West Middlesex University Hospital NHS Trust

Annual Report

1 April – 31 August 2015

Contents

Foreword from the Chief Executive

I am pleased to present the final annual report for West Middlesex University Hospital NHS Trust from 1 April to 31 August 2015. The reason this report only covers five months of activity is because on 1 September 2015 we became part of Chelsea and Westminster Hospital NHS Foundation Trust. Together we employ over 5,000 staff and provide a range of general hospital and specialist clinical services for a local population of nearly one million people and beyond.

However, whilst the integration of both trusts may have been the main headline over the past few months, I would like to highlight the progress that the hospital has made during a challenging five months. Although I only took up my post after both trusts had merged, I was privileged to visit the trust on many occasions prior to this and saw first-hand the outstanding contribution of our staff.

I would like to thank Jacqueline Totterdell, Chief Executive of the trust for the five months prior to integration and who told me that her focus during tenure was clear – to ensure the trust improved its quality of care, operational performance and financial position – and to effect a smooth transition in joining together with Chelsea and Westminster.

I believe she certainly did that and it is testament to everyone involved that whilst working hard to ensure everything was aligned across both sites to support the move, there was also a considerable increase in performance, particularly against some critical targets such as A&E waiting times.

We have also seen some innovative new models of care flourish, such as the Ambulatory Emergency Care (AEC) service which has now been open for a year and continues to receive excellent feedback, not least from Healthwatch Hounslow. Their recent independent review concluded 'the service is extremely well thought of, comprising of a clearly dedicated staff team which justifies consistently positive feedback among patients and healthcare professionals.'

As the new Chief Executive of the hospital, I am delighted that we continue to perform to the best of our ability and want to thank everyone for their extremely hard work over the past few months. I hope you are as keen as I am to embrace the opportunities that the integration will bring but equally to provide the best possible health and care services for our local communities.

Lesley Watts
Chief Executive

Welcome

Welcome to the final annual report for West Middlesex University Hospital NHS Trust. It covers the period between the Trust's last full annual report of 2014/15 up to the acquisition by Chelsea and Westminster Hospital NHS Foundation Trust – from 1 April 2015 to 31 August 2015. This report sets out our key achievements, successes and challenges during this period.

About us

West Middlesex is a busy modern hospital in Isleworth, serving a population of around 400,000 people in the London boroughs of Hounslow, Richmond upon Thames, Ealing and neighbouring areas. The West Middlesex University Hospital NHS Trust was established under the National Health Service and Community Care Act 1990 and became an NHS trust on 1 April 1993.

Our core services include:

- Full emergency department for major accidents and trauma, supported by an on-site urgent care centre (UCC)
- Emergency assessment and treatment services – we are a designated trauma unit and stroke unit
- Emergency and elective surgery, and medical treatments including day and inpatient surgery and endoscopy, outpatients, services for older people, acute stroke care and cancer services
- Comprehensive maternity services including consultant led care, a midwifery led natural birthing centre, antenatal and postnatal care, community midwifery support and a special care baby unit (SCBU)
- Children's services including emergency assessment, and inpatient and outpatient services
- Sexual health services
- Diagnostic services including an accredited pathology and imaging service
- A wide range of therapy services including physiotherapy and occupational therapy

Most of our services are commissioned by our local clinical commissioning groups, with the exception of our sexual health services which are commissioned by local authorities.

Strategic report

Our objectives

Our objectives inform the way in which we work and underpin the culture of our organisation overall – they are the standards against which we hold ourselves accountable and provide a solid foundation for continued and future improvements.

We are committed to providing a safe environment for patients and staff in which high quality care can be delivered and our objectives reflect this:

- **To improve health outcomes, clinical effectiveness, patient experience and safety**
- **To deliver financial and strategic sustainability**
- **To ensure we have a highly skilled, motivated and productive workforce**
- **To ensure our governance arrangements support organisational excellence**

We take information from a variety of sources – from patients, from the public, from staff, from local health partners, from regulators and from national guidance – and use this to review a range of areas across the trust to help maintain consistently high standards of care. Whenever we receive feedback – whether it is positive or not – we use this to shape our plans, train staff and drive improvements across our services. Our ultimate vision is to be a first class hospital for our community.

Improving health outcomes

We aim to achieve all of our performance initiatives to help improve patient outcomes, including reducing the number of avoidable days that patients spend in hospital and increasing the number of patients who can return home swiftly following discharge. We also want to reduce the need for patients to attend hospital in the first place by monitoring our outpatient follow up, non-elective re-attendance and readmission activity.

Improving clinical effectiveness

We want to ensure the care and treatment we provide not only serves to maintain and improve people's wellbeing, but also secures the greatest possible health gain. To do this, our teams work in a multi-disciplinary way, using well-established and evidence based practices within a safe and clean hospital environment. We also use national clinical effectiveness indicators to benchmark our performance.

Improving patient experience

A key priority for us is to meet the national waiting times for cancer, A&E and diagnostics, as well as the 18 week referral to treatment target. We have developed a set of standards that align with these goals which help us focus our efforts on achieving aggregate and speciality

targets. We also use information from patient surveys and the Friends and Family Test to develop action plans for improving our services in line with what people using our services tell us. Underpinning this is our strategic view of patient experience, which is to hold it in the same esteem as quality and safety of care.

Improving safety

We set ourselves very high targets for improving safety which are in line with national patient safety guidance. We also have ambitious standards for achieving the lowest possible rates of hospital acquired infections with a target of 19 per year for C.diff (Clostridium difficile) and 0 for MRSA (methicillin-resistant Staphylococcus aureus).

We also aim to achieve or good or better annual rating for PLACE (patient led assessments of the care environment) and for clinical cleanliness audits. All of this work is also carried out alongside our plans for maintaining our Care Quality Commission registration and delivering the improvements outlined by the regulator during our initial inspection last November and follow up unannounced visits in December.

To deliver financial sustainability

The NHS is experiencing significant financial pressures at the moment – more so now than at any time in its history. As such we remain committed to delivering against our financial plan and meeting the requirements of our cost improvement plans (CIPs). We do this by closely monitoring our activity and performance so that we can recognise potential risks and take swift action to mitigate these.

To deliver strategic sustainability

As a result of our financial position in 2012, the trust board carried out an assessment and concluded that West Middlesex University Hospital NHS Trust did not have long-term viability as a standalone organisation. Following a subsequent options appraisal and sustainability analysis review, we selected Chelsea and Westminster to be our partner.

As part of our aim to secure the future of the hospital, we joined forces on 1 September 2015. Although there is more work to be done as part of the 'Shaping a Healthier Future' programme for north west London, both hospitals are active participants in sector-wide strategies to help improve services and deliver better and more integrated models of care. These plans should provide the combined trust with greater resilience in the face of continuing and future challenges within the wider health economy.

To ensure we have a highly skilled, motivated and productive workforce

Whilst we are fortunate to have a staff with a strong work ethic, many of whom have been employed by the trust for some years, we want to reduce our trust-wide vacancies to 5% or below. We also want colleagues to feel supported in their development and to this end have

set targets for ensuring appraisals are carried out in a timely way and that there are strong job plans in place for our clinicians.

Following the latest staff survey we have also developed plans to improve staff engagement in areas where we scored in the bottom 20% or lower. We also have a monthly monitoring system to ensure that we are compliant with mandatory and statutory training targets, and have agreed our equality objectives for both our workforce and patient services.

To ensure that governance arrangements support organisational excellence

We have a robust board assurance framework that is linked to an action plan to support areas requiring development; this is reviewed on a quarterly basis. We also carry out quarterly internal self-assessments and inspections to ensure we remain compliant with our registration bodies, including the CQC (Care Quality Commission), MHRA (Medical and Healthcare Products Regulatory Agency) and HFEA (Human Fertilisation and Embryology Authority). We also have a communications strategy in place to support the delivery of a set of agreed key messages to articulate our overall governance aims and ambitions.

Our performance

Improving our services

In November 2014 West Middlesex underwent a four day inspection by the Care Quality Commission (CQC) under its new and more rigorous regime for hospital assessments. The CQC also made two further unannounced visits in December to gather further information before publishing their final report in April 2015.

Our services were rated against five key elements to examine if they were safe, effective, caring, well-led and responsive to people's needs. Across these domains CQC gave the trust 20 'good' ratings and 19 'requires improvement' – with one area not rated. The overall rating given to West Middlesex was 'requires improvement'.

Subsequently, CQC gave the trust 11 'must do' and 17 'should do' actions which were then discussed at a Quality Summit between the hospital, CQC and other local health partners. Following this a corporate action plan was developed which initially focussed on completing the 'must do' actions relating to quality and safety, and was then extended to include the 'should do' items as well.

A great deal of progress has been made since May 2015 and up until 1 September the trust board received regular updates on the status of each outstanding action, which were RAG (red amber green) rated to help the board scrutinise developments against the plan.

As part of the due diligence leading up to the integration of West Middlesex and Chelsea and Westminster – including discussions with CQC, NHS Trust Development Agency (TDA),

Monitor and local clinical commissioning groups – it was agreed the joint trust will conduct a full peer review across all CQC standards in October 2015 to ensure that we remain on track to achieve a good or outstanding status in all areas the next time we are assessed.

Safety and quality

We strive to provide a safe environment for patients and staff, in which high quality care can be delivered. We continually review our performance and take information from a variety of sources—from our patients, staff and partners – and from national findings such as the failings at Mid Staffordshire NHS Foundation Trust, outlined in the Francis report. We use this to review a range of themes to help maintain consistently high standards of care.

We are also transparent about patient safety incident reporting and use the NHS England 'Never Events' framework to openly tackle any potential issues that arise. 'Never Events' are serious cases that should not occur within a hospital if proper preventative measures have been implemented; data on 'Never Events' is recorded and published nationally. Between 1 April and 31 August 2015 we reported zero 'Never Events'.

We have an open culture where staff are encouraged to report incidents; in the 2014 NHS national survey we scored highly for staff feeling secure and supported when raising concerns about unsafe practices. We are also equally committed to being honest with the people who use our services, the wider public and everyone working with and for us.

Our core values form the basis of how we operate on a day to day basis to provide first class and compassionate care for every patient we see:

- **We will provide high quality and safe care**
- **We will be caring, respectful and welcoming**
- **We will be well organised**
- **We will listen and share information with you**

One of the reasons why we selected Chelsea and Westminster as our partner for integration was because they share very similar values to ourselves: safe, respectful, kind and excellent. Now that both trusts have joined forces we will be developing joint values together which underpin our ambitions for the combined organisation.

For more information on our approach to safety and quality you can read our Quality Account for 2014/15 online by visiting www.chelwest.nhs.uk.

Infection prevention and control

We take infection prevention and control very seriously – it is an essential part of the daily care we provide to patients and each member of staff working for the trust is committed to reducing hospital acquired infections. Not only do these contribute adversely to the quality of a patient's experience of care, they prolong stays in hospital and worsen existing health

conditions. We work closely with visitors to West Middlesex to help maintain good hand hygiene and a clean environment, which helps decrease the number of cases each year.

C.diff (Clostridium difficile)

Clostridium difficile is a type of infection that most commonly affects people who have received antibiotics during their time in hospital. Symptoms can range from mild to severe although once diagnosed it usually responds well to treatment.

In 2014/15 we saw just eight cases, which was significantly less than the upper limit of 19 which we had set. This year our goal has been no more than five cases and at 31 August 2015 we had only seen two cases in total, which suggests that our efforts to promote the careful use of antibiotics is helping to reduce the number of cases year on year.

MRSA (methicillin-resistant Staphylococcus aureus)

MRSA can be difficult to treat as it's resistant to a number of commonly used antibiotics and in serious cases it can also cause other life-threatening infections such as blood poisoning.

In 2014/15 we set an upper limit of zero and by the end of the year had three cases, which was two fewer than in the previous year. We set ourselves an upper limit of zero cases for 2015/16 and at 31 August 2015 we have had zero cases of MRSA, which is a direct result of our increased efforts to promote infection control measures across the hospital.

Information governance

Information governance is the term used to describe how we manage our organisational data to ensure it is dealt with legally, securely, efficiently and effectively – particularly in the case of personal or sensitive information. We adhere to the NHS national guidance for information governance and our board receives regular reports on any potential issues to ensure that these can be addressed at an early stage.

The four aims of good information governance are:

- To support high quality care through effective and appropriate use of information
- To help staff work closely together to prevent duplication of effort or data errors
- To provide staff with the tools to help them carry out their role and responsibilities to a high standard
- To give trusts critical information on their performance and help identify where opportunities exist for improvement

In the event of an information governance breach the incident must be rated and reported. Low severity events are defined at zero; two is the highest severity and must be reported to the Information Commissioner's Office. Between 1 April and 31 August 2015 we had zero information governance breaches.

Research and innovation

We are committed to using the latest research to help develop and deliver high quality and safe health care for patients which is supported by robust clinical evidence. Through sharing best practice and using cutting-edge innovative thinking we have been able to design new models of care to help patients access our services more effectively and to ensure that people receive the support and treatment they need at the right time and in the right place.

One example of this is our clinical research trials which study groups of patients with particular health needs to help improve care and treatment. Between April and September this year 329 patients took part in 42 research projects in 13 specialities.

We have also been awarded two grants from CLAHRC (Collaboration for Leadership in applied Health Research and Care) to fund two service improvement projects for asthma care and atrial fibrillation screening.

We are also an active member of the Imperial Academic Health Science Network, the Clinical Research Network North London and the Collaboration for Leadership in Applied Health Research and Care.

Emergency planning and preparation

Emergency planning involves making contingency plans and preparing for different types of serious events such as very bad weather, civil disasters or attacks. We use national NHS legislation and guidance to ensure we have detailed plans for responding to the increased demands that a major incident could make on our services, whilst continuing to provide care for existing and new patients.

To ensure we can manage any emergency with minimal disruption to our services we have an Emergency Preparedness Resilience and Response (EPPR) plan in place, together with a detailed Business Continuity plan. We train our staff in major incident procedures and regularly rehearse these plans, together with other partners in the local health care economy, such as neighbouring trusts, local authorities, police and ambulance services.

Additionally we carry out an annual review of our plans to make sure they are appropriately updated with the latest information based on existing intelligence about both the hospital and the environment external to the trust.

Our people

Staff gender breakdown

All Staff		
Gender	Headcount	%
Female	1581	79%
Male	417	21%
Total	**1998**	**100%**

Directors*		
Gender	Headcount	%
Female	3	50%
Male	3	50%
Total	**6**	**100%**

* as at 31 August 2015.

Senior Managers		
Gender	Headcount	%
Female	89	71%
Male	36	29%
Total	**125**	**100%**

Senior Manager Gender Breakdown by Agenda for Change Pay Bands		
Band	**Gender**	**Headcount**
Band 8 - A	Female	60
	Male	22
Band 8 - B	Female	19
	Male	7
Band 8 - C	Female	4
	Male	3
Band 8 - D	Female	5
	Male	3
Band 9	Female	1
	Male	1
Total		**125**

Most NHS staff (the main exceptions are doctors and directors) are paid within pay bands starting at band 1 through to band 9. For more information visit: www.nhscareers.nhs.uk/working-in-the-nhs/pay-and-benefits/agenda-for-change-pay-rates/

We provide services and care for an ethnically diverse local community across north west London which is reflected in the composite of our workforce. We have also maintained our 'two ticks' symbol in recognition of our positive approach to employing and supporting disabled colleagues who make up 3% of our staff.

Investing in and engaging with staff

We are fortunate to have a highly dedicated workforce at West Middlesex, completely committed to caring for the local communities we serve, many of whom have worked at the trust for years. We run a number of both staff recognition and health and wellbeing events to make sure colleagues feel valued and are supported with their own health and happiness.

