The Whittington Hospital

Board Memorandum on Projected Working Capital and Financial Reporting Procedures

Draft: 15 February 2008

The Whittington Hospital NHS
NHS Trust

Contents

Section 1

Purpose of this document

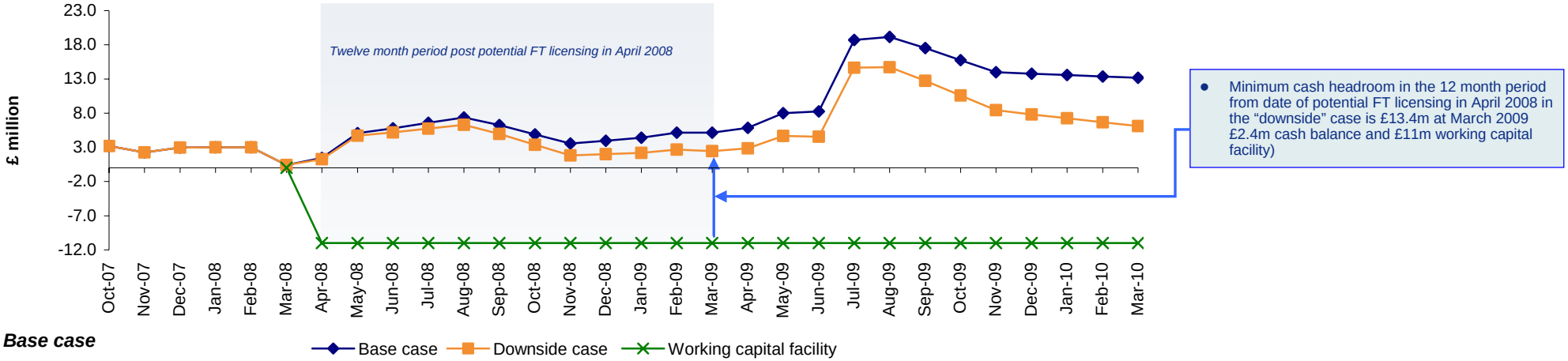
- This Board Memorandum ("memorandum") has been prepared by the Board of Directors ("the Board") of The Whittington Hospital NHS Trust ("the Trust") as part of the application by the Trust for NHS Foundation Trust ("FT") status. The purpose of the memorandum is to support the statements by the Board in respect of the Trust's working capital requirements and the Trust's financial reporting procedures for the first 12 months of operation as an FT. As the potential FT licensing date is 1 April 2008, the requirement in the first year will be the 12 months to 31 March 2009.
- The memorandum summarises all relevant information available to the Directors of the Trust to support the statements on working capital and financial reporting procedures. The information has not been independently verified. The working capital projections are based on the Integrated Business Plan 2007/08 to 2012/13 (version [8], dated [18] February 2008).
- Section 2 of this memorandum provides an analysis of the headroom between the projected cash position of the Trust and the facilities available to it. It also details sensitivities applied by the Trust to determine a potential downside ("worst case") scenario.
- The working capital projections set out in this Board Memorandum are solely the responsibility of the Board and were approved at a Board meeting on [20] [February] 2008.
- Section 4 of this memorandum details the financial reporting procedures in place at the Trust by means of which the Board intends to reach proper judgement as to the financial position and prospects of the Trust.
- Section 2 of this memorandum contains the Board statements on working capital adequacy and financial reporting procedures. These statements require the formal approval of the Trust, following which the statements will be signed and forwarded to Monitor, together with a copy of this Board Memorandum.
- The projections included in this memorandum are based on the projections prepared by Trust management in the format required by Monitor.

Executive Summary

2.1 Summary of Headroom

- Figure 2.1 shows the projected month-end cash balances ("base case") throughout the period of the projections to March 2010. In addition, the "base" cash position has been adjusted for 7 key risk factors ("sensitivities" – refer Page [x]), which the Directors consider could potentially impact the projected month-end cash balances post potential FT licensing at 1 April 2008. Both the "base" and "downside" month-end cash position has been compared to the available Working Capital Facility (refer Page [x]) to determine whether the facility is adequate.

Figure 2.1: Projected "base" and "downside" cash position/requirement versus available working capital facility



Base case

- Prior to potential FT licensing (October 2007 to March 2008), the Trust has a minimum month-end cash balance of £0.4m (March 2008) due to the year-end management of the Trust's cash position through the EFL mechanism.
- Post potential FT licensing in April 2008, the Trust maintains a positive monthly cash balance throughout the 24 month period to March 2010, with cash balances increasing to £1.5m (April 2008), £5.1m (March 2009) and £13.2m (March 2010) .

Downside case (adjusted for sensitivities)

- Over the 24 month period post potential FT licensing (April 2008 to March 2010), the minimum month-end cash balance and available headroom after applying all sensitivities and excluding any mitigating actions which the Trust may take, is £2.4m (cash balance) and £13.4m (available headroom) at March 2009. The year-end cash balance at March 2010 is £6.1m.

Asset disposal proceeds

- Cash balances increase in July 2009 through £10m of disposal proceeds from the planned sale of the Waterlow building and Nurses home. No binding sales contract has yet been entered into. Removing the disposal proceeds gives rise to a cash balance at July 2009 of £8.7m ("base case") and £4.6m ("downside case") with no recourse to the overdraft facility required.
- Phase 2 Maternity/NICU expenditure of £10m (£3.8m in 2009/10), to be funded from cash, is dependent on the £10m estate disposal proceeds (refer Section 3 Page [x]). If there is slippage of the planned sales proceeds, the Trust will either defer the expenditure as it is not yet committed, use other cash resources if available or bring forward planned loan financing (£13.5m planned in 2011/12). The overdraft facility is therefore forecast to remain unutilised over the 24 month period after adjusting for any potential disposal proceeds slippage in both the "base" and "downside" cases.

Executive Summary (continued)

2.2 Working Capital Facility ("WCF")

- As part of its application for FT status, the Trust will be arranging a committed WCF to ensure that the Trust has sufficient funds to cover any cash shortfalls. The only condition precedent in the agreement is authorisation as an FT.
- Subject to potential FT licensing on 1 April 2008, the Trust will therefore have access to a 2 year committed working capital facility of £11m with [TBC]. The facility is unsecured and has no fixed repayment terms.
- The facility is forecast to remain unutilised over the 24 month period to March 2010 in both the "base" and "downside" cases.

2.3 Prudential Borrowing Code

- There are five limiting factors which cover the maximum amount of the Prudential Borrowing Limit. These are set out in Table 2.3.

Table 2.3: Borrowing ratios

Ratio	Limit/ test	Threshold	2008/09	2009/10	2010/11	2011/12	2012/13	2016/17
Minimum dividend cover	Greater than 1 times	>1	2.9	2.8	2.8	3.0	3.0	4.0
Minimum interest cover	Greater than 3 times	>3	n/a	n/a	n/a	32.1	18.3	37.7
Minimum debt service cover	Great than 2 times	>2	n/a	n/a	n/a	15.9	11.9	23.4
Maximum debt: capital ratio	Less than 15%	*<15%*	n/a	n/a	n/a	*7.7%*	*7.1%*	*4.5%*
Maximum debt service to revenue	Less than 3%	*<3%*	n/a	n/a	n/a	*0.5%*	*0.7%*	*0.6%*

- The Trust is forecast to comply with these ratios throughout the period of the plan to 2016/17.

2.4 Monitor Financial Risk Rating

- To achieve successful authorisation as an FT, the Trust must demonstrate its ability to achieve a risk rating of 3 in the first year of authorisation i.e. 1 April 2008 to 31 March 2009 against the requirements of Monitor's Compliance Framework.
- Table 2.4 below shows that the Trust achieves a risk rating of 3 in 2008/09 followed by an improvement to four from 2009/10.

Table 2.4: Financial risk rating 2007/08 to 2012/13

Financial risk rating	2008/09	2009/10	2010/11	2011/12	2012/13
Overall rating (taking into account overriding rules)	3	4	4	4	4

Executive Summary (continued)

2.5 Financial Overview

Table 2.5.1: Income & Expenditure

£m	Actual 2006/07	Outturn 2007/08	Forecast 2008/09	Forecast 2009/10
NHS clinical income	115.3	125.2	131.2	136.4
Other income	27.1	26.3	22.7	23.0
Total income	**142.4**	**151.5**	**153.9**	**159.4**
Pay costs	(95.7)	(100.9)	(101.5)	(105.3)
Non-pay costs	(33.8)	(40.5)	(41.2)	(43.1)
Total operating expenses	**(129.4)**	**(141.4)**	**(142.7)**	**(148.3)**
EBITDA	**13.0**	**10.1**	**11.1**	**11.1**
Other costs	(7.8)	(5.1)	(4.5)	(4.2)
PDC dividend	(3.2)	(3.6)	(3.8)	(4.1)
Net surplus	**2.0**	**1.4**	**2.8**	**2.7**
Recurrent net surplus	**2.0**	**0.1**	**2.1**	**2.6**
Normalised net surplus per Monitor	**4.2**	**0.3**	**2.8**	**2.7**

- Key assumptions for Income & Expenditure items are discussed in Section 3 on Pages [x] to [x]

Table 2.5.2: Balance Sheet

£m	Actual 2006/07	Outturn 2007/08	Forecast 2008/09	Forecast 2009/10
Tangible fixed assets	83.1	91.5	94.9	95.0
PFI Residual interest	0.3	0.9	2.0	3.1
PFI Deferred assets	25.0	24.5	23.7	22.9
Total fixed assets	**108.4**	**116.9**	**120.6**	**120.9**
Current assets	12.3	7.5	12.0	20.6
Current liabilities	(13.7)	(13.2)	(14.7)	(14.9)
Net current (liabilities)/ assets	**(1.4)**	**(5.8)**	**(2.6)**	**5.7**
Net long-term liabilities	(0.3)	(0.1)	(0.1)	(0.1)
Total assets employed	**106.8**	**111.1**	**117.9**	**126.6**
Loans	-	-	-	-
Taxpayers equity	106.8	111.1	117.9	126.6
Total funds employed	**106.8**	**111.1**	**117.9**	**126.6**

- Key assumptions for Balance Sheet items are discussed in Section 3 on Pages [x] to [x]

Table 2.5.3: Cash Flow

£m	Actual 2006/07	Outturn 2007/08	Forecast 2008/09	Forecast 2009/10
EBITDA (adj. for non cash items)	12.7	10.9	11.8	11.7
WC movement	(5.9)	4.3	0.5	(0.3)
Capital expenditure	(8.4)	(9.3)	(4.1)	(10.0)
Asset disposal proceeds	-	-	-	10.0
Net financing and dividends	1.5	(6.0)	(3.5)	(3.4)
Net cash inflow	**-**	**-**	**4.7**	**8.0**
Bank and cash	**0.4**	**0.4**	**5.1**	**13.2**

- Key assumptions for Cash Flow items are discussed in Section 3 on Pages [x] to [x]

Executive Summary (continued)

