

A N N U A L R E P O R T & A C C O U N T S 2 0 0 7 / 0 8



WE CARE, WE DISCOVER, WE TEACH

Annual Report & Accounts 2007/08

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Front cover photo - Christie staff left to right:

Sam Smith, lead nurse for the young oncology unit, Sheena Chauhan, senior radiographer, Mr James Murphy, plastic surgeon, Dr Catherine McBain, consultant oncologist

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

Christie Hospital NHS Foundation Trust
Annual Report & Accounts 2007/08

One of Europe's leading cancer centres with exciting and ambitious plans for the future

About us

The Christie Hospital NHS Foundation Trust became a foundation trust on 1st April 2007 and was founded under the National Health Service Act 2006.

The Christie was founded in 1901 and is a specialist NHS cancer hospital offering:

- high quality diagnosis, treatment and care for cancer patients
- world class research
- education in all aspects of cancer

Behind our ambitions to be one of the world's leading cancer centres is a reputation for exceptional patient care and research, excellent performance and financial management, together with a high profile and huge public support.

As the lead cancer centre for the Greater Manchester and Cheshire Cancer Network we cover a population of 3.2 million. Our doctors run clinics at 14 other general hospitals. We register around 12,500 new patients and treat about 40,000 patients every year.

Our patients are referred from district general hospitals, having already had their cancer diagnosed, and often with complex or rare types of cancer. Many will also have had their first treatment, usually surgical, before referral.

Around 15% of our patients are referred from outside Greater Manchester and Cheshire, and our private patients unit provides care for people from across the world.

Our specialist cancer services

We provide specialist surgery, chemotherapy, radiotherapy, palliative and supportive care.

As one of the largest radiotherapy departments in the world we deliver around 84,000 radiotherapy treatments a year. We also annually deliver over 34,000 outpatient chemotherapy treatments and 6,600 admitted chemotherapy stays. Additionally we undertake around 3,700 surgical operations every year. We are one of only two hospitals in the country offering surgical treatment for patients with pseudomyxoma - a very rare type of cancer. Our young oncology unit is one of only eight dedicated teenage cancer units in the country.

Key player in Europe

We are a member of the Organisation of European Cancer Institutes (OECI) which provides a forum for discussion and agreement amongst the leading cancer centres in Europe as well as co-ordinating a number of specific projects.

The OECI is an important vehicle for taking forward the concept of comprehensive cancer centres in Europe. We were the first centre in the UK to be voted onto the OECI as a member in June 2007.

Leading clinical trials unit

We also run one of the largest clinical trials units in Europe for phase I/II cancer trials, with around 1,200 patients going on new trials every year. This is set to double over the next few years making us the largest early clinical trials unit in the world.

We are a partner in the Manchester Cancer Research Centre with the University of Manchester and Cancer Research UK.

The Manchester Cancer Research Centre brings together the expertise, ambition and resources of our organisations and will be one of the world's leading cancer research institutes by 2015.

A successful charity

We run the country's second largest hospital charity in terms of fundraising, with more than 2,000 fundraisers and 20,000 supporters.

We benefit from the support of many organisations including the Manchester United Foundation. Our charity contributes about £12 million a year from fundraising, donations and legacies.

'We care, we discover, we teach'



We care:

Everything we do is focussed on ensuring we provide the best possible care and experience for our patients. This means efficient, effective and safe services, using the latest technology and delivered by highly-skilled staff. As well as achieving the national cancer waiting targets and the highest accreditation by the NHS Litigation Authority for the safety of our services, we introduced our new surgical robot and state-of-the-art PET-CT scanner for faster and more accurate diagnosis.

A momentous year

Chairman & Chief Executive statement

We are pleased to present our annual report for 2007/08.

This report marks the end of our first year as a foundation trust and our first year working together as chairman and chief executive.

We are delighted to have achieved all our performance, quality and financial targets and to have been rated, by our patients, as one of the top five hospitals in the country. Our strong financial position has, for the first time in our history, enabled us to build up a surplus that can be reinvested to make our services even better for patients.

Strong financial and operational performance gives us the headroom to implement innovative approaches to service improvement and address our three key strategic objectives of improving clinical outcomes, developing networked services and undertaking world class research.

Everything we do is focussed on ensuring the best possible care and experience for patients. This means providing the latest technology such as a new surgical robot for treating prostate cancer and a state-of-the-art PET-CT scanner which provides faster and more accurate diagnosis. Our patients now wait for much shorter periods than ever before. We have met all our targets for completing investigations, diagnosis and treatment within 31 days of patients being referred to one of our consultants and within 62 days of being urgently referred to their local hospital by a GP.

As an indicator of our high safety standards for patients, we were one of the first hospitals to be awarded level 3 accreditation by the NHS Litigation Authority. This is the highest level of recognition for risk management in the NHS. During the year the board started to regularly review data on clinical outcomes and takes very seriously its responsibility for ensuring that this information is available to the public.

We are passionate about improving services for patients. During the year we have listened to staff and patients about what is important to them. From this we have developed the 'Christie Values Card' which is now worn with pride by every member of staff. Our values have also influenced how we develop our services and ensure best value for money. As one of Monitor's national pilot sites for Service Line Management, our clinicians were

encouraged to review the patient pathway and to identify opportunities for improving care and reducing costs. This has promoted real clinical engagement resulting in clinically-led changes for the benefit of patients. We have started well, but we recognise there is still more to do over the next 12 months and we will be focussing on further improvements in patient experience.

Christie consultants carry out clinics at 14 other hospitals in Greater Manchester and Cheshire, supervising chemotherapy treatments at nine of these to deliver Christie care closer to where patients live. As a further development of this strategy, business cases have been approved to develop the UK's first network of radiotherapy centres, making treatment more accessible for many of our patients. Our vision is for most patients in the region to be within 45 minutes of a Christie radiotherapy centre. The first new Christie centres will open in Oldham and Salford in 2009 and 2010. These major developments will firmly establish us as a networked organisation, offering uniformly high standards of care and local access for patients.

A particular strength of the Christie is the way in which we can integrate high service standards with research and education to produce improved outcomes for patients. To demonstrate our commitment to this, we have created a new research division and further developed our education directorate. Professor John Radford was appointed to lead our research division which will drive translation of new knowledge into clinical practice. Dr Richard Cowan has been appointed clinical director for education to implement our vision of creating the Christie School of Oncology, training the next generation of doctors, nurses and other professionals.



The strategy of our research division has been validated by Cancer Research UK who in partnership with the University of Manchester and the Christie have as their vision to be the world's leading cancer research centre by 2015.

Research and clinical services will be integrated in the new £35 million patient treatment centre which was approved by our board in November and our plan is for this to be operational by 2010. This will be one of the world's largest early clinical trials units, fully integrated with an expanded first-class chemotherapy service facility. This development will also accommodate private patient facilities enabling us to compete with independent sector providers, the benefits from which will be available for all patients.

The hallmark of a Christie professional is their involvement across the range of care, research and teaching. This has led to our recognition as one of Europe's leading cancer centres and admission to membership of the Organisation of European Cancer Institutes. We accepted the invitation to be an inaugural signatory to the Stockholm Declaration which has as its main objective the improvement of collaboration between the major cancer research centres in Europe and ensuring that scientific discoveries will make an early impact on patient treatments.

The council of governors has made a valuable contribution in this first year as a foundation trust, using their wide range of skills, experience and local knowledge to influence our strategy. They provide an important conduit between our members and the hospital and play an active role in challenging plans, and promoting the Christie reputation and developments within local communities.

Council of governors' committees have focussed on patient experience, environment and membership, and have contributed to improvements. In the last 12 months we have actively recruited new members so that at the end of the year we had 2,078 staff and 8,352 public members. Over the next 12 months, we will significantly increase the number of public members and ensure they are representative of the communities we serve. We are very grateful to the governors for all their hard work, dedication and continuing support.

We also owe a great debt of gratitude to our volunteers and those who support our charity so generously. We are enormously grateful to our 320 volunteers who support our staff in the delivery of services; making a major difference to our patients. This year, the Christie charity raised almost £13 million from fundraising, donations and legacies, allowing us to invest in advanced technologies and carry out research over and above the level of permitted NHS funding. During the year this has included support towards the extension of our haematology & transplant unit, introduction of laparoscopic robotic surgery and development of our radioisotope facilities. Charitable funds are also used to provide the extras that help to create a supportive and peaceful environment for our patients and carers. Our heartfelt thanks go to all those who have made this possible.

There have been changes to our board during the year. Lee Childs, who is a former partner in the accountancy firm PricewaterhouseCoopers became a non-executive director in August last year. Lee chairs the audit committee. Sir Duncan Nichol joined the board on 1st April 2008 as a non-executive director and has extensive experience of the NHS as its former chief executive. Sir Duncan replaces Tony Freemont, professor of osteoarticular pathology at the University of Manchester and head of research in the School of Clinical & Laboratory Sciences. We thank Tony for his invaluable support and wise counsel over the last seven years and look forward to working with Lee and Duncan.

Our staff are our most valuable asset and we are delighted that many of them have been recognised through a number of national and local awards, demonstrating their excellence in education, research and clinical care. In particular the lung cancer team received the 'oncology team of the year' award and our young oncology unit proved worthy recipients of the Nursing Times 'team of the year'.

We would like to express our gratitude and personal thanks to all our staff, volunteers, governors, members and supporters. You have made 2007/08 a truly remarkable year for the Christie.



Jim Martin
Chairman
9 June 2008

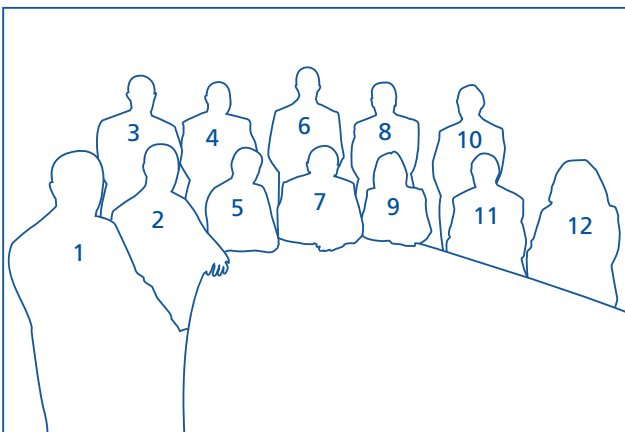


Caroline Shaw
Chief Executive
9 June 2008



Directors' report

The composition of the board of directors during 2007/08 was as follows:



Jim Martin (7)

Chairman

Caroline Shaw (9)

Chief Executive

Executive directors

Dr Chris Harrison (8)

Medical Director (joint post with Dr Ron Stout)

Ian Moston (2)

Director of Finance & Business Development

Alison Norman (5)

Director of Nursing & Governance

Roger Spencer (6)

Chief Operating Officer

Dr Ron Stout (10)

Medical Director (joint post with Dr Chris Harrison)

Non-executive directors

Lord Keith Bradley (1)

Lee Childs (4)

(Appointed 1st August 2007)

Yoni Ejo (12)

Bill Farndon (11)

Senior Non-executive Director

Professor Tony Freemont (3)

We discover:

Our own research efforts are now better co-ordinated than ever before. Professor John Radford was appointed to lead our newly created research division which will drive translation of new knowledge into clinical practice. An example of how research and clinical services will be integrated is our new £35 million patient treatment and research centre which we start constructing at the end of 2008.



A strong foundation for significant developments

Business review

The Christie Hospital is a specialist NHS cancer hospital offering high quality diagnosis, treatment and care for cancer patients, world class research and education in all aspects of cancer. We have a reputation for exceptional patient care and research, excellent performance and financial management, together with a high profile and huge public support.

Strategic objectives and milestones for 2007/08

- Ensuring our outcomes are consistent with the best European standards
- Developing a networked approach to deliver modern facilities and models of care at other sites
- Improving the quality and quantity of clinical research as partners in the Manchester Cancer Research Centre
- Providing leadership to our partners in the Greater Manchester & Cheshire Cancer Network, improving equality of access for all throughout the patient journey
- Ensuring individuals are treated with dignity, respect and care, throughout the patient journey
- Recruiting and retaining high calibre staff and investing in their education & training
- Maintaining financial viability and meeting the Standards for Better Health and other national performance and clinical standards
- Being an active and responsible corporate citizen, playing a full part in the local economy

Key achievements in 2007/08

Improvements in our services:

- Installing a new surgical robot, to give patients improved recovery through the latest technology
- Installing a new PET-CT scanner, to provide cutting edge diagnostics
- Opening a new assessment unit to enable faster, more efficient assessment of admitted patients
- Opening a procedures suite enabling on-the-day fast turn around interventions for patients
- Reorganising our wards to provide greater specialist care for each cancer type
- Doubling our chemotherapy day treatment capacity through ward refurbishment

Managing effectively

- Achieving the 62 day cancer waiting target from urgent GP referral to treatment
- Gaining NHS Litigation Authority level 3 accreditation, the first trust to gain this top level under the new criteria, confirming the safety of our services
- Achieving excellent results in nearly all aspects of the National Patient Survey (top 20% of all hospitals) and in our monthly patient satisfaction surveys
- Achieving the highest risk ratings possible for a first year foundation trust from Monitor, our independent auditor
- Moving from a historical recurrent financial deficit to a recurrent surplus

Planning and building for the future

- Gaining recognition as a leading European cancer centre through the Organisation of European Cancer Institutes (OECI)
- Approving plans to build a new Christie radiotherapy centre in Oldham, with support of the primary care trusts for a further development in Salford
- Approving plans for a new patient treatment centre for clinical trials, chemotherapy and private patients
- Approving plans to build a new multi-storey car park on our site

Our financial performance

Financial highlights

Metric	Actual	Rating
EBITDA margin	11.4%	5
Achievement of EBITDA plan	124.8%	5
Return on assets	5.8%	4
I&E surplus margin	3.6%	5
Liquidity	78.1 days	5
Weighted Average		5

As this is our first year as a foundation trust our rating is capped at 4.

Performance

This financial review analyses our performance for the financial year ended 31st March 2008 and there is no relevant information which has not been brought to the auditor's attention, so far as the directors are aware.