We have a strong internal communications function to help keep staff up to date with developments at the trust – this was particularly crucial during the integration process and

we set up a special series of additional channels to help communicate the organisational changes. These included:

- A new weekly e-bulletin called 'Integration news'
- A new monthly staff newsletter called 'Connect'
- A series of face to face meetings with the chief executives and directors from both trusts – open to all members of staff working at either trust

We also established an integration information stand in the main atrium of West Middlesex to explain the rationale behind the merger for staff, patients and members of the public.

As a university hospital we also have a strong learning and development record, and an excellent reputation for providing the very best teaching as well as being a very friendly place in which to learn. Our approach to personal development and staff engagement is supported by feedback from across the trust – such as the most recent national survey – which placed us in the top 20% of acute trusts for staff feeling that they have the ability to contribute towards improvements in their workplace.

Following the integration with Chelsea and Westminster we will be developing a strategy across our hospital and community sites for engaging with our combined workforce. We recognise that staff involvement is a key driver in delivering excellent care and developing new and improved ways of working. We want to do all that we can to help harness the innovative ideas of our highly experienced and motivated colleagues.

Our patients

Listening and learning

We know that patient experience is fundamental to providing high quality healthcare – for this reason we aim to listen carefully to each and every one of our patients to hear what they have to say about our services. Not only do we want to understand their experiences of care, we want to capture their feedback and learn from it so that we can continue to make improvements wherever possible. We also want patients to feel that we are treating them with honesty, dignity and respect, and that they have the information they need to make informed choices about their care or treatment, and feel both confident and in control.

There are many ways in which we seek the views of patients and other visitors to West Middlesex in order to better understand what we are doing well and where there is room for improvement, including the Friends and Family Test, national patient surveys, our CQC inspection and the information we receive via PALS and our social media channels.

Following our integration we are now part of a foundation trust, which means our links to our local communities are strengthened as patients and members of the public can now join

the organisation as a member. This gives them the opportunity to learn more about our work and to provide feedback to help shape our services to best meet local needs.

Compliments, complaints and comments

We adhere to best practice for complaints handling as set out by the Parliamentary and Health Service Ombudsman under their Principles for Remedy, which you can view here: www.ombudsman.org.uk/improving-public-service/ombudsmansprinciples/principles-for-remedy. This includes using an individual approach to each complaint, being open and transparent, and seeking to put things right through continuous improvement.

Details of our complaints procedure and our complaints annual reports can be found on our website – www.chelwest.nhs.uk – as well as in our 'How to make a complaint' leaflet or by calling 020 8321 5630. We aim to provide a written reply or arrange a local resolution meeting within 25 working days of receiving a complaint. This performance is closely monitored through our weekly complaints tracker and weekly review meetings.

Between 1 April and 31 September 2015 we received 202 formal complaints. This was a slight decrease on the same period in 2014 when there were 205 formal complaints. The main themes emerging from these complaints were:

- Clinical treatment
- Appointments including delays and cancellation
- Values and behaviour (staff attitude)
- End of life care
- Communications
- Patient care including nutrition and hydration

During the same time period, two cases were reported to the Ombudsman (PHSO) and one of these was upheld. We have written to the family apologising and an action plan has been developed which addresses the Ombudsman's recommendations.

Timely feedback

We make use of social media to engage with our local community and at the time of writing we have over 5,800 followers on our Twitter profile. We use this platform not only to listen to patient experiences but also to communicate outwards to the local community.

We also closely monitor the NHS Choices website where, although much of the feedback is left anonymously, patients can rate the services we provide and the care they have received from us. As of 31 August we had a rating of 4 out of 5 stars, which compares favourably with other hospitals of a similar size. The information we take from here is shared with our PALS team and with service managers to action as necessary.

The NHS Friends and Family Test (FFT) is also a very useful tool which is used by both staff and patients to rate the trust.

The FFT questionnaire is offered to patients using the following services:

- A&E – adults and paediatrics
- Inpatients (includes day cases and day attenders) – adults and paediatrics
- Maternity (Antenatal, Birth, Postnatal Ward, Postnatal Community)
- Outpatients – adults and paediatrics
- Community services (sexual health, paediatrics and our heart failure clinic)
- Transport

Our most recent results show that:

- 91% of staff recommend our hospital for care
- 90% of staff recommend the hospital as a good place to work
- 87% of patients would recommend the hospital and its services to friends and family

FFT patient feedback is shared monthly with our clinical teams and operational managers. Each area is responsible for reviewing their feedback and taking the appropriate action as required. Overall, our FFT feedback is overwhelmingly positive and this has proved to be a strong motivational factor for staff. We display feedback, grouped by themes, in some of our clinical areas for this reason – it also helps to provide patients with additional assurance.

Our partners

Working together for the benefit of patients

We work closely with partners to develop our services for the benefit of our patients. This includes clinical commissioning groups, local authorities, Healthwatch organisations and charities such as The Mulberry Centre (www.themulberrycentre.co.uk), which is a support and information centre for anyone affected by cancer. We also work with neighbouring trusts as part of the 'Shaping a Healthier Future' programme for north west London.

As part of our integration with Chelsea and Westminster we will now have the opportunity to work collaboratively with larger numbers of partners to develop innovative new models of care that keep pace with the changes taking place within the NHS nationally and which further the integration agenda locally.

Our environment

Patient Led Assessments of the Care Environment (PLACE)

In August we received the results of our Patient Led Assessments of the Care Environment (PLACE) which were carried out in April prior to integration with Chelsea and Westminster. These assessed the hospital environment across five non-clinical areas – cleanliness, food and hydration, privacy, dignity and wellbeing, condition/appearance/maintenance and dementia. The process involved patients, the public and organisations with an interest in healthcare, such as the local Healthwatch, all of whom worked in partnership with staff to identify how the hospital is currently performing and any areas which can be improved.

We were delighted to come out well above the national average in all five areas and also to have improved on our scores for the previous two in all areas but one. Details of our scores in each category can be found in the table below, alongside the national averages for all types of health care organisations and acute hospitals.

	Cleanliness	**Food and Hydration**	**Privacy, dignity and wellbeing**	**Condition, appearance and maintenance**	**Dementia**
West Middlesex	99.47%	92.86%	91.67%	96.91%	79.82%
National average*	97.57%	88.49%	86.03%	90.11%	74.51%
Acute hospital average	97.5%	88.1%	85.1%	89.8%	72.6%

*national average for all types of healthcare organisation.

Performance summary

As of 31 August 2015, we met the majority of the key standards that the government and our commissioners (the organisations that buy services from us on behalf of our patients) set for us, and only narrowly missed others. Doing well against these standards shows we are providing our patients with the best possible care. Below is a summary of some of our key performance indicators, which should be read in conjunction with the main narrative of our previous annual and quality reports for a better understanding of the context of the measures.

Area	Performance indicator	Target 2015/16	Our performance at 31/8/15	Target 2014/15	Our performance 2014/15
Safety	MRSA bacteraemia cases	0	0	0	3
Safety	*Clostridium difficile* infection cases	<=9	5	<=19	8
Quality	Total time in A&E / UCC – (all types*) patients treated, admitted or discharged within 4 hours	>95%	96.0%	>95%	95.1%
Quality	Total time in A&E – (type 1*) patients treated, admitted or discharged within 4 hours	>95%	91.4%	>95%	88.9%
Quality	Patients with breast cancer symptoms waiting less than two weeks from referral	>=93%	94.8%	>=93%	97.7%
Quality	Cancer 2 week wait	>=93%	93.9%	>=93%	94.1%
Quality	31 day diagnosis to treatment for cancer: 31 day 1st treatment – tumour 31 day subsequent treatment – treatment group: Surgery Drug	 >=96% >=94% >=98%	 99.5% 100% 100%	 >=96% >=94% >=98%	 99.3% 100% 100%
Quality	62 days urgent referral to treatment for cancer: 62 day standard – tumour 62 day screening standard – tumour 62 day consultant upgrade	 >=85% >=90% >=85%	 89.7 85.7 77.6	 >=85% >=90% >=85%	 83.5% 85.3% 88.9%
Patient experience	18 week referral to treatment times: Patients admitted to hospital Patients not admitted to hospital	 >=90% >=95%	 95.0 97.0	 >=90% >=95%	 94.8% 97.1%

Remuneration report

The Remuneration Committee is a sub-committee of the trust board which determines the contractual terms, conditions and benefits, including salaries, of executive directors.

Membership of the committee comprises all the non-executive directors and the chairman. The chief executive and the director of workforce and development may also attend at the invitation of the committee.

The committee meets at least twice a year, and on an ad hoc basis as required, to determine pay issues and other matters referred to it by the board. The key principles applied by the committee are:

1. To set objectives for executive directors that are linked to the trust's corporate objectives and strategic priorities

2. To assess the performance framework used to evaluate the executive directors via the annual appraisal process with the chief executive and performance assessment by the chairman. These discussions are supplemented by reviews throughout the year. In line with NHS Trust Development Agency (TDA) requirements, the chairman has an external appraisal arranged through the Appointments Committee.

3. To determine the approach for remunerating executive directors using national guidance and benchmarking within and outside the NHS to determine appropriate levels. Individual posts may be reviewed in light of changes to responsibilities, market factors, pay relativities or other circumstances. Pay is not performance related.

Due to the unique circumstances surrounding the acquisition by Chelsea and Westminster NHS Foundation Trust which took place on 1 September 2015 , permanent executives who left during the 2014/15 financial year were replaced by directors working on secondment, a fixed term contract or off-payroll engagement. The skills and experience of each appointee was agreed and authorised by NHS TDA.

Notice periods for executive directors vary according to their employment status and typically will be one month as a minimum.

All contracts are made and terminated in accordance with best practice, employment law and NHS requirements. The trust does not make provision for compensation for early termination.

Information relating to off-payroll arrangements at senior manager level is shown below:

Off-payroll engagements as at 31 August 2015 (in excess of six months and costing more than £220 per day)

Number of existing arrangements as of 31 August 2015	
Of which, the number that have existed:	
For less than 1 year at time of reporting	7
Between 1-2 years at time of reporting	6
Between 2-3 years at time of reporting	2
Between 3-4 years at time of reporting	0
4 years or more at time of reporting	0

Assurance regarding tax arrangements has been received for 7 of the 15 appointments. The remaining are employed via agencies.

All new off-payroll engagements between 1 April 2015 and 31 August 2015 (in excess of six months and costing more than £220 per day)

Number between 1 April 2015 and 31 August 2015	**14**
Number for whom assurance has been requested*	6
Of which:	
Assurance received	6
Assurance has not been received	0
Engagements terminated as a result not being received, or ended before assurance received	0

*Assurance regarding tax arrangements has been received for 6 of the 14 appointments. The rest were employed through agencies.

The trust predominantly works with agencies on NHS national framework agreements and where this is not the case agencies were asked to provide assurance on tax obligations.

Trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the workforce. The annualised banded remuneration of the highest paid trust director in the financial year 2015-16 was £210k – £215k (2014-15, £200k - £210k). This was 5.91 times (2014-15, 6.05) the median remuneration of the workforce, which was £35.5k (2014-15, £35.1k).

There are no employees who received a payment higher than the highest paid director in both 2014/15 and 2015/16.

The impending acquisition saw some movement at very senior manager level and to ensure that the organisation continued to provide strong leadership leading up to the acquisition the trust filled posts temporarily thus attracting a higher costs per annum pro rata.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. Further details of employee benefits are provided in note 1.5 and 7.6 of the Annual Accounts available on our website: www.chelwest.nhs.uk

Staff Sickness Absence

	1/4/15 – 31/8/15 Number	2014/15 Number
Total days lost	5,441	9,853
Total staff years	1,823	1,747
Average working days lost	2.98	5.64

Please note that the number of days lost for 2015/16 only reflects the period April 2015 to August 2015.

Reporting of other compensation schemes – Exit Packages

Exit Packages agreed in 2015-16 (April to August)

	2015-16 (April to August)			2014-15		
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	Number	**Number**	**Number**	Number	Number	Number
Less than £10,000	0	0	0	0	1	1
Total number of exit packages by type (total cost)	**0**	**0**	**0**	0	1	1
Total resource cost (£s)	**0**	**0**	**0**	0	6,017	6,017

This note provides an analysis of exit packages agreed during the reporting period. Redundancy and other departure costs have been paid in accordance with the provisions of Agenda for Change scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table. There were no exit packages agreed during the reporting period.

Exit packages - Other Departures analysis

	2015-16 (April to August)		2014-15	
	Agreements	**Total value of agreements**	Agreements	Total value of agreements
	Number	**£'000**	Number	£'000
Contractual payments in lieu of notice	0	0	1	6
Total	0	0	1	6
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

This disclosure reports the number and value of exit packages agreed in the year.
The Remuneration Report includes disclosure of exit payments payable to individuals named in that report.

Salary and pension entitlement of senior managers

Salary and pension disclosure tables

Salaries entitlements of senior managers												
Name and Title	**2015 - 16**						**2014 - 15**					
	Salary (bands of £5,000)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)	Salary (bands of £5,000)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)
	£000	**£00**	**£000**	**£000**	**£000**	**£000**	**£000**	**£00**	**£000**	**£000**	**£000**	**£000**
Nicholas Gash - Chairman (started April 2015) (Left role as Non-Executive Director in March 2015)	5 - 10	-	-	-	-	5 - 10	5 - 10	-	-	-	-	5 - 10
Tom Hayhoe - Chairman (Left March 2015)	No director costs in 2015-16						20 - 25	-	-	-	-	20 - 25
Jacqueline Totterdell - Chief Executive * (Started March 2015)	75 - 80	7	-	-	-	75 - 80	No director costs in 2014-15					
Dame Jacqueline Docherty - Chief Executive (Left March 2015)	No director costs in 2015-16						195 - 200	-	-	-	35 - 37.5	230 - 235
Susan Sinclair - Director of Strategy (Started June 2014, left August 2015)	55 - 60	Information not available as not directly employed by the Trust				55 - 60	85 - 90	Information not available as not directly employed by the Trust				85 - 90
Anne Gibbs - Director of Strategy / Deputy Chief Executive (Seconded to TDA June 2014, left June 2015)	-	-	-	-	-	-	15 - 20	-	-	-	0 - 2.5	15 - 20
Roger Chinn - Medical Director (Started September 2014)	55 - 60	Information not available as not directly employed by the Trust				55 - 60	65 - 70	Information not available as not directly employed by the Trust				65 - 70
Stella Barnass - Medical Director (Left role August 2014)	No director costs in 2015-16						65 - 70	-	-	-	22.5 - 25	90 - 95
Jyoti Grewal - Acting Director of Workforce & Development (Started January 2015)	40 - 45	-	-	-	-	40-45	20 - 25	-	-	-	17.5 - 20	40 - 45
Nina Singh - Director of Workforce & Development (Left January 2015)	No director costs in 2015-16						85 - 90	-	-	-	35 - 37.5	120 - 125
Robert Hodgkiss - Director of Operations (Started April 2015)	45 - 50	Information not available as not directly employed by the Trust				45 - 50	No director costs in 2014-15					
Lucy Connolly - Director of Nursing, Midwifery & Quality (Started June 2015)	30 - 35	Information not available as not directly employed by the Trust				30 - 35	No director costs in 2014-15					
Gerrie Adler - Interim Director of Operations ** (Left April 2015)	5 - 10	Information not available as contracted through an agency				5 - 10	Contracted through an agency. Cost to the Trust disclosed in note below					
Charlotte Hall - Director of Nursing and Midwifery (Left May 2015)	15 - 20	-	-	-	5 - 7.5	20 - 25	65 - 70	-	-	-	No director costs in	65 - 70
Tonie Neville - Acting Director of Nursing and Midwifery (April 2014 - August 2014)	No director costs in 2015-16						30 - 35	-	-	-	No director costs in	30 - 35
Jon Bell - Interim Director of Finance (Started January 2015)	85 - 90	-	-	-	-	85 - 90	55 - 60	-	-	-	-	55 - 60
Bimal Patel - Acting Director of Finance (December 2014 - January 2015)	No director costs in 2015-16						5 - 10	-	-	-	7.5 - 10	15 - 20
Jonathan Molyneux - Interim Director of Finance *** (Started January 2014, left November 2014)	No director costs in 2015-16						Contracted through an agency. Cost to the Trust disclosed in note below					
Stephen Clark - Non Executive Director **** (Started June 2015)	0 - 5	-	-	-	-	0 - 5	No director costs in 2014-15					
Sarah Cuthbert - Non Executive Director	0 - 5	-	-	-	-	0 - 5	5 - 10	-	-	-	-	5 - 10
Luke De Lord - Non Executive Director	0 - 5	-	-	-	-	0 - 5	5 - 10	-	-	-	-	5 - 10
Jenny Higham - Non Executive Director	0 - 5	-	-	-	-	0 - 5	5 - 10	-	-	-	-	5 - 10
Mark Jopling - Non Executive Director	0 - 5	-	-	-	-	0 - 5	5 - 10	-	-	-	-	5 - 10

