omitted from all disclosures other than the currency profile. Provisions should be shown gross. Any amount expected in reimbursement against a provision (and included in debtors) should be separately disclosed.

### Liquidity Risk

The NHS Trust's net operating costs are incurred under annual service agreements with local Primary Care Trusts, which are financed from resources voted annually by Parliament. The Foundation Trust also largely finances its capital expenditure from funds made available from Government under an agreed borrowing limit. The Foundation Trust is not, therefore, exposed to significant liquidity risks.

### Credit Risk

For the reasons stated above under Liquidity Risks, the Trust has no significant exposure to credit risks. In addition, although the Trust has an approved ovedraft facility of £11.0m, it was not used througout 2008-09.

### Interest-Rate Risk

All of the Trust's financial assets and all of its financial liabilities carry nil or fixed rates of interest. The Foundation Trust is not, therefore, exposed to significant interest-rate risk. The following two tables show the interest rate profiles of the Trust's financial assets and liabilities:

## 26.1 Financial Assets

| Currency | Fixed rate £000 | Floating rate £000 | Non-interest bearing £000 | 2008/09 £000 |
|---|---|---|---|---|
| At 31 March 2009 | | | | |
| Sterling | 12,000 | 6,349 | 102 | 18,451 |
| Other | 0 | 0 | 0 | 0 |
| **Gross financial assets** | **12,000** | **6,349** | **102** | **18,451** |
| | | | | |
| At 31 March 2008 (Prior year) | | | | |
| Sterling | 16,000 | 11,264 | 121 | 27,385 |
| Other | 0 | 0 | 0 | 0 |
| **Gross financial assets** | **16,000** | **11,264** | **121** | **27,385** |

## 26.2 Financial Liabilities

| Currency | Fixed rate £000 | Floating rate £000 | Non-interest bearing £000 | 2008/09 £000 |
|---|---|---|---|---|
| At 31 March 2009 | | | | |
| Sterling | 4,564 | 0 | 509 | 5,073 |
| Other | 0 | 0 | 0 | 0 |
| **Gross financial liabilities** | **4,564** | **0** | **509** | **5,073** |
| | | | | |
| At 31 March 2008 (Prior year) | | | | |
| Sterling | 5,078 | 0 | 535 | 5,613 |
| Other | 0 | 0 | 0 | 0 |
| **Gross financial liabilities** | **5,078** | **0** | **535** | **5,613** |

## 26.3 Fair Values

| | 2008/09 Book Value | 2008/09 Fair Value | Basis of fair valuation | 2007/08 Book Value | 2007/08 Fair Value |
|---|---|---|---|---|---|
| | £000 | £000 | | £000 | £000 |
| **Financial assets** | | | | | |
| Cash | 6,348 | 6,348 | | 11,255 | 11,255 |
| Debtors over 1 year: | | | | | |
| - Agreements with commissioners to cover creditors and provisions (see Note a) | 102 | 102 | | 121 | 121 |
| Investments | 12,001 | 12,001 | | 16,009 | 16,009 |
| **Total** | **18,451** | **18,451** | | 27,385 | 27,385 |
| **Financial liabilities** | | | | | |
| Provisions under contract | (509) | (509) | Note a | (535) | (535) |
| Loans | (4,564) | (4,564) | | (5,078) | (5,078) |
| Overdraft | 0 | 0 | | 0 | 0 |
| **Total** | **(5,073)** | **(5,073)** | | (5,613) | (5,613) |

**Notes**

a Fair value is not significantly different from book value since, in the calculation of book value, the expected cash flows have been discounted by the Treasury discount of 2.2% in real terms (2007/08 - 2.2%)

## 27. Third Party Assets

The Trust held £1,113 cash at bank at 31 March 2009 (31 March 2008 - £1,000) and these monies were held by the NHS Foundation Trust on behalf of patients. This amount has been excluded from the cash at bank and in hand figure reported in the accounts.

## 28. Intra-Government and Other Balances

| 28.1 Debtor and Creditor balances at 31 March 2009 | Debtors: amounts falling due within one year At March 2009 £000 | Creditors: amounts falling due within one year At March 2009 £000 |
|---|---|---|
| English NHS Foundation Trust | 89 | 1,389 |
| English NHS Trust | 334 | 577 |
| Department of Health | 0 | 0 |
| English Strategic Health Authority | 529 | 2 |
| English Primary Care Trusts | 2,614 | 67 |
| RAB Special Health Authorities | 16 | 1,130 |
| NHS CGA bodies | 0 | 0 |
| NHS WGA bodies | 0 | 25 |
| Other WGA bodies | 0 | 3,417 |
| | 3,582 | 6,607 |

| 28.2 Income and expenditure values for the year ending 31 March 2009 | Income Year Ended March 2009 £000 | Expenditure Year Ended March 2009 £000 |
|---|---|---|
| English NHS Foundation Trust | 4,259 | 308 |
| English NHS Trust | 430 | 4,030 |
| Department of Health | 23,388 | 0 |
| English Strategic Health Authority | 11,298 | 5 |
| English Primary Care Trusts | 121,239 | 343 |
| RAB Special Health Authorities | 0 | 6,232 |
| NHS CGA bodies | 0 | 0 |
| NHS WGA bodies | 10 | 0 |
| Other WGA bodies | 0 | 0 |
| | 160,624 | 10,918 |

## 29. Losses and special payments

| | Total £000 | Number |
|---|---|---|
| Losses | 8 | 19 |
| Special payments | 0 | 0 |
| | 8 | 19 |

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