£ million	06/07 actual	07/08 actual	variance
Total income	131.5	145.6	15.2
Total expenditure	(118.5)	(129.1)	(11.6)
EBITDA	13.0	16.5	3.5
Loss on Disposal	(0.1)	(0.2)	(0.1)
Depreciation	(5.9)	(7.3)	(1.2)
Dividend	(3.3)	(3.8)	(0.5)
Interest	0.1	1.0	0.9
I&E (before exceptionals)	3.7	6.2	2.6
Exceptional Items	0	(0.9)	(1.1)
Net I&E	3.7	5.3	1.5

These results reflect strong operating performance across all areas of the organisation.

Increases in revenue have been delivered against a background of strong cost control and improved productivity which has meant we have been able to generate £5.3m of surplus for reinvestment back into local facilities and services.

The reported position also includes a £0.9m impairment of our assets. This is the impact of the three year revaluation of our assets for which there is no positive revaluation reserve.

Activity and income

Total clinical income has increased by £10.9m over the last 12 months. After adjusting for price inflation this reflects a £8.3m investment by local commissioners in response to the need for additional cancer treatment in our local population.

This total includes an additional £3.5m over and above the investment by local commissioners at the start of the year. This has resulted from a significant over performance against our planned levels of activity for radiotherapy, chemotherapy, surgical activity and pseudomyxoma.

This position includes a negotiated settlement with local commissioners which reduced the value of over performance on local tariff activity by 50% for this year in return for increased and realistic planned levels of activity for 2008/09 onwards. The value of this price reduction was £1m.

Commercial income and the private patient cap

In accordance with our terms of authorisation private patient income is capped at 9.1% of patient related income. We have remained compliant with this for 2007/08 with private patient income of 7.7%. Further details on our private patient income are set out in note 3.2 of the financial statements on page 64.

Charitable funding

We are fortunate to be supported by the Christie Hospital Charitable Fund. All the funds that we benefit from are administered by this separate charity and are reported in its separate annual report.

Capital investments

Over the last 12 months we have invested £9.2m in maintaining and improving facilities and services. This includes additional medical equipment of £2.6m providing access to some of the newest surgical technologies and £6.6m in improving the environment for patients and staff (see table right).

Investment	NHS Funded £m	Donated £m	Total £m
Buildings	2.2	0.8	3.0
Asset under construction	1.0	2.6	3.6
Plant & machinery	0.5	1.5	2.0
Information technology	0.5	0.1	0.6
Total	4.2	5.0	9.2

Over the last 12 months we were able to spend £5m on capital projects because of their charitable grants and have received a charitable contribution of £5.2m to enable us to provide enhanced revenue services. Further information on contributions from the charity is provided on page 24.

Value for money and improved efficiency

Our total operating expenses rose during the year to £129.1m. Of this 50% was spent on staffing, ensuring we were able to continue to attract and retain over 163 doctors, 668 nurses, 417 clinical scientists and 553 other health professionals.

Equally importantly, 24% of the total was spent on chemotherapy and other cancer treatment drugs, an increase of £3.2m on the previous year. This has not only allowed us to provide an additional 2,189 courses of treatment but has ensured that local patients have continued to be able to access the latest treatments.

The £5.3m surplus has been achieved by delivering over £3.6m of cost savings across a number of identified schemes.

In delivering key services we have had a number of material contracts with the Department of Health, and organisations for which it is the parent body, and the University of Manchester. Further details on these are contained in note 23 of the financial statements on page 78.

Prudential Borrowing Limit

Monitor sets annually, by reference to our financial ratio, a Prudential Borrowing Limit (PBL) which is the maximum we can borrow. This year we have had no borrowing which is in line with our plans at the start of the year.



We teach:

Our board of directors approved the development of a new education directorate, led by Dr Richard Cowan. The new directorate will implement our plans for creating a Christie School of Oncology which is recognised as a major provider of cancer education to staff and the public.

Cash flow and balance sheet

There have been a number of significant changes in our balance sheet and working capital over the last year.

We ended the year with a cash balance of £20m. This was an increase of £19.7m on last year and an increase of £8.2m against plan. The improvement against plan was due to the improved operating surplus and a reduction in our planned capital spend.

As a foundation trust we are expected to follow UK Generally Accepted Accounting Practice (UK GAAP) and in particular Financial Reporting Standard 11 (FRS 11) when dealing with fixed assets. FRS 11 does not permit the holding of negative reserves and requires that they be taken to the I&E reserve and the opening balances of the foundation trust to be restated. The impact of this change in accounting treatment has been to move £2.9m between our revaluation reserve and our income and expenditure reserve in a restated opening balance sheet.

An interim revaluation of our assets by the District Valuer has had a net reduction to the value of our assets of £6.4m of which land values reduced by £8.5m. Positive revaluation reserves existed to cover the majority of the reduction, however a balance of £0.9m remained, which has been taken to the income and expenditure account. There are no significant events since the balance sheet date which materially affect our financial position.

Trading environment and financial risks

Whilst we have achieved a healthy financial position for 2007/08 we continue to monitor the external environment in which we operate and the internal risks we face. With all our major contracts for 2008/09 signed with commissioners by 29th February 2008, for levels of activity that reflect the current out-turn and underlying growth in demand, our key risks for next year link directly to our ability to control our cost base and deliver the additional activity. In particular we have established specific performance monitoring arrangements to ensure delivery of the savings programme and invested significantly over the last twelve months in our electronic prescribing system to control high cost drug treatments. Horizon scanning beyond the next 12 months, the introduction of a national tariff for radiotherapy and chemotherapy treatments represents our biggest financial risk. To ensure we have the correct information to manage this, we have introduced service line reporting across the organisation over the last six months and have plans in place to produce bottom up patient level data by the final quarters of 2008/09. We are also working with local commissioners and other North West providers to benchmark our services.

Going concern

After making enquiries, the directors have a reasonable expectation that the NHS foundation trust has adequate resources to continue in operation for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

External audit services

The council of governors approved the appointment of the Audit Commission as the Trust's external auditors from 1st April 2007 for a period of three years. We have incurred £60,000 in audit service fees in relation to the statutory audit of our accounts for the 12 month period to 31st March 2008. No other audit services were required during the accounting period.

Non-audit services provided by the auditor

The Audit Commission provides non-audit services in limited circumstances in accordance with a policy recommended by the audit committee and approved by the council of governors. Auditor objectivity and independence is safeguarded for any non-audit services provided by the auditor by limiting the fees arising from such work in any one year to £30,000 and ensuring that different auditors carry out the work.

Countering fraud and corruption

The board of directors attaches significant importance to the issue of fraud and corruption and has increased its investment in this area by 50% over the last 12 months. Reported concerns have been investigated by our local counter fraud specialists in liaison with the NHS Counter Fraud and Security Management Service and the police as necessary.

We work hard to create an anti fraud culture and have a range of policies and procedures to minimise risk in this area. A number of events have been held over the year to highlight to staff how to raise reasonable concerns and suspicions and over a third of all staff, including all new starters, received an appropriate fraud awareness session.

Efficient and effective services

Our service performance

As a foundation trust we are accountable to our local communities for our performance through local contracts and the key performance targets set for us by the independent regulator, Monitor.

As part of this process we are required to self certify on a quarterly basis against a range of service performance and clinical quality indicators. In addition we are also expected to certify using a traffic light system on our ability to continue to provide our mandatory services. Our financial risks are measured on a scale from 1 (poor) to 5 (excellent). The table below outlines our position in our first year as a foundation trust.

2007/2008	Governance	Mandatory services	Financial risk rating
Quarter 1	Amber	Green	4
Quarter 2	Green	Green	4
Quarter 3	Green	Green	4*
Quarter 4	Green	Green	4*

* Note: as a first year foundation trust the best financial risk rating that can be achieved is capped at 4. In the final 2 quarters had we not been a first year foundation trust we would have scored 5.

Delivering the 62 day waiting time target for urgently referred patients has been an important success in improving our governance rating. Before patients with suspected cancer are sent to us they are first referred to a general hospital by their GP. This means that to achieve the target we have had to implement a system to track patients across our cancer network. This ensures that patients are seen by us at an early enough stage to enable the complex treatment planning needed for radiotherapy to take place within the target timescales.

The following table shows our performance against the Monitor priority 1 and 2 service targets for 2007/8 which contribute to our green governance rating.

Priority 1 target

Target	Threshold	Q1	Q2	Q3	Q4
11 week outpatients	100%	100%	100%	100%	100%
20 week inpatients	100%	100%	100%	100%	100%
18 week referral to treatment - non admitted patients	90%	N/A	N/A	N/A	96%
18 week referral to treatment - admitted patients	85%	N/A	N/A	N/A	97%
MRSA year-on-year reduction (cumulative)	<9 cases	2	4	5	6
31 day cancer	98%	100%	100%	100%	100%
62 day cancer	93%	87%	98%	95%	93%

Priority 2 target

Target	Threshold	Q1	Q2	Q3	Q4
Minimise delayed transfers of care	Under 3.5%	Achieved	Achieved	Achieved	Achieved
2 week urgent cancer referral	98%	100%	100%	100%	100%
28 day readmission - cancelled operations	98%	100%	100%	100%	100%

At the heart of everything we do

Improving patient care

Foundation trust status has enabled us to embark on some major developments to further improve our patient care.

First class care closer to home

The financial freedoms of foundation trust status have enabled us to progress momentous plans to create a network of Christie radiotherapy centres across Greater Manchester and Cheshire. The network will be the first of its kind in the UK and will make treatment more accessible for cancer patients. Eventually most people in our region will be within 45 minutes of a Christie radiotherapy centre.

The first new Christie radiotherapy centres will be built in Oldham and Salford, with plans for the centre at the Royal Oldham Hospital to open in November 2009.

Our contract with primary care trusts for 2008/09 confirms their intention to support both of these new centres, indicating the strength of our business cases and the way in which we have worked with them to secure this significant progress.

Each centre will have two £1.3 million radiotherapy machines, and other high-tech equipment. Christie doctors, specialist radiographers, nurses and other medical experts will be able to treat 70 people a day who would have otherwise had to make the trip to the Christie site in south Manchester.

Re-designing and expanding our services

Plans to build a new £35 million patient treatment centre were approved this year, which will provide us with the biggest phase I clinical trials unit in the world and an expanded first class chemotherapy facility.

We already run one of the largest clinical trial units in Europe, but this new development will double the number of trials we undertake. Around 2,400 patients a year will be amongst the first in the world to access the latest and most innovative cancer treatments. This will allow us to build on the major changes that are taking place in the way chemotherapy treatments are given and will bring together all our chemotherapy facilities with clinical trials facilities in one place on the hospital site.

The development builds in future expansion capacity for trials by making use of the space created as our chemotherapy service becomes much more networked and locally delivered in line with national policy.

The centre will also provide new private patients facilities from which the profits will be invested back into further improving our NHS services. It will offer the type of

facilities required for us to attract private patients from throughout the UK and abroad. The centre is due to be completed in 2010.

Cutting-edge technology for improved treatment

We were the first hospital in the North West and currently one of only seven in the UK, to introduce the latest robotic technology. The £1.3 million surgical system is the latest advancement in robotic technology and will let surgeons remove the prostate through keyhole rather than major open surgery. For patients this means less trauma to the body than routine surgery, less anaesthesia, reduced blood loss, reduced pain and discomfort, less chance of infection and a faster recovery time.

High-quality diagnostic technology

We opened our new PET-CT scanning facility, enabling more accurate diagnosis and treatment for our patients. Each year over 2,500 patients across the North West will benefit from this £1 million imaging system.

Patient and public involvement

We are committed to involving and informing patients, carers, staff and the public on every aspect of our service.

Our patient and public involvement strategy ensures that their voices are heard at every level and that we use their feedback to build a patient-focussed service. Our governors have played a major role in developing this strategy over 2007/08.

As part of our patient and public involvement strategy we:

- Provide an extensive range of information to patients
- Recruit, inform and engage with our members
- Have a council of governors which has representatives from our public members
- Hold our quarterly council of governors meetings in public
- Keep interested members of the public well informed of developments and news through our website, the media and other communications channels
- Have a Freedom of Information (FOI) lead officer for all enquiries under the FOI Act
- Hold our monthly board of directors meetings in public
- Publicise our complaints procedure and ensure that investigation of any complaint is thorough and prompt
- Pursue an open and positive relationship with the media



Freedom of information and data protection

We combine a culture of openness about our services and developments with a robust process to ensure patient confidentiality and data protection. Independent audits have confirmed that we have clear systems and processes in place to manage data protection and all Freedom of Information requests.

Using patient feedback to improve our services

In the national inpatient survey in 2007/08 we were in the top 20% of all trusts for 55 of the 62 questions, and achieved the top score nationally for four questions:

- Involving patients in decisions about care
- Families having the opportunity to talk to the doctor
- Staff explaining what would be done during their operation or procedure
- Patients being told how they would feel after their operation or procedure

We were also fourth in the country for the key question "overall, how would you rate the care you received?" In addition to the national patient surveys, we run a monthly patient satisfaction survey. The survey includes at least 100 patients' views each month and enables us to improve areas of care and services. Our monthly patient satisfaction rates are also very high, with over 90% of surveyed patients rating the services they receive as either 'excellent' or 'good' each month. This information is published monthly on our website.

These surveys show that our patients rate our services highly, however, we did receive 106 complaints. We responded to 97.7% of our complaints within 25 working days. This is an improvement on last year's figure of 88%.

Through patient feedback we have been able to make service improvements in a number of different areas:

- Increasing our number of chemotherapy treatment areas to ensure patient treatments are not cancelled
- Refurbishing all our public toilets
- Employing additional cleaners and housekeepers to increase the frequency of cleaning across the hospital
- Approving a new £3 million multi-storey car park to expand car parking facilities
- Providing nurses to accompany patients in consultations to help them interpret what is said
- Extending the opening times of our transport department

Towards a future without cancer

Developing our research

Strength in partnership

During 2007/08 the Manchester Cancer Research Centre (MCRC), our partnership with the University of Manchester and Cancer Research UK, has continued to develop its world class research programme. Key developments this year include comprehensive tissue bio-banking, clinical proteomics, the expansion of our phase I clinical trials unit and the award of a Breakthrough Breast Cancer Unit. This has been supported by the recruitment of internationally acclaimed researchers.

Importantly our trials unit was successful in achieving full registration with the UK Clinical Research Collaboration - a prestigious award for trials units of excellence making us one of only 26 sites in the UK. This registration means we can run trials where patients are recruited at other sites.