Nicholas Gash - Joined the Trust as Non-Executive Director in November 2005 and left the post to become Chairman in April 2015
*Jacqueline Totterdell - Chief Executive - No pension benefits are calculated as no prior year data
**Gerrie Adler - Interim Director of Operations - Total banded cost (£'000) for 2014/15 (205 - 210) which includes Agency fee and VAT
***Jonathan Molyneux - Interim Director of Finance - Total banded cost (£'000) for 2014/15 (275 - 280) which includes Agency fee and VAT
****Stephen Clark - Joined as a Non-Executive Director in June 2015

Pension entitlements of senior managers								
Name and title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 August 2015 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 August 2015 (bands of £5,000)	Cash Equivalent Transfer Value at 31 August 2015	Cash Equivalent Transfer Value at 31 March 2015	Real increase in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Jacqueline Totterdell - Chief Executive * (started March 2015)	62.5 - 65	192.5 - 195	60 - 65	190 - 195	1,167	-	1,167	-
Dame Jacqueline Docherty - Chief Executive (left March 2015)	-	-	-	-	-	-	-	-
Susan Sinclair - Director of Strategy (started June 2014)	Information not available as not directly employed by the Trust							
Anne Gibbs - Director of Strategy / Deputy Chief Executive (left June 2015 from secondment)	-	-	-	-	-	363	-	-
Roger Chinn - Medical Director (started September 2014)	Information not available as not directly employed by the Trust							
Stella Barnass - Medical Director (left role August 2014)	-	-	-	-	-	1,037	-	-
Jyoti Grewal - Acting Director of Workforce & Development ** (started January 2015)	-	-	5 - 10	25 - 30	124	135	-	-
Nina Singh - Director of Workforce & Development (left January 2015)	-	-	-	-	-	489	-	-
Robert Hodgkiss - Director of Operations (started April 2015)	No director costs in 2015-16							
Gerrie Adler - Interim Director of Operations (left April 2015)	Information not available as not directly employed by the Trust							
Charlotte Hall - Director of Nursing and Midwifery (left May 2015)	0 - 2.5	0 - 2.5	30 - 35	90 - 95	608	559	16	-
Tonie Neville - Acting Director of Nursing and Midwifery (left August 2014)	-	-	-	-	-	971	-	-
Jon Bell - Interim Director of Finance (started January 2015)	Information not available as not on the NHS Pension Scheme							
Bimal Patel - Acting Director of Finance (December 2014 - January 2015)	-	-	-	-	-	180	-	-
Jonathan Molyneux - Interim Director of Finance (left November 2014)	Information not available as not directly employed by the Trust							

As Non-Executive members do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive members.

* Jacqueline Totterdell, Chief Executive - No director costs in 2014/15

** Jyoti Grewal, Acting Director of Workforce & Development - Current pension figures incomplete due to change of pension scheme

Cash equivalent transfer values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real increase in CETV

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

Signed by…….Chairman

Name…….

Date……..

Signed by…….Chief Executive

Name…….

Date……..

Sustainability report

'A sustainable health and care system is achieved by delivering high quality care and improved public health without exhausting natural resources or causing severe ecological damage.'

Sustainability is very important component in the day to day running of the trust and in recent years we have made considerable strides towards achieving carbon reduction targets to support and allow wider environmental, social and economic benefits to be achieved.

We are committed to achieving the aims set out by the NHS Sustainable Development Unit (SDU), which is responsible for delivering a sustainable health and care system across the NHS in England. Their objectives include:

- Integrating sustainability in culture, practice and training
- Ensuring a balanced use of resources where waste becomes a resource
- Making sustainability everyone's business across the NHS

The Carbon Reduction Strategy published by the SDU in January 2009, aims to reduce the NHS 2007 carbon footprint by 10% by 2015. Beyond that the strategy is aimed at achieving overall UK Government targets of a 34% cut in carbon dioxide by 2020 (compared with 1990 levels) and an 80% cut by 2050.

As part of this strategy, trusts are required to report each year on sustainability as part of their annual reporting process to demonstrate progress on towards achieving targets. Our strategy for developing sustainable healthcare includes the following aims:

- Commitment to reach and exceed the Government target of 10% reduction on energy by 2015
- Achieving a reduction on our annual £1.3m per year energy costs
- Achieving a reduction on the annual circa £100k per year in Carbon Reduction Commitment (CRC) cost

This is set against a backdrop of challenges including:

- CRC increasing from £12/tonne to £16/tonne in 2014/15
- Increasing energy costs – a doubling of costs expected by 2020
- Increasing financial budget constraint pressures
- 2020 targets are onerous and beyond light touches already achieved through no and low cost opportunities
- The need for staff engagement and awareness campaigns for sustainability activities

Energy and carbon management

In 2010 we developed a trust-wide Carbon Reduction Strategy. At that point in time, our CO2 emissions from electricity and gas were determined to be 8,462 tonnes per annum. To normalise for weather variances a baseline was established using an average of three years of consumption data from April 2009 to March 2012 for electricity and gas. This equated to 22,079,649kWh of energy consumption per annum. Converting this to CO2 is equivalent to an annual CO2 emission rate of 8,288 tonnes.

Working with our partners Bouygues E&S, an Energy Performance Contract was put in place, with the provision of an underwritten investment, which forms the basis of a partnership agreement. The contract targets a 15% energy consumption reduction against the defined baseline with a five year guaranteed payback period. This was developed to allow us to obtain the benefits of a performance contract solution.

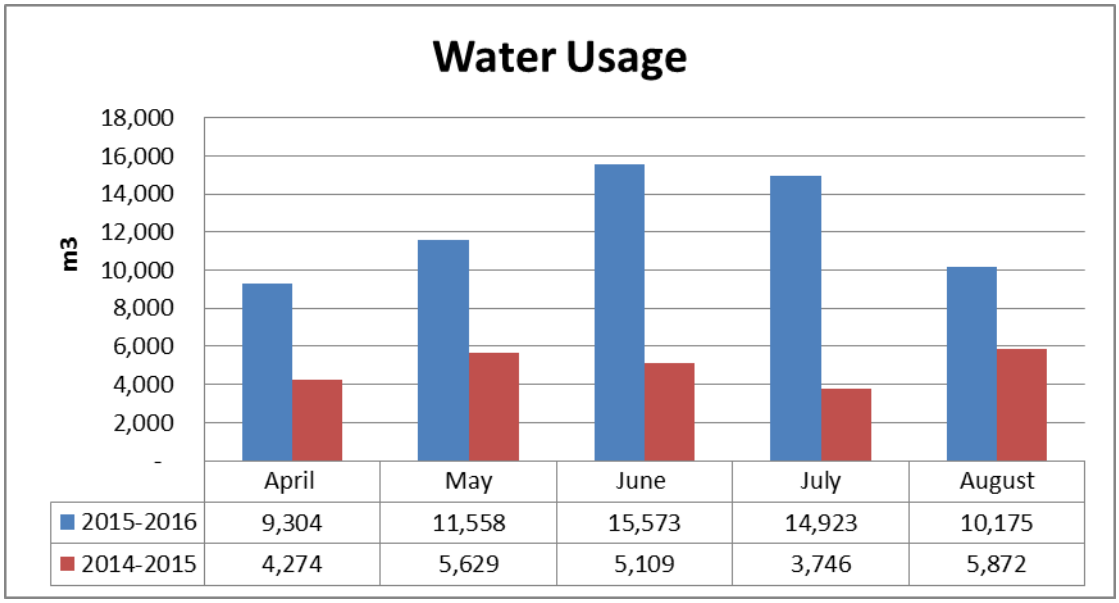
CRC reported figures

Footprint Report emissions (2010 - 2011)	7,119 /tCo^2	N/A
Annual Report emissions (2010 - 2011)	6,586 /tCo^2	£87,048
Annual Report emissions (2011 - 2012)	7,254/tCo^2	£81,276
Annual Report Submissions (2012 - 2013)	7,483/tCo^2	£89,796
Annual Report Submissions (2013 - 2014)	7549/tCo^2	£90,588
Annual Report Submissions (2014 - 2015)	7284/tCo^2	£119,457
Proposed Report submission (2015 -2016)		£16.90/tCo^2

Water

We are committed to reducing overall water consumption and wastage across the estate and as a result have been working with Thames Water to fit replacement valves to improve water reticulation systems on the hospital site. We have also undertaken verification and assessment of billing details.

The period 2014/2015 includes issues with the metering system which was resolved by Thames Water in April 2015. The average trend is shown below and is reducing.



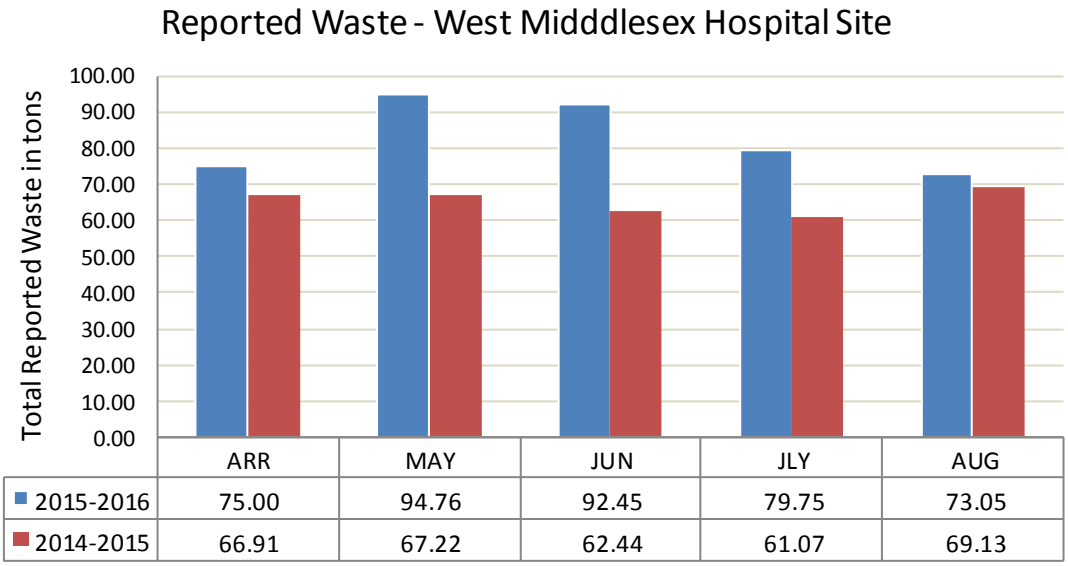
Waste minimisation and management

We continue to work hard on developing new opportunities to improve waste management at West Middlesex. Our current waste contractor is Biffa and we have an arrangement with them to help train staff in compliance with our waste policy, to assist in streamlining recyclable waste and to provide a single point of disposal for all types of waste.

The table below shows how our domestic waste tonnage is now significantly lower than in previous years and this trend is also reflected in our decreasing levels of clinical waste. The benefits of this are not just from an environmental perspective but clearly translate into a cost savings for the trust.

Waste 2015 - 2016	Apr-15	May-15	Jun-15	Jul-15	Aug-15	TOTAL
Infectious waste for incineration (Tonnes)	31.7	46.04	42.93	33.79	34.03	188.49
Infectious Health Care Sharps for incineration (Tonnes)	3.28	4.74	4.76	3.79	3.67	20.24
infectious Health Care Waste – Non Incineration	0	0	0	0	0	0
General Waste (Tonne) Open Skip	1.54	1.94	2.36	1.7	0	7.54
Waste Compactor Landfill Diversion generate Electricity	32.94	34.82	36.94	34.8	29.94	169.44
Trade Waste Landfill Diversion generate Electricity	1.6	3.11	0.86	0.84	1	7.41

Food Waste (Tonnes)	2.26	1.75	1.26	1.93	1.61	8.81
Confidential Collections (Tonnes)	1.68	2.36	3.34	2.9	2.8	13.08
Total Tonnes Waste	**75.00**	**94.76**	**92.45**	**79.75**	**73.05**	**415.01**



Our cost savings are a direct result of the reduced tonnage costs which ISS – our soft services facilities provider – has negotiated with its disposal contractors. This is essential to in order to promote the significance of waste reduction effectively across the trust.

Finance

The measures taken to achieve a reduction in energy usage have seen an improvement in financial terms as indicated below.

	2010/11	2011/12	2012/13	2013/14	2014/15
Energy Cost £	1,092,457	1,315,718	3,064,254	2,180,981	1,512,217

Governance Statement 1 April to 31 August 2015

Scope of responsibility

As Accountable Officer, and Chief Executive of the Trust Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives.

I also have responsibility for safeguarding quality standards, public funds and the organisation's assets for which I am personally responsible, as set out in the Accountable Officer Memorandum.

I assumed the role of chief executive on 14 September 2015 and received a full and comprehensive handover from Jacqueline Totterdell (former chief executive at West Middlesex) and induction which included meetings with the chairs of the sub-committees of the Trust Board both of which have provided me with assurance to enable me to make this Governance Statement.

A wide range of arrangements have been put in place to ensure the trust works closely with our partner organisations. Key examples include:

- Chief Executive and Director forums across the NHS in North West London
- Performance and quality review meetings with commissioners and the NHS Trust Development Authority (TDA)
- Health and Well Being Board
- The Health Overview and Scrutiny Committee
- Children's and Older People's Forums
- Hounslow and Richmond Healthwatch
- Academic Health Science Partnership
- London Cancer Alliance
- Shaping a Healthier Future Programme Board

The governance framework of the organisation

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

- Formulating strategy, defining objectives and agreeing plans for the trust
- Holding the organisation to account for delivery of that strategy and ensuring that systems for monitoring and control of performance are robust and effective
- Effecting a safe and appropriate transaction for the trust through a partnership with another organisation, thereby securing its long term future as a major hospital on the Isleworth site
- Shaping a positive culture for the Trust Board and the trust
- Ensuring financial stewardship
- Ensuring high standards of corporate and clinical governance
- Ensuring dialogue with external bodies and the local community.

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

The Trust Board is led by a non-executive chair and is made up of both executive and non-executive directors. The executive team consists of the chief executive and directors of the hospital who are responsible for the day-to-day running of the organisation. The non-executive directors bring their impartiality and specialised expertise to the Trust Board, providing the necessary scrutiny to ensure the effective governance of the organisation.