Table 2.6: Sensitivities and impact on projected cash headroom

Risk	Detail of sensitivity	Page	2008/09	2009/10
Base case cash (£'000)			**5,132**	**13,153**
Risk 1: CIP slippage	Underachievment of CIP plan: 20% of the 2008/09 CIP target of £3.8m is deferred to 2009/10, while 10% of the 2009/10 target of £4m is not achieved.	[x]	(768)	(1,197)
Risk 2: Fewer additional day cases	DTC: Only 50% (2008/09) and 20% (2009/10) of the planned increase in activity is achieved in year.	[x]	(1,035)	(2,001)
Risk 3: Lower population forecast	General population trend: Activity is based on GLA's low end parameter as a proxy for population changes instead of the mid point of the parameter.	[x]	(17)	(55)
Risk 4: Tariff increase of 2.3%	Tariff inflation: Reduced to 2.3% p.a. (as opposed to base case uplift of 2.5% p.a.).	[x]	(298)	(939)
Risk 5: SIFT reduction	SIFT reduction: Funding reduces to £35k p.a. per student from 2009/10.	[x]	-	(599)
Risk 6: Demand Management & alternative maternity activity projections	Further PCT demands: - Emergency inpatient activity short stay: 5% year on year reduction for Islington PCT; - Reduced re-admissions for long term care patients for Islington and Haringey PCTs. Alternative maternity activity projections: - Revised growth assumption for maternity deliveries; PCTs use GLA population growth rate with fertility statistics and applying weighting by age group.	[x]	(330)	(988)
Risk 7: ISTC reduced elective day case demand	ISTC: Initiative starts from last quarter of 2008/09 with full year impact in 2009/10, assumed elective day cases of £1m (as estimated by PCTs) are referred away from the Trust.	[x]	(246)	(1,268)
Combined downside cash position (£'000)			**2,439**	**6,106**

2.6 Sensitivities

- The purpose of the sensitivity analysis is to determine the cash impact of the sensitivities on the Trust's available cash or borrowing headroom in the event of a combined "downside" (sensitised) scenario occurring i.e. to test whether the Trust's available cash and/or WCF is adequate in the event of all potential risks to the business occurring simultaneously.
- The "downside" case results in a cumulative reduction in cash balances to £2.4m at 31 March 2009 and £6.1m at 31 March 2010. The WCF of £11m remains unutilised during this period and the Trust therefore has available cash and borrowing headroom of £13.4m at 31 March 2009 and £17.1m at 31 March 2010 to mitigate the potential financial impact of any further significant risks not yet identified.

2.6.1 Mitigating Actions

The Trust has identified the following principal mitigating actions which could be introduced should activity/income be less than assumed and/or there are additional cost pressures.

- **Risk 1: CIP slippage**
  - Use of substitute schemes of £0.2m currently identified for 2008/09. In addition, the Trust is currently in the process of identifying and quantifying further additional schemes;
  - Use of non-recurrent measures to offset any potential short term slippage e.g. short term vacancy freezes, one-off non-clinical income (e.g. internally developed software disposals);
  - Budgeted expenditure has been inflated by 5% with scope for savings within this uplift.
- **Risk 2: Fewer additional day cases**
  - Market capacity/form joint ventures with other Trusts for utilisation of any excess DTC theatre capacity (includes rationalisation of site so that surplus estate can be released).
- **Risk 3: Lower population forecast**
  - Extract capacity through natural wastage and redeployment.
- **Risk 4: Tariff increase**
  - Additional efficiencies from Patient level costing project with each service line recovering full cost. Consider disinvesting in non-contributing services in line with mandatory service provision.
- **Risk 5: SIFT reduction**
  - Review of the quantity of education provided and potential SIFT transitional arrangements given the impact on the wider health economy.
- **Risk 6: Demand Management & maternity activity projections**
  - Risk assess PCT plans for achievability;
  - Sell capacity to PCTs to assist with demand management initiatives. Work with PCTs to provide services in clinics, and Outpatient triage services;
  - Additional CIP by extracting capacity.
- **Risk 7: ISTC reduced elective day case demand**
  - Compete with Private Sector through Patient Choice and modern facilities;
  - Sell capacity to independent sector.

Executive Summary (continued)

2.7 Financial Reporting Procedures

- The financial reporting procedures have been assessed as adequate (refer Section 4, Pages [x] to [x]). Some changes will be made during the transition to FT, but existing procedures are well embedded, and the changes are mostly enhancements as opposed to rectifying weaknesses.

2.8 Conclusion

- The Board of Directors of The Whittington Hospital NHS Trust believes that this Board Memorandum contains sufficient detail to enable the board to sign the statements on the Trust's working capital and financial reporting procedures set out in Section 5, Page [x] of this document.

Signed for and on behalf of the Board:

…….. **……**

Chair **Date**

…….. **……**

Chief Executive **Date**

Income & Expenditure Overview

- Table 3.1 details the projected Income and Expenditure over the period to 31 March 2010.

Table 3.1: Detailed Income and Expenditure

£m	Actual 2006/07	Outturn 2007/08	Forecast 2008/09	Forecast 2009/10
NHS clinical income				
Elective	17.0	23.7	24.9	28.1
Non-Elective	47.8	47.7	47.2	49.2
Outpatient	26.1	28.6	27.8	27.6
A&E	8.1	8.1	8.4	7.8
Other	15.8	17.2	22.9	23.7
PBR relief	0.5	-	-	-
Total NHS clinical income	**115.3**	**125.2**	**131.2**	**136.4**
Non-NHS income				
Private patient income	0.3	0.2	0.2	0.2
Other non-protected income	0.5	0.5	1.0	1.1
Education and training	13.3	14.0	14.5	14.9
Research and development	1.1	0.9	0.6	0.3
Other income	11.3	10.2	6.2	6.6
PFI specific income	0.6	0.4	0.2	-
Total Non-NHS income	**27.1**	**26.3**	**22.7**	**23.0**
Total income	**142.4**	**151.5**	**153.9**	**159.4**
Costs				
Pay costs	(95.7)	(100.9)	(101.5)	(105.3)
Drug costs	(7.3)	(8.4)	(8.7)	(9.4)
Clinical supplies and services	(11.9)	(13.7)	(14.2)	(15.1)
Other costs	(12.2)	(13.5)	(12.3)	(12.6)
PFI specific costs	(2.3)	(5.0)	(6.0)	(6.1)
Total costs	**(129.4)**	**(141.4)**	**(142.7)**	**(148.3)**
EBITDA	**13.0**	**10.1**	**11.1**	**11.1**
Impairments	(3.4)	(0.8)	-	-
Depreciation	(4.7)	(4.6)	(4.8)	(4.9)
Interest	0.3	0.3	0.2	0.7
PDC dividend	(3.2)	(3.6)	(3.8)	(4.1)
Net surplus	**2.0**	**1.4**	**2.8**	**2.7**

3.1 Income & Expenditure Overview

- The net surplus is forecast to increase from £1.4m in 2007/08 to £2.7m in 2009/10 primarily through the following assumptions:

Income assumptions

- Increased clinical income as a result of activity growth (additional day casework generated through the new day care treatment centre to be opened in March 2008, combined with a projected population increase over the period) and additional MFF received on the increased clinical income (refer Pages [x] & [x]);
- A revised risk assessment of PCT demand management expectations resulting in increased clinical income in 2008/09, followed by a significant decrease thereafter as a result of reduced Emergency Department attendances and lower outpatient appointments (refer Pages [x] & [x]);
- Decreased "Other" income in 2008/09 largely as a result of a RAB adjustment of £2.1m for the 2006/07 surplus being rectified in 2007/08.
- Income inflation of 2.5% p.a. (refer Page [x])

Expenditure assumptions

- Increased expenditure as a result of the increased clinical activity growth (assumed marginal cost of 50% of the income tariff value on new day care treatment centre activity) (refer Page [x]);
- Increased pay costs of 5% comprising agenda for change, junior doctors' compliance, and pay awards (refer Page [x]);
- Non-pay expenditure inflation of 5% p.a. (although drug budgets have been inflated by 8% within this sum) (refer Page [x]); There is in addition 1.6% for new NICE directives.
- Additional PFI unitary charges (refer Page [x]);
- CIP savings at approximately 2.5% of total income (2008/09: £3.8m; 2009/10: £4m). The majority of savings are expected to be made on pay costs (approximately 89% p.a. in 2008/09 and 70% in 2009/10) (refer Page [x])

- Details of the key drivers of movements in projected Income & Expenditure items over the period to 2009/10 are highlighted in the normalised net surplus bridge on Page [x].
- The key assumptions for individual projected Income & Expenditure items are discussed on Pages [x] to [x].

Normalised Net Surplus

3.1.1 Normalised net surplus

- Figure 3.1 details the key drivers of movements in the normalised net surplus over the period 1 April 2005 to 31 March 2011.

Normalised Net (Deficit)/ Surplus

	Actual			Outturn	Forecast		
£m	**Mar - 05**	**Mar - 06**	**Mar - 07**	**Mar - 08**	**Mar - 09**	**Mar - 10**	**Mar - 11**
Net Surplus/ (deficit)	**2.0**	**0.0**	**2.0**	**1.4**	**2.8**	**2.7**	**2.8**
Less: non-recurring income							
PCT/ SHA support (consultant contract, EWTD etc)	(6.6)	(0.6)	(0.2)	-	-	-	-
WFL Compensation	(0.2)	-	-	-	-	-	-
Waterlow Impairment income	-	-	(3.4)	-	-	-	-
Capital to revenue transfer	-	(1.2)	-	-	-	-	-
RAB	-	-	-	(2.1)	-	-	-
WIC Start up fees	(0.1)	(0.1)					
LIS Funding		(0.2)	(0.2)	(0.4)			
Choose and Book		(0.3)					
	(6.8)	(1.8)	(3.6)	(2.1)	-	-	-
Less: normalising adjustments							
Income Reduction to PCT SLA - per SHA	-	-	2.3	-	-	-	-
Fixed Asset Impairments	-	-	3.4	0.8	-	-	0.3
	-	-	5.7	0.8	-	-	0.3
Add: non-recurring costs							
Creation of Inland Revenue provision	0.1	0.2	-	-	-	-	-
WIC Start up fees	0.1	0.1	-	-	-	-	-
redundancy costs		0.1	0.1				
WFL Claims	-	-	-	0.2	-	-	-
Other - Please specify		0.0	0.0				
	0.2	0.4	0.1	0.2	-	-	-
Add: normalising adjustments							
LIS Funding	-	0.2	0.2	0.4	-	-	-
Normalised Net (Deficit)/ Surplus	**(4.7)**	**(1.8)**	**4.2**	**0.3**	**2.8**	**2.7**	**3.1**

Key Income Assumptions

3.1.2 Key Income Assumptions

Key drivers	Key assumptions	Rationale
Activity growth/clinical income	• Activity assumed to grow inline with; – Estimated population growth of 7.3% over the next 10 years; – Birth rate increase of 10% over the next five years. • Critical care – 85% occupancy of 15 beds with a mix of 30% HDU and 70% ITU; • Excess bed days models a reduction of 10% in 2008/09 and 5% in 2009/10 and 2010/11. • Out-patient appointments includes PCT demand management schemes and population growth. – £1.3m Abatement (excluding MFF) in 2008/09 agreed with PCT following a re-assessment of the timing of various demand management schemes; – 5% Year-on-year reduction for Islington PCT and a 2% year-on-year reduction for Haringey PCT is assumed from 2009/10 to 2011/12, including 2008/09 slippage of £0.7m. The loss of income is in excess of £3m by 2011/12 with no mitigation assumed in the base case. • Market forces factor remains unchanged at 1.37. • Non recurrent income is negligible from 2008/09 onwards.	**Evidence** • GLA population statistics. • London Maternity Review 2007 Progress Report. • 2007/08 Activity data supporting the monitoring regime has been agreed with the PCT. • The Trust is closely monitoring activity to identify any potential deviations to plan. In addition, a working group is implementing an action plan to improve data recording and coding. At 30 November 2007, YTD actual clinical activity had exceeded planned activity by £4.9m primarily through adult intensive care bed days (£1.4m) • PCT commissioning intentions. • Agreement of Islington PCT to the adjustment of demand management assumptions. • Historically Islington and Haringey PCTs have not fully achieved their demand management targets and have paid for over performance. The Trust is continuing to risk assess future PCT demand management targets for achievability. **Sensitivity** • Refer sensitivities 3 and 6 on page [x].
18 Week target	• An estimate of the impact of the 18 week target has been calculated based on 2006/07 activity levels. • The 2007/08 18 week adjustment reflects additional clinical income of £1.3m and MFF of £0.5m. This total non-recurrent income is offset by additional non-recurrent expenditure of £0.9m and a credit note provision of £0.7m. The impact on the 2007/08 surplus is therefore only marginal at £0.2m. • Discussions with commissioners regarding the impact of the 18 week target for 2008/09 are still to be finalised.	**Evidence** • Waiting times have been reduced and the Trust is on target to meet the 18 week referral to treatment standard in 2007/08. **Sensitivity** • Given current performance and risk assessment, no sensitivity has been considered.