During the year we commissioned an external review of the strength of our clinical research, with the support of Cancer Research UK. The report confirmed our leading position in patient volume and legacy of innovative radiation related research; supporting phase I/II early drug development and biomarkers – tissues, serological and imaging; and building our presence in late stage research (phase III and beyond) trials through networks.

World's biggest trial

The 'CONVERT' trial is one of the world's biggest ever clinical trials, combining different types of treatment to boost the survival of small cell lung cancer patients, and is one of the first trials to be managed under our new research & development structure.

At the moment in the UK, most small cell lung cancer patients are given a course of chemotherapy followed by a course of radiotherapy. However, doctors now believe that giving the two treatments at the same time could increase survival.

The Christie will be co-ordinating the phase III trial which will involve 532 patients from at least 90 cancer hospitals from all over the world including countries across Europe and Canada. The trial is expected to take around four years, and doctors hope it will double survival rates in the UK from less than 15% to 25-30% at 5 years.

We care:

Once again, we received the highest possible endorsement from the people that matter the most - our patients - who voiced their approval in the annual patient survey results. We were in the top quartile of all NHS trusts for almost 90% of the questions, and fourth in the country for the key question about overall care. We also introduced our own monthly patient satisfaction survey this year to enable us to listen more closely to our patients and continue improving our services.





A learning curve

Building our education

We reviewed our educational programme and developed a strategy for education, which resulted in the establishment of a corporate department of education and the appointment of a director of education to bring together all the existing strands of education under one structure.

Our vision is to establish a Christie School of Oncology which is recognised as a major national provider of cancer education to staff and the public.

Key education priorities for 2008/09 will include an external programme of educational events, modernised library and post graduate facilities, expanded education centre opening hours, the development of dedicated clinical skills training facilities, providing central administrative support for key trainers and flexible training.

Public matters

Being a good citizen

As one of the major employers in the area, we recognise the significant responsibility we have to our local community and are truly committed to minimising the impact of our activities on the local environment.

Over the last 12 months we have appointed an environment manager for waste and energy consumption and have undertaken an impact assessment of our current practice. In our 2008/09 objectives we have set specific targets for reductions against this baseline.

In partnership with Manchester City Council and other local NHS organisations we have signed an agreement to work together to improve the employment opportunities for the local population, through a joint workforce planning programme.

As a specialist cancer treatment hospital we have also recognised the contribution we can make to the cancer awareness agenda and have built on the success of the *Manchester Versus Cancer* alliance which we initiated in 2007, by extending the 'Don't be a Cancer Chancer' pilot across Manchester and Wigan. We have supported them by producing a strategy for community engagement and initiated a new fundraising strategy.

Our greatest asset

Christie staff, recruitment & values

Involving our staff

We use a wide range of ways to engage with our staff and constantly review and develop these to ensure staff feel involved.

All our staff have access to a well-developed intranet, we have a quarterly staff magazine and an effective monthly team briefing system. Our monthly team briefing system is face-to-face as well as a written cascade and ensures staff are aware of our performance, financial position and plans.

There are also regular presentations, seminars and e-mail cascades to keep staff up-to-date with developments, and an active staff suggestion scheme.

All staff have the opportunity to voice their opinions via the staff satisfaction survey, a clear reporting system for any concerns and our union representatives. We always believe in open debate, and have an open-door policy for our human resources department to discuss matters of concern. Our monthly board of directors and council of governors meetings are public.

Health & safety

We have a positive approach to health & safety and acknowledge our duty to safeguard patients, staff and visitors through the use of effective management systems.

Managers have access to our specialist team comprising health and safety, moving and handling, fire and security. In addition, advice is available from radiation protection, infection control and occupational health.

We received maximum scores for health and safety management in our risk assessment by the NHS Litigation Authority.

There were 189 reported staff accidents in 2007/08 compared with 192 in 2006/07. These fell into categories of accidents such as burns, slips, trips and falls, needlestick injuries or moving and handling incidents. This decrease is in line with our target to reduce the number of accidents occurring on site. Regular reports of all accidents, dangerous occurrences and ill health are sent to our divisions and discussed at the quarterly meetings of the health & safety committee.

Occupational health

Our occupational health department has had a very productive year, working consistently to introduce activities which are required under legislation and promoting a well-being culture throughout our organisation.

Several groups of staff now have their health assessed on a regular basis to ensure that their job is not having an adverse affect on their health and that where there are health issues, which could be exacerbated by their role, appropriate action is taken. We have aimed to minimise sickness levels by ensuring that the appropriate referrals are made swiftly and followed up.

Equality & diversity

We continued to build on our strong commitment to inclusive access to healthcare and employment opportunities for everyone in the communities we serve.

Our equality & diversity team are responsible for leading the development and management of key plans to ensure that equality and diversity matters are integral to our everyday work. We continue to develop a range of policies relating to equality, human rights and respect and dignity at work, to ensure best practice is adhered to throughout our dealings with all our patients and staff.

We made good progress on our equality action plans which form the core of our race, gender and disability equality schemes. These three schemes, which set out our statutory and moral duties to our patients and staff, were reviewed during the year and our progress published.

We launched mandatory equality and diversity development programmes to ensure all our staff are aware of best practice in supporting the individual needs of every patient, whether these may be cultural, spiritual or relating to a disability.

Values card launched

We launched our new 'Christie Values Card' to staff this year. Produced to be worn as part of our photo identity badge, the values listed on the cards are based on extensive patient feedback and surveys on what is important to them.

As well as reinforcing our commitment to patients and key objectives, the cards confirm staff values around being helpful and smart, providing clear and accurate information and respecting confidentiality and dignity at all times.

High praise

Awards

During our first year as a foundation trust the excellence of our staff in education, research and clinical care has been recognised in the following awards:

- Our lung cancer team received 'oncology team of the year' at the Pfizer Excellence in Oncology Awards 2007
- Our young oncology unit won the Nursing Times 'team of the year'
- The *Manchester Versus Cancer* campaign launch won silver in the 'best campaign' and the 'Don't be a Cancer Chancer' campaign won silver in the 'most innovative communications' categories at the National Association of Healthcare Communicators Awards
- One of our leading computer scientists was runner-up for the 'innovation in service development award' at the Healthcare Scientist of the Year Awards 2007
- Our Wade radiotherapy research team and North West Medical Physics team won third prize at the North West NHS Innovation Awards
- The finance department won the 'clinical engagement award' at the Healthcare Financial Management Association (HFMA) Awards 2007

Public support

Our charity key highlights

Our charity raises vital funds every year, helping us to provide extra patient services, undertake important research and maintain high standards of care.

This year, thanks to the generosity of our supporters, we raised almost £13 million from fundraising, donations and legacies to continue making a huge difference to the care we provide to our patients.

Important projects we have been able to complete this year thanks to charitable funds include a ground-breaking PET-CT Scanner which was funded by the Pat Seed Appeal Fund - an independent charity that has funded diagnostic equipment for the past 30 years, an extension to our haematology & transplant unit that will provide an improved environment for patients being treated for leukaemia and other blood-related cancers and the introduction of the first surgical robot in the North West.

Further information about our charity is contained in our charity annual report or is available via our website www.christies.org



We care:

Thanks to the huge generosity of supporters, our charity is able to help fund treatments and research for patients and improve facilities for patient care. Projects supported by charitable funding this year include the extension of our haematology & transplant unit, introduction of laparoscopic robotic surgery and development of our radioisotope facilities.

Governance

The people's hospital

Public membership

Our public membership is open to everyone living in England and Wales over the age of 16 and operates on an 'opt in' basis. There are 13 areas within this constituency, 12 based on local government electoral boundaries within our network with the other covering the rest of England and Wales.

Staff membership

Our staff membership operates on an 'opt out' basis for staff employed over 12 months and all volunteers. The classes within the constituency are medical staff, nursing staff, other clinical staff, non clinical staff and volunteers.

Public membership by class:

Class	Total (31st March 2008)
Bolton	560
Bury	431
Macclesfield & Congleton	589
Manchester	1,060
Oldham	483
Rest of England & Wales	1,430
Rochdale	357
Salford	517
Stockport	826
Tameside & Glossop	535
Trafford	505
Vale Royal, Crewe & Nantwich	470
Wigan	589
Total members	8,352

Staff membership:

Class	Total (31st March 2008)
Staff	2,078
Volunteers	309
Total members	2,387



Our membership strategy

Throughout the year we carried out a wide range of recruitment activities which included:

- Actively recruiting patients and visitors in our reception and waiting areas
- Recruiting at fundraising events
- Encouraging existing members to recruit a member
- Linking with local businesses to act as membership advocates
- Telephone recruitment

The majority of these activities have been extremely effective with membership more than doubling over the first eight months of becoming a foundation trust.

A series of public engagement meetings began in January 2008 and will run over the year. These are proving extremely useful in engaging with local communities, encouraging an increase in membership and member involvement and making contact with hard to reach groups.

Future recruitment

Our target is to increase membership from 8,352 (at 1 April 2008) to 11,136 during 2008/09 and to have doubled membership by the end of March 2011.

As a membership organisation committed to being a good corporate citizen, we will ensure that we contribute to the communities we serve. Our aim is to encourage interest in the Christie and promote good relationships, particularly with our local community. We will therefore explore all other opportunities to reach out to the vast population we serve. This will include working with our equality & diversity team to identify a wide range of ethnic and other minority groups and communities and actively engage with them.

For further information on membership please contact:

Membership Office
Christie Hospital NHS Foundation Trust
Wilmslow Road
Withington
Manchester, M20 4BX

Tel: 0161 446 8616
Email: members@christie.nhs.uk

An important voice

Our council of governors

Each of our governors represents their constituency or their partner organisation in our health economy. They are integral to effectively communicating with our members and partner organisations about our vision, strategy and performance.

Our governors have a responsibility to maintain our membership strategy and increase our membership. They also have specific responsibilities with regard to the appointment and remuneration of our chairman and non-executive directors and the appointment of the external auditor. They are consulted by the board of directors when our annual plan is being prepared and may be consulted on other issues, such as the revision of our constitution and our declaration for 'standards for better health'.

We have 29 governors on our council – 15 representing the public, patients and carers, five representing our staff and nine appointed by partner organisations.

Working with our governors

Our board of directors and governors have worked together in a number of ways before and during our first year as a foundation trust to ensure that the governors' views are understood and that they receive appropriate support.

This has included five formal meetings of the council of governors, training events, committees of the council, a working group and a workshop with the board of directors. Information about our strategic capital development plans, the development of our five year strategy and our annual plan has been provided during the year. The governors have also received information on our performance and other activities in letters and reports.

Members of the board have attended many of the council meetings and the training and workshop events have been delivered by our executive directors. Bill Farndon was appointed as senior independent non-executive director on 17th September 2007 and Dr Donna Johnstone was appointed as vice-chair of the council of governors on 5th December 2007. Our board believes it has been effective in understanding the views of its governors and plans to work with the governors to improve its understanding of the views of members.

There are four committees of the council of governors. The nominations committee was formed in April 2007 and its terms of reference and membership were approved at the council meeting on 25th April 2007. The other three committees were formed after discussion at the council meeting on 20th June 2007. The chair of each committee provides an activity report to the council of governors at each meeting of the council.

The register of interests of our governors may be viewed at www.christie.nhs.uk

Nominations committee

This committee makes recommendations to the council of the appointment and remuneration of the chairman and non-executive directors.

During the year the nominations committee has recommended and had approved the appointment of two non-executive directors, Lee Childs and Sir Duncan Nichol. For both appointments open advertisements were used and shortlisted candidates were interviewed by the nominations committee. It has also presented a recommendation for the remuneration of the chairman and non-executive directors.

Membership and community engagement committee

This committee directs and monitors recruitment activity, manages our communication with members through our newsletters and letters and has organised a series of community engagement events.

Patient experience and involvement committee

This committee monitors reports and comments on patient experience and the arrangements for the patient and public information forum. A working group of governors from this committee has developed a strategy for patient and public involvement.

Environment of care and access to services committee

This committee monitors activities with regards to the quality of the hospital environment. It also receives information on the achievement of access targets such as the 62 day cancer waiting target. It supports the development of strategic capital developments which will deliver one of our strategic objectives to improve access to services both at the Christie site and at other local sites in the Greater Manchester and Cheshire area.

Note for table opposite

All governors took up office on 1st April 2007. Their election/appointments were announced at the first annual members meeting on 19th September 2007. All terms of office expire on 19th September one, two or three years after the day of that meeting.

Information about our governors

Name	Elected public Elected staff Appointed	Representing	Meetings attended out of 5	Duration (years)	Member of committee See key	Year Term ends See note
Dr Zuber Ahmed	Appointed	PCT - PEC Chair, Oldham	3	3		2010
Celia Ashton	Elected public	Tameside & Glossop	4	1	MCE	2008
Alan Barrass	Elected public	Oldham	3	1	MCE	2008
John Belcher	Elected public	Trafford	5	3	ECAS	2010
David Bowerman	Elected staff	Non-clinical staff	5	3	ECAS Chair	2010
Paul Calderbank	Elected staff	Volunteers	5	2	PEI	2009
Cllr Wayne Campbell	Appointed	Association of Greater Manchester Authorities	2	3		2010
Jackie Collins	Elected public	Stockport	3	2	PEI	2009
Alex Davidson until 16 March 2008 when he moved out of the area. Position now vacant.	Elected public	Bolton	5	1	PEI	N/A
Roy Dudley-Southern	Appointed	PCT - Greater Manchester PCT's Collaborative Commissioning team	5	3		2010
Racheline Garston	Appointed	Christie's charity	5	1	MCE	2008
Bryan Hellewell	Elected public	Rest of England & Wales	2	3	Nom	2010
Douglas Holbrook	Elected public	Rochdale	4	2	ECAS	2009
Dr Donna Johnstone*	Elected public	Macclesfield and Congleton	4	2	MCE	2009
Professor Nic Jones	Appointed	University of Manchester	1	3		2010
Wakkas Khan	Elected public	Manchester	4	3		2010
Peter Latimer	Elected public	Rest of England & Wales	4	3	PEI	2010
Dr Brian Magee	Elected staff	Registered Medical Practitioners	4	1		2008
David Makin	Appointed	Patient representative of the Greater Manchester and Cheshire Cancer Network	5	3	PEI Chair	2010
Fiona Mills Eric Hodgson appointed during Fiona's maternity absence.	Appointed	North West Development Agency	3	3		2010
Pam Morrison	Elected staff	Registered Nurses	5	3	PEI	2010
Martine Petty until 3 March 2008. Position now vacant.	Elected public	Vale Royal, Crewe and Nantwich	2	1	PEI	N/A
Marge Rose	Elected staff	Other clinical professional staff	5	2	Nom	2009
Carl Sharpe	Elected public	Wigan	5	2	PEI	2009
Roger Smith	Elected public	Manchester	5	3	ECAS	2010
Cllr Val Stevens	Appointed	Manchester City Council	5	3	ECAS	2010
Robert Tipper	Elected public	Salford	4	2	PEI	2009
Marcella Turner	Appointed	The Black Health Agency	2	3	MCE	2010
Dr John Wild	Elected public	Bury	5	1	MCE Chair	2008

KEY: ECAS Environment of care and access to services MCE Membership and community engagement
 Nom Nominations PEI Patient experience and involvement
 * Vice chair of council of governors

We care:

We were one of Monitor's national pilot sites for Service Line Management. This has allowed us to undertake a fundamental review of our quality of care and ensure that, for the first time, our clinical staff can bring together data on the quality and costs of care with information on clinical outcomes. This has promoted real clinical engagement and enabled clinically-led changes to be made which will benefit patients.