Five Trust Board meetings took place between 1 April and 31 August 2015 and were open to the public. The Trust Board has a number of sub-committees chaired by non-executive directors to provide greater scrutiny over the governance arrangements and to oversee all aspects of managing a complex organisation including clinical quality (patient experience, clinical effectiveness and safety) and operational performance of the hospital.

The Trust Board sub-committees are:

- **Remuneration Committee** – sets executive salary levels and monitors the NHS pay scheme
- **Audit Committee –** oversees the establishment and maintenance of an effective system of internal control throughout the organisation
- **Charitable Funds Committee** – oversees the management of the hospital's charitable funds

- **Finance and Performance Committee** – oversees financial and operational performance
- **Integrated Governance Committee** – monitors the clinical and non-clinical governance arrangements
- **Clinical Excellence Committee** – assesses and evaluates clinical performance
- **Equalities Committee** – oversees the delivery of the statutory duties in terms of staff and service delivery agendas

Prior to the acquisition of West Middlesex University Hospital NHS Trust, the Audit Committee reviewed internal and external auditor's reports. Following the acquisition the Chelsea and Westminster Hospital NHS Foundation Trust Audit Committee reviewed and approved the annual accounts.

In order for the Trust Board to receive assurance on the quality of data underpinning KPIs and the integrity of reporting of national targets we commissioned an internal audit review of data quality and assurance which concluded with a 'significant assurance' opinion with minor improvement opportunities. An action plan will be completed during 2015 to improve the quality of data to support the 18 week referral to treatment (RTT) indicator.

The Trust Board

Non-executive directors

Nick Gash, Chairman – appointed from 1 April 2015
Committees

- Remuneration (chair)
- Charitable Funds (chair)
- Finance and Performance (member)
- Clinical Excellence (member)
- Equalities (member)

Sarah Cuthbert
Committees

- Finance and Performance (chair)
- Clinical Excellence (member)
- Remuneration (member)
- Audit (member)

Jenny Higham
Committees

- Remuneration (member)

Mark Jopling

Committees

- Integrated Governance (chair)
- Remuneration (member)

Luke de Lord
Committees

- Audit (chair)
- Finance and Performance (member)
- Charitable Funds (member)
- Remuneration (member)

Stephen Clark – joined the Board on 20 May
Committees

- Clinical Excellence (chair)
- Finance and Performance (member)
- Remuneration (member)
- Equalities (chair)
- Integrated Governance (member)

Executive directors

Jacqueline Totterdell, Chief Executive – joined the Board 1 April 2015
Roger Chinn, Medical Director
Jon Bell, Finance Director
Charlotte Hall, Director of Nursing and Midwifery – left the Board on 22 May 2015
Lucy Connolly, Director of Nursing and Midwifery – joined the Board on 1 June 2015
Jyoti Grewal, Director of Workforce and Development
Gerrie Adler, Director of Operations – left the Board on 9 April 2015
Robert Hodgkiss, Director of Operations – joined the Board on 20 April 2015

All Trust Board members have signed a declaration of compliance with the NHS Codes of Conduct, Accountability and Openness and the trust has not reported any breaches of these codes. In addition all members have completed a self-declaration in accordance with 'fit and proper persons' regulations.

None of the executive or non-executive directors hold company directorships or other significant interests, which may conflict with their management responsibilities. A copy of the Register of Interests is available upon request from the Trust Chairman.

The directors confirm that as far as they are aware there is no relevant audit information of which the NHS body's auditors are unaware and they have taken all the steps that they

ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the NHS body's auditors are aware of that information.

Record of attendance at Trust Board and sub-committee meetings

The tables below detail attendance at the Trust Board and sub-committee meetings – all meetings were quorate between 1 April and 31 August 2015.

	Trust Board (held in public)	**Charitable Funds**	**Audit**	**Finance and Performance**
Number of meetings held in 2015	5	0	2	4
Nick Gash	5 of 5	N/A	N/A	3 of 4
Sarah Cuthbert	5 of 5	N/A	3 of 3	4 of 4
Mark Jopling	2 of 5	N/A	N/A	N/A
Jenny Higham	3 of 5	N/A	N/A	N/A
Luke de Lord	5 of 5	N/A	3 of 3	2 of 4
Stephen Clark	2 of 3	N/A	3 of 3	2 of 2
Jacqueline Totterdell	5 of 5	N/A	N/A	2 of 4
Susan Sinclair	4 of 4	N/A	N/A	1 of 4
Roger Chinn	5 of 5	N/A	N/A	N/A
Jon Bell	3 of 5	N/A	N/A	4 of 4
Jyoti Grewal	5 of 5	N/A	N/A	2 of 4
Charlotte Hall	1 of 2	N/A	N/A	N/A
Lucy Connolly	3 of 3	N/A	N/A	N/A
Gerrie Adler	1 of 1	N/A	N/A	1 of 1
Robert Hodgkiss	4 of 4	N/A	N/A	2 of 3

	Integrated Governance	Remuneration	Equalities	Clinical Excellence
Number of meetings held in 2015	1	1	1	4
Nick Gash	1 of 1	1 of 1	1 of 1	4 of 4
Sarah Cuthbert	N/A	1 of 1	N/A	2 of 4
Mark Jopling	0 of 1	1 of 1	N/A	N/A
Jenny Higham	N/A	1 of 1	N/A	N/A
Luke de Lord	N/A	1 of 1	N/A	N/A
Stephen Clark	1 of 1	1 of 1	1 of 1	2 of 2
Jacqueline Totterdell	N/A	N/A	0 of 1	N/A
Susan Sinclair	0 of 1	N/A	N/A	N/A
Roger Chinn	1 of 1	N/A	N/A	4 of 4
Jon Bell	N/A	N/A	N/A	N/A
Jyoti Grewal	N/A	N/A	1 of 1	N/A
Charlotte Hall	N/A	N/A	N/A	1 of 1
Lucy Connolly	0 of 1	N/A	N/A	2 of 3
Gerrie Adler		N/A	N/A	N/A
Robert Hodgkiss		N/A	N/A	N/A

Approved minutes of each sub-committee are presented to the Trust Board at meetings held in private and the chairs highlight key issues and decisions made at their meeting.

I can confirm the I have arrangements in place for the discharge of statutory functions and that these have been reviewed for irregularities and they are legally compliant with the exception of the trust's duty to break even which is described in more detail in the Finance Review of the Annual Report.

The trust directors are required to prepare a Quality Account (sometimes known as a Quality Report) for each financial year. This is developed by clinicians and senior managers within the trust, in conjunction with stakeholders and partner organisations including commissioners at Hounslow Clinical Commissioning Group and the local Healthwatch. The director of nursing, supported by the medical director, has overall responsibility to lead and advises on all matters relating to the preparation of the trust's Quality Account.

Each year our priorities remain the improvement of patient care and are identified under the three domains of quality:

- Patient Safety
- Clinical Effectiveness
- Patient Experience.

The Quality Account for West Middlesex University Hospital NHS Trust will be included in a report published by Chelsea and Westminster Hospital NHS Foundation Trust in June 2016.

There is a robust system for providing assurance through the reporting and responding to adverse incidents. All Serious Incidents, including Never Events, are investigated and reviewed on a regular basis by the Trust Board. The trust has reported zero 'Never Events' from 1 April to August 31 2015. 24 serious incidents were reported in the same timeframe, all of which were subject to a root cause analysis investigation.

The lessons learnt and subsequent action plans to mitigate future risks are shared within the relevant division and, where appropriate, more broadly across the organisation. Serious incidents are reported at each Trust Board meeting and a summary of each incident can be viewed in the papers published on our website. The incident categories are listed below.

Themes April 1 to August 31 2015	**Total YTD**
Unexpected admission to NICU	1
Pressure Ulcer Grade 3	12
Maternity /Obstetric Incident baby only	1
Unexpected potentially avoidable death	3
Delayed Diagnosis	3
Medication incident	1
Radiation incident (including exposure when scanning)	1
Other	1
Sub-optimal care of the deteriorating patient	1
Total	**24**

Analysis of these and all adverse incidents and near misses, actions taken and evidence of representation in the Risk Register is monitored by the Clinical Quality and Risk and Corporate Quality Committees which report to the Integrated Governance Committee. All and any incidents still ongoing at 31 August 2015 will be formally reviewed by the Chelsea and Westminster Hospital NHS Foundation Trust Quality Committee.

Clinical audit reports are presented to the Clinical Excellence Committee on a quarterly basis which provides assurance regarding the trust's participation in national clinical audits and confidential enquires as well as local audits. Issues are identified, collated and taken forward to improve the quality of healthcare.

The annual health and safety report is presented to the Trust Board and provides assurance that the trust is meeting its statutory obligations and that there are sound systems of control in place.

Risk Assessment

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 on-going process designed to:

- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in West Middlesex University Hospital NHS Trust for the year ended 31 March 2015 and continues through this half yearly update from 1 April to 31 August 2015.

The trust continues to give a high priority to addressing the risk management process. As Chief Executive Officer, I have explicit ultimate responsibility for the management of risk through the director of nursing and midwifery and the medical director who act as executive leads for governance and risk, covering all aspects of clinical and non-clinical risk with the exception of specific financial risk which is covered by the director of finance role.

The trust has a risk management strategy and policy that is reviewed and updated at least annually. The strategy defines the process by which risk to the organisation is identified and quantified using a risk scoring matrix to represent actual risk. The policy also lays down the structure of the trust Risk Register and the arrangements for regular review of the register at both the corporate and divisional levels.

The governance and risk function supports the trust-wide management of risk through the Divisional Quality and Risk Groups where learning from incidents, complaints and audits as well as best practice is shared. All risk management issues are reported to the Clinical Quality and Risk and Corporate Quality and Risk Committees. Both of these committees are chaired by an executive director and include other executive directors of the trust.

The Governance and Risk Department in conjunction with the Training and Development Department provides and monitors an extensive training programme to all staff covering all statutory and mandatory elements of risk management. This also includes training on risk awareness, assessment and mitigation and health and safety.

From the 1 April 2015, there was an average of 3 highest scoring red rated risks identified within the trust, which reduced over the year to 2 as at 31 August 2015. These high scoring risks are managed and monitored via the divisions and corporate department risk registers, where they identify the source of the risk and the respective actions or treatment required to either reduce or eliminate such risks.

A common theme of the red rated risks over the year relates to infection prevention and control risks and their associated targets. A new red risk emerged over the latter half of the year (2014/15), which identified a theme affecting a large majority of NHS trusts in the UK – compliance against A&E quality indicators.

The risk associated with the trust's long term future was reduced from a red risk as a result of assurance being gained through external scrutiny, including approval by the Competition and Mergers Authority following their analysis that did not find any negative impact on local healthcare by the proposal for Chelsea and Westminster Hospital NHS Foundation Trust to acquire West Middlesex University Hospital NHS Trust. This risk will now be removed from the register following the acquisition by Chelsea Westminster.

There were in total 224 active divisional or corporate department level risks on the trust's Risk Register as at 31 August 2015. All risks continue to be monitored and we have robust measures in place to mitigate and manage each one.

The Clinical/Corporate Quality and Risk Committees, which meet monthly/bi-monthly, have an overarching responsibility for ensuring there is continuous and measurable improvement in the quality of services provided. Through regular monitoring of their own work and the work of groups and committees from which they receive reports, it assures the Integrated Governance Committee (sub-committee of the Trust Board) of progress in the management of risks associated with its activities – clinical, financial, environmental and organisational, and that risks are being appropriately managed. The Clinical/Corporate Quality and Risk Committees receive the minutes from the monthly meetings of the divisional or corporate departments and reports on other business considered by those committees.

The risk and control framework

Risk management is embedded throughout the organisation from the Trust Board to the individual employee. This provides both a top down and bottom up approach to the management of risk in the trust.

The Trust Board reviews corporate risks against the achievement of the trust's objectives which are identified via the Board Assurance Framework (BAF). The BAF was in place throughout the year ending 31 March 2015, including this half yearly update ending 31 August 2015. The BAF was reviewed by the Trust Board on a regular basis.

At divisional and service level, risk is identified in the respective divisional Risk Registers and reviewed through the Corporate Quality and Risk Groups that report into the overarching Integrated Governance Committee. Aspects of risk management, particularly related to statutory and mandatory training are monitored centrally and followed up through the trust's appraisal processes in addition to monitoring at the Divisional and Corporate Quality and Risk Committee meetings.

Results of patient and staff surveys and resulting action plans are also incorporated into the Risk Register. Complaints and the resulting actions are reviewed and analysed through the Divisional Clinical Quality and Risk Groups. The Integrated Governance Committee is chaired by a non-executive director and oversees these arrangements on behalf of the Trust Board.

Over the past six months, the trust monitored its compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010. From 1 April 2015, new fundamental standards regulations came into force to provide a more comprehensive assessment of care quality. The trust incorporated these requirements into its risk and control framework.

In November 2014, the Care Quality Commission (CQC) carried out a planned inspection of the trust which reported in April 2015 an overall rating of 'requires improvement'. This was the first time the trust had been inspected under the new regime, which involves an in-depth review of the quality and safety of services, and of people's experiences of care.

The CQC report outlined some key areas of best practice and excellence which included a consistently 'good' rating for providing caring services. Inspectors observed that the hospital has a friendly and supportive culture, with medical, nursing and support staff working closely together in teams, and that patients and their families felt personally involved in their care plans and treatment. CQC also noted that the trust is very good at keeping patients safe whilst treating them with compassion, dignity and respect.

The inspection report made 11 'must do' recommendations which are the actions required to maintain our regulatory compliance with the CQC. A subsequent action plan was

produced which identified a lead executive director and a management lead against each compliance action. The 'must do' (compliance) plan has since been monitored weekly through the executive directors meeting and monthly via the Clinical Quality Risk Committee with individual directors providing assurance of progress to the Trust Board.

In addition there were also 17 'should do' recommendations which will form part of the expanded improvement plan. These actions, together with a number of 'areas for improvement' pulled directly from the report, should take the trust from 'Requires Improvement' to 'Good' or 'Outstanding'.

All three clinical divisions now have CQC action planning as a standing agenda item on their divisional Clinical Quality and Risk meetings and have developed a standard action plan to meet all areas for improvement. The Trust Board receives regular updates on progress.

Our external auditors, KPMG, carried out two audits in April and August 2015 (we received the report in September 2015), both recorded 'significant assurance' against the trust's risk management systems and included a high level review of the trust's Risk Strategy; this also looked at the process of maintaining, monitoring and reporting on the Corporate Risk Registers.

Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of our system of internal control. My review is informed in a number of ways:

- The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance as part of the internal audit work
- Executive directors who have responsibility for the development and maintenance of the system of internal control also provide me with assurance

The trust has well developed systems and processes for managing its resources. The annual budget setting process for 2015/16 was approved by the Trust Board and communicated to all managers in the organisation. The director of finance and his team worked closely with divisional and corporate managers throughout the year to ensure a robust annual budget was prepared and delivered.

An integrated finance and performance report is presented to the Executive, Finance and Performance Committee and Trust Board.

The Board Assurance Framework (BAF) provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. As the trust moved towards the acquisition, the Trust Board agreed the

transitions from the BAF to a new reporting mechanism – the Risk Assurance Framework. This was to enable a smooth transition and management of risks after 1 September 2015.

My review is also informed by reports from our external auditors in their Management Letter and other reports including: the self-assessment declaration against the Board Statement and Compliance Framework, the Care Quality Commission, the commissioners and NHS Trust Development Authority (TDA) monitoring of performance and clinical governance and other external bodies such as Imperial College and North West Thames Foundation School.

The Audit Committee provides assurance to the Trust Board on governance and internal controls through monitoring and interrogation of evidence throughout the year.

Our internal audit team also undertook two reviews between 1 April and 31 August 2015 – these were a core financial and risk management review – both of which enabled them to issue the head of internal audit opinion.