Key Income Assumptions (continued)

Key drivers	Key assumptions	Rationale
ISTCs	• Limited competition from ISTCs and local providers is currently assumed.	**Evidence** • Wave 1 diagnostic programme: local independent sector services are being delivered from a number of sites, although not within 3 miles of the Trust. • Wave 2 elective ISTC activity valued at £0.4m has been proposed by Islington PCT as part of the 2008/09 SLA negotiations, with a FYE of £0.8m in 2009/10. However, Islington PCT acknowledge that there is a high risk attached to them achieving this level of activity, so the actual figure is likely to be lower. Other PCTs have proposed no reduction in activity as a result of wave 2 elective ISTCs. **Sensitivity** • Refer sensitivity 7 on page [x]
Length of Stay	• Average length of stay for elective activity is forecast at 0.5 days (2007/08), 0.3 days (2008/09) and 0.2 days (2009/10). • Average length of stay for non-elective activity is decreasing from 5.4 days (2007/08) to 4.6 days (2008/09) to 4.2 days (2009/10). • Bed occupancy is 90% for the three year period while day cases increase from 83.5% in 2007/08 to 87.5% in 2009/10. • New technology (a web based bed management tool) will be fully operational in April 2008 and will improve bed management, and thus the timely assessment of patients by health professionals resulting in efficient discharging of patients.	**Evidence** • The Trust has continued to improve its average length of stay for inpatients over the period April 2004 to October 2007 through the implementation of the "Length of Stay Reduction Action Plan" (which forms part of the CIP programme). • The new bed system coming on line will improve efficiency in bed day use, however this remains at 90% (excluding DTC facility) since three wards will close, thus reducing the number of beds available. • Improvements in length of stay form a key component of the 2008/09 CIP. **Sensitivity** • Given current performance and risk assessment, no sensitivity has been considered.
Tariff and non-tariff activity	• Tariff and non-tariff inflation assumed at 2.5% from 2008/09.	**Evidence** • Tariff inflation confirmed at 2.3% for 2008/09. Other changes to tariff indicate that gains e.g. maternity, are offset by losses e.g. specialist top up adjustments. **Sensitivity** • Refer sensitivity 4 on Page [x]

Key Income Assumptions (continued)

Key drivers	Key assumptions	Rationale
Emergency Department attendances	• As a result of the "Right Care Right Place" initiative a 12.5% fall in total ED "minor type" attendances is forecast from 85,445 in 2006/07 to 75,151 in 2009/10 (this translates to a decrease in marginal income of £0.1m from 2008/09). • An increase in Paediatric ED growth will be generated primarily through the opening of a children's ED in May 2008. This is forecast to generate additional income of £0.2m and expenditure of £0.1m from 2008/09. • Islington PCT has stated its intention to tender for alternative providers for the assessment and management of minor ED attendances. The Trust assumption is that the Trust becomes the chosen provider and activity is retained at 80% of the current funding of £3m p.a. from 2008/09.	**Evidence** • Current PCT commissioning strategy plans. • Internal estimate of additional activity and related income and expenditure on opening dedicated children's ED unit. Assessment of condition of Paediatric ED facilities at our local hospitals suggests the improved facility will be more attractive to parents and therefore impact on choice and flows. **Sensitivity** • Refer sensitivity 6 on Page [x]
Day Treatment Centre Service Development	• Elective activity commences in the DTC in April 2008, and is forecast to generate additional income of £3.9m in 2008/09, £5m in 2009/10 and £5.3m from 2010/11 onwards (at current prices). Outpatient activity will generate an additional £0.6m in 2009/10, rising to £0.8m from 2010/11 onwards. • Elective day case activity will increase by a further 4,193 in 2008/09, 1,407 in 2009/10 and another 572 in 2010/11. This will result in utilisation of 56% by 2010/11, including existing day surgery activity. However, this does not include the transfer of existing dermatology and inpatient endoscopy work, which will increase utilisation to 64% (71% of usable capacity of 90%).Increased elective day case activity of 4,193 (2008/09), 1,407 (2009/10) and 572 attendances p.a. thereafter is assumed, which is forecast to result in the utilisation of only approximately 55.9% of the total available centre capacity by 2010/11.	**Evidence** • Forecast activity for 2008/09 is 13,597 cases (49% of capacity). This compares to an estimated full cost breakeven point of 13,173 (47% of capacity) based on existing casemix and overhead apportionment assumptions. • Of the further increase in activity of 4,193, a total 2,029 will result from repatriation of ophthalmology, ENT and interventional cardiology and radiology activity from other trusts. The remaining 2,164 cases will result from increased market share, based on evidence from Dr Foster market analysis and activity and population growth trends. **Sensitivity** • Refer sensitivity 2 on Page [x]

Key Income Assumptions (continued)

Key drivers	Key assumptions	Rationale
Maternity and NICU Service Development	• Increasing maternity and neonatal demand has driven the need to upgrade and modernise the maternity and NICU department. – Phase 1: Additional capacity operational in October 2007 offers capacity for up to 4,000 births. – Phase 2: £23.5m capital investment spread over five years from 2008/09. Funding generated from internally generated cash of £10m (through sale of the Waterlow building and Nurses homes in 2009/10 for £10m) and a loan of £13.5m in 2011/12. Phase 2 will provide capacity for a further 2,000 deliveries by 2013/14. Income is forecast to be generated from 2013/14. – The 2000 additional births results from the expected 10% total increase in birth rates over the next five years and an increase in market share.	**Evidence** • The Trust achieved designated NICU level 2 status in 2006. • The London Maternity Review projects a 1.9% p.a. increase in births in the next 2 years and a 10% total increase in the next 5 years. • The Trust achieved a 6% increase in deliveries in both 2006/07 and 2007/08. • The increased market share assumption is based on current and anticipated future limited capacity of other Trusts within the sector. • A full outline business case (including a detailed study of potential development costs) is being commissioned and will be approved prior to Phase 2 development commencing. **Sensitivity** • Refer sensitivity 3 on Page [x]
Non-NHS clinical income	• Inflation of 2.5% assumed from 2008/09. • Private patient income falls to within the level of the 0.2% cap (based on 2002/03 private patient levels).	**Evidence** • The inflationary uplift is in line with the national average. • Forecasts are in line with historically low levels of Private patient income (0.3% and 0.2% of total actual clinical income in 2006/07 and 2007/08). **Sensitivity** Refer sensitivity 4 on Page [x]
Education, Training and R&D	• Inflation of 2.5% assumed from 2008/09 for both E&T and R&D. • R&D funding is reduced recurrently by £0.5m (2007/08) and £0.3m (2008/09) in line with the falling trend in DH funding. This has however been mitigated by transitional funding of £0.4m (2007/08) and £0.3m (2008/09). • E&T funding was initially £13.3m in 2006/07; however the DH has confirmed to the Trust through a letter that there will be a £1m recurrent cut in funding from 2007/08 onwards. This is offset through additional junior doctor and other non medical training funding (CPD and NVQ) received in 2007/08. • SIFT funding (included in E&T funding) is not re-based from the 2006/07 funding level per trainee.	**Evidence** • Transitional R&D funding still in place during 2008/09, reducing by £0.3m in 2009/10. • Rebasing of SIFT allocations not due in 2008/09 as per current SHA notification. **Sensitivity** • Refer sensitivity 5 on Page [x]

Key "PFI" Assumptions

3.1.3 Key "PFI" Assumptions

Key drivers	Key assumptions	Rationale
PFI	• The Trust is committed to a PFI scheme in two phases; – Phase 1 represents the Trust's "new" building completed in October 2006 and the "managed equipment services contract" for imaging equipment. – Phase 2 is the refit of the Great Northern building into a new Day Treatment Centre ("DTC") to be opened in April 2008 to increase day case activity. • The Trust's PFI scheme is accounted for as per UK GAAP and is recorded as "off balance sheet". • The PFI unitary payment is forecast to increase to £5.2m in 2007/08 (£6.1m in 2008/09 onwards). • Deferred asset created in 2006/07 of £25.2m following the transfer of existing building to facilitate Phase 2 DTC. Amortised over useful economic life of 30 years. • The PFI residual interest is built up, on an actuarial basis, over the remaining life of the contract (27 years) by capitalising part of the PFI unitary charge, so that at the end of the contract the combined net book value of the residual asset and the PFI deferred asset, equal the expected fair value of the scheme buildings. • No revaluations of the deferred asset or residual interest are assumed in the Model.	**Evidence** • Residual interest values are in line with District Valuer assessments and have been approved by the external auditor. • Potential changes to the treatment of PFI schemes is awaited from the DH following the introduction of IFRS accounting standards from 2008/09. **Sensitivity** • Based on current risk assessment, no sensitivity has been considered.

Key Expenditure Assumptions (continued)

3.1.4 Key Expenditure Assumptions

Key drivers	Key assumptions	Rationale
Pay expenditure	• Overall pay inflation of 5% p.a. including AfC and EWTD. • AfC cost pressure assumed to be 1.4% of relevant staff groups in 2008/09 and 1.5% in 2009/10 (circa £1.0m p.a.). • It is assumed that the full costs of implementing the consultant contract have been incurred by 2005/06, while the costs of achieving the EWTD of 56 hours (2007/08) and 48 hours (2008/09) will be incurred by 2009/10. EWTD forecasts a £1.1m p.a. increase from 2008/9 to 2009/10. • The impact of EWTD on junior medical costs is 8.2% (2008/09) and 7.9% (2009/10). • The model assumes increasing maternity/ obstetric business case staffing as a result of increased activity. • The majority of CIP savings are expected to be made on pay costs; pay expenditure CIPs forecast at 3.2% of total pay expenditure in both 2008/09 and 2009/10. • Agency costs are forecast to decrease over the period through a decreased vacancy rate as staff are redeployed into vacant posts with ward closures, and the controlled use of bank staff to reduce reliance on agency staff.	**Evidence** • Pay inflation is in line with the national average. • AfC cost pressure is inline with the sector benchmark cost increase of £1m (2008/09) and £0.9m (2009/10). • EWTD is above the sector benchmark in both 2008/09 and 2009/10 due to the need to recruit an additional 18 junior doctors in the period (9 each year) to become compliant with the EWTD, the costs of which have been determined by an External Workforce Review Team (appointed through the NHS in August 2007). **Sensitivity** • Given current performance and risk assessment, no sensitivity has been considered.
Workforce	• The workforce strategy forecasts a decrease in staff numbers from 2,412 in 2007/08 to 2,280 in 2008/09 and 2,229 in 2009/10.	**Evidence** • The forecast total reduction will be achieved through the implementation of detailed work force plans each department develops prior to the start of each year. The Trust has recruited an external Workforce Review Team who have assessed staffing needs for the projected levels of activity. The CIP will detail the workforce, impact and timing of efficiency initiatives. • CIPs are performance managed to ensure delivery. **Sensitivity** • Failure to achieve staffing reductions is tested under the CIP sensitivity (refer sensitivity 1 on Page [x])

Key Expenditure Assumptions (continued)

Key drivers	Key assumptions	Rationale
Drugs	• Inflation of 9.6% (2008/09) and 9.5% (2009/10) is assumed. This is inclusive of NICE guidelines and technological developments.	**Evidence** • In line with national benchmarks/ other FT applicants. • Stable levels of expenditure from 2004/05 to 2006/07. • 2007/08 levels of expenditure are distorted by 18 weeks and are in part non-recurrent. **Sensitivity** • Given current risk assessment, no sensitivity has been considered.
Clinical supplies and services	• Inflation of 5% assumed in 2008/09 and 4.8% in 2009/10.	**Evidence** • Budgeted sum allows for cost pressures to be absorbed. • 2007/08 levels of expenditure are distorted by 18 weeks and are in part non-recurrent. **Sensitivity** • Given current risk assessment, no sensitivity has been considered.
Other costs	• Consists primarily of general supplies and services expenditure, establishment expenditure, premises and fixed plant costs, and the full year effect of the PFI unitary payment. • Inflation is assumed to be 5% (2008/09) and 4.8% (2009/10).	**Evidence** • Budgeted sum allows for cost pressures to be absorbed. • 2007/08 levels of expenditure are distorted by 18 weeks and are in part non-recurrent. **Sensitivity** • Given current risk assessment, no sensitivity has been considered.