Strong leadership

Our board of directors

Our board of directors directs the business of our Trust and is responsible for the management and governance of our organisation. All directors have a joint responsibility for decisions taken by the board.

The key responsibilities of the board are:

- To set strategic objectives, taking into account the view of the council of governors and other key stakeholders
- To provide the healthcare services required under its contracts with commissioners and other organisations
- To ensure appropriate governance and performance arrangements are in place to deliver the strategic objectives
- To ensure the quality and safety of all healthcare services, research and development, education and training
- To ensure that the Trust complies with the terms of its authorisation by Monitor, its constitution, relevant legislation, mandatory guidance and other relevant obligations

Our authorisation from the regulator Monitor and our constitution govern the operation of our Trust. The Schedule of Reservation and Delegation of Powers sets out the types of decisions that must be taken by the board of directors and those which can be delegated to management. The constitution defines which decisions must be taken by the council of governors and how disagreements between the board and the council should be resolved.

Composition of the board

The board consists of five executive directors (one post is held jointly), five non-executive directors and a non-executive chairman.

The composition of the board during 2007/08 was as follows:

Jim Martin	Chairman, Non-executive Director
Caroline Shaw	Chief Executive

Executive directors:

Dr Chris Harrison	Medical Director (joint post)
Ian Moston	Director of Finance & Business Development
Alison Norman	Director of Nursing & Governance
Roger Spencer	Chief Operating Officer
Dr Ron Stout	Medical Director (joint post)

Non-executive directors:

(All considered to be independent)

The Right Honourable, the Lord Keith Bradley	Non-executive Director
Lee Childs (appointed 1st August 2007)	Non-executive Director
Yoni Ejo	Non-executive Director
Bill Farndon	Senior Non-executive Director
Professor Tony Freemont	Non-executive Director

Biographies of our directors are on pages 34-36.

Our executive team has delivered an outstanding improvement in financial and service performance, as well as completing a successful application to become a foundation trust from 1st April 2007. The executive team has been balanced, complete and appropriate and has remained unchanged throughout the year.

The composition of our board was reviewed during our application to become a foundation trust. A further review of the skills of the board was undertaken in early 2007, in anticipation of the departure of the former chair, Professor Dame Joan Higgins and the appointment of Jim Martin as chairman. This review identified the need for additional non-executive skills and experience in finance. Lee Childs was appointed in August 2007 and provides recent and relevant financial expertise. Professor Tony Freemont stood down when his term of office expired on 31st March 2008. A further review of non-executive skills and experience identified the need to strengthen the senior health service management experience on the board. Sir Duncan Nichol's appointment on 1st April 2008 has addressed this.

The board believes that it has been balanced, complete and appropriate throughout the year other than the following exceptions. The requirements for at least half of the board, excluding the chair, to comprise non-executive directors and for one non-executive director to have recent and relevant financial experience were not met between 1st April and 31st July 2007. In all other respects the composition of the board complied with the constitution and the board is satisfied that it has a suitable range of appropriate and complementary skills and experience.

The board considers that all the non-executive directors are independent and the chairman was independent upon appointment. Bill Farndon was appointed as a senior non-executive director on 19th September 2007 with particular responsibility to make himself available to members and governors who have concerns they do not feel they can raise with the chairman or any executive director, and to lead the appraisal process of the chairman.



Evaluation of performance

All directors have an annual performance appraisal and a personal development plan.

The chief executive is responsible for the performance appraisal of the executive directors. The performance of the chief executive is reviewed by the chairman. The results of these appraisals are reported to the remuneration committee.

The performance of the non-executive directors is reviewed by the chairman.

The performance of the chairman is reviewed by the non-executives led by the senior independent director in a process agreed by our council of governors.

Board appointments

The expiry of the term of office for each non-executive director is stated in their biography on pages 33-34. The non-executive directors appointed on or before 31st March 2007 were appointed by the Appointments Commission for a term of four years, as amended by the transition arrangements on becoming a foundation trust.

All appointments made since 1st April 2007 were made by the nominations committee and approved by our council of governors and are for a term of three years. The chairman and any non-executive director may be removed by the council of governors in accordance with paragraph 20 of our constitution.

The executive directors were appointed through an open competition panel consisting of the chair, chief executive, a regional representative and an external assessor. Their contracts of employment do not contain an expiry date.

Interests and commitments

The register of interests of directors may be viewed at www.christie.nhs.uk

Jim Martin became chairman on 1st April 2007. At that time he was chairman of Alexon plc and remained so until 1st March 2008. He was a non-executive director of Redrow plc until September 2007. Between April 2007 and July 2007 he was interim non-executive chairman of Redrow plc. He is currently chairman of A J Bell Holdings Ltd and a non-executive director of Styles and Wood plc and is a member of the General Assembly of the University of Manchester.

Board meetings and committees

The board supports the Nolan principles of public life and makes the majority of its decisions in meetings open to the public. The board met in public 11 times during the year.

The board delegates some of its work to committees. There is a standing item at each board meeting to receive the minutes of meetings of the board committees. Attendance by directors at board and committee meetings is shown in the table on page 36.

At the start of the year there were six board committees, three of which were comprised solely of non-executive directors. The charitable funds committee was made up of all directors. A review of the effectiveness of the committees was carried out in February 2008. The board decided to retain the existing audit and governance committees to provide assurance on the internal systems of control. The responsibilities of the audit committee were extended to include assurance of the Trust's investment activity. The responsibilities of the charitable funds committee were altered and this became a non-executive committee of the board.

Audit committee

The audit committee provides independent assurance to the board that there are effective systems of governance, risk management and internal control for all matters relating to corporate, financial and investment governance and risk management.

Key activities during the year were:

- Reviewing the Trust's annual report and financial statements (2006/07)
- Receiving and acting upon the annual audit letter from the external auditor
- Monitoring the assurance framework
- Monitoring the auditor local evaluation assessment
- Approving the corporate governance documents of the Trust
- Receiving reports from the internal auditor

Governance committee

Our governance committee provides independent assurance to the board that there are effective systems of governance, risk management and internal control for clinical and research governance and risk management.

Key activities during the year have been:

- Reviewing the Trust's declaration of compliance with Standards for Better Health
- Receiving reports and action plans from internal and external assessments
- Monitoring the assurance framework
- Receiving internal reports
- To receive the clinical governance annual report and monitor progress against targets

Charitable funds committee

The role of our charitable funds committee is to oversee the management of the Christie Hospital Charitable Fund.

Remuneration committee

The remuneration committee is responsible for the appointment, remuneration and terms of service of the executive directors.

Management board

The management board has responsibility for day-to-day operational finance and performance management of our Trust including making recommendations on strategic matters. It is chaired by the chief executive and comprises the executive directors, divisional directors and other senior officers. It oversees the clinical and non-clinical operating divisions of our Trust and meets monthly.

Risk Committee

The risk committee has responsibility for risk management of our Trust and meets monthly. It is chaired by the chief executive and comprises the executive directors, divisional directors and other senior officers.

Board members

Jim Martin Chairman

Appointed as chairman from 1st April 2007 for a four year term expiring on 31st March 2011. Appointed as a non-executive director on 1st December 2005.

Jim is a qualified accountant and was chief executive of N Brown Group plc, a large home shopping company, for 18 years and deputy chairman for three years until his retirement in December 2005.

He was a non-executive director of Redrow plc for 10 years until September 2007 and was chairman of Alexon plc until March 2008. He was also previously chairman of Ethel Austin Ltd, Roseby Ltd and Stirling Group plc. He was governor of Manchester Metropolitan University.

He was chairman of the audit committee until 31st March 2007 when he became chairman of the hospital.

He is currently chairman of A J Bell Holdings Ltd and a non-executive director of Styles and Wood plc and is a member of the General Assembly of the University of Manchester.

Caroline Shaw Chief Executive

Caroline became chief executive of the Christie in September 2005. She has strategic, operational, clinical and change-management experience and an award-winning record of improving patient care through reform and modernisation. Caroline was previously deputy chief executive and director of operations, South Manchester University Hospital NHS Foundation Trust and prior to that held a number of senior posts in the NHS. She was the winner of the 2007 North West Inspiring Women award for services to the public sector and delivered the prestigious Geoff Scaife Memorial Lecture at the 2006 NHS Confederation conference. She holds a MSc in Health Policy and Management, an honours degree in Health Studies and is a registered midwife and registered nurse.

Executive directors

Dr Chris Harrison, MB ChB MSc (Public Health and Epidemiology) DRCOG DCH FFPHM.

Medical Director from June 2006 (joint post with Dr Ron Stout)

Chris came to the Christie in June 2006. Prior to that he had been medical director and director of public health of Greater Manchester Health Authority, deputy regional director of Public Health, (North West regional office), director of Greater Manchester Health Protection Unit and head of Regional Cancer Team (North West regional office). He has a long standing interest in the development of cancer services and improvements in clinical quality.

Ian Moston Director of Finance & Business Development

Ian was appointed as director of finance and business planning in July 2006. He was previously director of finance, performance and commissioning for Staffordshire Moorlands Primary Care Trust. Prior to this he held a number of senior finance posts within the NHS. He holds an honours degree in Management and Business Studies and is a qualified CIPFA accountant.

Alison Norman Director of Nursing & Governance

Alison was appointed as director of nursing in July 2001 and is now also responsible for governance, education and membership. She was previously director of nursing at North Staffordshire Combined Healthcare NHS Trust. She is the immediate past president of the Community Practitioners and Health Visitors Association and a visiting professor at the University of Staffordshire. She was president of the UKCC (United Kingdom Central Council for Nursing, Midwifery and Health visiting) from 1998 to 2001 and has also previously been chair of the Standing Nursing and Midwifery Advisory Committee (Department of Health). She was awarded a CBE in 1998 for services to nursing. She holds a post graduate diploma in Management Studies and is registered as a midwife, health visitor and nurse. She is also an Honorary Doctor of the Universities of Wolverhampton, Staffordshire and Kingston and an Honorary Fellow of the University of Central Lancashire.

Roger Spencer
Chief Operating Officer
(previous job title Director of Delivery)

Roger was appointed as director of delivery in April 2006. He was previously general manager for Emergency and Critical Care, Women and Children and Clinical Support Services at Salford Royal Hospitals NHS Foundation Trust. He has also worked for Greater Manchester SHA as national imaging contract manager and as deputy director of operations at Burnley Healthcare NHS Trust. Roger holds an MBA, an honours degree in nursing studies and is a registered nurse.

Dr Ron Stout, MB ChB, FRCP, FRCR
Medical Director from January 2001
(joint post with Dr Chris Harrison
since June 2006).

Ron came to the Christie to train in clinical oncology in 1976. He was appointed a Pat Seed research fellow in 1980 before taking up a post as consultant clinical oncologist in 1981, providing outreach services to Preston until 1993 and since then to Oldham. His special interests include brachytherapy and the management of lung cancer.

Non-executive directors

Rt.Hon. Lord Keith Bradley

Appointed as a non-executive director on 1st November 2006. Appointed for unexpired term on authorisation as a foundation trust (to 31st October 2010).

Lord Bradley of Withington was awarded a life peerage in July 2006. He was Labour MP for Manchester Withington from 1987 to 2005 during which time he was Minister of State for the Home Office, a member of the Health Select Committee and Government Deputy Chief Whip. He was made a privy councillor in 2001.

His previous experience includes being a local government councillor on Manchester City Council and Chief Officer of Stockport Community Health Council. He has also served as a non-executive director of Manchester Airport Group plc and Manchester Ship Canal Company.

His current activities include special advisor to the President of the University of Manchester, non-executive chair of the MAST lift company and undertaking an independent review of mental health and the criminal justice system for the Government.

Lee Childs

Appointed as a non-executive director on 1st August 2007 for a three year term expiring on 30th July 2010.

Lee is a qualified accountant and was a partner with PricewaterhouseCoopers from 1990 to 2007. He specialised in the public sector and led PWC's public service practice in the North West for the majority of this period. He was the lead engagement partner for PWC for a number of local authorities, NHS bodies and higher education establishments for both external, internal and consultancy assignments. He is active in CIPFA affairs at a national (former vice-chairman of the national audit panel) and at local level.

Lee has been chairman of the audit committee since 17th December 2007.

Yoni Ejo

Appointed as a non-executive director on 1st December 2001. Re-appointed on 1st December 2005. Appointed for unexpired term on authorisation as a foundation trust (to 30th November 2009).

Yoni is a family placement team manager with Manchester City Council, panel advisor for one of the Manchester Adoption and Fostering Permanence panels and a member of the Albert Kennedy Trust panel, a charity providing supported lodgings for homeless lesbian and gay young people. She was a founding trustee of the Manchester Black and in Care Group and former chief executive of the Bibini Centre for Young People, a children's charity for young black people. She has previously been a trustee of 'First Key', a national policy and advisory organisation for young people in care and leaving care.

Yoni also chairs the equality & diversity group.

Bill Farndon
Senior Non-executive Director

Appointed as a non-executive director on 1st January 2004 for a three year term expiring on 31st December 2007. Appointed on authorisation as a foundation trust for 12 month term expiring on 31st March 2008 (as unexpired term on 1st April 2007 was less than 12 months). Re-appointed from 1st April 2008 for a three year term expiring on 31st March 2011.

Appointed by the council of governors as the senior non-executive director on 19th September 2007.