I have been informed of implications of the result of my review of the effectiveness of the system of internal control through the Trust Board and sub-committees. I plan to address weaknesses and ensure continuous improvement of the systems in place.

Significant issues for the trust during 2015/16

1. As a result of the trust's financial position in 2012 the Trust Board carried out an assessment and concluded that the trust was not viable as a stand-alone organisation. In April 2013, it announced its preferred acquirer to be Chelsea and Westminster Hospital NHS Foundation Trust. Throughout 2014/15 the trust continued to work closely with Chelsea and Westminster on its plans for the acquisition. Significant progress was made during the year and a number of key milestones were met including approval of the outline business case by the Chelsea and Westminster Trust Board and also clearance by the Competition and Markets Authority to proceed to the next stages. The initial date for integration was 1 July but this was delayed until 1 September 2015 to ensure that the trust, along with our partners, could take the necessary time to get the important regulatory processes right.

2. The trust's self-certification against the Trust Board statements and compliance framework set out in the NHS Trust Development Authority (TDA) oversight and escalation process. During the year the trust declared non-compliance with the following Trust Board statement:

   Statement 13 – '*The Trust Board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their*

functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability'.

A risk was reported in relation to the overall resilience of the executive and senior management team. This was due to the relative lack of organisational memory and high turnover of staff in the executive team due to the proposed transaction with Chelsea and Westminster Hospital NHS Foundation Trust. Timely action was then taken to ensure that all Trust Board level and senior posts were recruited to on an interim basis or, where appropriate, a permanent basis to mitigate this risk.

Signed…… Dated……

Lesley Watts
Chief Executive Officer

Finance summary and review

West Middlesex University Hospital NHS Trust was acquired by Chelsea and Westminster Hospital NHS Foundation Trust on 1 September 2015.

As a result, West Middlesex University Hospital NHS Trust was dissolved by order of the Secretary of State for Health on 19 August 2015, with an effective date of transfer of 1 September 2015.

The finance report is, therefore, for the period April 2015 – August 2015.

The trust was unable to meet its statutory breakeven duty for the five month period, but did meet the NHS TDA's agreed plan of a £6.1m deficit position. This position was agreed in early April 2015 and the trust was monitored against this for the part-year.

A summary of the key financial targets for the part-year are:

	Target	Description
1.	Income and expenditure during the year	The trust reported a deficit of £6.1m in line with target
2.	Cumulative break even duty and in-year breakeven duty	Due to deficits in previous years, the trust started this year with a cumulative deficit of £30.9m. The mid-year reported deficit (see Statement of Comprehensive Income) of £6.1m has increased the cumulative deficit to £37m, and so cumulative and in-year break even duty target has not been met
3.	Manage cash within External Financing Limit (EFL) set by the Department of Health	The trust operated within its approved limits and had a cash holding of £4.3m at the end of August 2015
4.	Achieve a 3.5% return on assets employed	The trust expensed £0.9m in dividends to the Department of Health to meet this target
5.	Ensure Capital expenditure is within Capital Resource Limit (CRL) limits set by the	The trust spent £1.1m on capital expenditure which is in line with its resource limit

Department of Health

6.	Better payments practice code - to pay 95% of creditors within 30 days of invoice	For the mid-year, based on the value of invoices paid, the trust paid 93% of non-NHS and 62% of NHS creditors within 30 days.

The trust's income and expenditure position at the date of acquisition was a £6.1m deficit. Income totalled £70.0m and costs were £76.1m. The deficit was in line with the plan agreed by the TDA.

Together with the usual infrastructure upgrades and equipment replacement programmes, the trust has continued to invest in high specification technology while maintaining its general infrastructure.

Plans for 2015/16 include:

- Expansion of Paediatrics unit - £1.4m
- Trust-wide WIFI - £0.45m
- Pharmacy robot upgrade - £0.46m
- Maternity K2 system - £0.3m

The trust received £2.1m of cash (in the form of Public Dividend Capital) to support the deficit position and to carry on trading. The cash holding as at 31 August was £4.3m.

Other financial issues

In 2008/09, the trust received a £17 million loan from the Department of Health, of which £15.3 million remained outstanding at the end 2014/15. As part of the acquisition, the TDA agreed to write-off the loan and this transaction took place just before the acquisition, leaving West Middlesex without any Department of Health loans. More information can be found in the Borrowings Note in the trust's main accounts.

Directors' representation

The statement of directors' responsibilities in respect of the accounts is signed by the chief executive and director of finance. The statement confirms that the directors have, to the best of their knowledge, complied with all audit requirements and that there is no relevant information of which the trust's auditors are not aware. The directors have taken all steps they ought to have been taken in order to make themselves aware of any relevant audit information and to establish that the trust's auditors are aware of that information.

External auditors' remuneration

Ernst and Young (EY) are the trust's auditors for the five months in 2015-16 (as advised by the Audit Commission). The fees charged to the trust's expenditure account in respect of audit fees are £71k. EY will also be undertaking the audit of the West Middlesex Hospital Charity (Charity number 1061153). There are no non-audit fees that the trust pays to EY.

Internal audit

Internal audit services are provided by KPMG and they report to the Audit Committee. The annual internal audit plan ensures that regular checks are carried out on key financial and operational internal controls and that there is compliance with policies and procedures.

Counter fraud

The trust has a Whistle-blowing Policy to ensure all staff are able to report concerns regarding any aspect of their work, the conduct of others, or the running of the trust, in confidence and with confidence. Counter fraud services are provided via a contract with TIAA, who help to promote an anti-fraud culture within the trust and carry out reviews of trust policies to ensure they are aligned with the most up-to-date legislation. TIAA also investigate suspected cases of fraud, bribery or corruption and undertakes proactive reviews of areas identified to be at risk via Fraud Risk Assessments.

West Middlesex University Hospital NHS
NHS Trust

AUDITED FINANCIAL STATEMENTS

1st APRIL 2015 TO 31st AUGUST 2015

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF WEST MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST

We have audited the financial statements of West Middlesex University Hospital NHS Trust for the period ended 31 August 2015 under the Local Audit and Accountability Act 2014. The financial statements comprise the Trust Statement of Comprehensive Net Expenditure, the Trust Statement of Financial Position, the Trust Statement of Changes in Taxpayers' Equity, the Trust Statement of Cash Flows and the related notes 1 to 32. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2015-16 Government Financial Reporting Manual (the 2015-16 FReM) as contained in the Department of Health Group Manual for Accounts 2015-16 and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

We have also audited the information in the Remuneration and Staff Report that is subject to audit, being:

- the table of salary and pension entitlement of senior managers and related narrative notes on pages 22 - 24;
- the tables of exit packages and related notes on page 21; and
- the narrative note on pay multiples on page 19.

This report is made solely to the Board of Directors of West Middlesex University Hospital NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of Directors, the Accountable Officer and auditor

As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, set out on page 6, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error.

This includes an assessment of:

- whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the directors; and
- the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report and accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on the financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of West Middlesex University Hospital NHS Trust as at 31 August 2015 and of its expenditure and income for the period then ended; and
- have been prepared properly in accordance with the National Health Service Act 2006 and the Accounts Directions issued thereunder.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Accounts Direction made under the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the annual report and accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters:

- in our opinion the governance statement does not comply with the NHS Trust Development Authority's guidance; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

In respect of the following we have matters to report by exception:

- Referral to the Secretary of State

On 26 February 2016, we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014, as in reporting a deficit for the financial period ended 31 August 2015, and a cumulative deficit the Trust had breached its breakeven duty as set out in Paragraph 2(1) of Schedule 5 to the National Health Service Act 2006 as interpreted by the Department of Health in its detailed guidance on breakeven duties.

Certificate

We certify that we have completed the audit of the accounts of West Middlesex University Hospital NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Kate Handy

Kate Handy
for and on behalf of Ernst & Young LLP
Southampton25/5/2016

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- value for money is achieved from the resources available to the trust;

- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

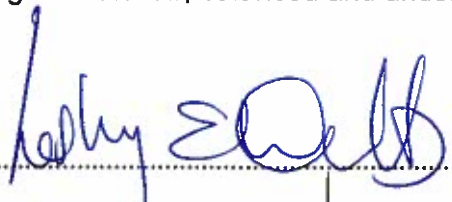
- effective and sound financial management systems are in place; and

- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

I confirm that, as far as I am aware, there is no relevant audit information of which the trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the trust's auditors are aware of that information.

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Signed.....  .....Chief Executive

Date.25.05.16

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

- make judgements and estimates which are reasonable and prudent;

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

25.05.16 Date..... Chief Executive

25.05.16 Date..... Chief Financial Officer

Statement of Comprehensive Net expenditure for 5 months ended 31 August 2015

	NOTE	2015-16 (April to August) £000	2014-15 £000
Gross employee benefits	7.1	(45,861)	(103,832)
Other operating costs	5	(27,154)	(64,506)
Revenue from patient care activities	3	63,088	146,936
Other operating revenue	4	6,899	20,452
Operating deficit		(3,028)	(950)
Investment revenue	9	8	16
Other gains	10	0	6
Finance costs	11	(2,194)	(5,060)
Deficit for the financial year		(5,214)	(5,988)
Public dividend capital dividends payable		(889)	(1,866)
Deficit for the year		(6,103)	(7,854)

Other Comprehensive Income

Net gain on revaluation of property, plant & equipment	12.1	2,114	617
Total comprehensive expenditure for the year		(3,989)	(7,237)

Financial performance for the year

Deficit for the year	(6,103)	(7,854)
Prior period adjustment to correct errors and other performance adjustments	0	0
IFRIC 12 adjustment	0	0
Impairments	0	0
Adjustments in respect of donated gov't grant asset reserve elimination	6	21
Adjusted deficit	(6,097)	(7,833)

NHS Trusts have a requirement to break even taking one year with another. The break even is calculated taking into account the retained surplus/deficit for the year adjusting for accounting differences arising under IFRS. The difference between the accounting outturn (£6,103k deficit) and the reported performance (£6,097k deficit) is in relation to the following accounting adjustments:

In respect of International Financial Reporting Interpretations Committee (IFRIC) 12 - Service Concession Arrangements. The Private Finance Iniative (PFI) is part of the Trust's Property, Plant and Equipment and therefore, may incur additional expenditure which is shown within IFRIC 12 adjustment. The IFRIC adjustment is showing as zero because under UK GAAP the PFI would have cost the Trust an additional £67k (as per note 26). The Department of Health does not reduce the Trust's performance as a result, and therefore the value shown is zero.

Impairment adjustments are made in respects of the revaluation of land and buildings for which there is no revaluation reserve. There were no such adjustment in 2015-16.

Accounting policy changes in 2011/12 for donated and government granted assets meant that depreciation on these assets can no longer be offset by release in reserves or income. Therefore, the adjustment of £6k reflects the position as though the release in reserves or income had been allowable.

The notes on pages 11 to 41 form part of this account.

Statement of Financial Position as at 31 August 2015

	NOTE	31 August 2015 £000	31 March 2015 £000
Non-current assets:			
Property, plant and equipment	12.1	**114,355**	113,687
Intangible assets	13.1	**754**	417
Total non-current assets		**115,109**	114,104
Current assets:			
Inventories	16	**2,071**	2,118
Trade and other receivables	17.1	**13,708**	12,495
Cash and cash equivalents	18	**4,287**	1,030
Total current assets		**20,066**	15,643
Total assets		**135,175**	129,747
Current liabilities			
Trade and other payables	20	**(23,106)**	(15,671)
Provisions	24	**(254)**	(245)
Borrowings	21	**(1,193)**	(1,133)
Working capital loan from Department of Health	21	**0**	(15,300)
Total current liabilities		**(24,553)**	(32,349)
Net current liabilities		**(4,487)**	(16,706)
Total assets less current liabilities		**110,622**	97,398
Non-current liabilities			
Provisions	24	**(498)**	(504)
Borrowings	21	**(35,075)**	(36,760)
Total non-current liabilities		**(35,573)**	(37,264)
Total Assets employed:		**75,049**	60,134
Financed by:			
Taxpayers' equity			
Public Dividend Capital		**52,910**	35,146
Retained deficit		**(30,224)**	(25,261)
Revaluation reserve		**52,363**	50,249
Total taxpayers' equity		**75,049**	60,134

The notes on pages 11 to 41 form part of this account.

The financial statements on pages 7 to 10 were approved by the Board on 24/03/2016 and signed on its behalf by

Chief Executive: _____ **Date:** 25.05.16

Statement of Changes in Taxpayers' Equity
For the period ending 31 August 2015

	NOTE	Public dividend capital	Retained earnings	Revaluation reserve	Total reserves
		£000	£000	£000	£000
Balance at 1 April 2015		**35,146**	**(25,261)**	**50,249**	**60,134**
Changes in taxpayers' equity for the year ended 31 August 2015					
Deficit for the year		0	(6,103)	0	**(6,103)**
Net gain on revaluation of property, plant, equipment	12.1	0	0	2,114	**2,114**
Public Dividend Capital (PDC) received - cash		17,764	0	0	**17,764**
Other movements		0	1,140	0	**1,140**
Net recognised revenue/(expense) for the year		**17,764**	**(4,963)**	**2,114**	**14,915**
Balance at 31 August 2015		**52,910**	**(30,224)**	**52,363**	**75,049**
Balance at 1 April 2014		27,196	(17,407)	49,632	59,421
Changes in taxpayers' equity for the year ended 31 March 2015					
Deficit for the year		0	(7,854)	0	(7,854)
Net gain on revaluation of property, plant, equipment	12 2	0	0	617	617
Transfers between reserves		0	0	0	0
Transfers under Modified Absorption Accounting - PCTs		0	0	0	0
New PDC received - cash		12,900	0	0	12,900
New PDC received - PCTs Legacy items paid for by Department of Health		0	0	0	0
PDC repaid in year		(4,950)	0	0	(4,950)
Net recognised revenue/(expense) for the year		7,950	(7,854)	617	713
Transfers between reserves in respect of modified absorption - PCTs		0	0	0	0
Balance at 31 March 2015		35,146	(25,261)	50,249	60,134

During the year the District Valuer carried out a full valuation of land and buildings on Modern Equivalent Asset (MA) basis, effective on 31st August 2015. This resulted in a net upward revaluation of £2,114k in the Trust's buildings. The valuation gain is recognised as an increase to the Revaluation Reserve.

Statement of Cash Flows for the Period ended 31 August 2015

	NOTE	2015-16 (April to August) £000	2014-15 £000
Cash Flows from Operating Activities			
Operating (Deficit)/Surplus		(3,028)	(950)
Depreciation and Amortisation		2,250	5,229
Impairments and Reversals		0	0
Interest Paid		(2,187)	(5,036)
Dividend Paid		0	(2,103)
Increase in Inventories	16	47	(397)
Decrease/(Increase) in Trade and Other Receivables		(1,213)	1,506
(Decrease)/Increase in Trade and Other Payables		6,703	(1,507)
Provisions utilised		(41)	(50)
Increase in Provisions		36	69
Net Cash Inflow/(Outflow) from Operating Activities		2,567	(3,239)
Cash flows from Investing Activities			
Interest Received		8	16
(Payments) for Property, Plant and Equipment		(1,270)	(4,759)
(Payments) for Intangible Assets		(28)	(208)
Proceeds of disposal of assets held for sale (PPE)		0	14
Net Cash Outflow from Investing Activities		(1,290)	(4,937)
Net Cash Inform / (outflow) before Financing		1,277	(8,176)
Cash Flows from Financing Activities			
Public Dividend Capital Received		17,764	12,900
Public Dividend Capital Repaid		0	(4,950)
Loans received from DH - New Revenue Support Loans (previously known as Working Capital Loans)		2,096	0
Loans repaid to DH - Working Capital Loans/Revenue Support Loans		(17,396)	0
Other Loans Repaid		(62)	(139)
Capital payments in respect of finance leases and PFI arrangements		(422)	(835)
Net Cash Inflow from Financing Activities		1,980	6,976
Net Increase/(Decrease) in Cash and Cash Equivalents		3,257	(1,200)
Cash and Cash Equivalents at Beginning of the Period		1,030	2,230
Cash and Cash Equivalents at End of Period		4,287	1,030

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS Trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2014-15 issued by the Department of Health and with consideration given to the draft DH manual for 2015/16. These accounting requirements will be furtherr eviewed on publication of the final 2015/16 DH manual for accounts for NHS Trusts.The accounting policies contained in the current published manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention and Going Concern

These accounts have been prepared under the historical cost convention, modified by the revaluation of property plant and equipment. Intangible assets and inventories are measured at cost. The accounts have been prepared on a going concern basis.