Key "CIP" Assumptions

Key drivers	Key assumptions	Rationale
CIPs	• CIPs are forecast at £8.4m (5.6% of income) in 2007/08, £3.8m (2.4% of income) in 2008/09, £4m (2.5% of income) in 2009/10. The 2.4% and 2.5% of income (2008/09 and 2009/10) represents the difference between the cost pressure assumption on expenditure of 5% and the assumed tariff uplift of 2.5%. • £3.4m of the recurrent £3.8m CIP target in 2008/09 has been allocated to pay. This consists mainly of productivity/ efficiency gains including improvements in LoS. • Table 3.1.5 below details the forecast CIP by theme and pay/non-pay for 2007/08 to 2009/10.	**Evidence** • The Trust achieved 100% of its CIP targets in 2005/06 and 2006/07 (percentage on a recurrent basis). • The Trust has successfully achieved 74% of the 2007/08 CIP Target of £8.5m by December 2007 and is confident that 100% of CIPs will be achieved at year end, based on the current level of cost control within the Trust, otherwise non-recurrent measures will be utilised. • The 2007/08 CIP schemes are supported by detailed plans and assigned responsibilities where there are weekly reviews by the Chief Executive. Future savings will tackle identified service lines which show inefficiency as part of the patient level costing project. • The 2008/09 CIP programme has identified schemes in excess of the target (£0.2m). Project plans have been approved by the Executive team. • CIP projections from 2008/09 onwards are significantly lower than those achieved in 2006/07 (£11.0m) and those planned for 2007/08 (£8.5m). **Sensitivity** • Refer sensitivity 1 on Page [x].

Table 3.1.5: Summary of forecast CIP

£m	Outturn 2007/ 08	Forecast 2008/ 09	Forecast 2009/ 10
Theme			
Service redesign	1.9	1.1	1.2
Increased productivity	2.6	1.1	1.2
Procurement	0.4	0.4	0.4
Other	3.5	1.1	1.2
Total CIP	**8.5**	**3.8**	**4.0**
CIP % of total income	**5.6%**	**2.4%**	**2.5%**
Pay	1.8	3.4	2.8
Non-pay	6.7	0.4	1.2
Total CIP	**8.5**	**3.8**	**4.0**
Recurrent	7.6	3.8	4.0
Non-recurrent	0.9	-	-
Total CIP	**8.5**	**3.8**	**4.0**

Balance Sheet Overview

Table 3.2 summarises the historical and forecast Balance Sheets

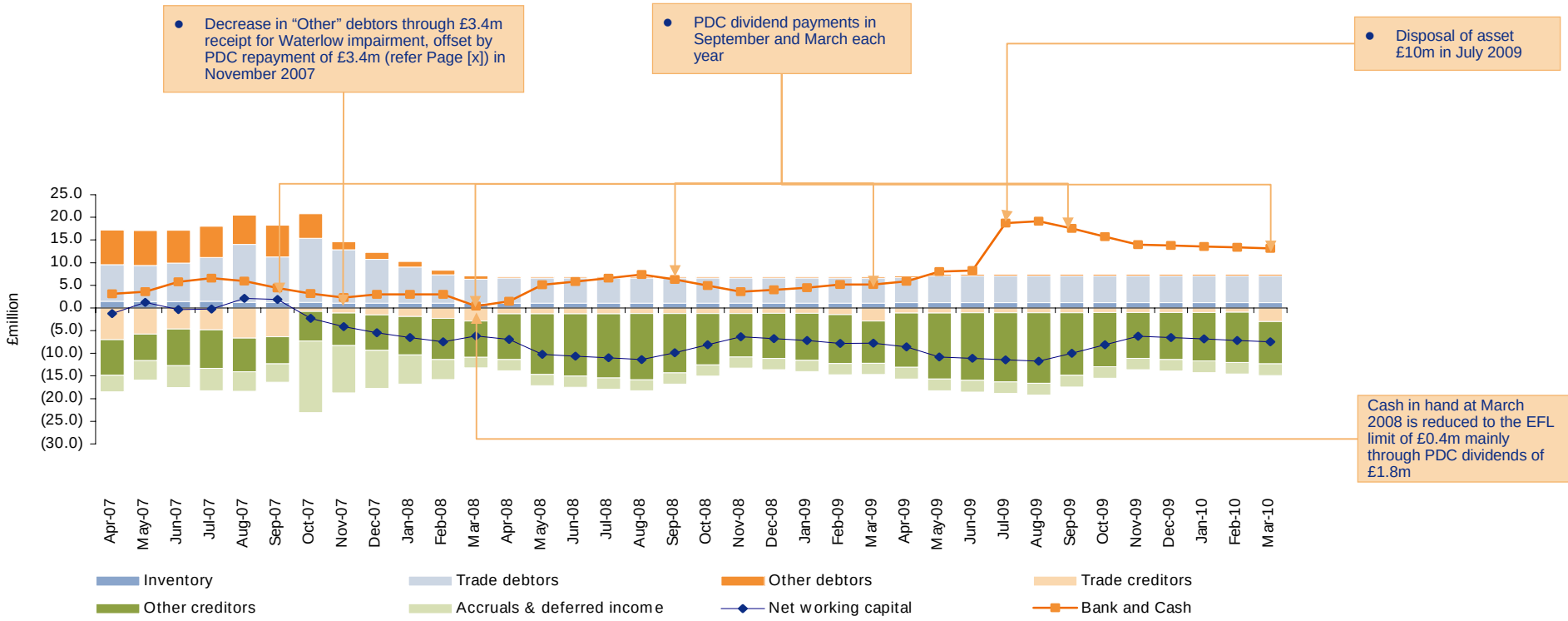
£m	Actual 2006/07	Outturn 2007/08	Forecast 2008/09	Forecast 2009/10
Fixed assets				
Tangible fixed assets	83.1	91.5	94.9	95.0
PFI Residual interest	0.3	0.9	2.0	3.1
PFI Deferred assets	25.0	24.5	23.7	22.9
Total fixed assets	**108.4**	**116.9**	**120.6**	**120.9**
Current assets				
Inventory	1.3	1.0	1.0	1.1
NHS trade debtors	2.3	4.4	4.8	5.2
Non-NHS trade debtors	2.3	0.9	0.8	0.8
Other debtors	3.4	-	-	-
Accrued income and prepayments	2.6	0.7	0.3	0.3
Cash at bank and in hand	0.4	0.4	5.1	13.2
Total current assets	**12.3**	**7.5**	**12.0**	**20.6**
Current liabilities				
Trade creditors	(2.8)	(2.9)	(2.9)	(3.0)
Other creditors	(5.3)	(4.9)	(5.3)	(5.4)
Capital creditors	(3.1)	(3.0)	(4.0)	(3.9)
Accruals and deferred income	(2.5)	(2.4)	(2.5)	(2.6)
Total current liabilities	**(13.7)**	**(13.2)**	**(14.7)**	**(14.9)**
Current (liabilities)/ assets	**(1.4)**	**(5.8)**	**(2.6)**	**5.7**
Net long term debtors/ provisions	(0.3)	(0.1)	(0.1)	(0.1)
Total assets employed	**106.8**	**111.1**	**117.9**	**126.6**
Taxpayers equity				
Public dividend capital	49.9	47.3	47.3	47.3
I&E reserve	20.1	21.6	24.4	27.1
Revaluation reserve	35.3	40.8	44.4	50.4
Donated asset reserve	1.4	1.5	1.9	1.8
Total taxpayers equity	**106.8**	**111.1**	**117.9**	**126.6**

3.2 Balance Sheet Overview

- The increase in total fixed assets over the period to 2009/10 is after:
  - Forecast non-maintenance capital expenditure (including Phase 2 of the Maternity/NICU development which commences in 2008/09) and the ongoing capital maintenance programme;
  - The recognition of the PFI residual interest, offset by the amortisation of the PFI deferred asset (Great Northern building) over the remaining 27 year period of the PFI scheme from 2008/09;
  - The sale of the Waterlow and Nurses home in July 2009 to fund part of the Phase 2 Maternity/ NICU development.
- Working capital balances are forecast based on 2007/08 outturn levels (refer Page [x] for explanations of monthly working capital movements). Net current assets are forecast to increase significantly from 2008/09 to 2012/13 due to significant increases in cash balances (refer Page [x] and Page [x].
- PDC has been kept constant from 2007/08 on the presumption that the Trust will become a Foundation Trust in 2008/09.
- The key assumptions for individual projected Balance Sheet items are discussed on Pages [x] to [x].

Balance Sheets – monthly working capital and cash movements

Figure 3.2.1 summarises the working capital and monthly cash movements over the period April 2007 to March 2010.



Balance Sheets – monthly working capital and cash movements (continued)

3.2.1 Working Capital

Stock

- The inventory balance remains at a similar level each month throughout the period and consists primarily of Drugs (approximately £0.9m).

Trade debtors

- NHS trade debtors are forecast to remain fairly constant from April 2008 to March 2010 (range from £6.7m to £6.8m) with approximately 90% of debtors expected to pay within a month from date of invoice.

Other debtors

- Other debtors at 2006/07 consists of £3.4m due from the PCT in relation to the Waterlow asset impairment which was received in November 2007.

Trade creditors

- Trade creditors are forecast to remain relatively stable from April 2008 to March 2010 and range from £0.9m to £3m during this period.

Other creditors

- Includes a monthly accrual for PDC dividends, which are paid in September and March annually.

3.2.2 Cash Profile

- The Trust is forecast to maintain a positive monthly cash balance throughout the period to March 2010. The increase in cash of £11.7m from April 2008 to March 2010 is largely dependant on planned asset disposal proceeds (to be used to fund capital expenditure) of £10m in July 2009. The Trust will mitigate any delay in the planned sale through the deferral of Phase 2 Maternity/NICU development expenditure of £3.8m in 2009/10 (not yet committed), or will bring forward it's application for loan financing to be used to fund the Phase 2 Maternity/NICU development expenditure (£13.5m planned in 2011/12).