Bill held senior management positions in strategic planning, business development, manufacturing, logistics and graduate development. These include being vice president of global supply chain at Elan Pharmaceuticals and planning and budgeting co-ordinator at Fisons plc. He has also been director of Manchester Manufacturing IGDS.

He has been chairman of the charitable funds committee from 10th February 2006 to 31 March 2008 and was acting chairman of the audit committee from 1st April - 17th December 2007.

Professor Tony Freemont, MD, FRCP, FRCPath

Appointed as a non-executive director on 1st December 2000. Re-appointed on 1st December, 2003 for four year term expiring on 30th November 2007. Appointed on authorisation as a foundation trust for 12 month term expiring on 31st March 2008 (as unexpired term on 1st April was less than 12 months).

Tony is professor of osteoarticular pathology at the University of Manchester and is head of Research School (School of Clinical & Laboratory Sciences). He has been a doctor in the NHS for over 30 years and is a member of the Postgraduate Medical Education and Training Board (PMETB) assessment committee. He was chairman of the governance committee until 31st March 2008.

List of Board of Directors' attendances for 2007/08

	Board of Directors out of 11	Audit Committee out of 7	Audit Committee out of 7	Charitable Funds Committee out of 13 *see note	Remuneration Committee out of 4
Jim Martin	11	N/A	3	5	4
Keith Bradley	11	7	4	10	4
Lee Childs	6 out of 8	3 out of 4	3 out of 4	3 out of 6	1 out of 2
Yoni Ejo	7	5	3	6	3
Bill Farndon	11	7	6	13	4
Tony Freemont	8	6	5	9	1
				Out of 12	
Caroline Shaw	10	N/A	N/A	7	N/A
Chris Harrison	11	N/A	N/A	8	N/A
Ian Moston	9	N/A	N/A	8	N/A
Alison Norman	9	N/A	N/A	10	N/A
Roger Spencer	11	N/A	N/A	10	N/A
Ron Stout	8	N/A	N/A	10	N/A

*Note: Charitable funds committee became a non-executive committee of the board from March 2008

We discover

We undertook an external review of our research programme with the support of Cancer Research UK. The review findings supported our existing strategic direction and will enable us - in partnership with the University of Manchester and Cancer Research UK through the Manchester Cancer Research Centre - to make Manchester one of the world's leading cancer research centres by 2015.



Code of governance

The board has adopted the principles set out in the NHS Foundation Trust Code of Governance and has conducted a review of its compliance with the code during its first year as a foundation trust.

The ways it has adopted the main and supporting principles of the code and identified areas where further work is taking place to achieve compliance are set out below:

A. Directors

- It has conducted itself as an effective board
- It has revised the job descriptions of the chairman and chief executive during the year to provide greater clarity over the separation of the two roles, and
- It has maintained a balance between executive and non-executive directors with the exception of the period from 1st April – 31st July when the numbers of each were equal

B. Governors

- The council of governors has developed during the year and it has been effective in carrying out its role as defined in the constitution and in the code of governance
- Training for governors had been provided and has enabled the governors to increase their understanding of the Christie's activities and their roles and responsibilities as governors

C. Appointments and terms of office

- The council of governors made two non-executive appointments to the board using the formal procedure set out in our constitution
- The board of directors has carried out a self assessment and has identified the need to address succession planning for the board
- All governors are appointed for a term of not more than three years

D. Information, development and evaluation

- Information in the form of a performance report, appropriate to their needs is provided to the board and all governors and additional information is available on request
- Induction training is provided for directors and governors and refresher training will be provided in future
- Annual evaluation of the performance of the board, its principal committees and individual directors is carried out
- A process for the appraisal of the chairman led by the senior non-executive director has been approved by the council of governors and the first appraisal will be complete in June 2008

- The Trust intends to facilitate an independent assessment of the performance of the council of governors during the coming year

E. Director remuneration

- The remuneration of executive directors is approved by the remuneration committee which comprises all the non-executive directors
- The council of governors approved an increase in remuneration for the chairman and non-executive directors during the year

F. Accountability and audit

- The board of directors receives a comprehensive report of the financial position every month and is able to present a balanced and understandable assessment of the Trust's position and prospects
- The Trust uses its audit and governance committees to review the systems of internal control to safeguard investment, assets, patient safety and service quality and to ensure compliance with legal duties
- The audit committee, led by a non-executive director with recent and relevant experience, carries out the role defined in its terms of reference to ensure appropriate financial reporting and internal control

G. Relations with stakeholders

- The board of directors has supported the public governors to provide local public engagement meetings and intends to develop further public and community engagement in the coming year
- The board of directors carries out extensive engagement with its various stakeholders and is currently undertaking an independent review of stakeholder engagement

The Trust is satisfied that it complies or is undertaking action to achieve compliance with the provisions of the code with the following exceptions:

1. The Medical Director position is undertaken as a joint role by Dr Ron Stout and Dr Chris Harrison. The constitution provides for this joint directorship
2. The requirement for at least half of the board, excluding the chair, to comprise non-executive directors was not met between 1st April and 31st July
3. The requirement for one non-executive director to have recent and relevant financial experience was not met between 1st April and 31st July

The Trust has made one disclosure to the Office of the Information Commissioner as set out in the table opposite.

Summary of serious untoward incidents involving personal data as reported to the Information Commissioner's office in 2007/08

Date of incident (month)	Nature of incident	Nature of data involved	Number of people potentially affected	Notification steps
January	Loss of two laptop computers from secured NHS premises	Name, address and NHS number	Pathology laptop: 10,283	Notified to: Police STEIS Office of Information Commissioner Monitor
	These were secured behind locked doors and were double password protected but were not encrypted	Excel spreadsheets listing test results and variable combinations of potentially identifiable patient data elements listed above	Radiology laptop: 12,355	No requirement to contact the individuals affected
Further action on information risk	A comprehensive action plan dealing with both physical security and the security of electronic data has been put in place. Encryption of all laptop computers has been completed since the incident.			

Remuneration report

Salary and pension entitlements of senior managers

The accounting policies for pensions and other retirement benefits are set out in note 1.15 to the financial statements and details of senior employees' remuneration can be found in the remuneration report below.

A) Remuneration

Name and title	2007/08			2006/07		
	Salary (bands of £5000) £000	Other remuneration (bands of £5000) £000	Benefits in kind rounded to the nearest £100	Salary (bands of £5000) £000	Other remuneration (bands of £5000) £000	Benefits in kind rounded to the nearest £100
J Martin Chairman	35-40	0	0	5-10	0	0
C Shaw Chief Executive	140-145	0	11,700	110-115	0	11,700
Dr C Harrison Medical Director	85-90	85-90	5,800	60-65	60-65	0
I Moston Director of Finance & Business Development	90-95	0	4,900	55-60	0	3,300
A Norman Director of Nursing & Governance	85-90	0	1,800	80-85	0	3,100
R Spencer Chief Operating Officer	100-105	0	0	80-85	0	0
Dr R Stout Medical Director	10-15	170-175	0	10-15	165-170	0
Lord Keith Bradley Non-executive Director	10-15	0	0	0-5	0	0
L Childs (from 1st August 2007) Non-executive Director	5-10	0	0	0	0	0
Y Ejo Non-executive Director	10-15	0	0	5-10	0	0
B Farndon Senior Non-executive Director	10-15	0	0	5-10	0	0
Prof T Freemont Non-executive Director	10-15	0	0	5-10	0	0

Benefits in kind relate to the provision of lease cars.

B) Pension benefits

Name	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2008 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2008 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2008 £000	Cash Equivalent Transfer Value at 31 March 2007 £000	Real Increase in Cash Equivalent Transfer Value £000
C Shaw	7.5-10	22.5-25	35-40	115-120	468	355	73
Dr C Harrison	2.5-5	12.5-15	45-50	135-140	660	553	65
I Moston	2.5-5	10-12.5	20-25	60-65	236	180	36
A Norman	0-2.5	5-7.5	40-45	120-125	678	615	34
R Spencer	5-7.5	17.5-20	25-30	85-90	361	268	60
Dr R Stout	0-2.5	2.5-5	60-65	190-195	1,178	1,105	32

As non-executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for non-executive members.

Cash Equivalent Transfer Values

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

Real Increase in CETV

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

Caroline Shaw

Caroline Shaw
Chief Executive
9 June 2008

We discover:

We run one of the largest clinical trials units in Europe for phase I/II cancer trials, with around 1,200 patients going on new trials every year. This is set to double over the next few years making us the largest early clinical trials unit in the world. Patients who volunteer to take part in clinical trials may be the first to benefit from the earliest possible access to the newest treatments.



Statement of accounting officer's responsibilities

Statement of the chief executive's responsibilities as the accounting officer of the Christie NHS Foundation Trust

The National Health Service Act 2006 states that the chief executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the accounting officers' memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

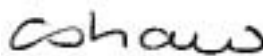
Under the National Health Service Act 2006, Monitor has directed the Christie Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Christie Hospital NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

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

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

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

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



Caroline Shaw
Chief Executive

9 June 2008

Independent auditor's report to the council of governors of Christie Hospital NHS Foundation Trust

I have audited the financial statements of Christie Hospital NHS Foundation Trust for the year ended 31 March 2008 under the National Health Service Act 2006. The financial statements comprise the income and expenditure account, the balance sheet, the cash flow statement, the statement of total recognised gains and losses and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the remuneration report that is described as having been audited.

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

Respective responsibilities of the accounting officer and auditor

The accounting officer's responsibilities for preparing the financial statements in accordance with directions made by the independent regulator of NHS Foundation Trusts (Monitor) are set out in the statement of accounting officer's responsibilities.

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

I report to you my opinion as to whether the financial statements give a true and fair view in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts. I report whether the financial statements and the part of the remuneration report to be audited have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts. I also report to you whether, in my opinion, the information which comprises the directors' report included in the annual report, is consistent with the financial statements.

I review whether the accounting officer's statement on internal control reflects compliance with the requirements of Monitor contained in the NHS Foundation Trust Financial Reporting Manual 2007/08. I report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information I am aware of from my audit of the financial

statements. I am not required to consider, nor have I considered, whether the accounting officer's statement on internal control covers all risks and controls. Neither am I required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

I read the other information contained in the annual report and consider whether it is consistent with the audited financial statements. This other information comprises the Chairman and Chief Executive statement, the governance section and the un-audited part of the remuneration report included in the annual report. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

Basis of audit opinion

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

- I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that:
- The financial statements are free from material misstatement, whether caused by fraud or other irregularity or error; and
- The financial statements and the part of the remuneration report to be audited have been properly prepared
- In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the remuneration report to be audited

Opinion

In my opinion:

- The financial statements give a true and fair view of the state of affairs of Christie Hospital NHS Foundation Trust as at 31 March 2008 and of its income and expenditure for the year then ended in accordance with the accounting policies adopted by the Trust
- The part of the remuneration report to be audited has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts; and
- Information which comprises the directors' report, included in the annual report, is consistent with the financial statements

Certificate

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

Jackie Bellard
(Officer of the Audit Commission)
11 June 2008
Aspinall House, Aspinall Close,
Middlebrook, Horwich, Bolton BL6 6ZA

Statement on internal control 2007/08

1. Scope of responsibility

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

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- Identify and prioritise the risks to the achievement of the policies, aims and objectives of the Christie Hospital NHS Foundation Trust
- 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 the Christie Hospital NHS Foundation Trust for the year ended 31 March 2008 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

The board of directors led by myself as chief executive officer has overall responsibility for the Trust's activities and risk management processes. The risk management arrangements in place are fit for purpose:

- The board receives assurances on the risk management and governance arrangements in place through the governance and audit committees. Both of these are non-executive board committees and each is chaired by a non-executive director. The governance committee receives minutes of meetings of the risk committee, chaired by the chief executive officer, and the clinical & research governance committee. These are the principal committees charged with managing

the systems and processes in place for managing risk and clinical governance issues across the trust. The audit committee reviews the systems and processes in place for managing corporate and financial governance across the Trust. It also monitors internal audit, external audit and counter fraud plans and activities and reviews all audit reports and associated action plans

- The responsibilities of all the board committees were reviewed in February 2008 and the audit committee has taken responsibility for providing assurance for all investment of hospital and charitable funds whether invested or held in cash. The membership of the charitable funds committee was altered in February 2008 and is also now a non-executive committee. All non-executive directors have independent access to internal and external audit
- Operationally, the director of nursing and governance has board-level responsibility for governance and risk management systems and processes including those associated with information. She discharges her responsibilities through:
 - The governance team, which includes the lead officers for the Standards for Better Health, the NHSLA risk assessment standards, the assurance framework, the risk register and the incident reporting management system, and
 - Co-ordinating the governance and risk management arrangements undertaken within the divisions through the divisional performance review meetings and the risk committee

Christie staff are trained/equipped to manage risk in a number of ways:

- The Trust's risk management strategy was reviewed and updated in August 2007
- The management and divisional structures, implemented towards the end of 2005/06 are now well established and identify clear responsibilities for governance and risk management at board, corporate and divisional level. The attainment of NHSLA Level 3 in September 2007 demonstrates that these are now embedded within the organisation
- Regular risk management awareness and training continues to take place in addition to regular training events addressing a number of risk areas such as lifting & handling, infection control, incident reporting and investigation and complaints handling

The organisation aims to ensure that it learns from good practice through:

- Action plans arising from external reviews such as the NHSLA risk assessment standards, MHRA, the Royal Colleges, peer review, PEAT etc
- Implementation of good practice guidance such as that contained within the NPSA patient safety alerts
- Publication of the quarterly incident report, which reports incidents, investigations and outcomes
- Level 2 Practice Development Units, which are established in a number of clinical areas
- Benchmarking with other, similar organisations

4. The risk and control framework

There is an agreed board reporting process in place which ensures that information relating to finance, performance, governance and risk management is presented to the board in a timely manner and in an appropriate format.