The Trust has recorded a deficit of £6.1m for the 5 month accounting period ended 31 August 2015 and a breakeven cumulative deficit of £37.0m as at 31 August 2015. This is further detailed in note 30.1 – breakeven performance.

The Trust has net current liabilities of £4.5m. The working capital loan of £15.3m, due to the Department of Health, included within net current liabilities in the prior year was settled during the current financial period.

The Trust Board carried out an assessment in 2012 and concluded that the Trust was not viable as a standalone entity and would need to be acquired by another organisation. The Trust announced in April 2013 that the preferred acquirer was Chelsea & Westminster Hospital NHS Foundation Trust (C&W). The Competition and Markets Authority (CMA) approved the acquisition in December 2014. As part of the planned acquisition by Chelsea and Westminster, West Middlesex University Hospital NHS Trust was dissolved, by Order of the Secretary of State for Health on 19 August 2015, with an effective date of 1st September 2015. This is further detailed in note 27 – events after the end of the reporting period.

Although the Trust will be dissolved, the functions, assets and liabilities will be transferred to the newly formed combined NHS organisation. When reconfigurations of this nature take place within the public sector, IAS1 Presentation of Financial Statements, requires management to assess, as part of the annual accounts preparation, as to the Trust's ability to carry on as a going concern. The Secretary of State further ordered, on the 21st of August 2015, under a Transfer Order with an effective date of the 1st of September 2015, that all staff, property and liabilities be transferred to the new combined organisation, the transferee, being Chelsea and Westminster Hospital NHS Foundation Trust. This confirmation of a continuation of the provision of the Trust's services by way of a Transfer order is sufficient evidence of a going concern and is the appropriate basis upon which to prepare these accounts. The combined larger Trust will benefit from clinical synergies as well as critical mass and will be better placed to respond swiftly to the rapidly changing healthcare environment as well as take advantage of initiatives such as Shaping a Healthier Future (SaHF) should see it able to sustain long term resillience.

The financial statements have therefore been drawn up at 31st August 2015 on the same basis as in previous years, reporting balances on the same basis as would a continuing organisation. As a result, the Trust has made no disclosures under IFRS 5, Non-Current Assets held for sale and Discontinued Operations.

1.11 Acquisitions and discontinued operations

Activities are considered to be acquired only if they are taken on from outside the public sector. Activities are considered to be discontinued only if they cease entirely. They are not considered to be discontinued if they transfer from one public sector body to another.

1.2 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of income and expenditure as well as assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods. Where income has been received in advance of the delivery of the associated service then the Trust will defer that income to the future period.

1.2.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

The Trust has adopted the 'IFRS Accounting for PFI Grantor' model as provided by the Department of Health to calculate the carrying values associated with the PFI.

1.2.2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Entries for the PFI are calculated from the Full Business Case and adjusted for the District Valuer's valuations at 30 April 2004, 31 March 2009 and each subsequent year thereafter.

Key estimations for the Trust are:

- Provisions for doubtful debts: refer to note 17
- Provisions: refer to note 24
- Estimated useful life of assets: refer to accounting policy number 1.9
- Valuations: refer to accounting policy number 1.7

1.3 Movement of assets within the DH Group

Transfers as part of reorganisation are accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCNE, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS20 and similarly give rise to income and expenditure entries.

For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, Treasury agreed that a modified absorption approach should be applied. For these transactions and only in the prior-period, gains and losses are recognised in reserves rather than the SOCNE.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.4 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay/costs incurred to date compared to total expected costs.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The NHS Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.5 Employee Benefits

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

Retirement benefit 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. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.6 Other expenses
Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.7 Property, plant and equipment

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

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

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value, excpet for fixtures and equipment which are held at depreciated replacement cost.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:
- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Notes to the Accounts - 1. Accounting Policies (Continued)

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.8 Intangible assets

Recognition

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

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.9 Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS Trust expects to obtain economic benefits or service potential from the asset. This is specific to the NHS Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives or the trem of the finance lease, if shorter.

At each reporting period end, the Trust considers whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Notes to the Accounts - 1. Accounting Policies (Continued)

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.

AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

The economic life of fixed assets are as follows:
- Buildings 4 - 69 years
- Plant and Machinery 7 - 15 years
- Information Technology 5 -10 years
- Furniture and Fittings 7 - 10 years

Amortisation
The economic life of intangible assets (Software licence's) up to 7 years.

1.10 Non-current assets held for sale

Non-current assets are classified as held for sale, within current assets, if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.
Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.11 Donated assets
Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.12 Government grants
The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.13 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as lessee
Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The Trust as lessor
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.14 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12 - Service Concession Arrangements. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:
a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI asset
The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16 - Property, Plant & Equipment.

PFI liability
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17 - Leases.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Trust to the operator for use in the PFI scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the NHS Trust's Statement of Financial Position.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.15 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.16 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

1.17 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.20% in real terms (1.30% for employee early departure obligations). This will be reviewed on confirmation by the DH of the final rates to be used for 2015/16.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

1.18 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 24.

1.19 Non-clinical risk pooling

The NHS Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS 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 as and when they become due.

1.20 Carbon Reduction Commitment Scheme (CRC)

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.21 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.22 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

Financial assets are classified into loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Notes to the Accounts - 1. Accounting Policies (Continued)

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

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

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

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.23 Financial liabilities
Financial liabilities are recognised on the statement of financial position when the NHS Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

1.24 Other financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

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

1.26 Foreign currencies
The Trust's functional currency and presentational currency is Sterling. Transactions denominated in a foreign currency are translated into Sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

1.27 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 32 to the accounts.

1.28 Public Dividend Capital (PDC) and PDC dividend
Public dividend capital represents taxpayers' equity in the NHS Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

1.29 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

Notes to the Accounts - 1. Accounting Policies (Continued)

1.30 Accounting Standards that have been Issued but have not yet been adopted

The Treasury Financial Reporting Manual (FReM) does not require the following Standards and Interpretations to be applied in 2015-16.

- IFRS 9 Financial Instruments - Application required for accounting periods beginning on or after 1 January 2018.
- IFRS 14 Regulatory Deferral Accounts - Not yet EU endorsed
- IFRS 15 Revenue from Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2017.

1.31 Subsidiaries

Following Treasury's agreement to apply IFRS 10 "Consolidated financial Statements" to NHS Charities from 1 April 2013, the Trust has established that as the Trust is the Corporate Trustee of the linked NHS Charity (West Middlesex University Hospital Charity), it effectively has the power to exercise control so as to obtain economic benefits. However the transactions are immaterial in the context of the group and transactions have not been consolidated.

2. Operating segments

The Trust Board has considered its reporting requirements under IFRS 8 "Operating segments" and has determined that the Tru activities fall within the scope of a single heading of healthcare for the purpose of disclosing operating segments within statements.

IFRS 8 requires that the Chief Operating Decision Maker (CODM) regularly reviews the performance of the operational ele organisation and makes decisions on resource allocation on this basis. The Trust has determined that the Trust Board of Directo the CODM and that they review operational performance and make key decisions at monthly Board meetings. There is n reporting for revenue, assets or liabilities of different operational areas of the Trust to the Trust Board. Expenditure is reported a level to the Trust Board. However, all activities of the Trust are considered to be one reportable segment, being Healthcare, and individual segments on which to make disclosures.

There are some minor differences between the financial information presented to the CODM, as at the 31st August 2015, and th presented in the Trusts draft accounts for 5 months to the end of August. These differences are expected as upto date informati the 2015/16 accounts is published by the DH.

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3. Revenue from patient care activities

	2015-16 (April to August) £000	2014-15 £000
NHS Trusts	489	1,044
NHS England	5,282	10,441
Clinical Commissioning Groups	55,235	131,234
Foundation Trusts	114	254
Non-NHS:		
Local Authorities	1,514	3,113
Private patients	69	149
Overseas patients (non-reciprocal)	181	256
Injury costs recovery	162	338
Other	42	107
Total Revenue from patient care activities	63,088	146,936

4. Other operating revenue

	2015-16 (April to August) £000	2014-15 £000
Recoveries in respect of employee benefits	815	1,030
Education, training and research	3,612	9,464
Non-patient care services to other bodies	100	198
Income generation	453	1,090
Rental revenue from operating leases	262	636
Other revenue	1,657	8,034
Total Other Operating Revenue	6,899	20,452
Total operating revenue	69,987	167,388

Other revenue is mainly in relation to support for the Transaction with C&W and Short-term Maternity expansion.

5. Operating expenses

	2015-16 (April to August) £000	2014-15 £000
Services from other NHS Trusts	1,942	4,643
Services from NHS Foundation Trusts	88	114
Total Services from NHS bodies*	2,030	4,757
Purchase of healthcare from non-NHS bodies	221	307
Trust Chair and Non-executive Directors	21	52
Supplies and services - clinical	11,688	27,873
Supplies and services - general	2,687	4,606
Consultancy services	511	2,223
Establishment	622	1,412
Transport	63	108
Service charges - PFI arrangements and other service concession arrangements	4,630	10,815
Business rates paid to local authorities	335	635
Premises	333	2,455
Hospitality	1	3
Insurance	2	4
Legal Fees	52	25
Impairments and Reversals of Receivables	82	124
Inventories write down	25	31
Depreciation	2,178	5,097
Amortisation	72	132
Impairments and reversals of property, plant and equipment	0	0
External auditor's remuneration for statutory audit	71	126
Internal auditor's remuneration	27	77
Clinical negligence	1,273	3,164
Education and Training	165	364
Change in Discount Rate	0	17
Other	65	99
Total Operating expenses (excluding employee benefits)	27,154	64,506
Employee Benefits		
Employee benefits excluding Board members	45,292	102,515
Board members**	569	1,317
Total Employee Benefits	45,861	103,832
Total Operating Expenses	73,015	168,338

* Services from NHS bodies does not include expenditure which falls into a category below.

** Board members include Executive Board members only as the pay for the Chair and Non-Executive Board members is included in operating expenses above as they are not employees of the Trust. Full Director disclosures can be found in the Remuneration Report.

6 Operating Leases

The Trust has an existing operating lease for the rental of the Maternity Theatres and Natural Birthing Unit, which commenced in 2009 and is for a nine year duration. In 2014-15, the Trust increased the number of leased units to include four more blocks, the contract commenced on 9th June 2014 and is for a duration of three years. The rent is determined by reference to the lease agreement.

The Trust entered into an operating lease for a Computerised Tomography (CT) scanner in 2010-11 for a duration of five years. The rent for this is also determined by reference to the lease agreement.

The Trust has entered in to a new operating lease for the supply of photocopying services across the Trust. This is for the period of seven years starting November 2013.

6.1 Trust as lessee

	Buildings	Other	2015-16 (April to August) Total	2014-15 Total
	£000	£000	£000	£000
Payments recognised as an expense				
Minimum lease payments	1,088	345	1,433	1,433
Total	**1,088**	**345**	**1,433**	1,433
Commitments in respect of leases expiring				
No later than one year	2,768	417	3,185	3,113
Between one and five years	3,412	0	3,412	6,333
After five years	0	0	0	151
Total	**6,180**	**417**	**6,597**	9,597

6.2 Trust as lessor

The Trust has three lessor agreements on Trust buildings and land. Imperial College lease the Renal Unit and charges are made with regard to actual costs associated with the premises. Alliance Medical lease land for their MRI unit and a contract has been agreed in respect of lease charges that takes into consideration charges from the company to the Trust for MRI scans. Hounslow and Richmond Community Healthcare NHS Trust lease land and building for the Urgent Care Centre (UCC).

	2015-16 (April to August) £000	2014-15 £000
Recognised as revenue		
Rental revenue	262	636
Total	**262**	636

The current year's rental revenue includes an amount of £37k relating to lease of building to Alliance Medical, £76k relating to the Renal Unit and nephrology leased by Imperial College NHS Trust and £149k relating to the lease of the UCC land and building to Hounslow & Richmond Community Healthcare NHS Trust. Due to the nature of the latter two lease agreements, the annual revenue amounts are variable and due to the uncertainty are not included in the disclosure below, as no reasonable estimate can be made.

	2015-16 (April to August) £000	2014-15 £000
Receivable in respect of leases expiring		
No later than one year	90	90
Between one and five years	248	285
After five years	0	0
Total	**338**	375

7 Employee benefits and staff numbers

7.1 Employee benefits

	Total £000	Permanently employed £000	Other £000
Employee Benefits - Gross Expenditure 2014-15			
Salaries and wages	39,095	31,028	8,067
Social security costs	3,041	2,878	163
Employer Contributions to NHS BSA - Pensions Division	3,802	3,645	157
Total employee benefits	45,938	37,551	8,387
Employee costs capitalised	77	0	77
Gross Employee Benefits excluding capitalised costs	45,861	37,551	8,310

Employee Benefits - Gross Expenditure 2014-15	Total £000	Permanently employed £000	Other £000
Salaries and wages	87,896	72,194	15,702
Social security costs	7,199	6,758	441
Employer Contributions to NHS BSA - Pensions Division	8,771	8,441	330
TOTAL - including capitalised costs	103,866	87,393	16,473
Employee costs capitalised	34	0	34
Gross Employee Benefits excluding capitalised costs	103,832	87,393	16,439

7.2 Staff Numbers

	2015-16 (April to August) Total Number	Permanently employed Number	Other Number	2014-15 Total Number
Average Staff Numbers				
Medical and dental	401	348	53	381
Administration and estates	380	327	53	355
Healthcare assistants and other support staff	286	215	71	275
Nursing, midwifery and health visiting staff	822	709	113	791
Scientific, therapeutic and technical staff	219	204	15	214
Other	16	16	0	15
TOTAL	2,124	1,819	305	2,031
Of the above - staff engaged on capital projects	2	0	2	1

7.3 Staff Sickness absence and ill health retirements

	2015-16 (April to August) Number	2014-15 Number
Total Days Lost	5,441	9,853
Total Staff Years	1,823	1,747
Average working Days Lost	2.98	5.64

	2015-16 (April to August) Number	2014-15 Number
Number of persons retired early on ill health grounds	0	5
	£000	£000
Total additional pensions liabilities accrued in the year	0	345

The staff sickness absence and ill health retirement information is provided by the DH.

Exit Packages agreed in 2015-16 (April to August)

	2015-16 (April to August)			2014-15		
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	Number	**Number**	**Number**	Number	Number	Number
Less than £10,000	0	0	0	0	1	1
Total number of exit packages by type (total cost)	0	0	0	0	1	1
Total resource cost (£s)	0	0	0	0	6,017	6,017

This note provides an analysis of exit packages agreed during the reporting period. Redundancy and other departure costs have been paid in accordance with the provisions of Agenda for Change scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table. There were no exit packages agreed during the reporting period.