Cash Flow

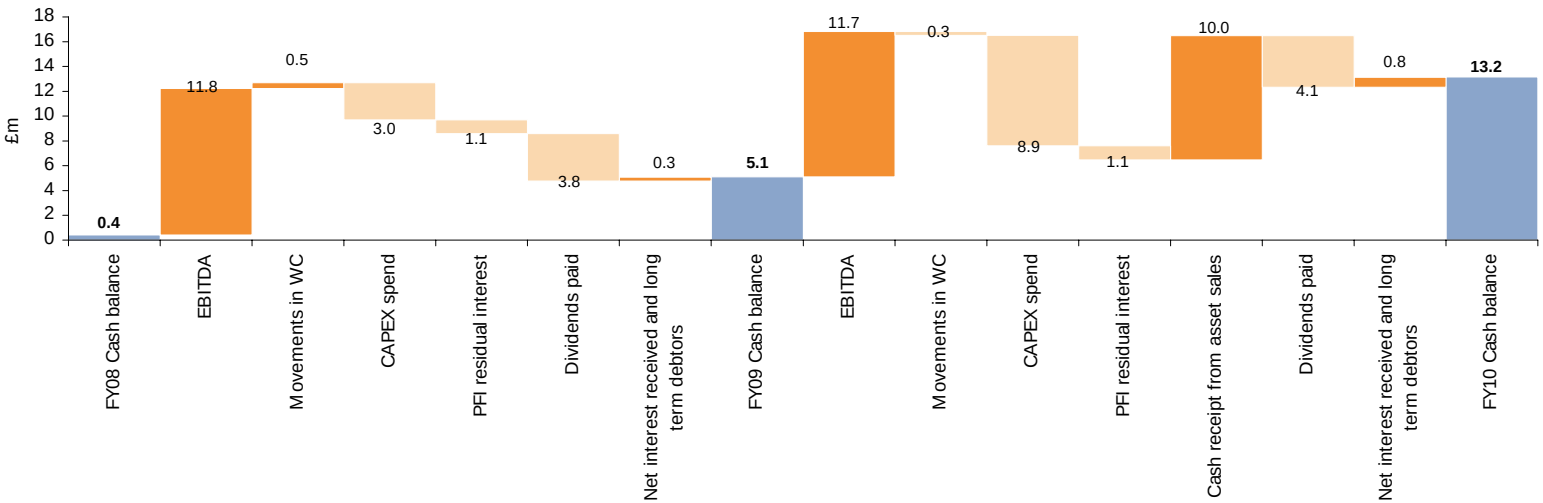
Table 3.3 summarises the historical and forecast Cash Flows

£m	Actual 2006/07	Outturn 2007/08	Forecast 2008/09	Forecast 2009/10
EBITDA	13.0	10.1	11.1	11.1
Excluding non cash I&E items	(0.2)	0.8	0.7	0.7
Movement in working capital	(5.9)	4.3	0.5	(0.3)
Cash flow from operations	**6.8**	**15.2**	**12.3**	**11.4**
Net capex spend	(8.4)	(9.3)	(4.1)	-
Cash flow before financing	**(1.5)**	**6.0**	**8.2**	**11.4**
Movement in LT debtors	-	-	0.1	0.1
Interest (paid)/ received	0.3	0.3	0.2	0.7
PDC received	4.4	2.7	-	-
PDC repaid	-	(5.4)	-	-
Dividends paid	(3.2)	(3.6)	(3.8)	(4.1)
Net cash inflow	**-**	**-**	**4.7**	**8.0**

3.3 Summary of Cash Flow

- Over the period 2007/08 to 2009/10, the net cash inflow increases by £12.7m (as detailed in Figure 3.3) largely through:
  - Increased EBITDA;
  - Improved working capital management, being mainly improved NHS debtor receipts offset by improved trade creditor settlements to comply with the BPPC (refer Page [x]);
  - Capital programme investment (refer Page [x]); offset by asset disposal proceeds of £10m for the Waterlow building in July 2009.

Figure 3.3.1 summarises the Cash Flow bridge over the period 2007/08 to 2009/10



Key Capital Investment, Financing, Disposal and Asset Impairment

3.4 Key Balance Sheet and Cash Flow Assumptions

Key drivers	Key assumptions	Rationale
Capital investment, financing, disposal and asset impairment	**Table 3.4: Future capital investment and financing**	**Evidence**

£m	Outturn 2007/ 08	Forecast 2008/ 09	Forecast 2009/ 10
Non-maintenance			
DTC Phase 2	0.8	-	-
Pathology system	0.6	-	-
Maternity/ NICU	-	0.4	3.8
Medical records rel.	0.5	-	-
Isolation rooms	0.3	-	-
Chemotherapy suite	0.3	-	-
CT Scanner room	0.3	-	-
Endoscope/video	0.4	-	-
Decontamination	0.4	-	-
Other schemes	3.0	1.6	3.0
	6.6	**2.0**	**6.8**
Maintenance			
ED redevelopment	1.0	-	-
GI Unit	0.5	0.5	-
ED facilities	0.5	0.2	-
Paediatric OPD	0.4	0.8	-
Other/ backlog	0.2	0.5	2.0
	2.6	**2.0**	**2.0**
Investment	**9.2**	**4.0**	**8.8**
PFI Residual	1.1	1.1	1.1
Capital exp.	**10.2**	**5.1**	**9.9**
Financed by:			
PDC received	2.3	-	-
Asset disposal	-	-	10.0
Other	7.9	5.1	(0.1)
Financing	**10.2**	**5.1**	**9.9**

Evidence

- **Capital investment**
  - Internal Capital Programme report.
  - Property appraisal performed by Nifes Consulting Group in July 2007.
- **Residual PFI interest**
  - Refer Page **[x]**.
- **Capital financing**
  - Recurrent capital expenditure is assumed to be funded mainly through depreciation and PFI deferred asset write down.
  - Maternity/NICU Phase 2 capital expenditure is funded from a combination of asset disposal and loan financing.
  - Higher projected cash balances provide an opportunity to either enhance the programme or provide an alternative to loan/asset disposal financing.
- **Capital disposal**
  - Forecast disposal of the Waterlow and Nurses home for £10m in July 2009/10.
- **Fixed asset impairment**
  - Fixed asset impairments of £0.8m are forecast in 2007/08 relating to equipment.
  - The next anticipated impairment is 2010/11 for approximately £0.3m.

Sensitivity

- Based on the current risk assessment, no sensitivity is deemed necessary for capital investment, financing and asset impairment.
- Regarding the asset disposal:
  - Feasibility of sale to timetable is established;
  - Any slippage in the sale will require a review of the loan phasing or use of cash balance or phasing of development.

  No sensitivity is therefore deemed necessary.

Working Capital Assumptions

Key drivers	Key assumptions	Rationale
Debtors	• The majority of NHS debtors are expected to pay within a month. 80% of invoices raised are assumed within the period. The remaining debt is assumed to be settled in equal portions within 30 to 60 days (10%) or after 60 days (10%). • The majority of non NHS debtors are also expected to pay within 30 days in most years. The collection profile is 30 days (42%), 60 days (29%) and 90 days (29%).	**Evidence** • Current debtor performance indicates a high rate of settlement from the two PCTs that constitute 83% of the clinical income (Whittington and Haringey). **Sensitivity** • Based on the current risk assessment, no sensitivity is deemed necessary.
Creditors	• Trade creditors: Approximately 85% of invoices are assumed to be settled within 30 days and 15% within 30-60 days. • Financial Plan flexed to increase settlement rate to 95% within 30 days. • Stock and other working capital balances are assumed to remain constant at 2007/08 outturn levels.	**Evidence** • The Trust historically achieves a creditor payment profile of approximately 85% in 30 days with more in the case of NHS liabilities. • Cash balances have remained high during the year. • EFL management requires a minimal cash target to be achieved at the 2007/08 year end under the Trust regime. **Sensitivity** • Based on the current risk assessment, no sensitivity is deemed necessary.

Financing Assumptions

Key drivers	Key assumptions	Rationale
PDC dividends	• Paid bi-annually in March and September of each year. • PDC dividend is set at 3.5% of net relevant assets which is calculated as the average between the start and the end of reserves (income and expenditure, revaluation and PDC reserves) for the period.	**Evidence** • No variation assumed from current methodology. **Sensitivity** • Based on the current risk assessment, no sensitivity is deemed necessary.
PDC paid/received	• 2007/08 forecast net payment of £3.6m is after: – Draw down of £2.7m to fund the 2007/08 capital programme, offset by; – PDC repayments of £5.4m, being £3.4m for the Waterlow building impairment and the forecast 2006/07 surplus of £2m. Waterlow building was impaired to zero following advice from District Valuer; asbestos was found within the derelict building. • No PDC is forecast to be received or paid from 2008/09 onwards.	**Evidence** • Finance Report to the Board which reconciles with SHA funding data. **Sensitivity** • Based on the current risk assessment, no sensitivity is deemed necessary.
Bank rates	• Interest rate on cash balances of 5.2% assumed in the model.	**Evidence** • Current rates as per OPG. **Sensitivity** • Based on the current risk assessment, no sensitivity is deemed necessary.
Loan rates	• Loan rates are assumed to be 6.5% in the model.	**Evidence** • Assumption based on FT financing network facility option. **Sensitivity** • Based on the current risk assessment, no sensitivity is deemed necessary.

Executive Summary

4.1 Executive Summary

- **Corporate Governance, Trust Board and FT Monitoring Regime (Refer Pages [x] to [x])**
  - The Board has developed an integrated governance, risk and financial assurance reporting process which is supported by a Committee structure that combines the management of clinical, financial, organisational and non-clinical operational risk.
  - The Board recently appointed a new Chairman, two replacement Non-Executive Directors ("NEDs") and an associate NED during the autumn of 2007 which strengthened the Trust's financial, commercial and corporate governance expertise prior to potential FT status. A tailored induction programme has been initiated to enable their effective integration and to accelerate their understanding of the healthcare sector and local issues.
  - The Board is reviewing Board Committee structures, processes, skills and competencies to identify areas requiring further development to ensure that the Board matures effectively and can meet the current and future needs of the Trust's patients and community.
  - Under the current governance arrangements the Trust has five Board Committees and two other "operational" committees in place. The Board receives minutes from each of these committees. The committees are properly constituted, chaired by a NED and reflect an appropriate mix of specialist and NED input.
- **Financial Performance Management (Refer Page [x])**
  - Reports to the Board have been strengthened during the current year through the inclusion of a rolling twelve-month cash flow forecast (effective from December 2007), and an integrated "dashboard" performance report (effective from April 2008) based on activity, workforce and finance metrics and which details key ratio performance.
  - Further improvements to be implemented focus primarily on improving the Trust's Management Accounting Reporting and Costing processes in line with FT requirements, through the planned full implementation of Service Line Reporting ("SLR") by April 2008.
- **Assurance Framework ("AF") (Refer Page [x])**
  - The Trust has a clearly defined AF (recently updated and will be ratified at February Assurance Committee) which identifies the potential risks which may prevent the Trust achieving its key strategic objectives and which prioritises and identifies the lead officers responsible for each risk area.
- **Risk Management (Refer Page [x])**
  - The Trust's Risk Management Strategy document (revised in March 2007 and to be reviewed in March 2008) incorporates clear accountability and detailed processes through which risk should be managed. Key financial and operational risks are reported to the Board on a monthly basis.
- **Treasury Management Policy (Refer Page [x])**
  - The Trust has a Treasury Management Policy (October 2007) which will be ratified by the Board in March 2008. The policy was implemented in January 2008.
- **Internal Audit (Refer Page [x])**
  - The function is provided by Parkhill Audit Agency (since 1996), who are a well established provider of audit services to a number of NHS organisations. The Internal Audit Letter (2006/07) suggests that the Trust's existing Accounting Systems are appropriate for current business activities, financial reporting and budgetary control and are operating effectively.
- **External Audit (Refer Page [x])**
  - The function is provided by the Audit Commission. The Trust's named auditor is Philip Johnson, District Auditor. No significant issues have been raised in the Annual Audit Letter and the auditors have given an unqualified opinion on the accounts for the last three years.
- **Information systems (Refer Page [x])**
  - The Trust is currently revising the IT strategy to meet its key strategic objectives and producing a three year plan which will be presented to the Board for approval in March 2008.
  - The Trust's IT Disaster Recovery plan is under continuous review (the latest plan was reviewed and approved by the Executive team in August 2007 and [Internal Auditor in [x]])

Corporate Governance and Trust Board

4.2 Corporate Governance

4.2.1 Integrated Governance

- The Trust Board ("Board") is responsible for ensuring the effective governance of the Trust with the Chief Executive as Accountable Officer.
- The Board has developed an integrated governance, risk and financial assurance reporting process which is:
  - Governed by the Trust's "Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions" document adopted in June 2006;
  - Supported by a Committee structure that combines the management of clinical, financial, organisational and non-clinical operational risk.
- The roles and responsibilities of the Board and Committees are understood throughout and well documented.