The reporting process includes:

- The corporate plan/strategic objectives – this identifies the strategic objectives of the Trust, and progress towards achievement, and is presented to the board twice per year
- The assurance framework – this is regularly reviewed and updated from the corporate plan and is presented quarterly to the audit and governance committees and twice per year to the board
- The risk register - this is regularly updated from the divisional risk registers and the assurance framework. All high level risks are presented to the governance committee quarterly and the top ten risks are reported to the board every month
- The organisation's response to national alerts or required governance action which is managed through the risk committee and management board and reported to the board of directors
- The integrated performance report is presented monthly to the board of directors
- The performance report - this is presented monthly to the management board and covers all aspects of the Trust's performance. A balanced scorecard approach is used which includes financial performance, governance, service delivery and workforce indicators

The key elements of the risk and control framework are:

- The annual strategic planning process and divisional planning process includes assessment of the risks to achievement of the objectives
- The incident reporting and management system which incorporates all information governance issues. The Caldicott and information governance committee oversees the policy and practice guidance relating to information management and monitors adverse incidents and action relating to this
- A standardised risk scoring system for assessing likelihood and impact, and a mechanism for moderating risk scores emerging from the divisions before inclusion in the risk register
- Divisional and departmental risk registers populated by staff working in the relevant area

The Trust has a clear divisional management process for implementing the framework which:

- Identifies the risks that might adversely affect outcomes
- Assesses and evaluates the risks and implements effective controls
- Delegates action to eliminate/reduce risks to the lowest practical level
- Reviews risks, and actions to address risks, through the risk committee

During the year the management and governance of research activity has been strengthened by the creation of a new research and development division under the leadership of a divisional director. In addition a director of education, reporting to the director of nursing & governance has been appointed. These actions will assist with the delivery of the corporate plan and strategic objectives.

The Trust has an information governance policy, contractual term and education and training to ensure that all employees are clear about their responsibilities. The lead for managing compliance with internal policies and external legal duties is held by the Caldicott guardian (the director of nursing and governance) and undertaken via the Caldicott and information governance committee. This committee reports directly to management board and has close links with the informatics structure. All untoward incidents involving hard or electronic information are reported to the Caldicott and information governance committee where decisions about required action and/or policy or education changes are made or monitored. The risk committee oversees action plans related to more

serious incidents.

The key elements of the assurance framework are:

- Strategic objectives distributed across the areas of strategy, finance, operations, HR and IM&T
- The key risks to achievement of the objectives, assessed and risk scored for likelihood and impact
- The key systems of control in place to manage the risks
- The key assurances that provide evidence that the systems of control are working effectively

The assurance framework provides an immediate means of alerting the board to areas of concern or failures of control, enabling the board to ensure that the appropriate management resource is committed to resolving any issue.

Risks identified in the assurance framework are transferred to the Trust's risk register, providing a single source of information for all risks across the organisation.

The assurance framework is reviewed by the audit and governance committees and updated quarterly, in the light of:

- Progress towards achievement of the strategic objectives
- Actions taken to mitigate or eliminate risk
- Changes to the risk scorings as a consequence of actions taken
- New risks that may have arisen or risks that have escalated as a result of new evidence or the failure of a mitigating action

The assurance framework for 2007/08 has not identified any significant gaps in either controls or assurances. It has been subject to an independent audit by the internal auditor. The conclusion of their audit was that the assurance framework was assessed as category A and the audit had identified areas of good practice and compliance with Department of Health guidance on developing an assurance framework. The audit opinion assigned a significant level of assurance to the assurance framework.

The Trust works with NHS North West and its partner organisations, as shown below, to ensure that risks to the Trust are identified, assessed and appropriate action is undertaken:

- Frequent correspondence and dialogue with NHS North West and Oldham PCT, the lead PCT for cancer services

throughout 2007/8, and the Greater Manchester & Cheshire Cancer Network on matters relating to the development of clinical services and the monitoring and appraisal of trust performance against national, local development plan and trust objectives

- Working closely with a range of PCTs through the Christie Commissioning Advisory Group (CCAG), which includes representatives of Oldham PCT, the Christie Hospital and NHS North West's specialist commissioning team, to ensure that appropriate clinical services are delivered in relation to cancer
- Improved links with the Greater Manchester and Cheshire Cancer Network
- Responsibility for the North West Cancer Registry
- Working with the University of Manchester and the University of Salford and a number of other academic institutes and professional bodies to ensure training & education are delivered in line with national standards and the academic expectations of relevant bodies
- Working through the Manchester Cancer Research Centre (MCRC), a partnership between the Christie Hospital, the University of Manchester and Cancer Research UK, to ensure that research undertaken at the Christie is properly and appropriately managed, takes account of national and international priorities and unifies the aims and principles for cancer research across the network.

The Trust also engages with stakeholders through a number of groups/committees where risks to the Trust might be identified, assessed or actioned. These include:

- Council of governors and committees of governors
- Local public engagement meetings
- The Christie Commissioning Advisory Group (led by Oldham PCT)
- The Greater Manchester and Cheshire Cancer Network
- PCT representation on the drugs management committee
- Patient and Public Involvement (PPI) Forum (up to 31 March 2008)
- Patient/user input into capital planning
- Patient surveys (both internal and external), suggestion schemes and the patient comment card system

We have maintained our partner and public stakeholder involvement following our authorisation as a foundation trust. In particular our public membership has increased to 8,352 during the year. The council of governors and committees of the council have been active in the areas of membership and community engagement, patient experience and involvement and environment of care and access to services.

5. Review of economy, efficiency and effectiveness of the use of resources

The Trust has a strong performance management system which is based on reporting key indicators in the areas of finance, performance, governance and risk management at department, divisional and board level. This system demonstrates economy, efficiency and effectiveness in the use of our resources. At the end of the year the Trust has exceeded its financial plan and achieved a financial risk rating of 4 and "green" ratings for governance and mandatory services.

6. Review of effectiveness

As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports.

My review is informed by a number of internal and external assurances. This year, these have included:

- Our quarterly submissions to Monitor and achievement of a financial risk rating of 4 throughout the year, a green rating of governance standards since quarter 2 and green rating for mandatory services
- The Head of Internal Audit Opinion Statement which indicates that for 2007/08 the Trust achieved significant assurance for the assurance framework
- Clinical audit reports
- Internal/external audit reports & reviews (eg the financial standard and governance standard audits, the acute hospital portfolio, the assurance framework)

- Self assessment against the Healthcare Commission core standards (Standards for Better Health). For 2007/08 the Trust was able to report full compliance with the core standards
- Level 3 compliance with the Clinical Negligence Scheme for NHS Trusts
- MHRA clinical pathology accreditation and research accreditation review
- PEAT inspection
- National staff and inpatient surveys during 2007
- Human Tissue Authority accreditation for our tissue bank

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board and the audit and governance committees. A plan to address weaknesses and ensure continuous improvement of the system is in place.

In January the Trust suffered a theft of two laptop computers, both of which held patient identifiable information. The computers were in locked offices and had double password protection, but were not encrypted. The theft was reported to the police, the lead commissioner through the STEIS system, the Office of Information Commissioner and to Monitor. An action plan dealing with augmented physical security and security awareness, together with a roll-out programme for encryption of laptop and mobile electronic media was shared with the inspector from the Information Commissioner's office on the 6th February 2008. The Trust was subsequently advised by the Information Commission that the inspector was satisfied that future compliance with the Act is likely and there is no requirement for the Commissioner to exercise his regulatory powers and that the matter was considered to be closed. The risk committee is monitoring the action plan and the information governance aspects of this will be completed by the end of June 2008. Action taken includes the encryption of all laptop computers and arrangements to close down stolen mobile electronic media.

The Trust has, and will continue to develop, a robust process for maintaining and reviewing the effectiveness of its systems of internal control as described in section 4.

During 2007/08 the trust has built on the arrangements put in place towards the end of 2005/06 and has seen further developments and improvements to governance and risk management systems across the Trust, and in the mechanisms for reporting to the board. These developments and improvements have included:

- Effective monitoring of progress towards achievement of the key corporate objectives for 2007/08 - the 62 day cancer waiting time target continued to be a high risk item throughout the year and was subject to close monitoring and management action throughout the year
- Effective operation of the SUI review panels, chaired by a non-executive director
- Continuing with our clear accountability arrangements for performance and risk management within the divisional structure introduced in 2006/07. In addition we have introduced a new research and development division, education department and strengthened the management arrangements for the charity
- Further development of the integrated performance report to the board, in addition to the extension of use of balanced scorecards throughout the organisation
- Our continuing board development has focussed on future strategy driven by strong financial and capital plans, and working as a unitary board. We have been supported by an external facilitator and have assessed the skills of the board prior to replacing two non-executives in order to strengthen the board. We have also participated in a board self assessment to identify future development needs

Development plans for 2009/10 include:

- Refinement of the presentation of the assurance framework to assist the board to judge the effectiveness of control measures intended to reduce the risks to the organisation in achieving its principal objectives
- Continuing to achieve compliance with the 62 day cancer waiting time target and sustained progress towards achieving the 18 week target
- Responding to the issues raised in the board assessment undertaken in early 2008 and in particular to the need to strengthen succession planning for the board

7. NHS Pension Scheme Contributions

As an employer with staff entitled to membership of the NHS pension scheme, we have received assurances from our payroll & pension services supplier (the University Hospital of South Manchester NHS Foundation Trust) that control measures were in place throughout 2006/07 to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

The Christie Hospital moved to a combined HR/payroll electronic staff record (ESR) in April 2007. The payroll department is taking the appropriate steps to ensure that satisfactory control measures are embedded in the new systems and processes relating to the pension scheme. An internal audit of the external payroll services was undertaken in October 2007 and received a limited audit assurance opinion. A further audit has been undertaken in April and the assurance opinion assigned has now improved to significant.

8. Conclusion

As accounting officer and based on the information provided above I am assured that no significant internal control issues have been identified other than the theft of two laptops described above. I am satisfied that the actions taken since this incident have significantly reduced the risk of a breach of information.



Caroline Shaw
Chief Executive
9 June 2008



We care:

As well as having a wide range of support and extra services for our patients, we also provide a high quality and welcoming environment. Our hospital environment is very important to our patients and can have a strong influence on their well-being.

Accounts 2007/08

Foreword to the accounts

These accounts for the year ended 31 March 2008 have been prepared by the Christie Hospital NHS Foundation Trust under paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006, in the form which Monitor, the Independent Regulator of NHS Foundation Trust has, with the approval of the Treasury, directed.



Caroline Shaw
Chief Executive
9 June 2008

Income and expenditure account for the year ended

31 March 2008

	NOTE	2007/08 £000
Income from activities	3	113,336
Other operating income	4	32,255
Operating expenses	5	(137,258)
OPERATING SURPLUS/(DEFICIT)		8,333
Cost of fundamental reorganisation/restructuring		0
Profit/(loss) on disposal of fixed assets	8	(165)
SURPLUS/(DEFICIT) BEFORE INTEREST		8,168
Finance income	9	957
Finance costs - interest expense	9	0
Other finance costs - unwinding of discount	17	(2)
Other finance costs - change in discount rate on provisions		0
SURPLUS/(DEFICIT) BEFORE TAXATION		9,123
Public Dividend Capital dividends payable		(3,833)
RETAINED SURPLUS/(DEFICIT) FOR THE YEAR		5,290

The notes on pages 57 to 81 form part of these accounts.
All income and expenditure is derived from continuing operations.

Balance sheet as at

31 March 2008

	NOTE	31 March 2008 £000	1 April 2007 £000
FIXED ASSETS			
Intangible assets	10	344	470
Tangible assets	11	148,014	153,367
Investments	12	0	0
		148,358	153,837
CURRENT ASSETS			
Stocks and work in progress	13	1,136	1,114
Debtors	15	12,149	20,681
Investments	14/19.3	5,024	0
Cash at bank and in hand	19.3	14,956	269
		33,265	22,064
CREDITORS: Amounts falling due within one year	16	(21,575)	(16,791)
NET CURRENT ASSETS/(LIABILITIES)		11,690	5,273
TOTAL ASSETS LESS CURRENT LIABILITIES		160,048	159,110
CREDITORS: Amounts falling due after more than one year	16	(3,946)	(3,841)
PROVISIONS FOR LIABILITIES AND CHARGES	17	(1,033)	(1,042)
TOTAL ASSETS EMPLOYED		155,069	154,227
FINANCED BY:			
TAXPAYERS' EQUITY			
Public dividend capital	18.2	52,480	52,480
Revaluation reserve	18.3	39,403	48,240
Donated asset reserve	18.3	55,906	51,432
Available for sale investments reserve		0	0
Other reserves		0	0
Income and expenditure reserve	18.3	7,280	2,075
TOTAL TAXPAYERS' EQUITY		155,069	154,227

The 2006/07 balances have been restated to reflect a change in accounting treatment of fixed assets in respect of SSAP 4 'Accounting for government grants' and FRS11 revaluation of fixed assets.

The financial statements on pages 52 to 81 were approved by the board on 9th June 2008 and signed on its behalf by:



Caroline Shaw
Chief Executive
9 June 2008

Statement of total recognised gains and losses for the year ended

31 March 2008

	2007/08 £000
Surplus/(deficit) for the financial year before dividend payments	9,123
Fixed asset impairment losses	0
Unrealised surplus/(deficit) on fixed assets and current asset investments revaluations	(6,196)
Net gains/losses on available for sale investments	0
Increase in the donated asset reserve due to receipt of donated assets	4,981
Reduction in the donated asset reserve due to depreciation, impairment, and/or disposal of donated assets	(3,233)
Additions/(reductions) in "other reserves"	0
Other recognised gains and losses	0
Total recognised gains and losses for the financial year	4,675
Prior period adjustments	0
Total gains and losses recognised in the financial year	4,675

Cash flow statement for the year ended

31 March 2008

	NOTE	2007/08 £000
OPERATING ACTIVITIES		
Net cash inflow/(outflow) from operating activities	19.1	26,450
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:		
Interest received		957
Interest paid		0
Interest element of finance lease rental payments		0
Net cash inflow/(outflow) from returns on investments and servicing of finance		957
CAPITAL EXPENDITURE		
(Payments) to acquire tangible fixed assets		(8,844)
Receipts from sale of tangible fixed assets		0
(Payments) to acquire intangible assets		0
Receipts from sale of intangible assets		0
(Payments)/receipts for fixed asset investments		0
Net cash inflow/(outflow) from capital expenditure		(8,844)
DIVIDENDS PAID		(3,833)
Net cash inflow/(outflow) before management of liquid resources and financing		14,730
MANAGEMENT OF LIQUID RESOURCES		
(Purchase) of current asset investments		(5,024)
Sale of current asset investments		0
Net cash inflow/(outflow) from management of liquid resources		(5,024)
Net cash inflow/(outflow) before financing		9,706
FINANCING		
Public dividend capital received		0
Public dividend capital repaid		0
Loans received from Foundation Trust Financing Facility		0
Other loans received		0
Loans repaid to Foundation Trust Financing Facility		0
Other loans repaid		0
Other capital receipts		4,981
Capital element of finance lease rental payments		0
Net cash inflow/(outflow) from financing		4,981
Increase/(decrease) in cash		14,687

Notes to the accounts

1. Accounting policies

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Financial Reporting Manual which shall be agreed with HM Treasury. Consequently the following financial statements have been prepared in accordance with the 2007/08 NHS Foundation Trust Financial Reporting Manual issued by Monitor. The accounting policies contained in that manual follow UK generally accepted accounting practices for companies (UK GAAP) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of tangible fixed assets at their value to the business by reference to their current costs. NHS foundation trusts in compliance with HM Treasury's Financial Reporting Manual are not required to comply with FRS3 requirements to report "earnings per share" or historical profits and losses.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are acquired 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.