Exit packages - Other Departures analysis

	2015-16 (April to August)		2014-15	
	Agreements	**Total value of agreements**	Agreements	Total value of agreements
	Number	**£'000**	Number	£'000
Contractual payments in lieu of notice	0	0	1	6
Total	0	0	1	6
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

This disclosure reports the number and value of exit packages agreed in the year.

7.6 Pension costs

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

In order that the defined benefit obligations recognised in the financial statemements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FREM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on valuation data as at 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19 "Employee Benefits", relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow contribution rates to be set by the secretary of Sate for Health, with consent of HM treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

Scheme provisions

The NHS Pension Scheme provides defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

- The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

- With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

- 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. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the retail Prices Index (RPI).

- Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable

- For early retirements other than those due to ill health the additional pension liabilities are not funded by the Scheme. The full amount of the liability for the additional costs is charged to the employer.

- Members can purchase additional service in the NHS Scheme and contribute to money purchase Additional Voluntary Contributions (AVC's) run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

8 Better Payment Practice Code

8.1 Measure of compliance

	2015-16 (April to August)		2014-15	
	Number	£000	Number	£000
Non-NHS Payables				
Total Non-NHS trade invoices paid in the year	**18,328**	**28,136**	41,802	70,953
Total Non-NHS trade invoices paid within target	**17,310**	**26,161**	40,084	67,402
Percentage of NHS trade invoices paid within target	**94%**	**93%**	96%	95%
NHS Payables				
Total NHS trade invoices paid in the year	**600**	**5,949**	1,498	15,279
Total NHS trade invoices paid within target	**413**	**3,706**	1,149	10,944
Percentage of NHS trade invoices paid within target	**69%**	**62%**	77%	72%

Under the Better Payment Practice Code the Trust aims to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

9 Investment Revenue

	2015-16 (April to August) £000	2014-15 £000
Bank interest	8	16
Total investment revenue	8	16

10 Other Gains

	2015-16 (April to August) £000	2014-15 £000
Gain on disposal of assets other than by sale (Property, Plant and Equipment)	0	6
Total	0	6

11 Finance Costs

	2015-16 (April to August) £000	2014-15 £000
Interest		
Interest on loans	368	812
Interest on obligations under finance leases	27	74
Interest on obligations under PFI contracts:		
- main finance cost	1,161	2,826
- contingent finance cost	630	1,325
Total interest expense	2,186	5,037
Provisions - unwinding of discount	8	23
Total	2,194	5,060

Interest on loans is final interest payments made to the Department of Health on permanent and interim loans. The Trust received Public Dividend Capital cash to make these payments.

12.1 Property, plant and equipment

2015-16 (April to August)	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:							
At 1 April 2015	31,000	69,568	780	28,418	10,773	1,396	141,935
Additions of Assets Under Construction	0	0	567	0	0	0	567
Additions Purchased	0	535	0	10	1	0	546
Reclassifications	0	40	(591)	170	0	0	(381)
Disposals other than for sale	0	0	0	(10,287)	(1)	0	(10,288)
Upward revaluation/positive indexation	0	1,096	0	0	0	0	1,096
At 31 August 2015	31,000	71,239	756	18,311	10,773	1,396	133,475
Depreciation							
At 1 April 2015	0	0	0	19,697	7,555	996	28,248
Disposals other than for sale	0	0	0	(10,288)	0	0	(10,288)
Upward revaluation/positive indexation	0	(1,018)	0	0	0	0	(1,018)
Charged During the Year	0	1,018	0	732	394	34	2,178
At 31 August 2015	0	0	0	10,141	7,949	1,030	19,120
Net Book Value at 31 August 2015	31,000	71,239	756	8,170	2,824	366	114,355
Asset financing:							
Owned - Purchased	31,000	34,491	756	8,134	2,824	366	77,571
Owned - Donated	0	102	0	3	0	0	105
Owned - Government Granted	0	0	0	33	0	0	33
Held on finance lease	0	386	0	0	0	0	386
PFI contracts	0	36,260	0	0	0	0	36,260
Total at 31 August 2015	31,000	71,239	756	8,170	2,824	366	114,355

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Assets under construction & payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
At 1 April 2015	25,486	24,763	0	0	0	0	50,249
Movements - Revaluation	0	2,114	0	0	0	0	2,114
At 31 August 2015	25,486	26,877	0	0	0	0	52,363

Additions to Assets Under Construction to end of August 2015	£000
Land	0
Buildings excluding Dwellings	567
Dwellings	0
Plant & Machinery	0
Balance as at YTD	567

During the accounting period the District Valuer (DV) carried out a full valuation of land and buildings with an effective date of the 31st August 2015, on a Modern Equivalent Asset (MEA) basis. The last quinquenial revaluation took place in the 2013/14 financial year and this was also carried out by the DV on a MEA basis. All revaluations have been taken to the revaluation reserve. The book value of non-property assets are deemed to be at fair value.

The DV is a member of the Royal Institute of Chartered Surveyors (RICS) which is an independent representative professional body which regulates construction and property professionals in the UK and around the world. Further the DV has been carrying out valuations for the Trust continuously since 2009 (and prior to that as part of the central DH exercise).

12.2 Property, plant and equipment prior-year

2014-15	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:							
At 1 April 2014	29,500	70,897	929	27,012	9,661	1,101	139,100
Additions of Assets Under Construction	0	0	780	0	0	0	780
Additions Purchased	0	1,952	0	1,599	201	295	4,047
Reclassifications	0	0	(929)	12	917	0	0
Disposals other than for sale	0	0	0	(205)	(6)	0	(211)
Revaluation	1,500	(3,281)	0	0	0	0	(1,781)
At 31 March 2015	31,000	69,568	780	28,418	10,773	1,396	141,935
Depreciation							
At 1 April 2014	0	0	0	18,248	6,556	947	25,751
Disposals other than for sale	0	0	0	(202)	0	0	(202)
Revaluation	0	(2,398)	0	0	0	0	(2,398)
Charged During the Year	0	2,398	0	1,651	999	49	5,097
At 31 March 2015	0	0	0	19,697	7,555	996	28,248
Net Book Value at 31 March 2015	31,000	69,568	780	8,721	3,218	400	113,687
Asset financing:							
Owned - Purchased	31,000	37,897	780	8,680	3,218	400	81,975
Owned - Donated	0	102	0	4	0	0	106
Owned - Government Granted	0	0	0	37	0	0	37
Held on finance lease	0	355	0	0	0	0	355
On-SOFP PFI contracts	0	31,214	0	0	0	0	31,214
At 31 March 2015	31,000	69,568	780	8,721	3,218	400	113,687

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Assets under construction & payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
At 1 April 2014	23,986	25,646	0	0	0	0	49,632
Movements - Revaluation	1,500	(883)	0	0	0	0	617
At 31 March 2015	25,486	24,763	0	0	0	0	50,249

13.1 Intangible non-current assets

2015-16 (April to August)	Software internally generated	Total
	£000	£000
At 1 April 2015	**1,249**	**1,249**
Additions Purchased	28	28
Reclassifications	381	381
Disposals other than by sale	0	0
At 31 August 2015	**1,658**	**1,658**
Amortisation		
At 1 April 2015	**832**	**832**
Charged during the year	72	72
At 31 August 2015	**904**	**904**
Net Book Value at 31 August 2015	**754**	**754**

All assets have been directly purchased. Assets funded from the receipt of government grants have been fully depreciated within the current accounting period.

13.2 Intangible non-current assets prior year

2014-15	Software internally generated	Total
	£000	£000
Cost or valuation:		
At 1 April 2014	1,041	1,041
Additions - purchased	208	208
At 31 March 2015	1,249	1,249
Amortisation		
At 1 April 2014	700	700
Charged during the year	132	132
At 31 March 2015	832	832
Net book value at 31 March 2015	417	417
Net book value at 31 March 2015 comprises:		
Purchased	415	415
Government Granted	2	2
Total at 31 March 2015	417	417

The fair value initially recognised for intangible asset acquired by government grants was £23k.

14 Analysis of impairments and reversals recognised in 2015-16

There was no impairment or impairment reversals recognised in the five months to the end of August 2015 and this was the same in the prior year.

15 Intra-Government and other balances

	Current receivables	Non-current receivables	Current payables and Borrowings	Non-Current payables and Borrowings
	£000	£000	£000	£000
Balances with Other Central Government Bodies	491	0	2,159	0
Balances with Local Authorities	704	0	0	0
Balances with NHS bodies outside the Departmental Group	56	0	55	0
Balances with NHS bodies inside the Departmental Group	9,060	0	8,309	0
Balances with Bodies External to Government	3,397	0	13,776	35,075
At 31 August 2015	**13,708**	**0**	**24,299**	**35,075**
Prior year:				
Balances with Other Central Government Bodies	1,490	0	44	0
Balances with Local Authorities	670	0	0	0
Balances with NHS bodies outside the Departmental Group	16	0	0	0
Balances with NHS Trusts and FTs	6,789	0	20,690	0
Balances with Bodies External to Government	3,530	0	11,370	36,760
At 31 March 2015	**12,495**	**0**	**32,104**	**36,760**

The balance with NHS bodies inside the DH Group included the Working Capital Loan outstanding with the DH of £15.3m in the prior year which has been settled with receipt of Public Dividend Cash in the current year.

Non-Current payables and borrowings is mainly the Trusts long term PFI creditor balance outstanding of £36m and also includes smaller balances for other loans and leases.

16 Inventories

	Drugs	Consumables	Energy	Other	Total
	£000	£000	£000	£000	£000
Balance at 1 April 2015	**815**	**1,201**	**60**	**42**	**2,118**
Additions	5,479	5,080	0	0	**10,559**
Inventories recognised as an expense in the year	(5,407)	(5,137)	(30)	(7)	**(10,581)**
Write-down of inventories (including losses)	(25)	0	0	0	**(25)**
Balance at 31 August 2015	**862**	**1,144**	**30**	**35**	**2,071**

17 Trade and other receivables

17.1 Trade and other receivables

	Current	
	31 August 2015	31 March 2015
	£000	£000
NHS receivables - revenue	**5,060**	4,208
NHS prepayments and accrued income	**3,941**	2,522
Non-NHS receivables - revenue	**588**	954
Non-NHS prepayments and accrued income	**3,935**	3,614
PDC Dividend prepaid to DH	**59**	59
Provision for the impairment of receivables	**(486)**	(404)
VAT	**465**	1,466
Other receivables	**146**	76
Total	**13,708**	12,495

The majority of trade is with Clinical Commissioning Groups (CCGs). As CCGs are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

The provision for the impairment of receivables includes bad debt provisions against Road Traffic Accident (RTA) income and other non-NHS income. The RTA provision is based on a percentage of income due to the Trust. The current year rate of 21.99% has been applied to the relevant aged RTA debt. Other non-NHS bad debt provisions are based on non-recovery of income on a case by case basis.

17.2 Receivables past their due date but not impaired

	31 August 2015	31 March 2015
	£000	£000
By up to three months	**2,484**	1,799
By three to six months	**1,410**	608
By more than six months	**1,721**	1,400
Total	**5,615**	3,807

17.3 Provision for impairment of receivables

	2015-16 (April to August)	2014-15
	£000	£000
Balance at 1 April 2015	**(404)**	(291)
Amount written off during the year	**0**	11
Amount recovered during the year	**59**	91
Increase in receivables impaired	**(141)**	(215)
Balance at 31 August 2015	**(486)**	(404)

18 Cash and Cash Equivalents

	31 August 2015	31 March 2015
	£000	£000
Opening balance	**1,030**	2,230
Net change in year	**3,257**	(1,200)
Closing balance	**4,287**	1,030
Made up of		
Cash with Government Banking Service	**4,257**	1,004
Commercial banks	**29**	26
Cash in hand	**1**	0
Cash and cash equivalents as in statement of cash flows	**4,287**	1,030
Patients' money held by the Trust, not included above	**0**	0

19 Non-current assets held for sale

There were no assets held for sale at the end of the reporting period. This was the same at the end of the prior year.

20 Trade and other payables

	Current	
	31 August 2015	31 March 2015
	£000	£000
NHS payables - revenue	**1,737**	1,920
NHS accruals and deferred income	**5,683**	3,470
Non-NHS payables - revenue	**1,882**	2,611
Non-NHS payables - capital	**571**	728
Non-NHS accruals and deferred income	**8,538**	6,623
Social security costs	**1,053**	15
PDC Dividend payable to DH	**889**	0
Tax	**1,081**	20
Other	**1,672**	284
Total payables	**23,106**	15,671

21 Borrowings

	Current		Non-current	
	31 August 2015	31 March 2015	**31 August 2015**	31 March 2015
	£000	£000	**£000**	£000
Loans from Department of Health	**0**	15,300	**0**	0
Loans from other entities	**123**	123	**2**	64
PFI liabilities:				
Main liability	**922**	865	**34,196**	35,754
Finance lease liabilities	**148**	145	**877**	942
Total	**1,193**	16,433	**35,075**	36,760
Total other liabilities (current and non-current)	**36,268**	53,193		

Borrowings / Loans - repayment of principal falling due in:

			31 August 2015	31 March 2015
	Dept of Health	**Other**	**Total**	Total
	£000	**£000**	**£000**	£000
0-1 Years	**0**	1,137	**1,137**	16,433
1 - 2 Years	**0**	1,160	**1,160**	1,221
2 - 5 Years	**0**	3,360	**3,360**	3,419
Over 5 Years	**0**	30,611	**30,611**	32,120
TOTAL	**0**	**36,268**	**36,268**	53,193

The Trust had a Working Capital Loan balance of £15.3m at the end of last year due to the Department of Health (DH). This was taken out in 2008/09 with an initial repayment period of 5 years at an interest rate of 5.31% per annum. The first repayment on the loan of £1.7m was made during 2008/09 according to plan, but the Trust was not able to make any further repayments when due because of liquidity pressures. The Trust has been able to make interest payments on the loan in accordance with the loan agreement.

The Trust received Public Dividend Cash, from the DH in August 2015, to settle the capital and interest amounts outstanding on the loan ahead of the acquisition with C&W.

22 Deferred revenue

	Current	
	31 August 2015	31 March 2015
	£000	£000
Opening balance at 1 April 2015	**2,803**	3,230
Deferred revenue addition	**1,640**	651
Transfer of deferred revenue	**(305)**	(1,078)
Current deferred Income at 31 August 2015	**4,138**	2,803
Total deferred income	**4,138**	2,803

23 Finance lease obligations as lessee

The Trust has two finance lease arrangements during 2015/16 \nd the outstanding periods for each lease at the end of August are:
1. MRI building. The outstanding period for this lease is 12 years and 7 months.
2. MRI scanner. The outstanding period for the lease is 4 years and 7 months.