4.2.2 Appropriate range of skills represented on the Board

- The Board recently appointed a new Chairman and two replacement Non-Executive Directors ("NEDs"), and an Associate NED during the autumn of 2007 which strengthened the Trust's financial, commercial and corporate governance expertise prior to potential FT status. A tailored induction programme has been initiated to enable their effective integration and to accelerate their understanding of the healthcare sector and local issues.
- The Board is reviewing Board Committee structures, processes, skills and competencies to identify areas requiring further development. In addition, the Trust has introduced a development programme effective from November 2007 for Executive Directors ("EDs") and NEDs to strengthen their skills and understanding of the new environment to oversee FT status. The programme builds on experience from established FT's and focuses on the new governance relationships, delivering effective challenge, the financial regime, managing risk and performance and exploiting the opportunities.

4.2.3 Trust Board ("Board")

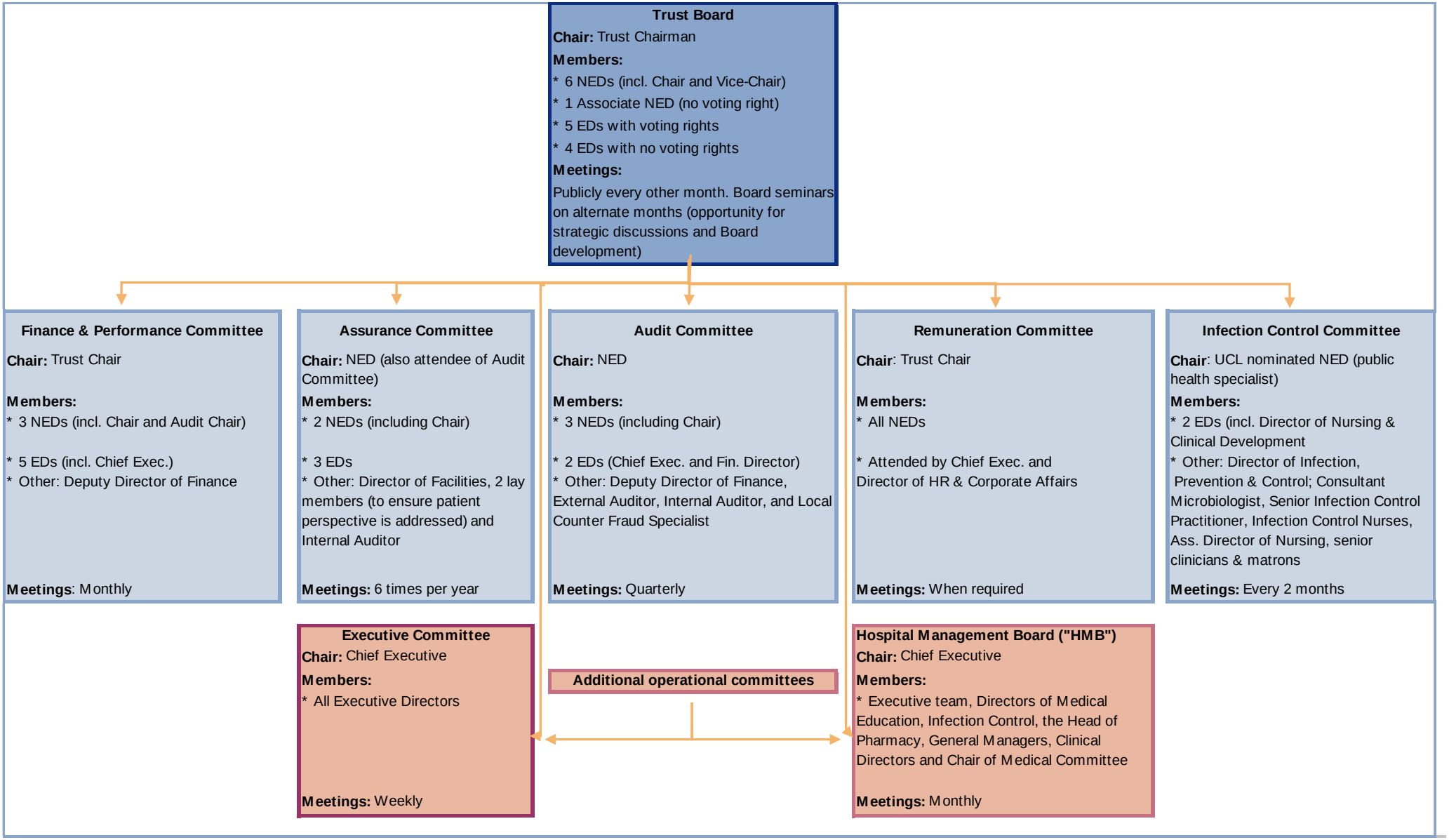
- Under the current governance arrangements the Trust has five Board Committees and two other "operational" committees in place. The Board receives minutes from each of these committees. The committees are properly constituted, chaired by a NED and reflect an appropriate mix of specialist and NED input.
- The principle committees and their terms of reference are;
  - **Finance & Performance Committee,** who examine in detail the Trust's financial position, performance against targets (financial, clinical and operational) and the capital programme;
  - **Assurance Committee,** who implement and monitor the Trust's risk management strategy, which includes updating the Trust's Assurance Framework ("AF"), compliance with Healthcare Commission Annual Core Standards, and informing the Board of significant issues arising from the AF and Risk Register;
  - **Audit Committee,** who through their cross-membership and exchange of minutes with the Assurance Committee, are able to provide independent scrutiny of the Trust's risk management systems, financial systems, financial information, and compliance with legislation, NHS guidance, the code of conduct, Standing Orders and Standing Financial Instructions;
  - **Remuneration Committee,** who advise the Board on remuneration and conditions of service matters for employees;
  - **Infection Control Committee,** who ensure that infection control and decontamination are properly managed within the hospital.

  The "operational" committees and their terms of reference are:
  - **Executive Committee,** who has delegated authority for the operational management of the Trust;
  - **Hospital Management Board ("HMB"),** which is an internal "multi-disciplinary" management board established to review clinical management issues, policy, and broad strategic direction.

  Refer Figure 4.2.3 on Page [x] for details of committee leadership, membership and meetings.

Trust Board (continued)

Figure 4.2.3: Current Board Committee Structure



Note: Executive Directors ("EDs") with voting rights are the Chief Executive, Medical Director, Director of Nursing & Clinical Development, Director of Finance and the Director of Strategy & Performance (Deputy Chief Executive)
Executive Directors without voting rights are the Director of Operations, Director of HR & Corporate Affairs, Director of Primary Care and the Director of Facilities

FT Monitoring Regime

4.2.4 Ensuring Compliance with the FT Monitoring Regime

- The specific requirements of FTs to operate in accordance with the terms of their Authorisation are set out in Section 1.3 of Monitor's Compliance Framework (updated April 2007). In anticipation of the rigour of the FT monitoring regime, the Board established a new Directorate of Strategy and Performance in August 2006. The Directorate, headed by the Deputy Chief Executive is responsible for co-ordinating the strategic planning and performance management infrastructure. It is also project managing the application for FT status. A small core team of senior managers and planners is supported by a number of project teams with members drawn from other Directorates.
- The Director of Strategy and Performance is responsible for ensuring that evidence of compliance with all standards, targets and legal requirements is appropriately documented and archived. All Board and key Committee papers have a cover sheet which identifies the relevant DoH/Monitor or third party inspection or regulation regime, and the specific element to which it relates.
- An integrated reporting format is being developed using principles set out in "The Intelligent Board" (Refer Section [x] on Page [x]).
- The Trust's solicitors, Bevan Brittan, are advising on a number of governance aspects including the development of the constitution and the conduct of elections. The role of Company Secretary has been incorporated into the portfolio of responsibilities of the Director of Strategy and Performance. The servicing of the Board of Directors and the Council of Governors, the management of the Membership Office and stewardship of the Trust's compliance under the FT Governance Regime is managed through the Directorate.

Financial Performance Management

4.3 Financial Performance Management

4.3.1 Overview

- The Performance Management Framework has evolved over the last three years following a board level review and the extension of the remit of the previously established Finance Committee into the Finance & Performance Committee.
- The Trust has regular agenda items at Board meetings. These include:
  - Strategy;
  - Operational performance (including financial report and access performance report);
  - Risk (including clinical governance, infection control, and risk management and assurance).
- A pre-determined programme of reporting has been implemented to manage performance within appropriate timescales so that effective remedial action can be taken if necessary.

4.3.2 Management Reporting Cycle

Table 4.3.2: The table below sets out the reporting timetable to the Trust Board and the executive committees

	Weekly	Monthly/ Bi-monthly	Quarterly	Annually
Trust Board (bi-monthly)		Financial Performance Access performance Service Improvement Performance (also to monthly Finance & Perf. Comm.) Minutes of the Finance & Perf. Comm. Clinical Governance	Human Resources Infection Control Visible Leadership Programme Provider Agency compliance report Audit Committee minutes Assurance Committee minutes	Annual Report and Accounts Healthcare Commission assessment Audit Commission ALE assessment External Auditor's Annual letter Medical School's annual assessment Local Authority OSC Research & Development Charitable Funds
Executive Team Hospital Management Board	Staff in post, bank and agency, trend lines Performance against CIP Non-pay commitments	 Finance Access Service Improvement Human Resources	 Visible Leadership Programme	 HCC Assessment Medical School assessment Research & development

4.3.3 Reports to the Board

- Reports to the Board have been strengthened in the current year. The most recent report presented to the Board in December 2007 contained the following sections:
  - 2007/08 financial plan commentary;
  - Detailed YTD income & expenditure position (actual vs. budget, in month actual vs. budget) including CIP performance;
  - Balance sheet performance (cash and EFL, debtors, creditors);
  - Workforce indicators;
  - A rolling twelve-month cash flow forecast (effective from December 2007).
  - An integrated "dashboard" performance report. The Trust has developed a prototype dashboard based on activity, workforce and finance metrics which details key ratio performance. The dashboard is designed to provide the Board with readily accessible, near-real time performance measures and provide early warning of potential authorisation breaches. The dashboard was presented to the Board Seminar in December 2007 and will be fully implemented from April 2008.
- Further improvements to be implemented:

  The Trust will improve its Management Accounting Reporting and Costing processes in line with FT requirements, through:
  - "Service Line Reporting" ("SLR"). The Trust currently has Patient Level Costing provided by Power Health Solutions ("PHS"). The Trust is currently in the process of implementing a trading account approach to support SLR and has procured SLR software from PHS which is being tested from December 2007, with SLR to be fully implemented by April 2008.