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

- a. the sale (this may be at nil consideration for activities transferred to another public sector body) or termination is completed either in the period or before the earlier of three months after the commencement of the subsequent period and the date on which the financial statements are approved;
- b. if a termination, the former activities have ceased permanently;
- c. the sale or termination has a material effect on the nature and focus of the reporting NHS foundation trust's operations and represents a material reduction in its operating facilities resulting either from its withdrawal from a particular activity or

from a material reduction in income in the NHS foundation trust's continuing operations; and

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

Operations not satisfying all these conditions are classified as continuing.

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

1.3 Income recognition

Income is accounted for applying the accruals convention. The main source of income for the trust is under contracts with NHS commissioners (PCT's) in respect of healthcare services. Income is recognised in the period in which services are provided. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

The NHS foundation trust changed the form of its contracts with NHS commissioners to follow the Department of Health's Payment by Results methodology in 2005/06. To manage the financial impact of this change on the NHS foundation trust and its commissioners, income was made available to the Trust by its commissioners to smooth the transition in 2007/08; this income amounted to £983,413.

1.4 Expenditure

Expenditure is accounted for applying the accruals convention.

1.5 Intangible fixed assets

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

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

Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred and amortised using the straight line basis over five years.

1.6 Tangible fixed assets

Capitalisation

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

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

Valuation

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

All land and buildings are restated to current value using professional valuations in accordance with FRS15 every five years. A three yearly interim valuation has been carried out during 2007/08 and reflected in these accounts.

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The 2007 valuation was carried out by the District Valuer of the Valuation Office, who is an MRICS chartered surveyor.

The valuations are carried out primarily on the basis of Depreciated Replacement Cost for specialised operational property and Existing Use Value for non-specialised operational property. The value of land for existing use purposes is assessed at Existing Use Value. For non-operational properties including surplus land, the valuations are carried out at Open Market Value.

Additional alternative Open Market Value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal.

In accordance with FRS 11 negative balances held in the revaluation reserve have been transferred to the I&E reserve and opening 2007/08 balances have been restated. In addition SSAP 4 has been applied to government granted assets.

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

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

Operational equipment is valued at net current replacement cost using an appropriate index. IT equipment is valued at depreciated historic cost. Equipment surplus to requirements is valued at net recoverable amount.

Depreciation, amortisation and impairments

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

Assets in the course of construction and residual interests in off-balance sheet PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

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

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

	Years
Medical equipment and engineering plant and equipment	5 to 15
Furniture	10
Mainframe information technology installations	8
Soft furnishings	7
Office and information technology equipment	5
Set up costs in new buildings	10

Fixed asset impairments resulting from losses of economic benefits are charged to the Income and Expenditure Account. All other impairments are taken to the revaluation reserve and reported in the statement of total recognised gains and losses to the extent that there is a balance on the revaluation reserve in respect of the particular asset.

1.7 Donated fixed assets

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

1.8 Government grants

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

1.9 Private Finance Initiative (PFI) transactions

The NHS follows HM Treasury's Technical Note 1 (Revised) "How to Account for PFI transactions" which provides definitive guidance for the application of Application Note F to FRS 5 and the guidance 'Land and Buildings in PFI schemes Version 2'.

Where the balance of the risks and rewards of ownership of the PFI property are borne by the PFI operator, the PFI payments are recorded as an operating expense. Where the trust has contributed land and buildings, a prepayment for their fair value is recognised and amortised over the life of the PFI contract by charge to the income and

expenditure account. Where, at the end of the PFI contract, a property reverts to the trust, the difference between the expected fair value of the residual on reversion and any agreed payment on reversion is built up over the life of the contract by capitalising part of the unitary charge each year, as a tangible fixed asset.

Where the balance of risks and rewards of ownership of the PFI property are borne by the trust, it is recognised as a fixed asset along with the liability to pay for it which is accounted for as a finance lease. Contract payments are apportioned between an imputed finance lease charge and a service charge.

1.10 Stocks and work-in-progress

Stocks and work-in-progress are valued at the lower of cost and net realisable value, except for pharmacy stocks which are valued at average cost. This is considered to be a reasonable approximation to current cost due to the high turnover of stocks.

1.11 Cash, bank and overdrafts

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

1.12 Research and development

The revenue costs of personnel, consumables, etc. engaged in research & development activities is shown as direct expenditure of the Trust. Some of these activities are funded through charitable sources and therefore an amount corresponding to the expenditure charged to the Income & Expenditure Account is included in operating income as charitable and other contributions to expenditure.

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

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

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

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

1.13 Provisions

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

1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one

or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 22 where an inflow of economic benefits is probable.

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

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

Clinical negligence costs

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

Non-clinical risk pooling

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

1.15 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.pensions.nhsbsa.nhs.uk. 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.

The scheme is subject to a full actuarial valuation every four years (until 2004, based on a five year valuation cycle), and a FRS17 accounting valuation every year. An outline of these follows:

a) 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 to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date.

The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the scheme actuary reported that employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008, the vast majority of employees paid contributions at the rate of 6% of pensionable pay. From 1 April 2008, employees contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

b) FRS17 Accounting valuation

In accordance with FRS17, a valuation of the scheme liability is carried out annually by the scheme actuary as at the balance sheet date by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2008, is based on detailed membership data as at 31 March 2006 (the latest midpoint) updated to 31 March 2008 with summary global member and accounting data.

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) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also

be obtained from The Stationery Office.

Scheme provisions as at 31 March 2008

The scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement, less pension already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die 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 income and expenditure account at the time the Trust commits itself to the retirement, regardless of the method of payment.

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

Scheme provisions from 1 April 2008

From 1 April 2008 changes have been made to the NHS Pension Scheme contribution rates and benefits. Further details of these changes can be found on the NHS Pensions website www.pensions.nhsbsa.nhs.uk.

1.16 Liquid resources

Deposits and other investments that are readily convertible into known amounts of cash at or close to their carrying amounts are treated as liquid resources in the cashflow statement. The Trust does not hold any investments with maturity dates exceeding one year from the date of purchase.

1.17 Value Added Tax

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

1.18 Foreign exchange

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

1.19 Leases

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

1.20 Public Dividend Capital (PDC) and PDC Dividend

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

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

1.21 Financial instruments and financial liabilities

Recognition

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

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described above.

De-recognition

All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as 'loans and receivables'.

Financial liabilities are classified as 'other financial liabilities'.

Loans and receivables

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

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

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

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

Financial liabilities

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

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

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

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from discounted cash flow analysis.

Impairment of financial assets

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

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the income and expenditure account and the carrying amount of the asset is reduced through the use of a bad debt provision when it is uneconomical to recover.

1.22 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 each individual case is handled.

Losses and Special Payments are charged to the relevant functional headings in the Income and Expenditure Account on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). Note 27 is compiled directly from the losses and compensations register which is prepared on a cash basis

2. Segmental reporting

The Trust operates in the healthcare sector only therefore there is no requirement for segmental reporting.

3. Income from activities

3.1 Income by type

	2007/08 £000
Elective income	25,782
Non Elective income	6,359
Outpatient income	7,342
Chemotherapy/radiotherapy treatments	49,852
Pseudomyxoma treatments	3,134
Drug treatments	7,604
Treatments at peripheral clinics	908
Matched Unrelated Donor treatments	1,721
Other types of activity	911
PBR clawback	983
Private patient income	8,740
Total	113,336

3.2 Private patient income

	Total £000	Base year 2002/03 £000
Private patient income	8,740	5,347
Total patient related income	113,336	58,842
Proportion (as percentage)	7.7%	9.09%

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

3.3 Income by source

	2007/08 £000
NHS Foundation Trusts	299
NHS Trusts	1,792
Strategic Health Authorities	450
Primary Care Trusts	92,490
Department of Health - other	5,067
NHS Other	4,356
Non NHS:	
- Private patients	8,740
- Prescription income	11
- Macmillan income	131
Total	113,336

NHS other includes £3,134k income relating to pseudomyxoma from the London Specialised Commissioning Group.

4. Other operating income

2007/08
£000

Research and development	4,141
Education and training	4,702
Charitable and other contributions to expenditure	5,250
Transfers from donated asset reserve	3,233
Non-patient care services to other bodies	3,172
Income generation	2,252
North West Medical Physics	6,584
Cancer Network	2,921
Total	32,255

5. Operating expenses

5.1 Operating expenses comprise:

2007/08
£000

Services from foundation trusts	1,574
Services from NHS trusts	1,324
Services from other NHS bodies	2,900
Non-executive directors' costs	105
Executive directors' costs	958
Staff costs	64,209
Drug costs	31,033
Supplies and services - clinical	7,560
Supplies and services - general	1,321
Establishment	2,161
Research and development	4,270
Transport	19
Premises	6,040
Increase/decrease in bad debt provision	52
Depreciation and amortisation	7,338
Fixed asset impairments	858
Audit fees	
- audit services - statutory audit	60
Clinical negligence	182
Redundancy	446
Cancer Network	2,921
Consultancy fees/legal fees	1,228
Other	699
Total	137,258

5.2 Operating leases

5.2/1 Operating expenses include:

2007/08
£000

Other operating lease rentals	393
Total	393

5.2/2 Annual commitments under non-cancellable operating leases are:

Other leases:

2007/08
£000

Operating leases which expire:

Between 1 and 5 years	300
Total	300

6. Staff costs and numbers

6.1 Staff costs

	Total	2007/2008 Permanently employed	Other number
	£000	£000	
Salaries and wages	56,325	53,052	3,273
Social Security costs	4,105	4,105	0
Employer contributions to NHS BSA - Pensions Division	6,425	6,425	0
Agency/contract staff	775	0	775
Total	67,630	63,582	4,048

R&D salaries totalling £2,436,029, are included within this note but are excluded from staff costs in note operating expenses (note 5.1), as R&D has its own separate heading.

Capitalised staff costs are excluded from this note and total £373,418.

6.2 Average number of persons employed

	Total number	2007/2008 Permanently employed number	Other number
Medical and dental	163	110	53
Medical secretaries & records	162	155	7
Administration and estates - admin	302	292	10
Administration and estates - clinical support	89	89	0
Healthcare assistants and other support staff	115	115	0
Nursing, midwifery and health visiting staff	553	552	1
Scientific, therapeutic and technical staff	417	412	5
Total	1,801	1,725	76

6.3 Employee benefits

This relates to non-pay benefits which are not attributable to individual employees. The Trust had no such benefits this year.

6.5 Retirements due to ill-health

During 2007/08 there was one early retirement from the Trust on the grounds of ill-health. The estimated additional pension liability of this ill-health retirement will be £6,146. The cost of this ill-health retirement will be borne by the NHS Business Services Authority - Pensions Division.

7. Better Payment Practice Code

7.1 Better Payment Practice Code - measure of compliance

	2007/08 number	2007/08 £000
Total Non-NHS trade invoices paid in the year	31,887	64,302
Total Non-NHS trade invoices paid within target	26,342	57,785
Percentage of Non-NHS trade invoices paid within target	83%	90%
Total NHS trade invoices paid in the year	1,485	14,874
Total NHS trade invoices paid within target	1,102	12,902
Percentage of NHS trade invoices paid within target	74%	87%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

7.2 The Late Payment of Commercial Debts (Interest) Act 1998

There are no amounts included within Interest Payable (Note 9) arising from claims made or compensation paid to cover debt recovery costs under this legislation.

8. Profit/(loss) on disposal of fixed assets

Profit/(loss) on the disposal of fixed assets is made up as follows:

	2007/08 £000
Loss on disposal of other tangible fixed assets	(165)
Total	(165)

The loss on disposal relates to protected assets.

9.1 Finance income

	2007/08 £000
Interest on loans and receivables	957
Total	957

9.2 Finance costs - interest expense

The Trust had no interest payable for the year ended 31st March 2008.

9.3 Other net gains/(losses) on financial instruments

There were no net gains/losses during the year ended 2007/08.

10. Intangible fixed assets

	Software licences £000	Total £000
Gross cost at start of period for new FTs	581	581
Gross cost at 31 March 2008	581	581
Amortisation at start of period for new FTs	109	109
Provided during the year	128	128
Amortisation at 31 March 2008	237	237
Net book value		
- Purchased at 1 April 2007	472	472
- Total at 1 April 2007	472	472
- Purchased at 31 March 2008	344	344
- Total at 31 March 2008	344	344

11. Tangible fixed assets

11.1 Tangible fixed assets at the balance sheet date comprise the following elements:

	Land	Buildings excluding dwellings	Assets under construction and payments on account*	Plant and machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Cost or valuation at start of period for new FTs	46,709	86,352	2,225	36,829	5,008	177,123
Additions purchased	0	2,233	1,034	438	466	4,171
Additions donated	0	837	2,531	1,524	89	4,981
Impairments	0	(858)	0	0	0	(858)
Reclassifications	0	2,798	(3,789)	991	0	0
Other revaluations	(8,470)	1,835	21	994	0	(5,620)
Disposals	0	(77)	0	(10,732)	(708)	(11,517)
Cost or valuation at 31 March 2008	38,239	93,120	2,022	30,044	4,855	168,280
Depreciation at start of period for new FTs	0	0	0	21,473	2,281	23,754
Provided during the year	0	4,098	0	2,499	613	7,210
Other revaluations	0	0	0	576	0	576
Disposals	0	0	0	(10,566)	(708)	(11,274)
Depreciation at 31 March 2008	0	4,098	0	13,982	2,186	20,266
Net book value						
- Purchased at 1 April 2007	44,866	44,319	1,785	8,810	2,156	101,936
- Donated at 1 April 2007	1,843	42,033	440	6,546	571	51,433
- Total at 1 April 2007	46,709	86,352	2,225	15,356	2,727	153,369
- Purchased at 31 March 2008	36,534	43,516	1,034	8,881	2,143	92,108
- Donated at 31 March 2008	1,705	45,506	988	7,181	526	55,906
- Total at 31 March 2008	38,239	89,022	2,022	16,062	2,669	148,014

Buildings depreciation of £4,098,000 includes £562,000 for accelerated depreciation in respect of the planned demolition of the Derek Crowther Unit as part of the new patient treatment centre.