Amounts payable under finance leases (Buildings)	**Minimum lease payments**		**Present value of minimum lease payments**	
	31 August 2015	31 March 2015	**31 August 2015**	31 March 2015
	£000	£000	**£000**	£000
Within one year	**45**	45	**22**	21
Between one and five years	**180**	180	**101**	99
After five years	**336**	355	**263**	276
Less future finance charges	**(175)**	(184)	**0**	0
Minimum Lease Payments / Present value of minimum lease payments	**386**	396	**386**	396
Included in:				
Current borrowings			**22**	21
Non-current borrowings			**364**	375
			386	396

Amounts payable under finance leases (Other)	**Minimum lease payments**		**Present value of minimum lease payments**	
	31 August 2015	31 March 2015	**31 August 2015**	31 March 2015
	£000	£000	**£000**	£000
Within one year	**165**	165	**126**	124
Between one and five years	**586**	656	**513**	567
After five years	**0**	0	**0**	0
Less future finance charges	(112)	(130)	**0**	0
Minimum Lease Payments / Present value of minimum lease payments	**639**	691	**639**	691
Included in:				
Current borrowings			**126**	124
Non-current borrowings			**513**	567
			639	691

24 Provisions

	Total	Injury benefit	Legal Claims
	£000	£000	£000
Balance at 1 April 2015	**749**	540	209
Arising during the year	**122**	0	122
Utilised during the year	**(41)**	(15)	(26)
Reversed unused	**(86)**	0	(86)
Unwinding of discount	**8**	8	0
Change in discount rate	**0**	0	0
Balance at 31 August 2015	**752**	533	219
Expected Timing of Cash Flows:			
No Later than One Year	**254**	35	219
Later than One Year and not later than Five Years	**141**	141	0
Later than Five Years	**357**	357	0
	752	533	219

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

	£000
As at 31 August 2015	**42,582**
As at 31 March 2015	40,996

The Injury benefit provision of £0.5m relates to the Trust's liability for injury benefits for a previous back to back provision. This is no longer a back to back provision because Hounslow PCT settled the debt in respect of this in 2012-13. The legal claims provision relates to specific cases that the Trust is involved in, and the value above is an estimate of likely costs based on information available at the end of August.

£42.6m is included in the provisions of the NHS Litigation Authority at 31 August 2015 in respect of clinical negligence liabilities of the Trust (31 March 2015: £41.0m). The large increase can be explained by new cases totalling £5.4m and a decrease in the provisions of the NHSLA for cases ongoing from prior years totalling £3.8m.

25 Private Finance Initiative (PFI)

The information below is required by the Department of Heath for inclusion in national statutory accounts

Charges to operating expenditure and future commitments in respect of ON SOFP PFI	2015-16 (April to August) £000	2014-15 £000
Service element of ON SOFP PFI charged to operating expenses in year	4,630	10,815
Total	4,630	10,815
Payments committed to in respect of OFF SOFP PFI and the service element of ON SOFP PFI		
No Later than One Year	12,775	12,642
Later than One Year, No Later than Five Years	54,036	53,527
Later than Five Years	262,157	268,067
Total	328,968	334,236

Imputed "finance lease" obligations for ON SOFP PFI contracts due	2015-16 (April to August) £000	2014-15 £000
No Later than One Year	3,663	3,635
Later than One Year, No Later than Five Years	14,269	14,294
Later than Five Years	53,141	55,801
Subtotal	71,073	73,730
Less: Interest Element	(35,954)	(37,108)
Total	35,119	36,622

Present Value Imputed "finance lease" obligations for ON SOFP PFI contracts due Analysed by when PFI payments are due	2015-16 (April to August) £000	2014-15 £000
No Later than One Year	923	865
Later than One Year, No Later than Five Years	4,008	3,909
Later than Five Years	30,188	31,848
Total	35,119	36,622
Number of ON SOFP PFI Contracts		
Total Number of on PFI contracts	1	1
Number of on PFI contracts which individually have a total commitments value in excess of £500m	0	0

The Trust has a PFI scheme with Bywest Limited, for a 33 year period, which commenced in 2004. At the end of this period the Trust takes possession of the buildings and equipment funded and maintained by Bywest over the duration of the scheme. The Trust makes an annual unitary payment to cover facilities management, lifecycle maintenance and finance costs. Unitary payments may vary in the future and are dependent on the Retail Price Index. Facilities Management services are subject to market testing every five years. The market testing and formal tender of these services was last carried out in 2012-13. A new provider for Soft Facilities Management services commenced in June 2013. Soft servives include building cleaning and ground and site maintenance.

Under IFRIC12 the asset is treated as an asset of the Trust, the substance of the contract is that the NHS Trust has a finance lease and payments comprise of imputed finance lease charges and service charges.

26 Impact of IFRS treatment - current year

The information below is required by the Department of Heath for budget reconciliation purposes

	2015-16 (April to August) £000	2014-15 £000
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 for PFI		
Depreciation charges	334	789
Interest Expense	1,791	4,151
Other Expenditure	4,630	10,815
Impact on PDC dividend payable	(67)	(189)
Total IFRS Expenditure (IFRIC12)	6,688	15,566
Revenue consequences of PFI schemes under UK GAAP	(6,751)	(15,854)
Net IFRS change (IFRIC12)	(63)	(288)
Capital Consequences of IFRS : PFI and other items under IFRIC12		
Capital expenditure	337	888
UK GAAP capital expenditure (Reversionary Interest)	2,320	4,147

The PFI is part of the Trust's Property, Plant and Equipment and therefore may incur additional expenditure which is shown within the Net IFRS change (IFRIC 12). In the five months to the end of August this value was -£0.1m. The Department of Health do not reduce the Trust's performance as a result of a negative net IFRS movement, and therefore the value shown is zero in the Statement of Comprehensive Income.

Ernst and Young LLP reviewed the assumptions containd within the PFI accounting model and found errors relating to some revenue and expenditure streams totalling £1.14m. These have been adjusted against the long term liability of the PFI scheme. This did not result in any change to the Trust's reported defecit.

27 Financial Instruments

27.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Clinical Commissioning Groups (CCGs) and the way those CCGs are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust is able to borrow from government for capital expenditure, subject to affordability as confirmed by the Trust Development Authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 August 2015 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with primary care organisations, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

27.2 Financial Assets

	Loans and Receivables
	£000
Receivables - NHS	8,834
Receivables - non-NHS	1,493
Cash at bank and in hand	4,287
Total at 31 August 2015	**14,614**
Receivables - NHS	5,368
Receivables - non-NHS	3,785
Cash at bank and in hand	1,030
Total at 31 March 2015	10,183

27.3 Financial Liabilities

	Other
	£000
NHS payables	2,661
Non-NHS payables	13,142
Other borrowings	125
PFI & finance lease obligations	37,285
Total at 31 August 2015	**53,213**
NHS payables	2,743
Non-NHS payables	9,986
Other borrowings	15,486
PFI & finance lease obligations	37,708
Other financial liabilities	0
Total at 31 March 2015	65,923

Prepayments, Other tax and social security payments and deferred income are not considered to be financial instruments under IFRS and therefore have been excluded from the above analysis.

28 Events after the end of the reporting period

West Middlesex University Hospital NHS Trust was acquired by Chelsea and Westminster NHS Foundation Trust on the 1st September 2015. As at that date the Trusts assets and liabilities and reserves have been transferred to Chelsea and Westminster.

29 Related party transactions

During the accounting period none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with West Middlesex University Hospital NHS Trust.

The Department of Health is regarded as a related party. During the accounting period West Middlesex University Hospital NHS Trust has had a significant number of material transactions with the Department.

The Trust has had significant transactions, defined as an income/expenditure balance or a receivables/payables balance of over £100k with the following related bodies:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
Hounslow CCG	0	40,186	1,945	3,050
Richmond CCG	0	11,100	359	451
Ealing CCG	4	5,421	339	2,471
NHS England Core	0	4,507	49	180
Health Education England	0	3,390	931	8
Hounslow London Borough Council	335	1,313	0	419
North West Surrey CCG	0	735	169	143
Chelsea And Westminster Hospital NHS Foundation Trust	216	529	322	587
Hounslow and Richmond Community Healthcare NHS Trust	566	514	621	506
Hillingdon CCG	0	481	16	1
Imperial College Healthcare NHS Trust	1,600	378	1,882	291
London North West Healthcare NHS Trust (Established WEF 01/10/14)	9	151	31	148
Hammersmith And Fulham CCG	0	133	2	29
Kingston CCG	0	101	2	16
West London Mental Health NHS Trust	292	65	291	90
HM Revenue and Customs	3,041	0	2,134	465
NHS Blood and Transplant	262	0	55	56
National Health Service Pension Scheme	3,802	0	25	0
NHS Litigation Authority	1,277	0	0	715
NHS Business Services Authority	77	0	101	2
NHS Trust Development Authority	0	0	133	106
	11,481	69,004	9,407	9,734

2014-15	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
Hounslow CCG	240	91,967	1,848	4,038
Richmond CCG	0	27,746	338	1,364
London Regional Office	0	10,622	0	229
Health Education England	0	8,840	351	117
Ealing CCG	20	8,617	266	973
Hounslow London Borough Council	635	2,495	0	402
Central London (Westminster) CCG	113	1,975	11	14
North West Surrey CCG	0	1,822	31	0
Imperial College Healthcare NHS Trust	3,941	1,252	1,570	656
Hillingdon CCG	0	1,232	18	17
Hounslow and Richmond Community Healthcare NHS Trust	1,495	1,187	648	100
NHS Trust Development Authority	0	1,170	24	296
Chelsea And Westminster Hospital NHS Foundation Trust	228	302	116	98
Ealing London Borough Council	0	270	0	78
Hammersmith And Fulham CCG	0	267	3	4
Kingston CCG	0	249	3	41
Surrey County Council	0	207	0	68
Wandsworth CCG	0	172	1	32
Surrey Downs CCG	0	162	1	51
West London Mental Health NHS Trust	0	145	0	102
Brent CCG	0	141	0	14
Harrow CCG	0	140	1	4
West London (K&C & Qpp) CCG	0	126	0	4
Barnet CCG	0	102	1	60
Herts Valleys CCG	0	101	0	42
London North West Healthcare NHS Trust (Established WEF 01/10/14)	106	29	33	5
Frimley Health NHS Foundation Trust (Acquires RD7 WEF 01/10/14)	155	0	17	3
National Health Service Pension Scheme	8,771	0	0	0
HM Revenue and Customs Trust Statement	7,189	0	35	1,466
NHS Litigation Authority	3,164	0	4	920
	£37,538	£230,342	£14,727	£20,932

The Trust has also received revenue payments from the West Middlesex University Hospital Charitable Fund as a recharge for Trust staff time provided to the Charity and as reimbursement for goods purchased by the Trust on behalf of the Charity.

The West Middlesex University Hospital Charitable Fund was operated on a corporate trustee basis within the Trust until 31 August 2015 and was transferred to Chelsea and Westminster Hospital NHS Foundation Trust from that date on the same basis following the merger of the two trusts. As permitted by the Department of Health the results and net assets of the Charitable Fund were not consolidated within the Trust's annual accounts at 31 March 2015 on the grounds of materiality and the net assets of the Charitable Fund have not significantly changed since that date. The Trust Board has considered both the size and nature of the charitable funds and taken the decision not to consolidate the Charitable Fund in the annual accounts at 31 August 2015 on the grounds of materiality as permitted by Sections 3.10 and 3.76 of the Manual for Accounts 2015/16, and is aware that the Charitable Fund will not be consolidated within the results of the Chelsea and Westminster Hospital NHS Foundation Trust at 31 March 2016. The West Middlesex University Hospital Charitable Fund Accounts for the year ended 31 March 2015 may be viewed on the Chelsea and Westminster Hospital NHS Foundation Trust website. It is intended that the West Middlesex University Hospital Charitable Fund Accounts for the year ended 31 March 2016 will be available to view in November 2016 on the Chelsea and Westminster Hospital NHS Foundation Trust website.

30. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

30.1 Breakeven performance

	2005-06 £000	2006-07 £000	2007-08 £000	2008-09 £000	2009-10 £000	2010-11 £000	2011-12 £000	2012-13 £000	2013-14 £000	2014-15 £000	2015-16 (April to August) £000
Turnover	103,117	118,854	129,285	132,894	143,804	149,638	148,943	154,187	154,980	167,388	69,987
Retained surplus/(deficit) for the year	(9,024)	(3,295)	19	(3,534)	(5,541)	104	1,547	1,667	(4,892)	(7,854)	(6,103)
Adjustment for:											
Timing/non-cash impacting distortions:											
2006/07 PPA (relating to 1997/98 to 2005/06)	3,991	0	0	0	0	0	0	0	0	0	0
Adjustments for impairments	0	0	0	0	20	0	0	47	(145)	0	0
Adjustments for impact of policy change re donated/government grants assets	0	0	0	0	0	0	31	28	23	21	6
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*	0	0	0	0	525	110	199	0	0	0	0
Break-even in-year position	(5,033)	(3,295)	19	(3,534)	(4,996)	214	1,777	1,742	(5,014)	(7,833)	(6,097)
Break-even cumulative position	(9,976)	(13,271)	(13,252)	(16,786)	(21,782)	(21,568)	(19,791)	(18,049)	(23,063)	(30,896)	(36,993)

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2005-06 %	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 (April to August) %
Materiality test (i.e. is it equal to or less than 0.5%):											
Break-even in-year position as a percentage of turnover	(4.9)	(2.8)	0.0	(2.7)	(3.5)	0.1	1.2	1.1	(3.2)	(4.7)	(8.7)
Break-even cumulative position as a percentage of turnover	(9.7)	(11.2)	(10.3)	(12.6)	(15.1)	(14.4)	(13.3)	(11.7)	(14.9)	(18.5)	(52.9)

The amounts in the above tables in respect of financial years 2005-06 to 2008-09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.

30. Financial performance targets continued

30.2 Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets at the end of August 2015 and therefore the actual capital cost absorption rate is automatically 3.5%.

30.3 External financing
The Trust is given an external financing limit which it is permitted to undershoot.

	2015-16 (April to August) £000	2014-15 £000
External financing limit (EFL)	(1,277)	8,206
Cash flow financing	(1,277)	8,176
External financing requirement	(1,277)	8,176
Underspend against EFL	0	30

30.4 Capital resource limit
The Trust is given a capital resource limit which it is not permitted to exceed.

	2015-16 (April to August) £000	2014-15 £000
Gross capital expenditure	1,141	5,035
Less: book value of assets disposed of	0	0
Charge against the capital resource limit	1,141	5,035
Capital resource limit	1,141	5,153
Underspend against the capital resource limit	0	118

31 Losses and special payments

The total number of losses cases in 2015-16 (April to August) and their total value was as

	Total Value of Cases £	Total Number of Cases
Losses	24,802	5
Special payments	1,624	5
Total losses and special payments	26,426	10

The total number of losses cases in 2014-15 and their total value was as follows:

	Total Value of Cases £	Total Number of Cases
Losses	48,952	95
Special payments	25,863	19
Total losses and special payments	74,815	114

The value of losses and special payments is lower than in the prior year and this is mainly attributable to the shorter accountable period. In 2014/15 the Trust incurred losses for writing off bad debts and also for compensation made under legal obligations which have not arisen within the 5 months to the end of August.

32 Third party assets

The Trust held £433 cash and cash equivalents at 31 August 2015 (£147 at 31 March 2015) which relate to monies held by the NHS Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

INDEPENDENT AUDITOR'S STATEMENT TO THE DIRECTORS OF WEST MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST ON THE NHS TRUST CONSOLIDATION SCHEDULES

We have examined the consolidation schedules designated TRU01 to TRU26 (TRU09a, TRU23, TRU24 and TRU26 are excluded) of West Middlesex University Hospital NHS Trust for the period ended 31 August 2015, which have been prepared by the Director of Finance and acknowledged by the Chief Executive.

This statement is made solely to the Board of Directors of West Midlesex University Hospital NHS Trust in accordance with Part 5 paragraph 20(5) of the Local Audit and Accountability Act 2014 and paragraph 4.2 of the Code of Audit Practice and for no other purpose.

For the purpose of this statement, reviewing the consistency of figures between the audited financial statements and the consoldiation schedules extends only to those figures within the audited financial statements which are also published in the consolidation schedules.

Auditors are required to report on any differences over £250,000 between the audited financial statements and the consolidation schedules.

Unqualified audit opinion on the audited financial statements; no differences identified:

The figures reported in the consolidation schedules are consistent with the audited financial statements, on which we have issued an unqualified opinion.

Kate Handy

Kate Handy
for and on behalf of Ernst & Young LLP
Southampton
25/5/16