Table 4.3.3: The table below sets out the contents of performance management reports

Finance	Access	Service Improvement	Human Resources	Clinical Governance
Income/expenditure	Local and national waiting targets	Current priorities:	Employment	Patient feedback
SLAs	Activity trends	Referral to treatment	Turnover	Complaints
CIP	MRSA	Making best use of beds – reducing LoS	Stability	Specific topics from Steering Group
Balance sheet	Delayed transfers of care		Sickness absence	
Cash flow			Disciplinary and grievance hearings	
CRL/EFL				
Capital programme				

4.3.4 External reporting

- The External Performance Management Framework has been designed by the Provider Agency of NHS London to reflect the Monitor Compliance Framework using similar risk ratings relating to financial, service and governance risks. On the basis of the first quarter's monitoring, the Trust was placed on quarterly rather than monthly monitoring.

Assurance Framework and Overview of controls over key cost categories

4.4 Assurance Framework ("AF")

4.4.1 Overview

- The Board is accountable for internal control through the Standing Orders and Standing Financial Instructions (both dated June 2007 and reviewed annually) which provide a regulatory framework for the business conduct of the Trust.
- The Chief Executive as Accountable Officer makes an annual Statement of Internal Control (SIC) as part of the Trust's annual report and accounts. The Trust's SIC (2006/07) details the Trust's ability to manage risk, the risk and control framework, and a review of the effectiveness of internal controls.
- The Trust has a clearly defined AF (dated March 2007) which identifies the potential risks which may prevent the Trust achieving its key strategic objectives. The framework prioritises these and identifies the lead officers responsible for each area, together with the assurances that are, or need to be, in place. This then forms part of the Board's overall assessment of risk and allocation of resources.
- The Board has delegated responsibility for monitoring the AF and performance against the Healthcare Commission's Annual Health Check Standards to the Assurance Committee. The AF is reviewed quarterly by the Assurance Committee and twice a year by the Board. For each risk; key controls, gaps in controls, assurances including categorisation and gaps in assurances are identified.
- In accordance with the principles of integrated governance, there is cross reference and overlapping membership between the Assurance Committee and the Audit Committee, to enable the Audit Committee to verify that the Assurance Committee is fulfilling its role.
- Where risks are identified, an appropriate lead officer is assigned responsibility for the formulation of required actions and their associated timescales for implementation. Progress is reviewed through the process of updating the AF.
- The AF uses a risk scoring matrix which enables risk to be rated as either high, medium or low risk. This risk scoring is consistently applied.
- The Internal Auditor's Annual Report (2006/07) provided significant assurance for the Trust's overall systems of governance and internal control.

4.4.2 Overview of controls over key cost categories

- As per Section 3 on Page [x] of the memorandum, the most significant cost categories include:
  - **Pay** (£92.5m in 2005/06 and £95.7m in 2006/07) which amounts to approximately 75% of the Trust's total expenditure. The Trust will continue to manage pay costs through taking action to reduce agency spend and through all recruitment to vacancies being controlled by a structured authorisation process;
  - **Clinical supplies and services** (£11m in 2005/06 and £11.9m in 2006/07). To control this expenditure the Trust will continue to maintain a list of authorised signatories and operate an electronic ordering system that allows authorisation levels to be set depending on the level of control required;
  - **Drug costs** (£7.3m in 2005/06 and 2006/07). The Trust will continue to monitor this expenditure on a monthly basis with all requests for additions to the formulary needing to be clinically approved by the Drugs and Therapeutics Committee and then reviewed financially at the Business Planning Group;
- The Trust has a strong track record of achieving CIPs, delivering savings of £6.5m (5%) in 2005/06, and £11m (7.7%) in 2006/07. Management established robust processes to identify and project manage the delivery of identified schemes during 2006/07 and the approach has continued during 2007/08. Progress on the achievement of the planned CIP is reported to the Finance and Performance Committee on a monthly basis and is also provided to the Board on a monthly basis within the finance report. Weekly detailed reviews are undertaken with the Chief Executive and lead Directors concerned on individual schemes to assist with the monitoring of the various work-streams. The additional CIP for 2007/08 of £8.5m (5.6%) is progressing well (YTD achievement is £6.3m at December 2007). Future years' CIPs are set at approximately 2.5% or £3.8m for which specific proposals have been compiled for 2008/09.
- The Trust has an RCI of 96. The Trust aims to reduce high RCI scores within Cardiology and Midwifery.

Risk Management

4.5 Risk Management

4.5.1 Strategy

- Key organisational risks are identified from the Board Assurance Framework ("AF") through which risks are managed and mitigated.
- Key financial and operational risks are reported to the Board on a monthly basis.
- The Board recognises the importance of sound risk management throughout the Trust and will continue to:
  - Place great significance on the training, education and development of staff (through induction, specific and refresher training) to identify and manage risk to ensure that patients are cared for in a safe and effective way;
  - Implement improvements identified in external assessments and internal audit reviews.
- The Trust's Risk Management Strategy document (revised in March 2007 and to be reviewed in March 2008) incorporates clear accountability and detailed processes through which risk should be managed (refer Table 4.5.2 below). The overall philosophy is to minimise risk within a progressive, honest, open and non-punitive environment, where mistakes and untoward incidents are identified quickly and acted upon in a positive and constructive way.
- Within the Risk Management Strategy the following core areas are explained:
  - Risk management and structure;
  - Responsibility of Employees;
  - Role of committees;
  - Risk management process (identification and assessment);
  - Recommended management action for risk prioritisation.

4.5.2 Allocation of Responsibilities

- At a corporate level the Assurance Committee oversees integrated risk management across the Trust which is monitored through the Board Committee structure.

Table 4.5.2: Allocation of Responsibilities

Chief Executive	Accountable for overall risk management and providing assurance to the Board
Director of HR & Corporate Affairs	Verification of risk management controls, collation of the assurance framework, regular review of the strategy
Director of Nursing & Clinical Development, and Medical Director	Jointly responsible for the implementation of clinical governance and risk management
Director of Facilities	Responsibility for fire prevention and security aspects of non-clinical risk management
Director of Finance	Implementation of financial controls and business risk management

- All managers have responsibility for ensuring awareness and understanding of risk management within their departments. The Risk Manager, on behalf of the Assistant Director of Nursing, is responsible for the maintenance and completeness of the Trust's Risk Register which is populated from Directorate specific Risk Registers.
- The Director of HR & Corporate Affairs and the Director of Nursing and Clinical Development are responsible for ensuring that there are effective links between the Risk Register and AF.

Risk Management (continued)

4.5.3 Risk Assessment

- At Directorate and specialty level, all risks are assessed annually and graded through an impact and probability matrix which enables a RAG score to be attributed to each risk. Material risks are identified as those for which the probability of occurrence combined with the severity of the impact (each graded on a scale of 1 to 5), gives a score greater than 10. These risks which are recorded centrally on the Risk Register are then monitored, with responsibility assigned to an executive lead and mitigating actions identified with timescales.
- The Risk Register is reviewed by the Executive Committee every three months and annually by the Assurance Committee. In addition to the annual review, a systemic procedure for reporting adverse incidents is incorporated into risk registration and monitoring on an ongoing basis.
- The risk management process is closely aligned to the assessment of performance against the Healthcare Commission's Annual Health Check Standards. In 2006/07 the Trust declared it was compliant against the twenty-four Healthcare Commission core standards as at 31 March 2007. The Trust was able to declare full year compliance to twenty-two of the standards with two (C4a and C4c) becoming compliant during the year. The only significant control issue that arose during the course of 2006/07 was in relation to infection control. The Trust is currently implementing a recovery plan to reduce its MRSA bacteraemia rate, which was above the trajectory set by the Department of Health.
- The Trust achieved CNST Level 2 for both its acute and maternity standards which will be reviewed again in 2008. Level 3 awaited (maternity)

4.5.4 Governance arrangements over major capital projects and PFI schemes

- In line with good practice, the Trust has a Capital Monitoring Group to decide on the content and monitor the implementation of the current year capital programme. This reports to the Finance & Performance Committee and to the Board.
- Refer Section [x] on Page [x] for a detailed description of the PFI and their related accounting assumptions.
- The PFI governance arrangements are as follows:
  - The Standing Orders contains a provision for a PFI Decision making sub-committee, chaired by a NED, which has delegated powers to make decisions on urgent matters;
  - The Director of Strategy & Performance (Deputy Chief Executive) is the Trust's PFI representative and is accountable to the Board;
  - There are regular meetings of the Liaison Committee (Trust and WFL**)** which is chaired by the Director of Strategy & Performance and attended by the Director of Facilities, the Associate Project Director, and staff from the DH Private Finance Unit ("PFU"). The Committee is the first stage of any required Disputes Resolution Procedure. The committee meets regularly (in excess of once every six months as stipulated by the Project Agreement);
  - Regular meetings of the operational teams (which include the Director and Deputy Director of Facilities), are held to discuss issues relating to the operational performance of the Facilities Management company. Monthly reports are provided to the Finance & Performance Committee;
  - Weekly meetings between the Associate Project Director and technical advisor are held to monitor the progress of the Daycare Treatment Centre (Phase II of the PFI scheme);
  - In addition, there are weekly meetings of the project team that update and review a detailed risk analysis relating to the overall project which is chaired by the Project Director (an ED).
- In summary, there is high level management attention to and visibility of current PFI contracts, with governance arrangements fully embedded.

Finance Department

4.6 Finance Department

- The Finance Department has the following 2007/08 establishment detailed in Table 4.6.

Table 4.6: Finance department establishment for 2007/08

	Number of Posts	CCAB Qualified	CCAB Student/ Part Qualified	AAT*	None	Total
Director	1	1				1
Deputy Director	1	1				1
Assistant Director	4	3	1			4
Costing	3	1	2			3
Fin. Management	10		9		1	10
Fin. Accounting & Charitable Funds	4		3		1	4
Treasury Management /Corporate Finance	2	2				2
Subtotal – Accounting	**25**	**8**	**15**	**-**	**2**	**25**
%	***100.0***	***32.0***	***60.0***	**-**	***8.0***	***100.0***
Cashiers	3				3	3
Accounts Payable	5			1	4	5
Accounts Receivable	2		1		1	2
Payroll	20				20	20
PA/Secretarial Roles	2				2	2
Subtotal – Transaction Processing	**32.0**		**1.0**	**1.0**	**30.0**	**32**
%	***100.0***	**-**	***3.1***	***3.1***	***93.8***	***100.0***
TOTALS	**57**	**8**	**16**	**1**	**32**	**57**
%	***100.0***	***14.1***	***28.1***	***1.7***	***56.1***	***100.0***

- The Finance Department is well resourced and comprises 57 WTE.
- A high level of formal financial training is being undertaken in respect of the core accounting function which supports the requirement for a skilled and flexible finance workforce. The overall level of CCAB qualified staff as a proportion of all Finance Staff, is typical of trusts and in the case of the Whittington needs to take into account the large shared payroll service. A more meaningful indication is the large proportion of core Accounting Staff that are either qualified or studying at CCAB level (88.5%).
- The Department has benefited from low staff turnover in recent years and whilst the current Director of Finance was recently appointed in January 2007, his predecessor is the Deputy Chief Executive who is employed in another Executive Board role within the Trust, co-ordinating the FT application. Key staff are experienced within their roles and the proportion that are undergoing formal financial training is indicative of the Trust's commitment to investing in an appropriately skilled workforce.
- To help facilitate the transition to FT status a review of the Finance Team has been undertaken and some additional posts have been added to strengthen the Department. These posts relate to Costing, Treasury, Management Accounting, Income Dispute Resolution and Financial Governance.
- Training sessions are planned to ensure awareness of the FT regime amongst finance staff and other key Trust staff members, utilising the expertise of external consultants experienced in the FT financial regime. The potential implications of the move to International Accounting Standards will also form part of the development programme for Finance Staff.