11.2 Tangible fixed assets at the balance sheet date comprise the following elements:

	Land	Buildings excluding dwellings	Assets under construction and payments on account*	Plant and machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Net book value						
- Protected assets	23,504	64,325	0	0	0	87,829
- unprotected assets	14,735	24,697	2,022	16,062	2,669	60,185
Total	38,239	89,022	2,022	16,062	2,669	148,014

Cost or valuation at 31 March 2008

11.3 Assets held at open market value

At the balance sheet date there was no land, buildings or dwellings valued at open market value.

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

At the balance sheet date there were no assets held under finance leases and hire purchase contracts.

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

There was no depreciation charged to the income and expenditure account in respect of assets held under finance leases and hire purchase contracts.

11.5 The net book value of land, buildings and dwellings at 31 March 2008 comprises:

	Total £000	Protected £000	Unprotected £000
Freehold	127,261	87,829	39,432
Total	127,261	87,829	39,432

11.6 Impairment of assets:

	31 March 2008 £000
Loss as a result of day nursery fire	20
Changes in market price	838
Total	858

12. Fixed asset investments

The Trust did not hold any investments at 31st March 2008.

13. Stocks and work in progress

	31 March 2008 £000	1 April 2007 £000
Raw materials and consumables	1,136	1,114
Total	1,136	1,114

14. Current asset investments

	31 March 2008 £000
Cost or valuation at start of period for new FTs	
Additions	5,024
Cost or valuation at 31 March	5,024

15. Debtors

	31 March 2008 £000	1 April 2007 £000
Amounts falling due within one year:		
NHS debtors	6,364	3,530
Provision for irrecoverable debts	(56)	(30)
Other prepayments and accrued income	659	539
Other debtors	5,182	16,642
Total	12,149	20,681

Other debtors at 1 April 2007 included a debtor with charitable funds for £13.8m that has been paid in 2007/08 and is now shown in cash.

15.2 Analysis of impaired debtors

	31 March 2008 £000	1 April 2007 £000
Aging of impaired debtors		
Up to three months	0	0
In three to six months	8	7
Over six months	48	23
Total	56	30

	31 March 2008 £000	1 April 2007 £000
Aging of non impaired debtors past their due date		
Up to three months	600	781
In three to six months	1,249	104
Over six months	67	404
Total	1,916	1,289

16. Creditors

16.1 Creditors at the balance sheet date are made up of:

	31 March 2008 £000	1 April 2007 £000
Amounts falling due within one year:		
Payments received on account	1,180	1,066
NHS creditors	3,063	2,280
Other tax and social security costs	1,442	76
Non-NHS trade creditors - revenue	6,204	3,829
Non-NHS trade creditors - capital	2,308	1,999
Other creditors	1,292	1,739
Accruals and deferred income	6,086	5,802
Sub Total	21,575	16,791
Amounts falling due after more than one year:		
Other	3,946	3,841
Sub Total	3,946	3,841
Total	25,521	20,632

Other creditors due within one year include £816k outstanding pensions contributions at 31st March 2008, (1st April 2008 £705k; and deferred income for the Cancer Network £1,630k (1st April 2008 £1,115k).

Accruals and deferred income includes a creditor of £936k in respect of government granted income. This is a change in accounting treatment as per SSAP 4.

Other creditors due after more than one year comprise the following:

	31 March 2008 £000	1 April 2007 £000
Pseudomyxoma income		
- Income for national specialist commissioning	219	773
Research & Development		
- Income received for clinical trials & other research projects	3,727	3,067

16.2/1 Loans

There were no loans outstanding at the 31st March 2008 or at the 31st March 2007.

16.3 Prudential Borrowing Limit

The Trust is required to comply and remain within a Prudential Borrowing Limit.

This is made up of two elements:

- The maximum cumulative amount of long term borrowing. This is set by reference to the five ratio tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratio and therefore can impact on the long term borrowing limit.
- The amount of any working capital facility approved by Monitor.

In the year ending 31st March 2008 the Trust has a prudential borrowing limit of £31,900,000 and a working capital facility of £10,000,000. The Trust did not require any borrowing nor did it require to use working capital facility.

The following table shows actual ratio values as compared to the approved ratios set out in the Trust's 2007/08 annual plan.

Financial Ratios	2007/08 actual	2007/08 planned
Minimum dividend cover	4.5	3.8
		£000
Long term borrowing set by Monitor		31,900
Working capital facility		10,000
Total Prudential Borrowing Limit		41,900

16.4 Finance lease obligations

The Trust has not entered into any finance leases.

17. Provisions for liabilities and charges

	Pensions relating to other staff	Personal injury claims	Pay modernisation	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2007	83	68	372	519	1,042
Arising during the year	32	47	0	49	128
Utilised during the year	(11)	(59)	(43)	0	(113)
Reversed unused	0	(13)	0	(13)	(26)
Unwinding of discount	2	0	0	0	2
At 31 March 2008	106	43	329	555	1,033

Expected timing of cashflows:

Within one year	10	31	329	527	897
Between one and five years	50	12	0	28	90
After five years	46	0	0	0	46

The above provision for personal injury is based upon information supplied by the Litigation Authority. The associated contingent liability is shown under note 22.

The year end pay modernisation relates to Agenda for Change outstanding settlements in respect of enhancements on annual leave, bank staff assimilation and preceptorship payments.

The other provision relates to a potential tax liability of £41k based on information supplied by Internal Audit, £465k for a potential repayment of Public Dividend Capital to the SHA and £49k for relocation expenses.

£1,924k is included in the provisions of the NHS Litigation Authority at 31 March 2008 in respect of clinical negligence liabilities of the Trust.

18.1 Movements in tax payers equity

£000

Tax payers equity at start of period	154,227
Surplus/(deficit) for the financial year	9,123
Public dividend capital dividends	(3,833)
Surplus/(deficit) from revaluations of fixed assets and current asset investments	(6,196)
Additions/(reductions) in donated asset reserve	1,748
Total	155,069

18.2 Movement in public dividend capital

£000

Public dividend capital at start of period	52,480
Total	52,480

18.3 Movements on reserves

Movements on reserves in the year comprised the following:

	Revaluation reserve £000	Donated asset reserve £000	Income and expenditure reserve £000	Total £000
At start of period	48,240	51,432	2,075	101,747
Transfer from the income and expenditure account			5,290	5,290
Surplus/(deficit) on other revaluations/indexation of fixed/current assets	(8,922)	2,726		(6,196)
Receipt of donated/government granted assets		4,981		4,981
Transfers to the income and expenditure account for depreciation, impairment, and disposal of donated/government granted assets		(3,233)		(3,233)
Other transfers between reserves	85	0	(85)	0
At 31 March 2008	39,403	55,906	7,280	102,589

19. Notes to the cash flow statement

19.1 Reconciliation of operating surplus to net cash flow from operating activities:

	2007/08 £000
Total operating surplus/(deficit)	8,333
Depreciation and amortisation charge	7,338
Fixed asset impairments	858
Transfer from donated asset reserve	(3,233)
(Increase)/decrease in stocks	(22)
(Increase)/decrease in debtors	8,608
Increase/(decrease) in creditors	4,579
Increase/(decrease) in provisions	(11)
Net cash inflow/(outflow) from operating activities before restructuring costs	26,450
Net cash inflow from operating activities	26,450

19.2 Reconciliation of net cash flow to movement in net funds/(debt)

	2007/08 £000
Increase/(decrease) in cash in the period	14,687
Cash (inflow)/outflow from (decrease)/increase in liquid resources	5,024
Change in net funds/(debt) resulting from cash flows	19,711
Net funds/(debt) at start of period	269
Net funds/(debt) at 31 March 2008	19,980

19.3 Analysis of changes in net debt

	Cash at start of period £000	Cash changes in year £000	At 31 March 2008 £000
Commercial cash at bank and in hand	1	12,362	12,363
OPG cash at bank	268	2,325	2,593
Current asset investments	0	5,024	5,024
Total	269	19,711	19,980

Cash now includes £13.8m for the drawdown of the charitable funds debtor at the start of 2007/08.

20. Capital commitments

Commitments under capital expenditure contracts at 31 March 2008 were £1,771k (1 April 2008 £1,889k).

Material projects over £250,000	Source of Funds	£000
Haematology & transplant unit, radiopharmacy and Wolfson Molecular Imaging Centre link	Exchequer / Charitable Funds	712
Interventional radiology	Charitable Funds	436

21. Post balance sheet events

There were no post balance sheet events requiring disclosure.

22. Contingent (liabilities)/assets

	2007/08 £000
Gross value of contingent liabilities	(26)
Net value of contingent liabilities	(26)

The contingent liability relates to personal injury claims based upon information supplied by the NHS Litigation Authority.

23. Related party transactions

The Christie Hospital NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

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

The Department of Health is regarded as a related party. During the year the Christie Hospital NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. Material transactions greater than £2.5m with these entities are listed below:

	£000
Ashton, Leigh & Wigan PCT	6,942
Bolton PCT	5,494
Bury PCT	4,343
Heywood, Middleton & Rochdale PCT	4,717
London Specialised Commissioning Group	3,134
Manchester PCT	16,024
North West Specialist Commissioning team hosted by Western Cheshire PCT	18,737
North West SHA	5,371
Oldham PCT	11,176
Salford PCT	5,897
Stockport PCT	9,661
Tameside & Glossop PCT	5,481
Trafford PCT	6,565

Other material transactions the Trust has had with other health bodies include the University Hospital of South Manchester NHS Foundation Trust, Pennine Acute NHS Trust, the Blood Transfusion Service, NHS Litigation Authority, NHS Purchasing and Supply Agency and other health authorities.

In addition, the Trust has had a number of material transactions with other Government Departments, local Government bodies and the University of Manchester.

The Trust has also received revenue (£5.2m) and capital payments (£3.2m) from the Christie Hospital Charitable Fund, for which the Trust is the sole corporate trustee and for which the Trust board is responsible for the management and accountability.

A separate Trustees Report and Accounts for the Christie Hospital Charitable Fund can be obtained from the Finance Department on 0161 446 3806.

24. Private finance transactions

24.1 PFI schemes deemed to be off-balance sheet

2007/08
£000

Amounts included within operating expenses in respect of PFI transactions deemed to be off-balance sheet - gross	919
<u>Net charge to operating expenses</u>	<u>919</u>

The Foundation Trust is committed to make the following payments during the next year.

PFI scheme which expires;	
Within one year	0
2nd to 5th years (inclusive)	0
6th to 10th years (inclusive)	0
11th to 15th years (inclusive)	720

£000

Estimated capital value of the PFI scheme	1,790
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Contract Start date: September 2003
Contract End date: August 2019

Description of the scheme: Provision of an Energy Management Service

25. Financial instruments

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

Liquidity risk

The Foundation Trust's net operating costs are incurred under annual service agreements with local Primary Care Trusts, which are financed from resources voted annually by Parliament. The Trust has achieved a risk ratio for liquidity of 5 as defined by Monitor's compliance framework. This illustrates the liquidity risk to the Trust is low.

Interest-rate risk

As none of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest, the Christie Hospital NHS Foundation Trust is not exposed to significant interest-rate risk. The following tables show the interest rate profiles of the Trust's financial assets and liabilities.

25.1 Financial assets

	Total £000
Currency	
At 31 March 2008	
Sterling	31,470
Gross financial assets	31,470
At 1 April 2007	
Sterling	20,131
Gross financial assets	20,131

25.2 Financial liabilities

	Total £000
Currency	
At 31 March 2008	
Sterling	(21,841)
Gross financial liabilities	(21,841)
At 1 April 2007	
Sterling	(17,910)
Gross financial liabilities	(17,910)

25.3a Financial assets by category

	Total	Loans and receivables	Held to maturity
	£000	£000	£000
NHS debtors (net of provision for irrecoverable debts)	6,335	6,335	0
Other debtors	5,155	5,155	0
Current asset investments	5,024	0	5,024
Cash at bank and in hand	14,956	14,956	0
Total at 31 March 2008	31,470	26,446	5,024
NHS debtors (net of provision for irrecoverable debts)	3,530	3,530	0
Other debtors	16,332	16,332	0
Cash at bank and in hand	269	269	0
Total at 1 April 2007	20,131	20,131	0

25.3b Financial liabilities by category

	Total	Other financial liabilities
	£000	£000
NHS creditors	(3,063)	(3,063)
Other creditors	(16,648)	(16,648)
Accruals	(2,130)	(2,130)
Total at 31 March 2008	(21,841)	(21,841)
NHS creditors	(2,280)	(2,280)
Other creditors	(12,551)	(12,551)
Accruals	(3,079)	(3,079)
Total at 1 April 2007	(17,910)	(17,910)

Foreign currency risk

The Trust has no/negligible foreign currency income or expenditure.

25.4 Fair values

For all of the financial assets and liabilities at 31st March 2008 and 1st April 2007 the fair value is equal to the book value.

25.5 Maturity of financial liabilities

	2007/08 £000	1 April 2007 £000
Less than one year	(21,841)	(17,910)
Total	(21,841)	(17,910)

26. Losses and special payments

There were 46 cases of losses and special payments totalling £119,992 paid during 2007/08.

Note: The total costs included in this note are on a cash basis and will not reconcile to the amounts in the notes to the accounts which are prepared on an accruals basis.

[Back page picture](#): We are passionate about improving our services for patients. During the year we listened to our staff and patients about what is important to them. From this we developed the 'Christie Values Card' which is now worn with pride by our staff.



Christie Hospital

NHS Foundation Trust

Christie Hospital NHS Foundation Trust, Wilmslow Road,
Manchester, M20 4BX, United Kingdom

Tel: 0845 226 3000 Fax: 0161 446 3977
Email: enquiries@christie.nhs.uk Web: www.christie.nhs.uk