Cash Flow Forecasting/ Treasury Management and Budgeting

4.7 Cash Flow Forecasting/Treasury Management

- The Trust has a Treasury Management Policy (October 2007) which will be ratified by the Board in March 2008 and implemented in January 2008.
- The Trust's policy for Cash and Treasury Management will continue to be updated to take account of the requirements of the FT regime. The development of such an organisational framework will clarify changes to established processes necessary when transferring to a FT.
- A high level Cash Flow Statement is reported to the Board each month, along with an annual forecast outturn for cash at the year end. This has been adapted from December 2007 to include a rolling cash flow forecast.
- The Trust's Internal Auditors provided substantial assurance within their 2006/07 report that the Trust's Treasury Management function is operating effectively.

4.8 Budgeting and Forecasting

- Budget setting occurs on an annual basis and is based on the following principles:
  - Previous activity and activity demand assumptions;
  - Local Health Economy financial position;
  - Likely impact of cost pressures underpinning DH funding increases (tariff, CIP, pay awards).
- The budgeting process commences in November following commissioning priorities being produced by the PCT. Between December and January the Trust meets with the Commissioners to discuss activity levels and demand management assumptions.
- In December the Business Planning Group scrutinizes the assumptions and agrees them for the following year. Following this, the draft budgets are discussed and prepared with each Directorate between January and March with the high level assumptions and information also being reviewed by the Executive team during this period.
- The Board approved SLAs and outline budgets for 2007/08 in March 2007. In accordance with the long-term objective to reduce costs and increase efficiency, the 2007/08 budgets included an additional £8.4m of savings in comparison with the prior year. The final approved budgets were available to the Directorates from the first week of April.
- The Trust is enhancing its budgeting processes further through the development of Patient Level Costing in 2007/08. High Level SLR has previously been undertaken and shared with clinicians throughout the Trust and used in decisions on recruitment to vacant posts.
- Each Division works with a dedicated finance manager and monthly meetings are held with budget managers to review performance, supported by monthly Divisional performance meetings where finance is a key agenda item.
- There are also General Manager's monthly review meetings attended by the General Managers, Deputy Director of Finance, Deputy Director of Strategy & Performance, the finance manager and other members of teams where appropriate, to review financial performance, implementation of CIPs, the activity position and any cost pressures identified.

Budgeting (continued)

Table 4.8.1: Budgeting accuracy

£m	2005/06 Actual	Opening budget	Variance	Variance %	Closing budget	Variance	Variance %
Income	132.1	125.8	6.3	*5.0%*	129.6	2.5	*1.9%*
Expenditure	(132.1)	(130.4)	(1.7)	*1.3%*	(129.6)	(2.5)	*1.9%*
Net surplus/ (Deficit)	**-**	**(4.6)**	**4.6**	***100.0%***	**-**	**-**	**-**

£m	2006/07 Actual	Opening budget	Variance	Variance %	Closing budget	Variance	Variance %
Income	142.7	134.8	7.9	*5.9%*	142.2	0.5	*0.4%*
Expenditure	(140.7)	(134.8)	(5.9)	*4.4%*	(140.9)	0.2	*(0.1)%*
Net surplus	**2.0**	**-**	**2.0**	***100.0%***	**1.3**	**0.7**	***53.8%***

£m	2007/08 Actual	Opening budget	Variance	Variance %
Income	149.2	146.5	2.7	*1.8%*
Expenditure	(146.7)	(145.1)	(1.6)	*1.1%*
Net surplus	**2.5**	**1.4**	**1.1**	**-**

4.8.1 Budgeting Accuracy

2005/06 Actual

- The 2005/06 actual breakeven position was £4.6m greater than the opening budget, resulting in an EBITDA surplus of £7.3m. The opening budget planned surplus was based on a reduction in non-recurrent support from the SHA (£7.2m in 2004/05 to £4.1m in 2005/06).
- The closing plan was revised and finalised in September 2005 (month 6) when SHA agreement was reached. In 2005/06, SLAs were part block contract, part PbR arrangements. These were negotiated to reflect activity growth which resulted in improved performance.
- Income increases of £6.3m (5%) versus the original budget were greater than expenditure increases of £1.7m (1.3%) as a result of the SLA negotiations.

2006/07 Actual

- The 2006/07 actual net surplus exceeded the original budget by £2m and the closing target surplus by £0.7m (1% of revenue)
- The £0.7m variance against closing budget was a result of additional SLA clinical income (above that originally negotiated) from Islington PCT, Haringey PCT and Barnet PCT.
- The income increase of 6% was in line with increased costs which were offset by large 2006/07 CIPs (4%).

2007/08 Outturn

- The 2007/08 actual YTD net surplus at December 2007 (month 9) of £1.1m exceeds the level of surplus originally planned of £0.9m at December 2007. The Trust is therefore on target to achieve the budgeted 2007/08 surplus of £1.4m.
- At the end of December 2007, income is £2.7m ahead of budget mainly as a result of SLA and activity over-performance (£2.3m) and additional NICU activity (£0.1m). This is offset through an adverse expenditure variance of £1.6m mainly as a result of the increased activity and the initial impact of non-pay cost pressures for delivering activity to meet the 18 week target (expected to be neutral by March 2008).

Audit

4.9 Audit

4.9.1 Internal Audit

- The Internal Audit function is provided by Parkhill Audit Agency (since 1996), who are a well established provider of audit services to a number of NHS organisations.
- The Annual Audit Plan together with the Counter Fraud Plan is agreed by the Audit Committee after scrutiny of the Internal Control Framework and any priority risk areas identified therein. The Head of Internal Audit Opinion for 2006/07 concluded that significant assurance could be given on the system of controls. There was only one report during the year which concluded with "limited assurance" and this related to debtors. In response, a number of changes were made and the auditors were invited to repeat the audit. Significant improvements were found and the Trust is prioritising this area as part of future restructuring.
- The Internal Audit Plan for 2007/08 (approved by the Trust's Audit Committee in March 2007) has focused on the following three areas:
  - Fundamental Financial Systems Reviews;
  - Key Business Systems;
  - Governance and Risk Management Review.
- The Internal Audit Letter (2006/07) suggests that the Trust's existing Accounting Systems are appropriate for current business activities, financial reporting and budgetary control and are operating effectively.

4.9.2 External Audit

- The External Audit function is provided by the Audit Commission. Our named auditor is Philip Johnson, District Auditor, The Audit Commission, 1st Floor, Millbank Tower, Millbank, London, SW1P 4HQ.
- No significant issues have been raised in the Annual Audit Letter and the auditors have given an unqualified opinion on the accounts for the last three years.
- In the 2006/07 Auditor Local Evaluation ("ALE"), the Trust was awarded an overall score of three, which represents "good performance". Level three was awarded in all categories except for financial reporting as a result of some adjustments in the final accounts. These adjustments related to a transfer between the revaluation reserve and the income and expenditure reserve and had no impact on the surplus or cash position for 2006/07. The Trust is keen to address any identified areas of relative weakness and has put in a plan to monitor the improvements made in processes and procedures on an ongoing basis.
- The Audit plan for 2007/08 is focussed on the following areas:
  - Work under the code of practice (financial statements, use of resources – value for money conclusion and use of resources (ALE)

4.9.3 Counter-fraud work

- Parkhill provides the Trust's Local Counter Fraud Service ("LCFS") which is operating in line with the NHS Fraud and Corruption manual.
- The Trust's policy on Counter Fraud and Corruption was implemented in July 2003. A LCFS update is presented to the Audit Committee at each of its meetings

Information Systems

4.10 Information Systems

4.10.1 Overview

- The Trust has a significant IT department which is split into IT support, Patient Systems, Telecommunications, technical services and web services.
- The Trust is currently revising the IT strategy to meet its key strategic objectives and producing a three year plan which will be presented to the Board for approval in March 2008.
- The 2007/08 work plan (approved by the HMB) details the proposed IM&T developments which includes implementation of ESR (refer below), a new pathology system and SLR. Update reports are presented to the HMB on a six month basis, with external audits of IM&T projects performed by BT and Connecting for Health. In addition the Trust has been selected:
  - By BT to be a discovery site for the new initiative on wireless hospitals. BT are going to carry out an audit and produce a Local Business Plan for the Trust which will be incorporated into the IT strategy and presented to the Board in March 2008
  - As an NHS pilot for a “virtual EPR (Electronic Patient Record)” solution from McKeeson which enables access to a range of patient data from disparate systems on one application. The solution is being piloted in Chest Medicine, Cardiology and Orthopaedics.
- The IM&T Directorate plans to contribute to cost savings/ benefits in three ways:
  - Through taking part in and delivering towards the Trust CIPs
  - Managing its own costs (including potentially transferring the expensive current network contract back in house)
  - Through generating additional income through provision of telecoms to academics at UCL, project management (for example the retinal screening programme for Islington and Camden PCT), selling software developed on site to other NHS Trusts.

4.10.2 Disaster Recovery and Business Continuity

- The Trust’s IT Disaster Recovery plan is under continuous review (the latest plan was reviewed and approved by the Executive team in August 2007. A strategy of disaster prevention is being actively pursued through investment in increasingly secure and resilient technology to minimise the risk of unscheduled downtime. This includes enhancing the resilience of the network infrastructure and service provision.
- IT operational services are split between different locations, three onsite, one offsite, in order to minimise the risk associated with a single point of failure.

Section 5

Board Statement

To: Monitor – Independent Regulator of NHS Foundation Trusts

Date: [x]

From: The Whittington NHS Trust

Working Capital

In connection with the application of The Whittington NHS Trust for NHS Foundation Trust status the Board of Directors have reviewed the NHS Trust's future working capital requirements from 1 April 2008. The results of this review are set out in the attached Board Memorandum dated [x] which has been prepared after due and careful enquiry.

In the opinion of the Board of Directors, (taking into account the Trust's new working capital facilities), the working capital available to the Trust is sufficient for its present requirements, that is at least the 12 months from 1 April 2008.

Financial Reporting Procedures

The Board of Directors confirm that they have established procedures, which provide a reasonable basis for them to reach proper judgement as to the financial position and prospects of the Trust.

The basis of the Board of Directors confirmation is set out in the attached Board Memorandum dated **[x]**. The Board of Directors confirm that it will continue to maintain procedures at or exceeding this level of quality subsequent to 1 April 2008.

Yours faithfully

Name: **……**

Title: **……**

Date: **……**

Name: **……**

Title: **……**

Date: **……**

For and on behalf of the Board of Directors

The Whittington NHS Trust

Section 6

Factual Accuracy

Factual Accuracy Confirmation issued by the Trust

We have read the report on the Trust's projected working capital requirements and financial reporting procedures report prepared by Ernst & Young LLP dated 23 November 2007 and confirm the following:

- We are not aware of any factual inaccuracies within the draft report;
- Opinions and representations which have been attributed to persons referred to in the report are properly attributed to those persons.

Yours faithfully

Name: ……

Title: ……

Date: ……

Name: ……

Title: ……

Date: ……

For and on behalf of the Board of Directors

The Whittington NHS Trust